

<b>A</b>	<b>Airway</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• For any signs of airway obstruction.</li> <li>• For evidence of mouth/neck/swelling/haematoma.</li> <li>• For security of artificial airway.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• For noisy breathing e.g. gurgling, snoring or stridor.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• For the presence of air movement.</li> <li>• For security of artificial airway.</li> </ul>
<b>B</b>	<b>Breathing</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• At the chest wall movement, to see if it is normal and symmetrical.</li> <li>• To see if the patient is using their neck and shoulder muscles to breathe (accessory muscles).</li> <li>• At the patient to measure their respiratory rate.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• To the patient talking to see if they can complete full sentences.</li> <li>• For noisy breathing e.g. stridor, wheezing.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• For the position of the trachea to see if it is central.</li> <li>• For the surgical emphysema or crepitus.</li> <li>• If the patient is diaphoretic (sweaty).</li> </ul>
<b>C</b>	<b>Circulation</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• At the skin colour for pallor and peripheral cyanosis.</li> <li>• At the capillary refill time.</li> <li>• At the patient's central venous pressure and jugular venous pressure.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• To the patient for complaints of dizziness and headaches.</li> <li>• For patient's blood pressure and heart sounds.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• Your patient's hands and feet to see if they are warm or cold.</li> <li>• Your patient's peripheral pulses for presence, rate, quality, regularity and equality.</li> </ul>
<b>D</b>	<b>Disability</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• At the level of consciousness.</li> <li>• For facial symmetry, abnormal movements, seizure activity or absent limb movements.</li> <li>• At pupil size, equality and reaction to light.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• To patients response to external stimuli and pain.</li> <li>• For slurred speech.</li> <li>• For patient's orientation to person, place and time.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• For patient's response to external stimuli.</li> <li>• For muscle power and strength.</li> </ul>
<b>E</b>	<b>Exposure</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• For any bleeding e.g. investigate wounds and drains that may be hidden by bed clothes.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• For air leaks in drains.</li> <li>• For bowel sounds.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• The patient's abdomen.</li> </ul>
<b>F</b>	<b>Fluids</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• At the observation and fluid charts, noting the fluid input and output.</li> <li>• At losses from all drains and tubes.</li> <li>• At the amount and colour of the patient's urine and urinalysis results.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• For patient's complaints of thirst.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• The skin turgor.</li> </ul>
<b>G</b>	<b>Glucose</b>	<b>Look</b> <ul style="list-style-type: none"> <li>• At blood glucose levels.</li> <li>• For signs of low glucose, including confusion and decreased conscious state.</li> <li>• At medication chart for insulin and oral hypoglycaemics.</li> </ul>	<b>Listen</b> <ul style="list-style-type: none"> <li>• For patient's complaints of thirst.</li> <li>• For patient's orientation to person, time and place.</li> </ul>	<b>Feel</b> <ul style="list-style-type: none"> <li>• If the patient is diaphoretic (sweaty, cold or clammy).</li> </ul>
<b>Give oxygen</b>		<ul style="list-style-type: none"> <li>• Based on your assessment (above) decide on an appropriate oxygen flow rate or percentage. If in doubt commence on 4L/min on a Hudson mask and increase as indicated by oxygen saturation or patient condition</li> </ul>		
<b>Position your patient</b>		<ul style="list-style-type: none"> <li>• Position your patient to optimise their breathing – usually this is as upright position as possible and as tolerated by the patient.</li> <li>• Place the patient in the left lateral position if they are unconscious but have adequate breathing and circulation and where there is no evidence of spinal injury.</li> </ul>		
<b>Call for help if you can't manage</b>		Establish IV if not present, +/- fluids.		
<b>Never leave a deteriorating patient without a priority management and review plan</b>		Document and communicate clearly: <ul style="list-style-type: none"> <li>• All treatments provided.</li> <li>• Outcomes of treatment implemented.</li> <li>• What care is still required.</li> </ul> The plan should include expected outcomes and when the patient will be reviewed again		