

Text Version- ABCDEFG Algorithm

A	Airway	Look <ul style="list-style-type: none">For any signs of airway obstructionFor evidence of mouth/neck/swelling/haematomaFor security of artificial airway	Listen <ul style="list-style-type: none">For noisy breathing e.g. gurgling, snoring or stridor	Feel <ul style="list-style-type: none">For the presence of air movementFor security of artificial airway
B	Breathing	Look <ul style="list-style-type: none">At the chest wall movement, to see if it is normal and symmetricalTo see if the patient is using their neck and shoulder muscles to breathe (accessory muscles)At the patient to measure to measure their respiratory rate	Listen <ul style="list-style-type: none">To the patient talking to see if they can complete full sentencesFor noisy breathing e.g. stridor, wheezing	Feel <ul style="list-style-type: none">For the position of the trachea to see if it is centralFor surgical emphysema or crepitusIf the patient is diaphoretic (Sweaty)
C	Circulation	Look <ul style="list-style-type: none">At the skin colour for pallor and peripheral cyanosisAt the capillary refill timeAt the patient’s central venous pressure and jugular venous pressure	Listen <ul style="list-style-type: none">To the patient for complaints of dizziness and headachesFor patient’s blood pressure and heart sounds	Feel <ul style="list-style-type: none">Your patient’s hands and feet to see if they are warm or coldYour patient’s peripheral pulses for presence, rate, quality, regularity and equality.
D	Disability	Look <ul style="list-style-type: none">At the level of consciousnessFor facial symmetry, abnormal movements, seizure activity or absent limb movementsAt pupil size, equality and reaction to light	Listen <ul style="list-style-type: none">To patient’s response to external stimuli and painFor slurred speechFor patient’s orientation to person, place and time.	Feel <ul style="list-style-type: none">For patient’s response to external stimuliFor muscle power and strength
E	Exposure	Look <ul style="list-style-type: none">For any bleeding e.g. investigate wounds and drains that may be hidden by bed clothes	Listen <ul style="list-style-type: none">For air leaks in drainsFor bowel sounds	Feel <ul style="list-style-type: none">The patients abdomen
F	Fluids	Look <ul style="list-style-type: none">At the observation and fluid charts, noting the fluid input and outputAt losses from all drains and tubesAt the amount and colour of the patient’s urine and urinalysis results	Listen <ul style="list-style-type: none">For patient’s complaints of thirst	Feel <ul style="list-style-type: none">The skin turgor
G	Glucose	Look <ul style="list-style-type: none">At blood glucose levelsFor signs of low glucose, including confusion and decreased conscious stateAt medication chart for insulin and oral hypoglycaemics	Listen <ul style="list-style-type: none">For patient’s complaints of thirstFor patient’s orientation to person, place and time	Feel <ul style="list-style-type: none">If the patient is diaphoretic, (sweaty, cold or clammy)
Give oxygen		Based on your assessment (above) decide 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.		
Position your patient		<ul style="list-style-type: none">Position your patient to optimise their breathing-usually this is as upright position as possible and as tolerated by the patient.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		
Call for help if you can’t manage		Establish IV If not present, +/- fluids		
Never leave a deteriorating patient without a priority management and review plan		Document and communicate clearly <ul style="list-style-type: none">all treatment provided,outcomes of treatment implementedwhat care is still required The plan should include expected outcomes and when the patient will be reviewed again.		