Basic Assessment: and Alphabet soup!

You can use for all patients!

This topic will review the nurses assessment importance in the assessment of all types of patients that present to ED and also can be used on inpatients.

Let's get Started

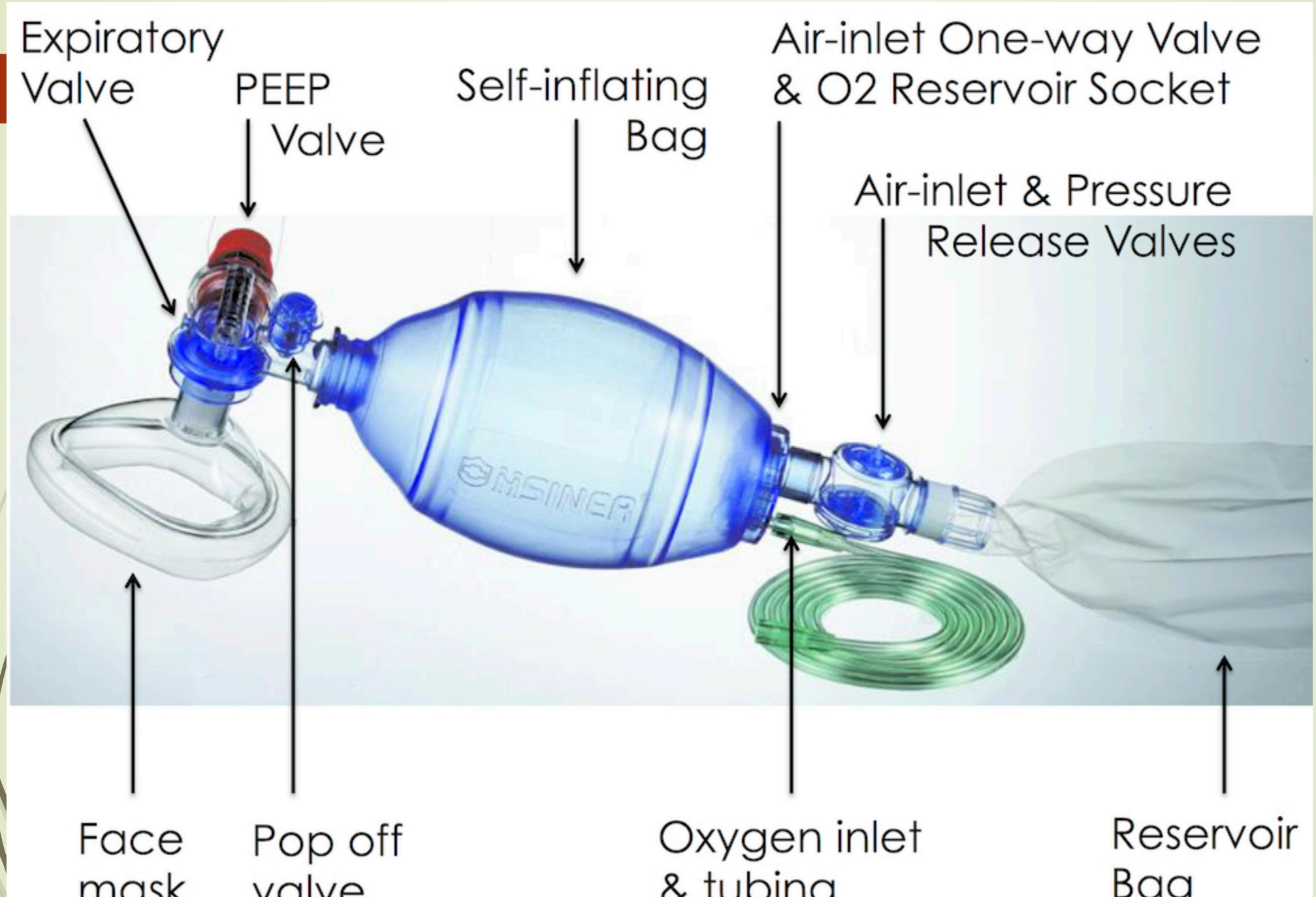
- What do the acronyms mean and do they help!!
- Well Yes they do
- Follow up every patient every time and you won't miss a thing!

- Let's start :

Now A,B,C, D (sing along)

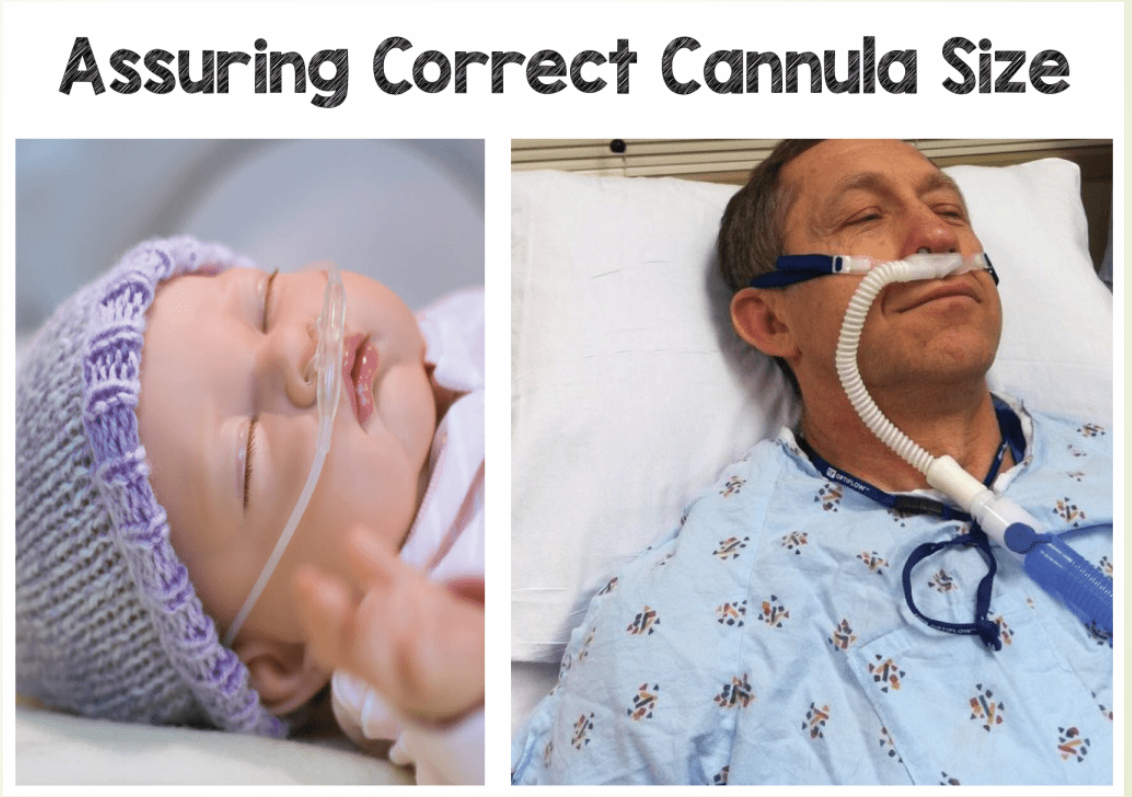
- C AND A together : Bleeding(circulation Obvious bleeding) Stop and control
- Airway and C spine: Look, into the airway, listen for noises, breathing, Feel for air movement: Intervene: How?
- Reposition, Suction, Apply O2, Stop and Bag: Is that easy?
- Jaw thrust and EC Technique

Let’s describe the BVM


Expiratory Valve
PEEP Valve
Self-inflating Bag
Air-inlet One-way Valve & O2 Reservoir Socket
Air-inlet & Pressure Release Valves
Face mask
Pop off valve
Oxygen inlet & tubing
Reservoir Bag

High Flow Oxygen Therapy

Neonatal to Adult



Are we breathing yet??

- For the patient
- Or patient on their own
- How effective are we or they
- Rate and deep of respirations
- Effectiveness: Color improving
- Are we tiring or is the patient tiring?

B: Breathing is it effective??

- Color
- Alert
- Rate and depth
- Is our adjunct working
- Can we move on?

C: Circulation

- Bleeding?
- Color
- Central and peripheral pulses
- If weak or different why?
- Do we need blood, fluids,Oxygen, More cardiac output
- What is the patients chief complaint?

D: Disability

- Neuro status
- Mentation: BS
- Pupils
- GCS Score

Feature	Response	Score
Best eye response	Open spontaneously	4
	Open to verbal command	3
	Open to pain	2
	No eye opening	1
Best verbal response	Orientated	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No verbal response	1
Best motor response	Obeys commands	6
	Localising pain	5
	Withdrawal from pain	4
	Flexion to pain	3
	Extension to pain	2
	No motor response	1

E: Exposure and Environmental Control

Get the patients clothes off, place in gown

All patients get naked!!!

Cover, protect modesty and quick assess the skin

F: Full set of Vital Signs

- This includes Temperature
- Heart rate
- Respiratory rate
- Blood pressure:
- How to take blood pressure: This is when I auscultate one if the patient is sick”

G: Give comfort measure and Get Monitoring devices

- Comfort: Pain, Non pharmacological measures
- Pain medications
- All monitors on, reassess Vital signs
- Blood sugar
- L: IV,labs if not done
- M: Monitor
- Oxygenation: Reassess, Saturation work of breathing, Capnography? Do we need it?
- Depends on patient

H: History

- Why are the here
- What is chief complaint today
- Is it related to prior History: Thanks to electronic health records we can usually find some information
- Findings to cause alarm: Alert provider
- Medications: Have they been taking them and if so when,what and how much
- Diagnostics : What do you anticipate will be needed?
- Help your provider out as you see the patient first and last in most cases.

Inspect and reassess

- Head to toe assessment and don’t forget the backside
- We might notice skin color changes, start of decubiti's ulcer, unkempt hygiene

With each patient each time We will have good out comes

- Diligent by bedside care givers saves patients and hopefully prevents decline.

References

- ENA.org
- American Association of Critical care: AACN.org
- EM rap