

CLINICAL SKILLS: THE 'DR ABCDE' ASSESSMENT

The 'DR ABCDE' approach to assessing an acutely unwell patient should be at the front of every junior doctor's mind whenever they get beeped or asked to see a patient.

Is this patient becoming unwell rapidly? What can I do about it? The first response should be to carry out an A - E assessment and deal with each issue as it is discovered. We have illustrated a basic approach below, and in our other 'acute scenario' pages we will go through special circumstances and specific management plans. The core method of assessing these patients, however, remains unchanged.

Airway, breathing and circulation should all be assessed using the 'look, feel, listen, measure, treat' algorithm. 'Measure' usually involves taking vital observations, as well as bedside investigations and basic imaging. 'Treat' involves administering any urgent treatment to counteract each abnormal finding.

Treat and reassess** at each stage of ABCDE - do not move on to the next stage unless you are satisfied you have optimised any abnormalities you have found. For example, don't assess breathing and circulation if you have found an airway obstruction that hasn't been dealt with! **Vitaly, consider calling for help at EVERY STAGE of this process.

****These tools are for revision purposes only and should be supported by use of National and Local Guidelines****

Wash hands and put on gloves



Shout for help



Approach with care



D: Assess for danger



R: Evaluate patient response



A: Airway

If the patient is talking then the airway is patent

If not - put your face sideways by the patient:

Look for:

- Obstructions in the airway
- Chest movements
- Cyanosis

Feel for:

- Breath on your cheek

Listen for:

- For breath sounds
- Stridor (inspiratory)
- Wheeze (expiratory)
- Gargling

If there is no patent airway - call for help! Give your name, location and the event.

Treat:

- Remove any solid obstructions with Magill forceps
- Remove liquid obstructions with a Yankauer sucker
- Consider airway manuvres such as a head-tilt/chin-lift or jaw-thrust
- If required insert an airway adjunct such as a nasopharyngeal tube or if GCS<8 use a Guedel (oropharyngeal) airway (you should have called for expert by this stage)

Reassess!



B: Breathing

Look for:

- Respiratory distress
- Use of accessory muscles
- Cyanosis
- Gasping, pursed lips, nasal flaring
- Tracheal tug (more common in children)
- Sweating
- Thoracic wounds/scars

Feel for:

- Tracheal deviation
- Asymmetry in chest expansion
- Change in percussion note (?effusion)

Listen for:

- Asymmetry of breath sounds
- Added sounds
- Crepitations in lung bases
- Wheeze

Measure:

- **Pulse oximetry**
- **Respiratory rate**
- Consider an ABG
- Consider a chest radiograph
- Consider a peak flow if asthma related distress

Treat:

- Give 85% oxygen >10 l/min via an oxygen mask and reservoir bag
- If the patient has COPD, give 35% oxygen via a Venturi variable valve mask and reservoir bag until you have an ABG (reassess)
- Aim to keep sats >94% unless known CO2 retainer
- Monitor effectiveness with ABGs
- If anaphylaxis with bronchospasm - consider adrenaline/steroids
- If infection - consider antibiotics
- If wheeze - consider salbutamol
- Consider asking for further help, e.g.: do you need to consider non-invasive ventilation/intubation

Reassess!



C: Circulation

Look for:

- Pallor (anaemia?)
- Visible blood loss
- Cyanosis
- Sweating
- **Jugular venous pressure**

Feel for:

- Peripheral perfusion (is the hand cold?)
- Peripheral capillary refill
- Pulse rate and character
- Peripheral oedema

Listen for:

- Heart sounds (gallop/third heart sound of failure/significant murmur)

Measure:

- **Temperature**
- **Heart rate**
- **Blood pressure**
- **Urine output**
- **Central capillary refill time**

Treat:

- **2 wide bore IV cannulae** in the ante-cubital fossae
- Take bloods as necessary (eg **FBC, U&Es, LFTs, Cross-match, Clotting**, Cultures, Toxicology screen, Calcium, Magnesium)
- IV fluids: fast if signs of shock (250mls stat fluid challenge)
- Blood if active blood loss (if urgent, O -ve until cross-matched blood arrives)
- Antipyrexial medication (paracetamol) if appropriate
- Consider catheterisation, and strict fluid input/output chart

Reassess!

- Take care with fluids in: **cardiogenic shock** (raised JVP, crackles, swollen ankles, sacral oedema), **renal failure** (check U&Es and refer to renal team), **post renal failure**



D: Disability

Consciousness:

- **AVPU: alert/**responds to **voice/**responds to **pain/unresponsive**
- Formal GCS if response impaired
- **Blood glucose level (Don't Ever Forget Glucose!)** - if low give PO/IV glucose, if high consider sliding scale



E: Exposure

- Top to toe examination
- Look for any signs of haemorrhage, bruising, infection, injury, etc.
- Examine for gross neurological deficit
- Check for pupillary response and papilloedema

Next step:

- Continuous reassessment
- Discuss with seniors and ITU (if not already involved)
- Look at patient's notes and charts
- Gather collateral history - 'AMPLE'
 - Allergies
 - Medications
 - Past medical history
 - Last oral intake
 - Events leading up to deterioration
- Review results of routine investigations (including biochemistry, microbiology, haematology, radiology, ECG, ABG)