

### **Apply A to G assessment:**

*Look; listen and feel*

**Airway:** Look for sign of airway obstruction, listen to noisy breathing, feel for presence of airway

**Breathing:** look chest movement, is pt using neck and shoulder muscle to breath, SPO<sub>2</sub>, respiratory rate, rhythm, depth, listen if pt able to speak full sentence, quality of breathing sound (crackles, wheezing); and feel for the position of trachea to see if it is central

**Circulation:** Look for skin colour (pallor), Listen to pt dizziness and headache, BP, chest pain, and feel hand that is it cold or warm, peripheral pulse rate and rhythm

**Disability:** look at the level of consciousness; facial symmetric; abnormal movement; pupil size, equality and reaction to the light; Glasco coma scale GCS; Listen to response of patient to external stimuli and pain; slurred speech; feel the pt response to external stimulation; muscle power; GCS.

**AVPU:** **A**lert; yellow zone If pt risable just by **V**oice, **R**ed zone: pt response to **P**ainful stimulation; the pt is completely **U**nconscious. Also red zone drop 2 or more GTS and GCS = or less than 8.

**Exposure:** look at body temperature (36-37.5 normal and yellow zone: less than 35.5/ Over 38.5); look for any bleeding and investigating wound, abdominal inspection; listening: Auscultation bowel sound, Feel: abdominal palpation

**Fluid:** look: fluid balance chart, noting input and output, amount and colour of urine, check the drain and tubes (IDC); (0.5 per kilo per hour. yellow zone: less than 0.5 or less than 100mL for 4 hours via an IDC); urine more than accepted= Polyuria U/O more than 200 mLs/hour in 2 hours. **Red** zone U/o persist for 8 hours less than 200 mL/over 8 hours or less than <0.5mL/kg hrs via IDC); Mucous membrane; Listen, for pt thirst; feel skin turgor

**Glucose:** Look at BGL, any sign of low glucose, decrease conscious state; a medical chart for insulin and oral hypoglycaemia. Listen: pt thirst; sign of low glucose level, confusion. Feel: if the pt is diaphoretic (sweaty, cold, clammy).

Glucose less than 4 or over 20 mmol/L with no decreased level of consciousness is additional yellow zone but with decreased level of consciousness Red Zone.

hypoglycaemia symptoms:

Feeling shaky.

Being nervous or anxious.

Sweating, chills and clamminess.

Irritability or impatience.

Confusion.

Fast heartbeat.

Feeling lightheaded or dizzy.

Hunger

Blurred/impaired vision

**Thus for hypoglycaemia** experienced pt first giving fast acting carbohydrate (100 mL Lucozade, 150 mL lemonade or other soft drink, 3 tea spone sugar desolve in 50 mL water, 4 small or 7 Large glucose jellybeans, after 15 minutes check the BGL if greater than 4

serve slow acting carbohydrate (250 mL Milk, 200 mg yogurt, 1 slice bread, 2 sweet plains biscuits, and next meal serve by 30 minutes.

### **Why A-G assessment is important for nurses and patients?**

A-G assessment regularly help nurses detect any pt deterioration and changes and ensure pt safety and promote and provide care to the pts.

### **Why we have Airway first? (10-25 consider between flag)**

Basic airway assessment is a priority before any other assessment because an ineffective airway can be life-threatening within minutes and should be treated immediately.

### **Basic airway management?**

Involve the implementation of a variety of simple interventions aimed at opening and maintaining the patency of the patient's airway. such as suctioning the airway, relaxation of tung. If pt conscious seat upright.

### **What is pulmonary clinical emergency response system?**

Three colours:

*Yellow*: Medical review and repeat observations at 30 minutes. Talk to senior or nurse in responsse

*Red and blue* both terms that are often used to refer to a cardiopulmonary arrest and immediate rapid response and must review aim 10 minutes.

### **Types and oxygen aid:**

Nasal prongs (1-4 L/min 24/ 40%)

Simple face mask (hudson) (5-10 L/ min 40/ 60%)

Venturi mask (dependent on attachment 24/ 50%)

Non-breather mask (10-15 L/ min 40/90%)

### **Notice:**

Increasing oxygen requirement is an additional YELLOW ZONE criteria

Increasing oxygen requirements to maintain SpO<sub>2</sub> > 90% is an additional RED ZONE criteria

### **Chest pain Assessment?**

(PQRST)

Provoking factors: What factors or activities provoking pain (e.g. exercise, argument, resting)

Quality of pain: what does the pain feel like (pressure, aching, squeezing, heaviness)

Radiation and region: where is the pain located \, does pain radiate to other areas. (Back, neck, arms, jaw, shoulder, elbow)

Severity of pain: one a scale of 0-10 o no pain and 10 being the most severe pain, what number would you give the pain.

Time: When did the pain began? Has the pain change since this time? Have you had pain like this before?

**Notes:**

While on the Standard adult general observation (SAGO) chart the accepted between the flags range for BP is between 100-180mmHg, which pressure is trigger for calling criteria based on?

*Systolic blood pressure (SBP)*

What do you think is the accepted range for HR to be between the flags on the SAGO chart is between what range?

*50-120*

**ISBAR:**

Introduction: Hi, my name is ... I've been a nurse looking after pt; He is 65 male.

Situation: He presented ED yesterday with shortness of breath, reduce mobility and lethargy, he has been admitted under the medical team for investigation.

Background: His medical history include Diabetic, Hypertension and high cholesterol.

Assessment: This morning he was stable and his OBS are between flag, he hasn't got any complains pain, but this morning we had called a clinical review for HR of 125, medical officer consider him to be slightly dehydrated and then prescribed 500mL saline IV over an hour and then the remaining for 500mL for 10 hours.

Recommendation: He is waiting for physio review for his mobility, the medical team will review him after that, and he may be able to go home after that.

**As a scenario case study pt has signs of deterioration include SPO2 91% respiratory rate high, temp 38 Which action should you as the RN take?**

Initiate appropriate bedside clinical care, help pt seat upright,

Repeat observations and increase their frequency, Temp, SPO2, Respiratory rate

Nurses must not delay and wait, Consult the nurse-in-charge promptly to decide whether to call for a clinical review

Full handover using ISBAR highlighting her concern about yellow zone observations and additional Criteria.

Till medical review Perform an A-G assessment and observations

## Multi-disciplinary fluid + electrolyte imbalances? And nurses responsibility?

- . It can be deficit or excesses
  - . Managing deficit involving correction and underlying causes and replacement both water and electrolytes
  - . Management depend on the severity and types of volume loss. E.g. IV macro 20; micro 60 normally use 0.9% sodium chloride.
  - . Management of fluid excess involving treatment and underlying causes and removing fluid. E.g. diuretic drugs, sodium restriction in their diet.
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- Fluid restriction: pt needs to know why they have a fluid restriction, how much they can have with each meal (morning and afternoon 7 to 3 while most medication taking during that time), involve pt in their decision making for their health, mouth care rational: as decrease risk of dry mucous membrane and maintain pt comfort.
  - Daily weight: as the increase of one kilo can consider 1-kilo fluid retention, then we weight them at the same time everyday and same weight scale.
  - Fluid balance charting: intake it and output. Intake such as oral, input IV fluids, and output such as urine, wound, tube drainage, also urine amount and colour, urine specific gravity which should be low and if high specific gravity (e.g. increase concentration of solution in the urine) maybe associated with dehydration, diarrhea, vomiting (emesis), decrease blood flow to kidney, UTI/ bladder infection, ...
  - Physical assessment + vital signs: Perform A-G assessment, e.g. in fluid deficit palpate pulse might be weak and assess for change position lying to seating. Also Auscultate lung sound, fluid excess can cause pulmonary oedema (congestion), and pt will experience shortness of breath and crackling noise in auscultation. Other hand pt with fluid deficit can demonstrate increase respiratory rate and result in hypoxia
  - skin: we need to really protect oedema's skin for extremes of heat and cold for long pressure and trauma, skincare change position, moisturising the skin. \_\_Oedema: build-up of fluid causes affected tissue to become swollen, skin turgor monitoring by skin pinch normally forearm in fluid deficit skin turgor diminished, just notice in elderly as physiology and losing elastic tissue is difficult to distinguish as fluid deficit. Thus need frequently skin care and change position, in order to prevent skin break down. application of oil and moisturising can help protective skin in general.
  - Safety when mobility: fluid deficit can change the level of consciousness pt muscle strength, fall risk, therefore need educate the pt to how rise, sit and slowly change the position or how come to edge of bed and educate them to standing up and walking safety.

## What is Cannula?

A Peripheral Intravenous Catheter PIVC is a small flexible tube that insert through the skin into peripheral vein. Able to administration of range of therapy such as medication and fluid directly to vein-stream, which cant given orally or will be less effective