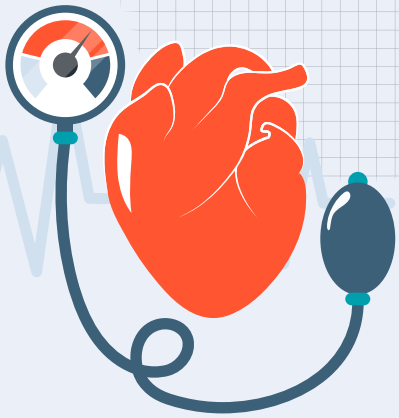
A-E assessments& SBAR

OSCE revision by Humza Awan



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Structure of session

Introducing the A-E assessment OSCE station
My approach to these stations (helped me get 100% in my assessment stations)
SBAR handover made easy
Work through some scenarios together as a group
Questions

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The assessment OSCE station

2 minutes to read vignette
8 minutes for station
6 minutes to do the assessment
At 2 minutes handover to examiner

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Structure of assessment

01
Brief focused questions

- Establish what happened
- Risk factors/PMH
- AMPLE for trauma
- Can continue asking more questions throughout A-E

02
A-E assessment

- Aim is to manage the patient effectively and safely
- They expect you to do each action before they give you the finding eg. put on the sats probe etc
- Try not to focus too much on what the diagnosis is

03
SBAR

- Keep it brief and to the point
- Justify your reasoning

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A-E

Airway
Breathing
Circulation
Disability
Exposure

Common acute scenarios e.g Anaphylaxis, sepsis, Asthma/COPD exacerbation, MI, Bowel obstruction etc – back of cheese and onion book

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How to structure each section of A-E

Relevant obs

B - RR, O2 sats
C- CRT, BP, pulse/HR
D- BG, Temp, AVPU

Look, Feel, Listen

Focused exam of each section, LFL

Treat as you go

Reassess after every intervention and justify each Ix.

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Airway

Exam

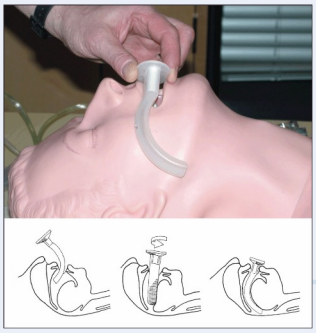
If patient talking = patent

If not LFL:
Look for obvious secretions/obstructions that can be removed
Feel – airway manoeuvres
Listen for abnormal BS eg. stridor/audible wheeze

Ix/Mx

Airway adjuncts – NP/OP
If tolerating OP not a good sign

ESCALTE EARLY !!!!
Airway concern – anaesthetics/ITU reg
Medical concern – med reg/your consultant
Surgical concern – surgical reg
2222 peri-arrest if you need more people asap



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Breathing

Obs

RR and O2 sats

Exam

Look for any cyanosis and chest rise
Feel for expansion, trachea and percuss
Listen for air entry and added breath sounds

Do the actions as you are saying it
"Are there any abnormalities ?"

Ix/Mx

Low O2 sats – 15 L of ox NRB – reassess obs before moving on to next section
ABG – RF, CO2, Lactate
Portable chest x-ray – e.g pneumonia, effusion etc
CTPA if suspecting PE

Pneumonia – Abx referring to local guidelines
Asthma/COPD – Salbutamol & ipratropium nebs back to back
Tension Pneumothorax – Needle decompression 2nd ICS MC line
Anaphylaxis – IM 500 micrograms 1:1000 Adrenaline

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Circulation

Tip: you may be handed results to interpret. Key is to mx pt safely - escalate

Obs	CRT, BP, Pulse/HR
Exam	Look for any scars or pacemakers, Feel for apex beat Listen for HS and murmurs "Are there any abnormalities ?"
Ix/Mx	ECG – STEMI, AF, Pericarditis, sinus tachycardia Insert 2 IV wide bore cannula and take bloods from it– FBC for anaemia and WC for infection, CRP for infection, U&Es and LFTs for electrolytes, baseline kidney and liver function, VBG for lactate, Blood cultures for sepsis/IE, G&S and crossmatch for blood products/surgery - specific tests eg. Troponin for MI etc Low BP – 500ml saline over 15 min– reassess obs before moving on to next section ECHO – If any murmurs, reduced HS
	Major haemorrhage protocol if sig bleeding/HB <70 need blood products If shocked (high HR low BP) with raised infection markers/lactate – sepsis 6

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Disability

Tip: you may be handed results to interpret. Key is to mx pt safely - escalate

Obs	Glucose, AVPU/GCS (remember GCS <8 intubate), temp
Exam	Look at pupils PEARL, any agitation Feel for any focal neurology and weakness/numbness Listen to patient ask about drug/alcohol hx if relevant, review drug chart for any allergies/contraindications
Ix/Mx	Don't ever forget glucose–hypos, DKA etc Consider toxicology screen if relevant Look for sources of infection if concerned about sepsis eg. urine dip Acute confusion – infection/UTI
	Alcohol abuse - pabrinex Status epilepticus mx – lorazepam DKA – fluid resus Hypo – oral glucose if conscious IV glucose 20% in 100ml over 15 min if not Parcetamol OD – LFTs, paracetamol levels/staggered OD - NAC

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Exposure

	Everything else – expose the patient fully
Exam	Look for any rashes, bleeding, bruising, fractures, swelling/oedema, sources of pain/tenderness, wounds Feel abdomen – SNT ? Guarding/peritonitis = surgical Listen for bowel sounds
Ix/Mx	Erect CXY & CT abdomen - bowel perforation/obstruction – rigid peritonitic abdomen haemounstable, reduced BS FAST SCAN – US abdomen any fluid/ascities/abdominal trauma Ascitic tap/drain for ascities Swabs of infected wounds X-ray for fractures
	Analgesia for any pain if haven't given already NBM if bowel obstruction/perf concern Non blanching rash – meningococcal septicaemia - Abx Surgical review Diuretics for fluid overload – IV furosemide

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Questions so far ?

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SBAR – Short, sweet, simple

Situation

I'm an F1 in ED and would like you to come see a pt who I am concerned may be.... E.g septic

Background

They came in with...
On a background of...

Assessment

On assessment positive findings were...
Relevant negative findings were...

Recommendation

I am concerned the patient is...
I have done ...
Is there anything else you would like me to do in the meantime ?

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Scenario 1

You are an F1 in ED
56 yr old male presents to ED with severe central chest pain for the past few hours. Please perform an A-E assessment and at 6 minutes handover the patient to your senior

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Scenario 1

What quick focused questions can we ask to narrow down the differentials ?

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A-E

Airway
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A-E

Airway	Patient talking airways patent
Breathing	
Circulation	
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	CRT 3 seconds BP 132/92 HR 112 regular HS 1+2+0
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	CRT 3 seconds BP 132/92 HR 112 regular HS 1+2+0 Troponin
Disability	
Exposure	

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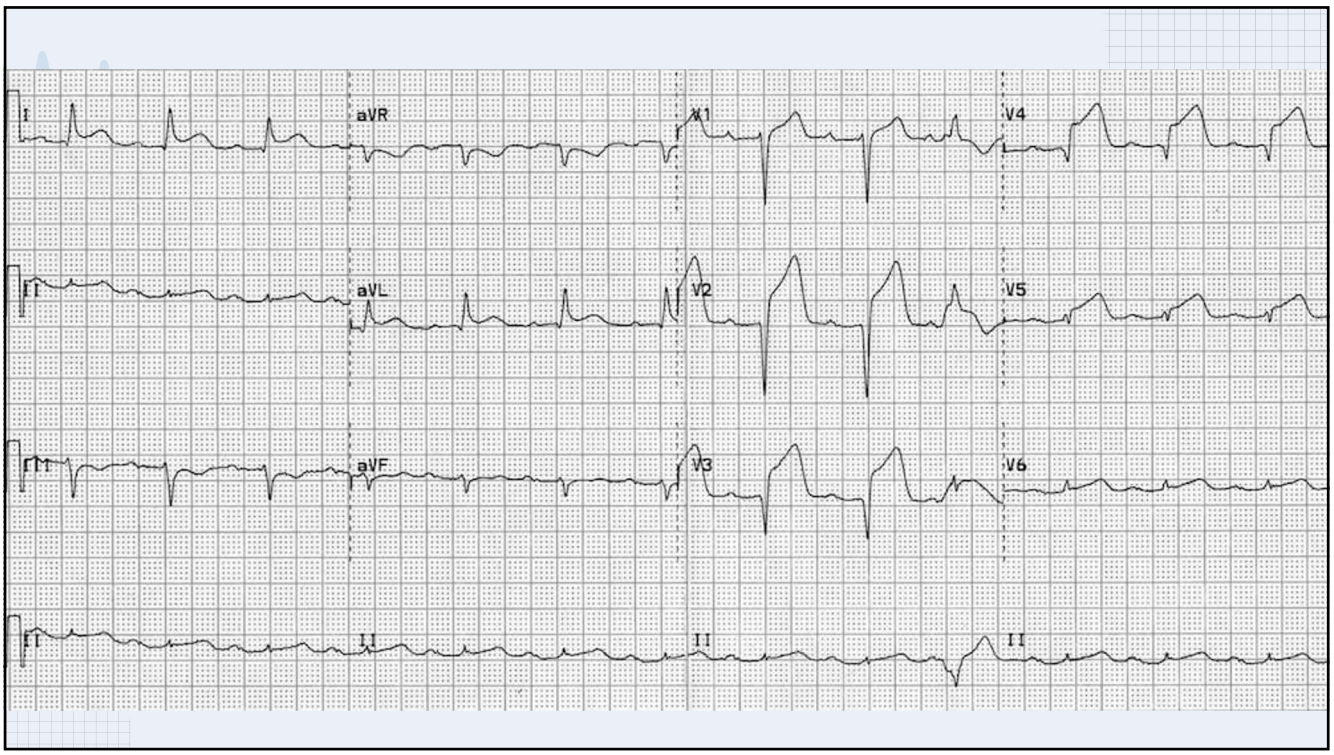

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	CRT 3 seconds BP 132/92 HR 112 regular HS 1+2+0 Troponin PCI
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	CRT 3 seconds BP 132/92 HR 112 regular HS 1+2+0
Disability	PEARL Glucose: 7 Temp: 36.1
Exposure	

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A-E

Airway	Patient talking airways patent
Breathing	Ox 92% RR 18 no abnormal BS
Circulation	CRT 3 seconds BP 132/92 HR 112 regular HS 1+2+0
Disability	PEARL Glucose: 7 Temp: 36.1
Exposure	Abdomen SNT, no rashes, Pt sweating profusely

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Scenario 1

What are we concerned about ?

What are the key positive and negative findings we want to handover ?

What have we done and what is our recommendation for what needs to happen next ?

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Scenario 2

You are an F1 in ED
47 yr old female presents with severe central abdominal pain. Please perform an A-E assessment and at 6 minutes handover the patient to your senior

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Scenario 2

What quick focused questions can we ask to narrow down the differentials ?

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A-E

Airway
Breathing
Circulation
Disability
Exposure

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	
Circulation	
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	CRT 3 seconds BP 90/72 HR 109 regular HS 1+2+0
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	CRT 3 seconds BP 90/72 HR 109 regular HS 1+2+0 Lactate: 3
Disability	
Exposure	

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	CRT 3 seconds BP 90/72 HR 109 regular HS 1+2+0
Disability	PEARL Glucose: 8 Temp: 36.1
Exposure	

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	CRT 3 seconds BP 90/72 HR 109 regular HS 1+2+0
Disability	PEARL Glucose: 8 Temp: 36.1
Exposure	Horizontal C-section scar, Abdomen distended, rigid and tender all over, Tinkling BS

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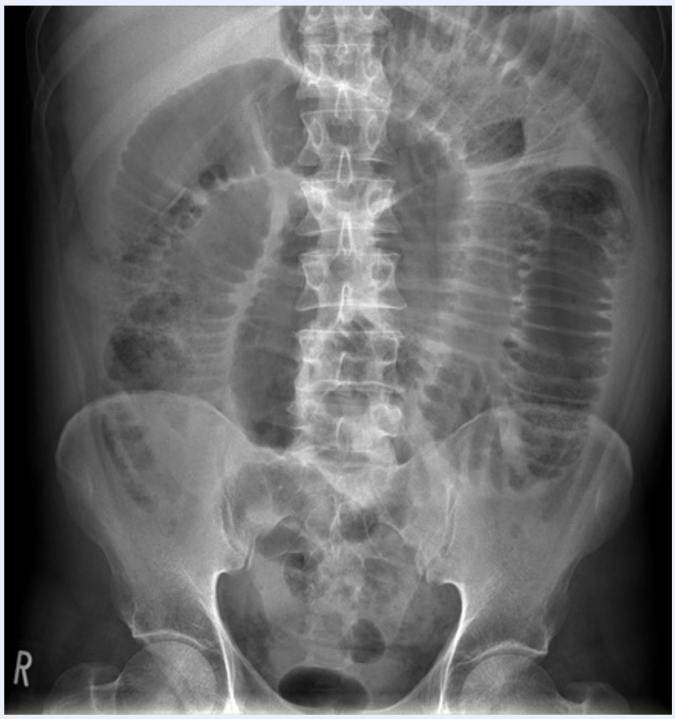

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A-E

Airway	Patient talking airways patent but is actively vomiting
Breathing	Ox 94% RR 22 no abnormal BS
Circulation	CRT 3 seconds BP 90/72 HR 109 regular HS 1+2+0
Disability	PEARL Glucose: 8 Temp: 36.1
Exposure	Horizontal C-section scar, Abdomen distended, rigid and tender all over, Tinkling BS NBM, Fluids + NG – surgical review

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Scenario 2

What are we concerned about ?

What are the key positive and negative findings we want to handover ?

What have we done and what is our recommendation for what needs to happen next ?

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Resources

Condition	A-E Approach	Specific Management	Escalation	Key Differentials
Anaphylaxis	A: Airway compromised – 2222 peri-arrest call – initiate management – remove trigger (if applicable), 500ug (0.5mg) adrenaline IM (1:1000) (0.5ml), chlorphenamine 10mg IV/IM, hydrocortisone 200mg slow IV B: High flow O2 Consider ABG C: IV fluid bolus – 500-1000mL 0.9% NaCl over 15 minutes D: Drug chart – check for allergies E: Further Ix: 2 blood samples for mast cell tryptase (ideally 1st within 30 mins and 2nd within 2 hours)	Call peri-arrest 2222 and bring resus trolley Record time and immediate circumstances beforehand Position flat if hypotensive or sitting if comfortable Remove any trigger Adrenaline 500ug (0.5mg – 0.5ml) (1:1000) IM (can repeat after 5 mins if no response) Consider intubation High flow O2 via non-rebreathe Chlorphenamine 10mg slow IV / IM (can repeat up to 4x) Give cetirizine if persisting skin symptoms (non-sedating) – 10mg PO Hydrocortisone 200mg slow IV – **not routine** IV fluids – crystalloid (colloid risks anaphylaxis) Add allergen to notes Consider inhaled salbutamol or ipratropium therapy if the person is wheezy (especially in people with known asthma)	2222 peri-arrest call	Stridor: Foreign body Peritonsillar abscess Croup Epiglottitis Mass obstruction Other acute dyspnoea: Acute asthma ECOPD Pulmonary oedema

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Questions ?

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Feedback Form

Thank you for attending this session

Please fill in the feedback form :
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