# The ABCs of Health - Review

Use this sheet as a review of the different mnemonics and acronyms presented during the session!

**Pre-admission**

- F.A.S.T (for suspected stroke)
    - Face (drooping, asymmetry)
    - Arm weakness (ask to raise their arms and observe for dropping of arm)
    - Speech/stability (watch for stumbling and falls, slurred or confused speech)
    - **Time to call 911**

**Prioritization**

- CTAS
    - Level 1 - Resuscitation: immediate threat to life or limb, requiring aggressive intervention
    - Level 2 - Emergent: cases that are a potential threat to life, limb or function, requiring rapid care. Could deteriorate and escalate to a level 1.
    - Level 3 - Urgent: cases that could progress to a severe problem if not treated, often with significant pain or discomfort
    - Level 4 - Less urgent: cases that are generally linked to age, distress or that have the potential for deterioration, which would benefit from treatment within 1 to 2 hours
    - Level 5 - Non-urgent: cases where intervention can be delayed or referred to other areas within the hospital or to other health care systems

**History**

- SAMPLE
    - Signs and symptoms (signs are observed, symptoms are felt)
    - Allergies (including reaction to the allergens)
    - Medications (prescription, over the counter, supplements, drugs and alcohol)
    - Past medical history of illness, surgery and injury (including family history)
    - Last oral intake (medication, food, drinks. May also ask about general diet)
    - Environment and events leading up to injury

**Assessment**

- Vitals: Temperature-Pulse-Respiration rate-Blood Pressure-Oxygen saturation
    - Normal temperature: 36.5-37.5°C
    - Normal pulse: 60 to 100 bpm
    - Pulses are rated from 0 to +3. +2 is the normal rating
    - Normal respiration rate: 12 to 20 respirations per minute
    - Normal blood pressure: 120/80
    - Normal oxygen saturation: 95 to 100%

- PERRLA
    - Pupils are
    - Equal
    - Round
    - Reactive to
    - Light and
    - Accommodation
- OPQRSTU
    - Onset (what were you doing when it started? When did it start)
    - Palliating and Precipitating factors (what makes it worse? better?)
    - Quality (what does it feel like)
    - Region and Radiating (where does it hurt)
    - Severity (Scale)
    - Timing (is it constant or intermittent? How long has it been lasting for?
    - Understanding (how does it affect you? Do you have an idea what might be causing it?)
- IPPA/AIPP
    - Inspection (visual)
    - Palpation (feel)
    - Percussion (listening for dull vs resonant sounds - hollow, dense, fluid and air)
    - Auscultation (listening with a stethoscope to body sounds)
    - ** Always auscultate the abdomen **before** touching it as to not create false bowel sounds **

**Documentation/Communication**

- SOAP documentation
    - Subjective (patient narrative)
    - Objective (provider observations)
    - Assessment (synthesis of findings, possible diagnosis)
    - Plan (Treatment, referrals, follow-up)
- SBAR
    - Situation (current patient concern)
    - Background (patient history and information related to concern)
    - Assessment (what you believe is happening)
    - Recommendation (specific request)