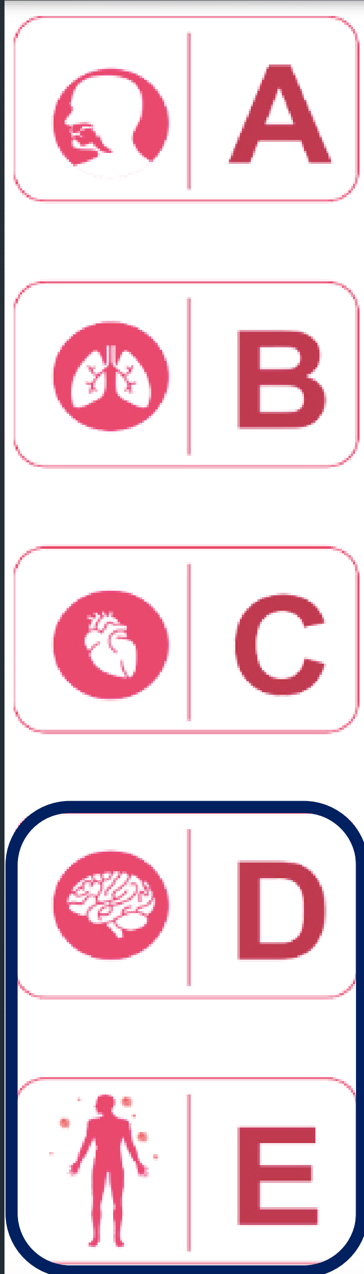


A-E Assessment

Disability & Exposure

Katie Quinn
Clinical Practice Educator
Neuro Critical Care
Leeds Teaching Hospitals NHS Trust

Pre-course assessment - Mentimeter

Disability

- Level of consciousness
- Delirium
- Pain
- Blood glucose

Level of consciousness: AVPU

A	**Alert** • Fully awake
C	**Confusion (new)** • New-onset or worsening confusion
V	**Voice** • Responds to verbal stimulus
P	**Pain** • Responds to pain stimulus (e.g. supra-orbital pressure)
U	**Unresponsive** • No response to verbal or pain stimulus

Level of consciousness: GCS

Glasgow Coma Scale		
Response	**Scale**	**Score**
Eye Opening Response	Eyes open spontaneously	4 Points
	Eyes open to verbal command, speech, or shout	3 Points
	Eyes open to pain (not applied to face)	2 Points
	No eye opening	1 Point
Verbal Response	Oriented	5 Points
	Confused conversation, but able to answer questions	4 Points
	Inappropriate responses, words discernible	3 Points
	Incomprehensible sounds or speech	2 Points
	No verbal response	1 Point
Motor Response	Obeys commands for movement	6 Points
	Purposeful movement to painful stimulus	5 Points
	Withdraws from pain	4 Points
	Abnormal (spastic) flexion, decorticate posture	3 Points
	Extensor (rigid) response, decerebrate posture	2 Points
	No motor response	1 Point

Level of consciousness: RASS

Richmond Agitation-Sedation Scale

Target RASS Value		RASS Description
+4	Combative	Combative, Violent, Immediate Danger to Staff
+3	Very Agitated	Pulls or Removes Tube(s) or Catheter(s); Aggressive
+2	Agitated	Frequent non-Purposeful Movement, Fights Ventilator
+1	Restless	Anxious, Apprehensive but Movements are not Aggressive or Vigorous
0	Alert and Calm	
-1	Drowsy	Not Fully Alert, but has Sustained Awakening to Voice (Eye Opening & Contact >10sec)
-2	Light Sedation	Briefly Awakens to Voice (Eye Opening & Contact <10sec)
-3	Moderate Sedation	Movements or Eye Opening to Voice (BUT NO Eye Contact)
-4	Deep Sedation	No Response to Voice, BUT has Movement or Eye Opening to Physical Stimulation
-5	Unarousable	No Response to Voice or Physical Stimulation

Assessing sedation on ICU using RASS (Richmond Agitation Sedation Scale) - YouTube

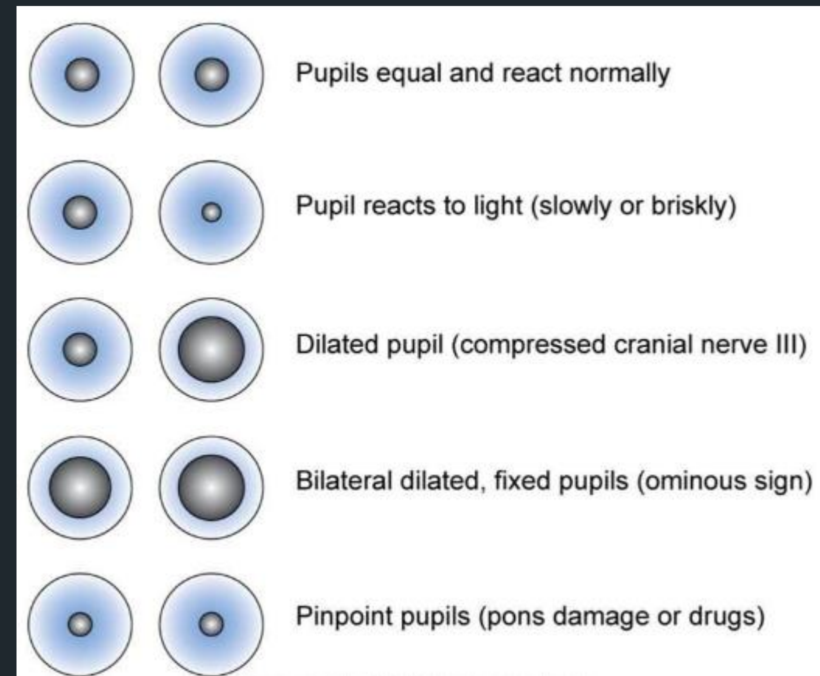
Pupil Assessment

Size - average is 2-5mm.

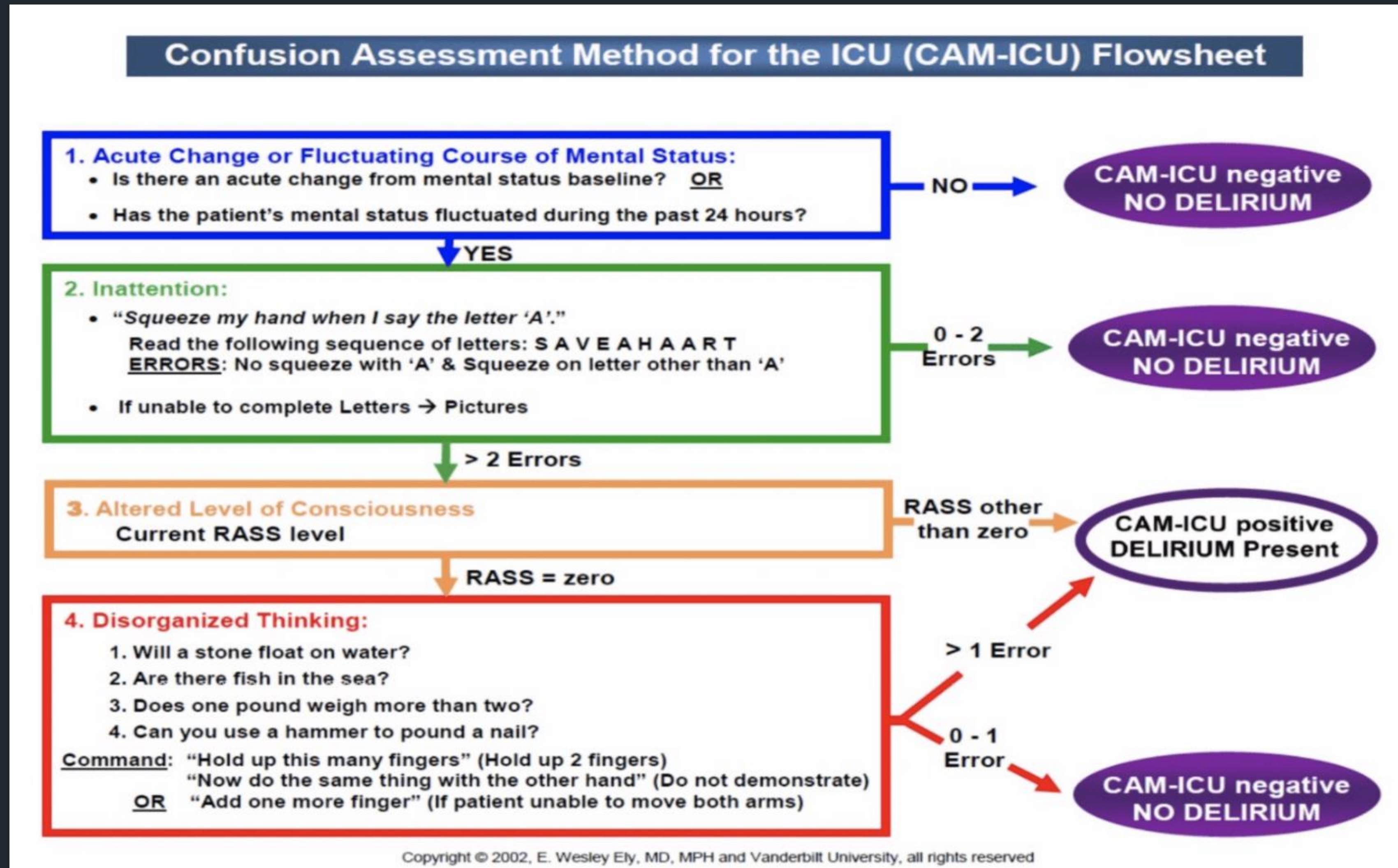
Shape - should be round

Symmetry - both pupils should be the same size & shape

Reactivity to light - should be brisk, and after removal of the light source the pupil should return to its original size.



Delirium



[CAM ICU Training Video - YouTube]

Documentation

- Patient diary commenced for appropriate patients (locally determined)
- Daily update in nursing records relating to 'DREAMS' elements, including plan of care and evaluation
- Provision of information relating to delirium for patients and relatives following admission

Rehabilitation

- To be commenced early (NICE CG83, QS158) including assessment, goal setting and structured programme, early mobility flowchart. Audit programme established to assess compliance
- Reviewed by physiotherapist at least 5 days per week
- Daily activity/mobility record 7 days per week

Early Identification

- Assessment for delirium using CAM-ICU tool 3 times per day and on change of condition

Aids to Communication

- Hearing aids' spectacles available as appripriate.
- Condider barriers to effective communication and implement strategies to overcome e.g translation services

Medication

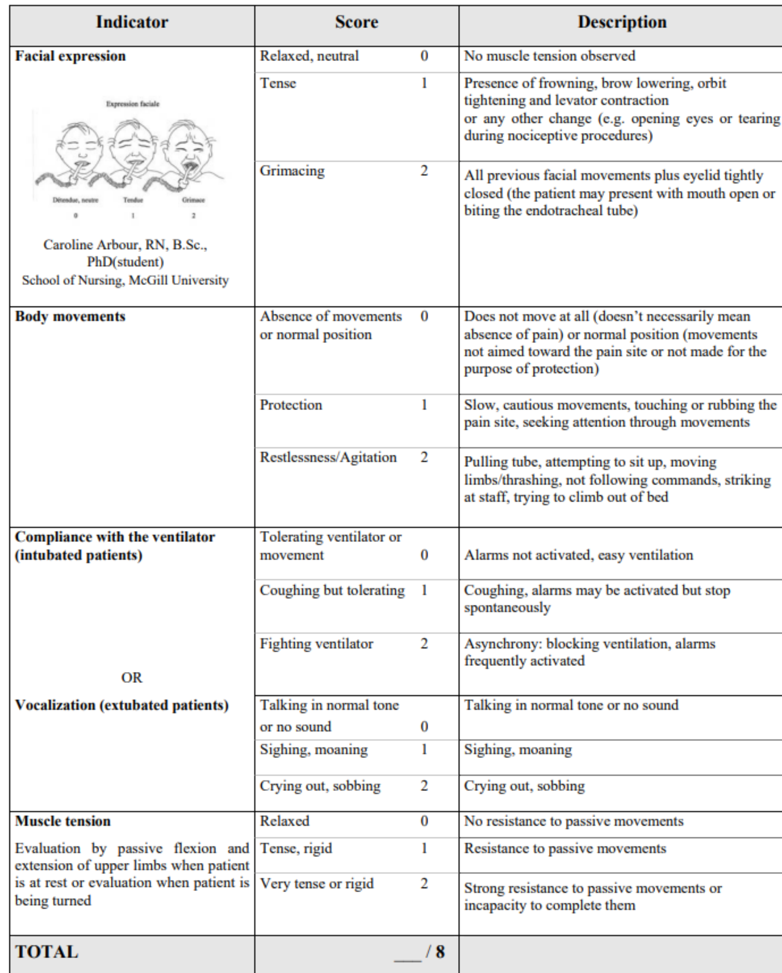
- Assess sedation using Richmond Agitation Sedation Score (RASS) as a minumum 4 hourly, utilising local sedation and pain assessment protocol
- Daily review of sedation including setting target RASS and/or daily sedation hold
- Daily (Mon - Fri) review of prescription by critical care pharmicist to ensure effective prescribing practices.
- Medication review on admission and discharge to promote effective medicines reconcilliation

Sleep Bundle

- Reduce light and noise between 2300hrs and 0700hrs to promote sleep
- Offer eye mask and ear plugs to patients who can tollerate
- Group care interventions to minimise disturbance

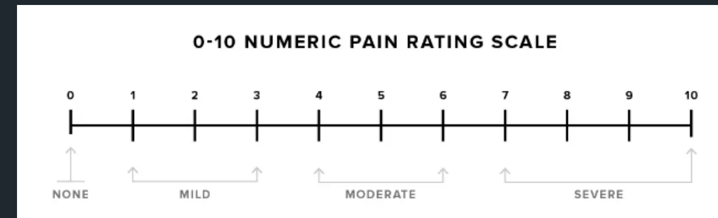
West Yorkshire
Critical Care & Major Trauma
Operational Delivery Networks

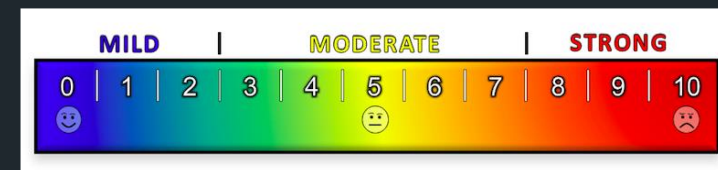
Pain



The Critical-Care Pain Observation Tool (CPOT)
(Gélinas et al., 2006)

Indicator	Score		Description
Facial expression	Relaxed, neutral	0	No muscle tension observed
	Tense	1	Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)
Caroline Arbour, RN, B.Sc., PhD(student) School of Nursing, McGill University	Grimacing	2	All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)
Body movements	Absence of movements or normal position	0	Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness/Agitation	2	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement	0	Alarms not activated, easy ventilation
	Coughing but tolerating	1	Coughing, alarms may be activated but stop spontaneously
OR	Fighting ventilator	2	Asynchrony: blocking ventilation, alarms frequently activated
Vocalization (extubated patients)	Talking in normal tone or no sound	0	Talking in normal tone or no sound
	Sighing, moaning	1	Sighing, moaning
	Crying out, sobbing	2	Crying out, sobbing
Muscle tension	Relaxed	0	No resistance to passive movements
Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned	Tense, rigid	1	Resistance to passive movements
	Very tense or rigid	2	Strong resistance to passive movements or incapacity to complete them
TOTAL		___ / 8	



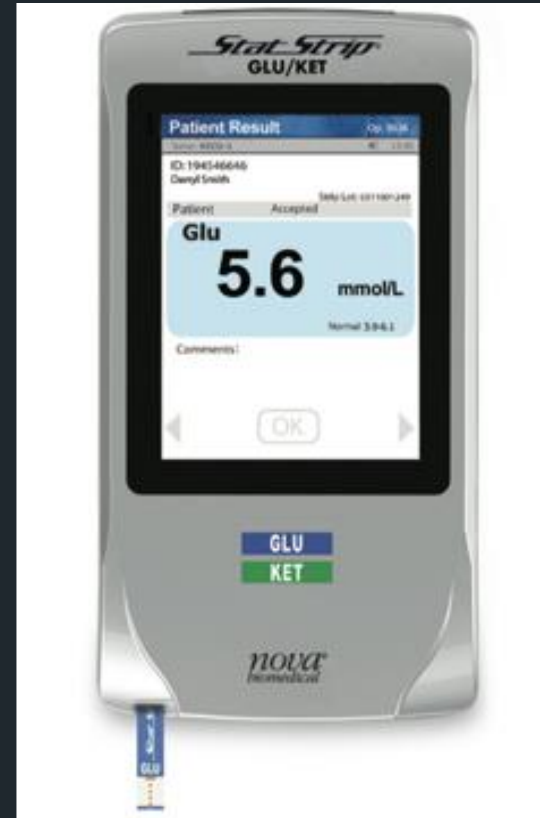


Blood glucose

Measurement report

16.02.17 09:10
Serial number : 4500
Instrument ID : QF4500
Operator ID : DR.ABG
CCU Local District Hospital

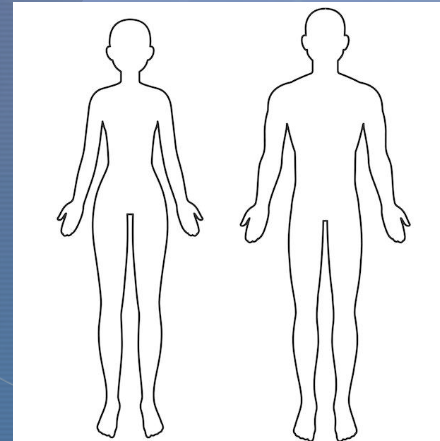
Pat. ID	047328	
Patient Name	Mr. White	
Date of birth	03.05.72	
Remark	Room Air	
FIO_2	0.21	
Temperature	37.0 °C	
pH	7.390	[7.350 – 7.450]
pCO_2	4.99 kPa	[4.67 – 6.00]
pO_2	12.25 kPa	[10.67 – 13.33]
$cHCO_3^-$	24.0 mmol/L	[22 – 26]
BE	0.7 mmol/L	[-2.0 – +2.0]
Na^+	140.0 mmol/L	[135.0 – 148.0]
K^+	3.90 mmol/L	[3.50 – 4.50]
Cl^-	100.0 mmol/L	[98.0 – 107.0]
Ca^{2+}	1.200 mmol/L	[1.120 – 1.320]
Hct	40.0 %	[35.0 – 50.0]
tHb	130.0 g/L	[120.0 – 150.0]
COHb	1.0 %	[0.5 – 2.5]
O_2Hb	97.0 %	[95.0 – 99.0]
MetHb	1.0 %	[0.4 – 1.5]
SO_2	99.0 %	[75.0 – 99.0]
Glu	4.0 mmol/L	[3.3 – 6.1]
Lac	1.0 mmol/L	[0.4 – 2.2]

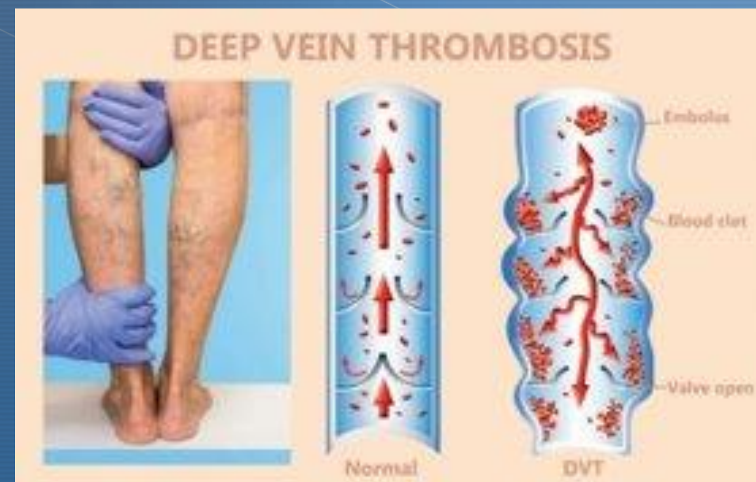


Pre-course assessment - Mentimeter

Exposure

- Head to toe visual inspection
- Eyes & mouth
- Skin
- Lines
- Drains
- Bowels
- Feeding
- Calves
- Temperature





Collaborative Regional Benchmarking Group

Eye Care in Critical Care

Aim: To provide guidance on nursing care for the eyes of patients in Critical Care
Scope: All adult patients in Critical Care

ASSESS EYES / PATIENT

- Within **2hours** of admission
- At least **12hourly** thereafter

PATIENT AWAKE & ABLE TO BLINK

- Allow patient to perform own eye care (or with assistance when required) by cleaning eyes as part of the patient facial wash or at patients request.
- If eye become sticky or encrusted use sterile gauze and sterile water

Seek senior medical / ophthalmology advice for patients with eye disease, infection or injury, including post-op surgery and chemo/radiotherapy related red eye.

Standard Eye Care	
1	Clean eyes with sterile water soaked gauze , cleaning from inner aspect of lids at the nose and sweep across the lids to outer aspect. This prevents the spread of infection or debris being introduced into the lachrymal system .
2	Clean along both sets of lashes; do not drag debris across the surface of the eye.
3	Use new gauze swab for each sweep and for each eye.
4	Apply prescribed ocular lubricant.

Sedated Patient (Difficulty Blinking)

- Standard eye care 4 hourly
- Consider taping eyelids closed, especially during interventions e.g. proning, transfers and procedures.

Sedated & Paralysed (Unable To Blink)

- Standard eye care 2 hourly
- Consider taping eyelids closed, especially during interventions e.g. proning, transfers and procedures.

HIGH RISK OF EYE INJURY

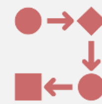
Please see your units full guidelines for more information

(V1 2019)

West Yorkshire Critical Care & Major Trauma · North Yorkshire & Humberside Critical Care Network NHS · NoECCN North of England Critical Care Network

A-E Assessment Summary

Use the ABCDE approach for all critically ill patients



Undertake initial assessment at start of shift and re-assess regularly

Treat issues prior to moving on to the next part of the assessment

Recognise when to escalate / ask for help

[Pre-course assessment - Mentimeter]