



A general approach to resuscitation

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The objective of First10EM is to review specific emergency medicine scenarios that require urgent action, allow little time for thought, and therefore benefit from a pre-thought out plan. However, one of the exciting aspects of emergency medicine is that you can never predict what will roll through your doors. Unfortunately, due to fatigue, stress, and many other factors, our minds are not always functioning at 100%. Therefore, I find it useful to have a general framework to follow every time I step into the resuscitation room. This post will not be about a specific problem, but rather my general approach to any resuscitation.

This approach borrows (steals) heavily from an excellent post and video by Reuben Strayer (@emupdates) that you should definitely check out ([First five minutes of resuscitation](#) video at [emupdates.com](#).) Reuben seems to be a lot more efficient than I am, being able to get through all these steps in only 5 minutes. At First10EM, I will continue to focus on the first ten minutes in the resus room.

This basic approach is a slightly expanded version of the ABCs that can be used for board exams and those real life scenarios when the lights and sounds of the resus room have combined to wipe your mind blank. It serves as my mental checklist to help ensure I am thorough. My mnemonic is: (I am sorry if you are offended by profanity. If you are, please turn away now. Also, if you are, how is it possible for you to work in an emergency department? That being said, if you have a better mnemonic, please let me know.)

SAFETY

This is second nature to EMS folks, but we often get complacent in the emergency department. Hopefully recent Ebola scares will remind us that we must always ensure that it is safe to approach the patient before rushing in with our team. Could there be a toxicological exposure that requires the decontamination room first? What is the infective risk? Make sure everyone has appropriate PPE.

HELP

Call for help early. It will probably never arrive in the first 10 minutes, but it never hurts to call early. If you know a critically ill pediatric patient is on there way in, call peds before they hit the door. As soon as you recognize a difficult airway, get anaesthesia paged. If they walk away without having to do anything, no worries.

Aside from physician help, ask yourself how many sets of hands you need. Most academic centres have too many people around, but in a small community hospital, certain situations might require calling extra nursing help down from the floor or getting paramedics to stick around.

IDENTIFY TEAM AND TEAM LEADER

In an ideal scenario, everyone in the resus room will know each other by name, but that doesn't always happen. If there was a heads up before the ambulance arrives, gather the team, introduce everyone, and assign roles. If you walk into the middle of a resuscitation, identify yourself to the room. For example, when a code pink takes me away from the familiar confines of the emergency department to a L&D ward where none of the nurses know me, as soon as I enter the room I state loudly, "Hi everyone. I am Justin, the emergency doctor on tonight."

Occasionally you will walk into a room with multiple staff doctors. It is important to know who is in charge. The easiest way to do that is just to ask, "who is in charge?" When no one answers, you will quickly realize that you are in charge. At that point, identify yourself out loud as the team leader.

TOOLS

You never want to have to search for items at the moment that you need them. If there are tools you might need, get them ready as soon as possible (ideally before the patient even arrives). For example, if you are involved in a [precipitous delivery in the ED](#), make sure a neonatal warmer is out and all equipment is available for the imminent [neonatal resuscitation](#).

Although I have written a lot about the S.H.I.T. steps, all 4 occur in less than the 20 seconds that it takes me to walk down the resus hallway and enter the room.

GOALS OF CARE

Before jumping in with invasive procedures, do your best to quickly assess the patient's wishes regarding end of life care. Is there a DNR or living will? Does the family know their wishes? Are there indicators of dismal outcome?

AIRWAY

Although the airway always comes first on the list, that doesn't mean a definitive airway needs to be done immediately. In fact, it is often best to start with basic airway maneuvers, and address oxygenation and circulatory issues before proceeding with RSI.

BREATHING

Although it is not always possible, it is nice to know a room air sat prior to oxygen application.

CIRCULATION

DISABILITY

EXPOSURE

- **Assessment**
 - Completely undressed
 - Rash?
 - Trauma?
 - Medic alert bracelet?
 - Medications (lists or pill bottles)
 - ID

- **Treatments**
 - Remember to cover the patient back up and warm as necessary, especially with kids, elderly, and trauma

These are the basic first steps of resuscitation that we are all familiar with. Although they are listed in alphabetical order, they certainly do not have to be addressed in that order. For example, it is important to get a brief neurological exam before pushing paralytics to secure the airway.

To complete the mnemonic, I include four items that are usually done automatically in a resuscitation, but are occasionally missed. (Who hasn't made it 30 minutes into a resus before remembering about

pain meds?) The order isn't important, but completing the checklist is.

FAMILY / FRIENDS

- Who is available to provide more information?
- Are there contact numbers available - on the chart, in a wallet, or in a cell phone?
- Is there an advanced directive?
- Does the family want to be in the room?

GERMS

Are empiric antibiotics required? Start them

HURT

INFANT

These initial steps will generally get you through the first 10 minutes of any resuscitation. Once things have settled a bit, you can now start a more thorough head to toe exam, consider further investigations, or run to google for answers.

