OSCE Checklist | ABCDE Approach

	Initial steps	
1	Introduce yourself to whoever has requested a review of the patient and listen carefully to their handover	
2	Ensure the patient's notes, observation chart and prescription chart are easily accessible	
3	Ask for another clinical member of staff to assist you if possible	
4	Introduce yourself to the patient (including your name and role) and confirm patient details	
5	Ask how the patient is feeling (if conscious)	
6	If the patient is unconscious and there are no signs of life, start basic life support	
	Airway	
7	Check the patency of the airway (look for signs of airway compromise, listen for abnormal airway noises, inspect inside the mouth)	
8	If required: perform basic airway manoeuvres (head-tilt chin-lift, jaw thrust) and consider inserting an airway adjunct (OP/NP)	
9	Re-assess the patient after any intervention	
	Breathing	
10	Review respiratory rate and oxygen saturation	
11	Inspect for signs of respiratory problem (cyanosis, increased work of breathing, cough, Kussmaul's respiration)	
12	Assess tracheal position	
13	Perform brief respiratory assessment: chest expansion, percussion, auscultation	
14	Request an ABG and portable chest X-ray if indicated	
15	Administer oxygen if indicated	
16	Initiate appropriate management for specific respiratory problems (e.g. nebulised salbutamol for asthma)	
17	Re-assess the patient after any intervention	
	Circulation	
18	Review heart rate and blood pressure	
19	Review the fluid balance chart and calculate the patient's fluid balance; consider catheterisation to monitor urine output	
20	Inspect for signs of a circulatory problem (pallor, oedema)	
21	Assess temperature and measure capillary refill time	
22	Assess the radial/brachial pulse	
23	Briefly inspect for a significantly raised JVP	
24	Briefly auscultate for heart sounds	

25	Inspect the ankles and sacrum for oedema	
26	Insert at least one wide-bore intravenous cannula and take appropriate blood tests	
27	Consider continuous cardiac monitoring and perform a 12-lead ECG if indicated	
28	Administer intravenous fluid bolus if hypovolaemic	
29	Initiate appropriate management for specific circulatory problems (e.g. control bleeding, treat acute coronary syndrome, start sepsis six)	
30	Re-assess the patient after any intervention	
Disability		
31	Assess level of consciousness using ACVPU or GCS	
32	Assess the pupils	
33	Perform a brief neurological assessment (ask patient to move their limbs if able)	
34	Review the drug chart for relevant medications (e.g. opioids, sedatives, anxiolytics)	
35	Measure capillary blood glucose	
36	Request CT head if intracranial pathology suspected (e.g. stroke)	
37	Initiate appropriate management for specific causes of reduced consciousness (e.g. naloxone)	
38	Re-assess the patient after any intervention	
Exposure		
39	Exposure the patient as appropriate and inspect for relevant clinical signs (e.g. rashes, cellulitis, infected surgical wound, swollen calf)	
40	Briefly palpate the abdomen for any tenderness/distension	
41	Palpate the calves for tenderness	
42	Review the patient's temperature	
43	Request swabs/samples to be taken from any potential infective sources	
44	Initiate appropriate management for identified problems (e.g. warming for hypothermia, treat infection, control bleeding)	
45	Re-assess the patient after any intervention	
Escalation and handover		
46	Seek appropriate advice from a senior clinician or specialist team	
47	Use an effective SBAR handover to communicate key information	