# ABCDE — The Pocket Card



One per person, issued at registration and kept in the top pocket. **The card is not a reference to read during an emergency — it is what you rehearsed until you did not need it.** Print duplex with page 2 on the reverse.

LIMA PULSE · DAY 2

## A · AIRWAY

Is the airway patent?

**ASSESS**

- Can they **speak**? A sentence answers A
- **Stridor** · gurgling · snoring
- Secretions, vomit, blood, swelling
- See-saw movement · reduced consciousness

**TREAT**

- Position · head tilt–chin lift · **jaw thrust if trauma**
- Suction under direct vision
- Adjunct — trained staff only
- Oxygen · call for advanced airway help

**SAY IT:**
*"A — airway patent, talking."*

Name _____

LIMA PULSE · DAY 2

## B · BREATHING

Is ventilation adequate?

**ASSESS**

- **Count the rate — a full minute**
- Work of breathing · accessory muscles
- Symmetry · air entry · auscultate
- $SpO_2$ · trachea · neck veins

**TREAT — OXYGEN IS A DRUG**

- **94–98%** usual acute target
- **88–92%** if hypercapnic risk known
- Asthma: **only if $SpO_2$ <92%**, upper limit **95%** (GINA 2026)
- Bronchodilator · assist ventilation · treat the cause

**RED FLAG:**
*RR ≥25 or ≤8 scores 3 on NEWS2 alone.*

Role _____

LIMA PULSE · DAY 2

## C · CIRCULATION

Is the patient perfusing?

**ASSESS**

- Rate · rhythm · pulse quality
- **Capillary refill** · skin temperature and colour
- Bleeding — obvious *and* occult
- BP · ECG · 12-lead · urine output

**TREAT**

- **Stop the bleeding** — pressure, packing, tourniquet
- IV/IO access · bloods with the first cannula
- **Cause-specific** fluid, then reassess
- Treat the rhythm if the rhythm is the problem

**A NORMAL BLOOD PRESSURE DOES NOT EXCLUDE SHOCK.**

Date _____

LIMA PULSE · DAY 2

## D · E · LOOP

Brain, glucose, exposure — then start again

**D · DISABILITY**

- **ACVPU** · pupils · focal signs
- **GLUCOSE — every altered conscious level**
- Seizure? Start the timer.

**E · EXPOSURE**

- Temperature · rash · bleeding · patches · wounds
- Dignity · prevent heat loss · SAMPLE history

**THEN GO BACK TO A.**
*ABCDE is a loop, not a checklist.*

Centre _____

# ABCDE — The Pocket Card

Print on the reverse of page 1, flipping on the **short edge**. Check one card before printing the whole set.

STOP TRIAGING · START ABCDE

## RED FLAGS

Any one of these ends the triage

- Airway obstruction or **stridor**
- Severe respiratory distress · cyanosis
- Cannot speak in sentences
- Shock or markedly poor perfusion
- Major haemorrhage
- Altered consciousness · active seizure
- Acute stroke features
- Suspected ACS with instability
- Anaphylaxis · major trauma
- Rapidly deteriorating observations

> *A red flag is not a reason to triage* **FASTER**. *It is a reason to* **STOP**.

ESCALATION THRESHOLDS

## NEWS2

RCP escalation guidance — adapt to the Lima / Oman MOH route

- **0** — routine monitoring per local policy
- **1–4** — registered nurse assesses, decides escalation
- **3 in any single parameter** — urgent clinician review
- **5–6** — **key threshold.** Urgent review by a clinician competent in acute illness
- **≥7** — emergency assessment, continuous monitoring, senior clinician, consider transfer

> **CLINICAL CONCERN OVERRIDES A REASSURING SCORE.**
> *Escalate anyway and say why.*

RECOGNITION WITHOUT ESCALATION IS INCOMPLETE

## SBAR

The call that follows the assessment

- **S** — who you are, where, who the patient is, what is happening now
- **B** — relevant history, briefly
- **A** — ABCDE findings, observations, NEWS2, response to treatment
- **R** — **exactly what you need, and by when**

> *"I am concerned this patient is critically ill because…* **I NEED YOU HERE NOW.** *"*

ONE CHANGE AT THE FRONT

## <C>ABCDE

Trauma — catastrophic haemorrhage first

- **<C>** Catastrophic external bleeding — **before the airway**
- Direct pressure, firm and sustained
- Limb bleeding not controlled → **tourniquet, high and tight, time written on it**
- Pelvic binder at the greater trochanters, if held and you are trained
- Then A · B · C · D · E as taught

> *Blood hides where pressure cannot reach: chest · abdomen · pelvis · long bones · the floor.*

# Emergency Drugs & Scope — Lima Health Centre



**The clinical standard below is the same for everyone in the team. What differs is who performs each part of it.** Doses are the guideline reference figures — use them to **check** a prescription and to prepare accurately. **Prescribing authority and administration rights follow the Lima job descriptions and Oman MOH medication policy.**

## 1 Convulsive status epilepticus

A generalised convulsive seizure lasting 5 minutes or longer

**START THE TIMER**
first action

| SITUATION | DRUG | DOSE AND RATE |
|---|---|---|
| IV access available | **Diazepam IV** | **DOSE 10 mg** — or **5 mg** if elderly or under 50 kg<br>**RATE** slowly, maximum **5 mg per minute** |
| No IV access | **Midazolam buccal** | **DOSE 10 mg** — or **5 mg** if elderly or under 50 kg |

**TWO DOSES. THEN STOP.** One repeat at **10 minutes** if the seizure continues. Maximum **two** benzodiazepine doses. Failure after two doses is established status epilepticus and needs a second-line agent — **Lima holds none. At that point the treatment is the transfer.**

Benzodiazepines cause dose-dependent depression of consciousness and respiratory drive — **including after the seizure stops**. Keep monitoring; be ready to support ventilation. *NICE NG217 first-line for adults in hospital is IV lorazepam 4 mg, which Lima does not hold; this pathway follows NHS GGC.*

## 2 Hypoglycaemia

Check the glucose in every patient with an altered conscious level

**> 4.0 mmol/L**
target, and recovered

| SITUATION | TREATMENT |
|---|---|
| Conscious, safe to swallow | **15–20 g** rapid-acting carbohydrate · recheck at **10–15 min** · repeat up to **3 times** · then **20 g** long-acting carbohydrate |
| Unconscious, fitting, or unable to swallow | **Glucose 20% — 100 mL IV over ~15 min**<br>or **Glucose 10% — 200 mL IV over ~15 min**<br>**Both = 20 g.** Recheck at **10 minutes** |
| No IV access | **Glucagon 1 mg IM** — less effective in malnutrition, starvation, alcohol excess, liver disease · **no second dose** · needs **40 g** follow-on carbohydrate |

**GLUCOSE 50% — NOT THE FIRST CHOICE.** JBDS no longer recommends 50% for IV use. It is strongly hypertonic (≈2522 mOsm/L against 506 for 10%) with real potential for **tissue damage and skin necrosis on extravasation**. We stock it; use 20% or 10% first, and if you do use 50%, say so in the handover.

**Do not omit a due insulin dose.** After a sulfonylurea or long-acting insulin the risk persists **24–36 hours** — observe or transfer, do not discharge.

REVIEWED BY _____ DATE _____

# Emergency Drugs & Scope — Lima Health Centre



**Antimicrobial selection is a prescriber decision**, made from the suspected source, severity, allergy history and resistance patterns. The doses below are the guideline reference figures for checking and preparing. **Who prescribes and who administers follows Lima job descriptions and Oman MOH medication policy.**

## 3 The three IV antimicrobials we hold

Selection is a prescriber decision

**WHO AWaRe** classification

| AGENT | AWARE | REFERENCE ADULT IV DOSE | ITS REAL ROLE |
|---|---|---|---|
| **Ceftriaxone** | Watch | 1–2 g once daily (severe at the 2 g end), infuse over 30 min. **Meningitis: 2 g every 12 h** | The backbone of almost every regimen here |
| **Metronidazole** | Access | 500 mg every 8 h (common international regimen). Halve in severe liver impairment | Anaerobic cover — **only with an anaerobic source** |
| **Ampicillin** | Access | 150–200 mg/kg/day in divided doses. Meningitis: 2 g every 4 h | **Listeria** (over 50, pregnant, immunocompromised) and enterococci |

**METRONIDAZOLE IS NOT A HARMLESS ADD-ON.** Surviving Sepsis 2026 suggests **against** empiric anaerobic cover with no anaerobic risk factor — observational data showed **increased mortality**. Add it for intra-abdominal, gynaecological and obstetric, necrotising soft-tissue, head and neck, empyema and CNS abscess sources. **Not** for undifferentiated sepsis, ordinary pneumonia or pyelonephritis.

**CEFTRIAXONE PRECIPITATES WITH CALCIUM.** Never reconstitute, dilute, co-infuse or Y-site it with **Hartmann's or Ringer's**. Use **0.9% sodium chloride**. In a resuscitation running one or two lines, this *will* happen unless the team is trained for it.

**WHAT WE CANNOT COVER.** No aminoglycoside, macrolide, antipseudomonal, MRSA cover or antifungal. The WHO AWaRe first-choice regimen **cannot be completed here** for severe community-acquired pneumonia, severe pyelonephritis, sepsis of unknown source, or neutropenic sepsis. **“We gave the antibiotic” is not the same as “the pathogen is covered.”**

**Allergy:** a rash with penicillin does not bar ceftriaxone. **Anaphylaxis, angioedema or a severe cutaneous reaction to any beta-lactam — the drug is not given here.** Resuscitate, transfer, hand over the allergy history explicitly.

## 4 Who does what

The standard does not change. Who performs each part of it does.

| INTERVENTION | LED BY | THE REST OF THE TEAM |
|---|---|---|
| **Airway management** and adjuncts | **Doctors** | Positioning · suction · oxygen · bag-mask within training · **call early** |
| **Synchronised cardioversion and pacing** | **Doctors** | Recognise instability · attach monitor and pads · prepare the defibrillator · call |
| **Antimicrobial selection** | **Prescriber** | Prepare and give what is prescribed · check allergy and line compatibility · **record the exact time** |

REVIEWED BY _____ DATE _____

# Who Do You Call



**This page is printed blank on purpose.** These names, numbers and times belong to this centre — they are not something a lecture can supply. Fill it in as a room, photograph it, and fix it beside the emergency trolley. **A pathway nobody can dial at two in the morning is not a pathway.**

## 1 The call list

Name the person, not the department

**LAST COLUMN** is the clinical one

| WHEN YOU NEED… | WHO EXACTLY | HOW YOU REACH THEM | REALISTIC TIME TO ARRIVE |
|---|---|---|---|
| **A second pair of hands, now** | | | |
| **The doctor on duty** | | | |
| **The doctor out of hours** | | | |
| **Ambulance — road** | | | |
| **Ambulance — marine** | | | |
| **The receiving hospital** | | | |
| **Controlled-drug access** | | | |

**WHY THE LAST COLUMN MATTERS.** Transfer time is a clinical variable here, not an administrative one. If help is forty minutes away, the decision to call is taken forty minutes earlier — which means it is taken on the **trend**, before the numbers are frankly abnormal. **Distance is the reason this whole day is about recognising early.**

## 2 Three questions that need a written answer

If the answer is “it depends who is on”, that is a gap — record it in the Corrective Action Register

| QUESTION | WRITTEN ANSWER | WHERE IT IS RECORDED |
|---|---|---|
| May a nurse give the **first IM adrenaline dose in anaphylaxis** before a prescription? | | |
| Who may give **buccal midazolam** out of hours? | | |
| Who holds the **controlled-drug key** at 02:00? | | |

The clinical standard taught on Day 2 does not depend on these answers — a patient in anaphylaxis needs intramuscular adrenaline immediately regardless of who is standing there. What these answers decide is **who performs which part of it**, and where authority stops, the task becomes **getting the person who holds it, faster**. That is an action, not a delay.

COMPLETED BY _____ DATE _____

# NEWS2 — Scoring Chart

Royal College of Physicians **National Early Warning Score (NEWS) 2**. Score logic reproduced unaltered. Validated in adults ≥16 years. **Not** for use in pregnancy or in children. **If the patient is obviously critically ill — do ABCDE first, score afterwards.**

| PARAMETER | 3 | 2 | 1 | 0 | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|
| Respiration rate (/min) | ≤8 | – | 9–11 | 12–20 | – | 21–24 | ≥25 |
| $SpO_2$ — **Scale 1** (%) | ≤91 | 92–93 | 94–95 | ≥96 | – | – | – |
| $SpO_2$ — **Scale 2** (%)<br>target 88–92% · confirmed hypercapnic risk only | ≤83 | 84–85 | 86–87 | 88–92<br>or ≥93 on air | 93–94<br>on $O_2$ | 95–96<br>on $O_2$ | ≥97<br>on $O_2$ |
| Air or oxygen | – | Oxygen | – | Air | – | – | – |
| Systolic blood pressure (mmHg) | ≤90 | 91–100 | 101–110 | 111–219 | – | – | ≥220 |
| Pulse (/min) | ≤40 | – | 41–50 | 51–90 | 91–110 | 111–130 | ≥131 |
| Consciousness (ACVPU) | – | – | – | Alert | – | – | C V P U |
| Temperature (°C) | ≤35.0 | – | 35.1–36.0 | 36.1–38.0 | 38.1–39.0 | ≥39.1 | – |

**Response thresholds. 0 routine · 1–4 registered nurse assesses and decides escalation · 3 in any single parameter urgent clinician review · 5–6 KEY THRESHOLD — urgent review by a clinician competent in acute illness · ≥7 emergency assessment, continuous monitoring, senior clinician, consider transfer.**

Who is called, by what method and within what timeframe follows the **Lima Health Centre / Oman MOH escalation policy** — not an imported hospital structure.

| PATIENT / BED | RR | $SPO_2$ | AIR/$O_2$ | SBP | PULSE | ACVPU | TEMP | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## 1 ABCDE drill — spoken aloud

In pairs. One is the patient, one assesses out loud. 4 minutes each, then swap.

**Assessor**

**Participant**

**Date**

| # | OBSERVED BEHAVIOUR | NOT DONE | PARTIAL | DONE |
|---|---|---|---|---|
| 1 | States safety and first impression before touching the patient | | | |
| 2 | Speaks to the patient — uses the reply to answer A, B and C | | | |
| 3 | **Names each letter aloud** as they reach it | | | |
| 4 | Announces each finding in a form a colleague could write down | | | |
| 5 | **Declares the treatment at the letter** — does not defer it | | | |
| 6 | Counts the respiratory rate rather than estimating it | | | |
| 7 | Checks glucose at D without prompting | | | |
| 8 | **Returns to A** after the loop and says so | | | |

**Critical: moving past an untreated life-threatening finding is an automatic “not yet” for the station, whatever the rest of the score.**

**One thing done well**

**One thing to change next time**

RESULT PASS REPEAT

Assessor signature

## 2 NEWS2 scoring & escalation

Three written observation sets. Score on paper in under a minute each, then confirm against the calculator.

**Assessor**

**Participant**

**Date**

| # | OBSERVED BEHAVIOUR | NOT DONE | PARTIAL | DONE |
|---|---|---|---|---|
| 1 | Set A total correct | | | |
| 2 | Set B total correct | | | |
| 3 | Set C total correct | | | |
| 4 | **Identifies a single parameter scoring 3** and says why it matters | | | |
| 5 | States the required response for the score obtained | | | |
| 6 | Knows when Scale 2 applies — and that it needs a confirmed prescription | | | |
| 7 | Says that clinical concern overrides a reassuring score | | | |
| 8 | Completes each set in under one minute | | | |

**Critical: a participant who scores correctly but cannot name the escalation has not passed this station. The number exists to make someone come.**

- [ ] One thing done well
- [ ] One thing to change next time

RESULT PASS REPEAT

Assessor signature

## 3 Oxygen & delivery devices

Our actual equipment on the table. Handle each device and state the target and the reason.

**Assessor**

**Participant**

**Date**

| # | OBSERVED BEHAVIOUR | NOT DONE | PARTIAL | DONE |
|---|---|---|---|---|
| 1 | States the usual acute target **94–98%** | | | |
| 2 | States **88–92%** where hypercapnic risk is known | | | |
| 3 | States asthma oxygen: **only if $SpO_2$ <92%, upper limit 95%** | | | |
| 4 | Selects an appropriate device for a stated target and flow | | | |
| 5 | Assembles the bag-mask correctly and achieves a seal | | | |
| 6 | Ventilates at **1 breath every 6 seconds** in respiratory arrest with a pulse | | | |
| 7 | Assembles and uses a spacer correctly with a pMDI | | | |
| 8 | Says that oxygen is a drug, given for hypoxaemia and titrated | | | |

**Critical: reflex high-flow oxygen for every acutely unwell patient, with no stated target, is a fail — as is a bag-mask assembled without a reservoir when one is available.**

**One thing done well**

**One thing to change next time**

RESULT PASS REPEAT

Assessor signature

## 4 SBAR — the escalation call

Delivered aloud to the room as if on the telephone, immediately after the simulation.

**Assessor**

**Participant**

**Date**

| # | OBSERVED BEHAVIOUR | NOT DONE | PARTIAL | DONE |
|---|---|---|---|---|
| 1 | **S** — identifies self, place, patient and what is happening now | | | |
| 2 | Signals severity in the **first ten seconds** | | | |
| 3 | **B** — relevant background only, no narrative | | | |
| 4 | **A** — ABCDE findings with numbers, including NEWS2 | | | |
| 5 | States what was given and the response to it | | | |
| 6 | **R** — an explicit request (“I need you here now”) | | | |
| 7 | The request is **time-bound** and confirms what happens next | | | |
| 8 | Delivers it in under 60 seconds | | | |

**Critical: a handover with no Recommendation is a fail, however complete the rest. The listener must know exactly what is being asked of them.**

**One thing to change next time**

RESULT PASS REPEAT Assessor signature

# Simulation — Performance Scoresheet



Scored **live**, by a facilitator who is not running the scenario. Retrospective scoring drifts towards kindness. Print two — one per simulation. **Scores are not read out to the group.** Debrief on behaviour; the numbers go to the programme record.

**Simulation** **Team / group** **Leader** **Date** **Scored by**

| # | DOMAIN | GROUP | NOT DONE 0 | PARTIAL 1 | DONE 2 |
|---|---|---|---|---|---|
| 1 | Recognises critical illness | ABCDE | | | |
| 2 | Calls for help early | ABCDE | | | |
| 3 | Uses ABCDE systematically | ABCDE | | | |
| 4 | **Treats life-threatening abnormalities before moving on** | Treatment | | | |
| 5 | Uses oxygen and ventilation appropriately | Treatment | | | |
| 6 | Initiates monitoring and access appropriately | Treatment | | | |
| 7 | Checks glucose when relevant | Treatment | | | |
| 8 | **Reassesses after intervention** | Treatment | | | |
| 9 | Makes an appropriate escalation / transfer decision | Communication | | | |
| 10 | Gives structured SBAR communication | Communication | | | |

| SUB-SCORE | POINTS | MAXIMUM | % | WHAT A LOW SCORE HERE MEANS |
|---|---|---|---|---|
| **ABCDE** (items 1–3) | | 6 | | The sequence itself is not yet automatic — repeat Station 1. |
| **Treatment & reassessment** (4–8) | | 10 | | They assess well and act late. Drill “treat at the letter, then reassess”. |
| **Communication & escalation** (9–10) | | 4 | | Recognition without escalation. Repeat Station 4 and re-audit next drill. |
| **OVERALL** | | 20 | | — |

**System gaps found during this simulation — equipment missing, drug not stocked, expiry passed, pathway unclear. These go to the Corrective Action Register the same day.**

☐

DEBRIEF COMPLETED YES NO

Facilitator signature

## D2-SIM-A Respiratory deterioration — the diagnosis is never announced

***Say only this:*** *"This 34-year-old was brought in by a relative. She is struggling to breathe. That is all you know."*
*Do not name the condition. Do not confirm or deny a diagnosis if asked.* ***Alternative version*** *— collapse 10 minutes after an intramuscular antibiotic in the injection room; run this one if the team solves the asthma too quickly.*

**Equipment:** manikin or simulated patient · monitor · pulse oximeter · oxygen with reservoir mask · nebuliser or pMDI + spacer · ipratropium · oral prednisolone (mock) · adrenaline ampoule (mock) · glucometer · timer. **Team:** 4–5, one named leader.

`Sitting forward · short phrases` → `RR 32 · SpO₂ 89%` → `O₂ to target + bronchodilator` → `RR 26 · SpO₂ 94%` → `Partial only` → `Repeat · steroid · monitor` → `Transfer + SBAR`

| STAGE | PATIENT STATE | EXPECTED TEAM RESPONSE |
|---|---|---|
| 0:00 | RR 32 · $SpO_2$ 89% on air · HR 124 · BP 118/74 · T 37.1 · glucose 6.4 · Alert. Sitting forward, three-word phrases. | Call for help early · sit her up · monitor on · **A: patent, speaking** |
| 0:30 | **B:** accessory muscles, widespread expiratory wheeze, reduced air entry both bases, cannot complete a sentence. | Oxygen **only if $SpO_2$ <92%**, upper limit **95%** · repeated salbutamol via spacer or nebuliser · add ipratropium |
| 1:30 | **C:** HR 124 sinus, warm, CRT 2 s. **D:** Alert, glucose normal. **E:** no rash, no lip swelling *(anaphylaxis version: urticaria + swollen lips)*. | IV access, bloods · **no reflex fluid bolus** · glucose checked without prompting |
| 4:00 | RR 26 · $SpO_2$ 94% on oxygen · HR 116 · longer phrases. **Partial improvement only.** | Recognise partial ≠ resolved · repeat bronchodilator · systemic corticosteroid · **do not stand down the transfer** |
| If delayed | Bronchodilator (or adrenaline) later than ~3 min → RR falls to 10, chest quiet, $SpO_2$ 84%, ACVPU Voice. If still unrecognised → respiratory arrest. | Must recognise the quiet chest as pre-arrest, not improvement · transition to the **AHA 2025** pathway if arrest occurs |
| Freeze | Doctor at the bedside, transfer activated, reassessment continuing. | Structured **SBAR** delivered aloud |

**Debrief — five questions.** 1 · What was your first clue this was severe? 2 · When did you call for help, and would you call earlier next time? 3 · What did you reassess after the first treatment? 4 · What did the quiet chest mean? 5 · If she had arrested, what would have changed?

**Anaphylaxis version — the one thing that must happen first:** lay flat, **adrenaline 500 micrograms IM into the anterolateral thigh**, before any antihistamine or steroid. Repeat at 5 minutes if ABC problems persist.

## D2-SIM-B Shock / altered patient — physiology first, label last

***Say only this:*** *"This 67-year-old man was found confused at home this morning. His daughter says he has been unwell for two days."*
***Alternative version*** *— a convulsing patient with a reversible metabolic cause; run this if the team has already met sepsis today.*

**Equipment:** manikin or simulated patient · monitor · oxygen · IV cannulae and fluid · blood culture bottles (mock) · lactate meter if held · glucometer · urinary catheter in situ · timer. **Team:** 4–5, a **different** named leader from Simulation A.

`Drowsy · hot · fast breathing` → `CRT 4 s · BP 92/54 · new confusion` →
`O₂ · access · antimicrobial per protocol` → `Fluid in aliquots` → `HR 108 · BP 100/60` →
`Still confused` → `Transfer + SBAR`

| STAGE | PATIENT STATE | EXPECTED TEAM RESPONSE |
|---|---|---|
| 0:00 | RR 26 · $SpO_2$ 93% on air · HR 118 · BP 92/54 · T 38.9 · glucose 9.1 · **new confusion**. Usual systolic 150. | Recognise critical illness · call for help · **A: patent but at risk** · oxygen to target |
| 1:00 | **B:** tachypnoeic, crackles right base. **C:** CRT 4 s, cool peripheries, no bleeding. | IV access with bloods · lactate if available · cultures **without delaying antibiotics** · NEWS2 scored (=10) |
| 2:00 | **D:** new confusion, pupils equal, glucose as above. **E:** hot, no rash, probable chest source, urinary catheter present. | Source-focused examination · **antimicrobial prescribed by the doctor — ceftriaxone is the backbone here** · transfer activated *now*, not after the fluid |
| 4:00 | After 500 mL and oxygen: HR 108 · BP 100/60 · CRT 3 s · **still confused**. | Partial response · second aliquot reasonable **with a check for fluid intolerance** (new crackles, rising $O_2$ need) |
| If delayed | Recognition or fluid later than ~5 min → BP 78/40, ACVPU Voice then Pain, mottled peripheries. | Teaching point: **the blood pressure fell last.** The perfusion signs were there from the beginning |
| Freeze | Antimicrobial given, transfer activated with a clear time, reassessment continuing. | Structured **SBAR** delivered aloud |

**Debrief — five questions.** 1 · What told you this was shock before the blood pressure did? 2 · How much fluid did you give, over what time, and what did you check afterwards? 3 · When was the transfer decision made — could it have been earlier? 4 · What did you do about the source? 5 · What would you want written in the notes?

**Seizure version:** actively convulsing, glucose 1.8, everything else initially unobtainable. Expected: **start the timer** · protect from injury, do not restrain · airway and oxygen · glucose checked and corrected (**glucose 20% 100 mL or 10% 200 mL IV over 15 min = 20 g**) · if still seizing at 5 minutes, **diazepam 10 mg IV** (max 5 mg/min) or **buccal midazolam 10 mg** if no IV — **maximum two doses**. Postictal is not recovered — recovery position, oxygen, someone stays.