

STUDY STAT

AIRWAY, BREATHING + CIRCULATION

Recognize compromise. Support oxygen delivery. Reassess response.

LOOK

LISTEN

MEASURE

SUPPORT

ESCALATE

PRIMARY SURVEY LEARNING PATH

Educational draft: assess the patient, follow current orders and facility policy, and escalate clinical deterioration.

Use ABC to find the immediate threat

Treat life threats as they are found; do not wait to finish the assessment.

A - AIRWAY

Can air move from the environment to the lungs? Listen for voice changes, snoring, gurgling, stridor, silence, secretions, swelling, or foreign material.

B - BREATHING

Is ventilation and oxygenation adequate? Assess rate, depth, pattern, effort, chest rise, breath sounds, SpO2, skin, speech, and mental status.

C - CIRCULATION

Is blood reaching tissues? Assess pulse, heart rate and rhythm, blood pressure, skin, capillary refill, bleeding, urine output, mental status, and chest pain.

REASSESSMENT IS PART OF EVERY INTERVENTION

After positioning, suction, oxygen, ventilation, bleeding control, fluids, medication, or escalation, repeat ABC and compare the response.

Airway: decide whether it is patent

A normal voice strongly suggests airflow; a deteriorating voice is an early warning.

PATENT

Speaking clearly; air movement present; no obstructive sound.

PARTIAL OBSTRUCTION

Snoring, gurgling, hoarseness, stridor, drooling, weak cough, retractions, or difficulty speaking.

COMPLETE / FAILING

Unable to speak or cough effectively, silent airflow, apnea, severe cyanosis, or rapidly decreasing consciousness.

HIGH-RISK CAUSES

Tongue obstruction, secretions, vomit, blood, foreign body, edema/anaphylaxis, trauma, burns, infection, sedation, or neuromuscular weakness.

ACT WITHIN TRAINING AND POLICY

Call for help early. Position and open the airway as appropriate, use suction or approved adjuncts, prepare bag-mask ventilation and definitive airway support, and protect the cervical spine when trauma is suspected.

Airway sounds localize the problem

Listen before the stethoscope; audible sounds may signal severe narrowing or fluid.

SNORING

Soft-tissue or tongue obstruction, often with decreased consciousness. Reposition/open airway and reassess.

GURGLING

Liquid or secretions in the upper airway. Suction and protect against aspiration per policy.

STRIDOR

Harsh inspiratory upper-airway sound. Treat as urgent; consider edema, foreign body, or obstruction.

HOARSE / MUFFLED

Voice change can precede worsening edema or obstruction. Escalate and prepare airway equipment.

SILENCE

Absent air movement in a distressed patient is ominous, not reassuring. Activate emergency support.

WHEEZE

Usually lower-airway narrowing; severe asthma may become quiet as airflow falls.

FOREIGN-BODY RESPONSE

Use the current age-appropriate choking and BLS algorithm. If the patient becomes unresponsive, activate emergency response and begin the indicated resuscitation sequence.

Breathing: ventilation and oxygenation are different

SpO2 estimates oxygenation; it does not directly measure ventilation or carbon dioxide.

VENTILATION

Air movement removes CO2. Watch rate, depth, tidal volume, effort, mental status, chest rise, and capnography when available.

OXYGENATION

Oxygen transfer depends on ventilation, diffusion, hemoglobin, and perfusion. Trend SpO2 with the whole patient.

WORK OF BREATHING

Accessory muscles, retractions, nasal flaring, tripod position, pursed lips, inability to speak, diaphoresis, or fatigue signal distress.

FAILURE CUES

Decreasing effort after severe distress, apnea, bradypnea, exhaustion, worsening confusion, cyanosis, or silent chest require immediate support.

NUMBERS CAN LAG

A patient can be in respiratory distress with a temporarily acceptable SpO2. Carbon monoxide exposure and poor perfusion can make pulse-oximetry interpretation especially unreliable.

Breath sounds: connect sound to mechanism

Compare side to side and interpret with effort, oxygenation, and symptoms.

CRACKLES

Discontinuous popping; may reflect fluid, atelectasis, or opening of small airways.

WHEEZES

Musical, often expiratory; airflow through narrowed lower airways.

RHONCHI

Low-pitched coarse sounds; may reflect secretions in larger airways.

DIMINISHED

Reduced air movement from shallow breathing, obstruction, effusion, pneumothorax, or other causes.

ABSENT UNILATERAL

Urgent when new, especially with trauma, severe dyspnea, or tracheal shift.

PLEURAL RUB

Grating sound from inflamed pleural surfaces; correlate with pain and respiratory findings.

DO NOT DIAGNOSE FROM ONE SOUND

Reposition, encourage a cough when appropriate, reassess, compare with baseline, and escalate new asymmetry or worsening respiratory status.

Support breathing in a stepwise way

Use the least invasive effective support while preparing for deterioration.

POSITION

Upright positioning often improves expansion; use recovery positioning when appropriate and safe.

OXYGEN

Give the ordered or emergency-protocol device and flow; target oxygenation according to condition and local policy.

SUCTION

Use when secretions obstruct airflow and within competency; preoxygenate and monitor when indicated.

MEDICATION

Administer ordered bronchodilators, steroids, epinephrine, diuretics, reversal agents, or antimicrobials for the cause.

VENTILATE

If breathing is inadequate, provide bag-mask or advanced support with trained help; monitor chest rise and response.

REASSESS

Repeat rate, effort, sounds, SpO₂, mental status, color, and vital signs; document the response.

ESCALATE BEFORE EXHAUSTION

Rapidly worsening effort, falling consciousness, inadequate ventilation, refractory hypoxemia, or inability to protect the airway warrants immediate emergency response.

Circulation: assess perfusion, not one vital sign

Blood pressure may remain normal early in shock.

CENTRAL

Mental status, heart rate/rhythm, blood pressure trend, chest pain, dyspnea, urine output, and lactate when ordered.

PERIPHERAL

Pulse quality, symmetry, skin temperature/color/moisture, capillary refill, edema, and limb pain.

BLEEDING

Expose enough to find hemorrhage while preserving dignity and temperature. Control external bleeding immediately.

SHOCK PATTERN

Tachycardia, cool clammy skin, delayed refill, weak pulses, anxiety/confusion, oliguria, hypotension, or rising lactate.

LOOK FOR THE CAUSE

Consider hemorrhage or volume loss, pump failure, dysrhythmia, sepsis/distributive shock, obstruction, anaphylaxis, medication effects, or endocrine/metabolic causes.

Match immediate actions to the circulation threat

Activate emergency response for pulselessness or unstable deterioration.

PULSELESS

Start the current BLS/ACLS pathway, high-quality CPR, AED/defibrillation as indicated, and team resuscitation.

HEMORRHAGE

Direct pressure, approved tourniquet/hemostatic measures, rapid escalation, warmth, access, and blood products per protocol.

HYPOTENSION / SHOCK

Position as appropriate, establish monitoring and IV access, obtain ordered labs, give fluids/blood/vasoactive therapy by cause and order.

CHEST PAIN / ACS

Rapid assessment, ECG, monitoring, access, and ordered therapy; recognize atypical presentations and contraindications.

DYSRHYTHMIA

Assess pulse and stability first. Treat the patient, verify the rhythm, and follow the appropriate emergency algorithm.

SEPSIS

Recognize infection plus organ dysfunction, escalate promptly, obtain ordered cultures/labs, and deliver time-sensitive treatment.

REASSESS THE ENDPOINT

Improved blood pressure alone is not enough. Recheck mental status, pulse quality, skin, capillary refill, urine output, symptoms, oxygenation, and trend.

Rapid ABC handoff

Say the threat, evidence, intervention, response, and next need.

SITUATION

"I am concerned about an acute airway/breathing/circulation problem."

EVIDENCE

State the most abnormal cues and trend: voice, effort, sounds, SpO2, pulse, BP, skin, mental status, bleeding.

ACTION

Report positioning, suction, oxygen, ventilation, access, monitoring, medications, fluids, or bleeding control already completed.

RESPONSE

State what improved, worsened, or did not change after intervention.

REQUEST

Ask for immediate bedside review, rapid response/code activation, respiratory therapy, equipment, orders, or transfer level.

SAFETY

Continue ABC reassessment, assign roles, confirm closed-loop communication, and document times and response.

EXAMPLE

"New stridor and muffled voice after medication; SpO2 is falling despite oxygen. Epinephrine was given per protocol. Airway equipment and immediate provider response are needed."

Practice: name the first threat

State the first assessment, immediate action, and reassessment cue.

1

Drowsy postoperative patient with snoring and shallow respirations.

2

Sudden stridor, hives, and facial swelling after an antibiotic.

3

Asthma patient becomes quiet after prolonged severe wheezing.

4

Trauma patient with absent left breath sounds and hypotension.

5

GI bleed with tachycardia, cool skin, and new confusion.

6

Monitor shows VT; patient is awake but hypotensive and pale.

7

Patient has organized rhythm on monitor but no palpable pulse.

8

SpO₂ is 97%, but respiratory rate is 6 after opioid administration.

9

Septic patient remains confused with weak pulses after initial therapy.

10

After suctioning, gurgling resolves but effort and SpO₂ worsen.

Sources + clinical boundaries

Current standards, facility policy, and trained emergency response supersede this guide.

American Heart Association, 2025 Adult Basic Life Support

Recognition and response to cardiac arrest, respiratory arrest, and foreign-body obstruction.

cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-life-support

OpenStax Medical-Surgical Nursing, Ch. 11 and 33

Respiratory assessment, ABCDE triage, and nursing priorities.

openstax.org/books/medical-surgical-nursing

OpenStax Medical-Surgical Nursing, Postanesthesia Care

ABC assessment and postoperative physiologic stability.

openstax.org/books/medical-surgical-nursing/pages/27-1-postanesthesia-recovery-and-care

NIH MedlinePlus

Patient-facing emergency, respiratory, cardiac, and diagnostic references.

medlineplus.gov

Local policy and emergency algorithms

Oxygen, suction, airway adjuncts, rapid response, BLS/ACLS, bleeding, and sepsis workflows.

Verify the current version in the clinical setting.

BOUNDARY

This educational draft supports nursing-student review. It is not a treatment order, competency validation, BLS/ACLS replacement, or substitute for bedside assessment and escalation.