PATIENT ASSESSMENT

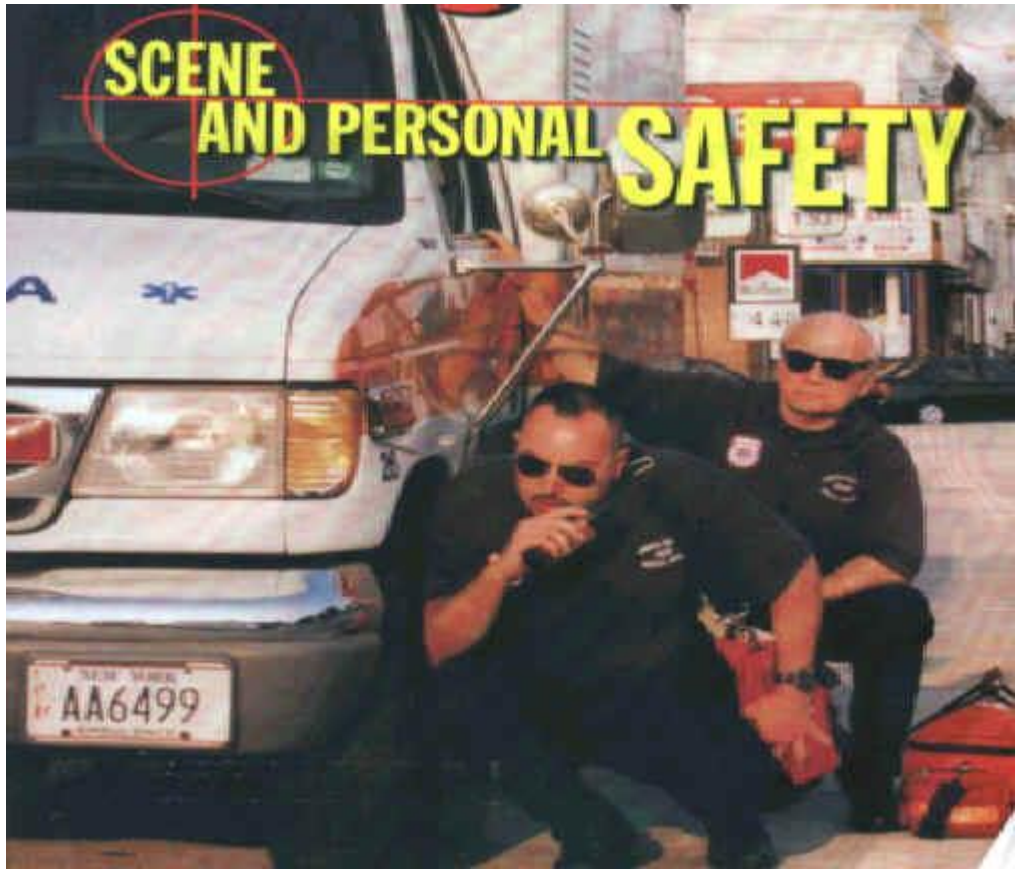
PATIENT ASSESSMENT

Patient assessment in emergency medicine as performed by First Responders & EMS providers consists of 7 parts:

1. Scene evaluation
2. Initial assessment (6 components)
3. Focused history and physical exam
4. Detailed assessment
5. Ongoing assessment
6. Communications
7. Documentation

SCENE EVALUATION

- Evaluate the **safety** of the scene



- Follow **BSI** (body substance isolation) precautions as needed, minimum standard requires gloves but additional PPE should be worn as the situation requires

SCENE EVALUATION

- Determine **<u>mechanism of injury</u>** for a trauma victim or **<u>nature of illness</u>** for a medical victim.
  - ***Mechanism of injury***=force that caused the injury (gun shot)

SCENE EVALUATION

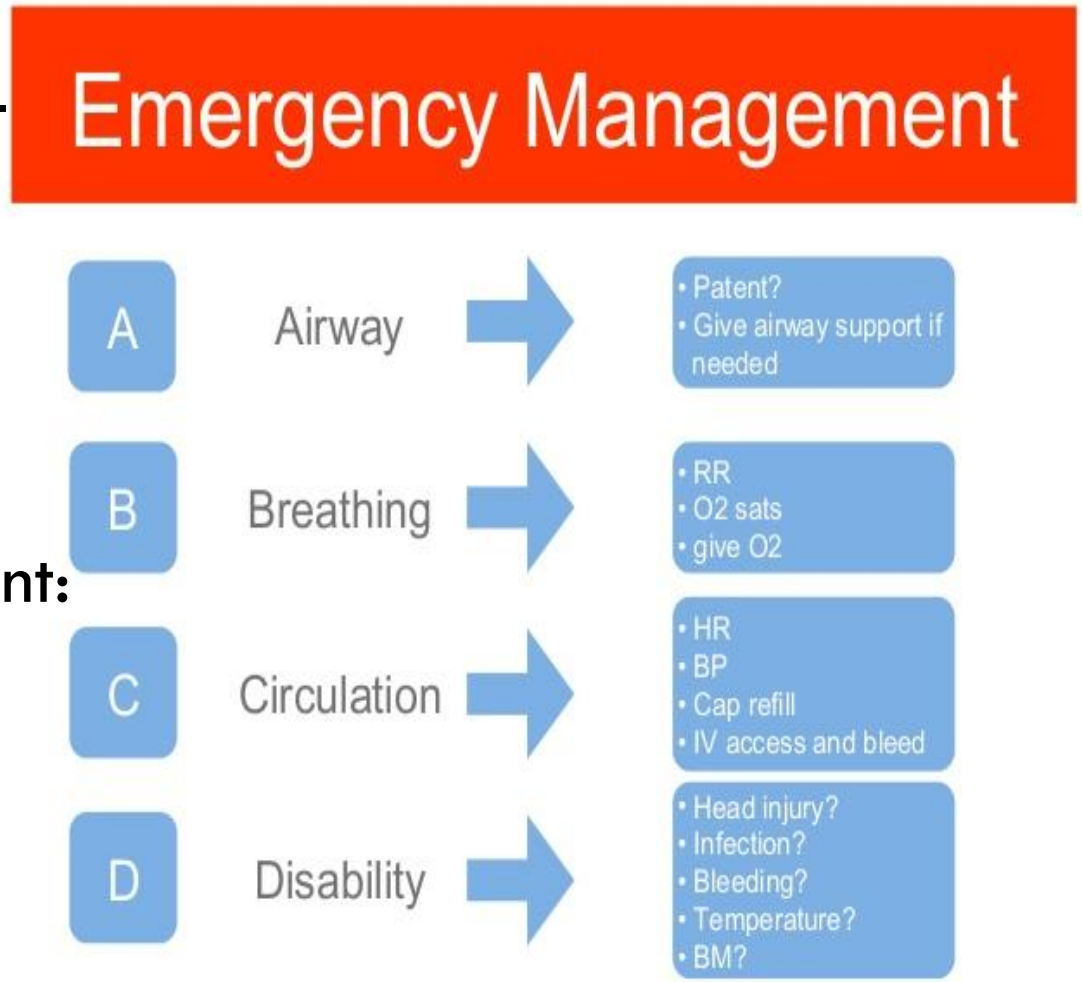
- ***Nature of illness***=condition such as chest pain or abd pain that helps determine the specific problem to look for

SCENE EVALUATION

- Number of victims

INITIAL ASSESSMENT

- Done to detect & immediately correct any life-threatening problems of the airway, breathing, and circulation
- Corrections of life-threatening problems are essential to survival
- There are 6 components of the initial assessment: form a general impression, determine level of responsiveness, assess the airway, assess breathing, assess circulation, assess priority

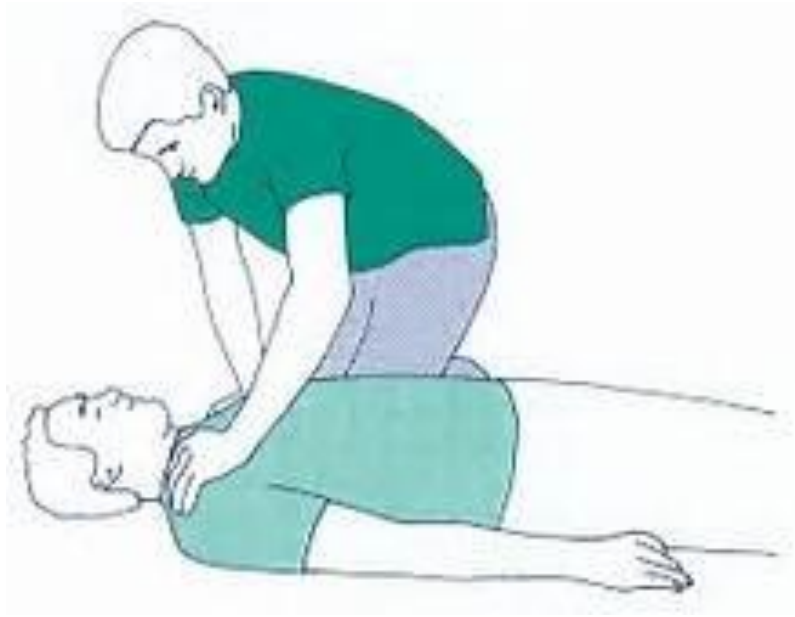


1. GENERAL IMPRESSION

- Make a general impression of pt's surroundings & condition
- If **mechanism of injury** suggests an injury to the spine, apply manual immobilization of the neck to protect the spine and prevent further movement

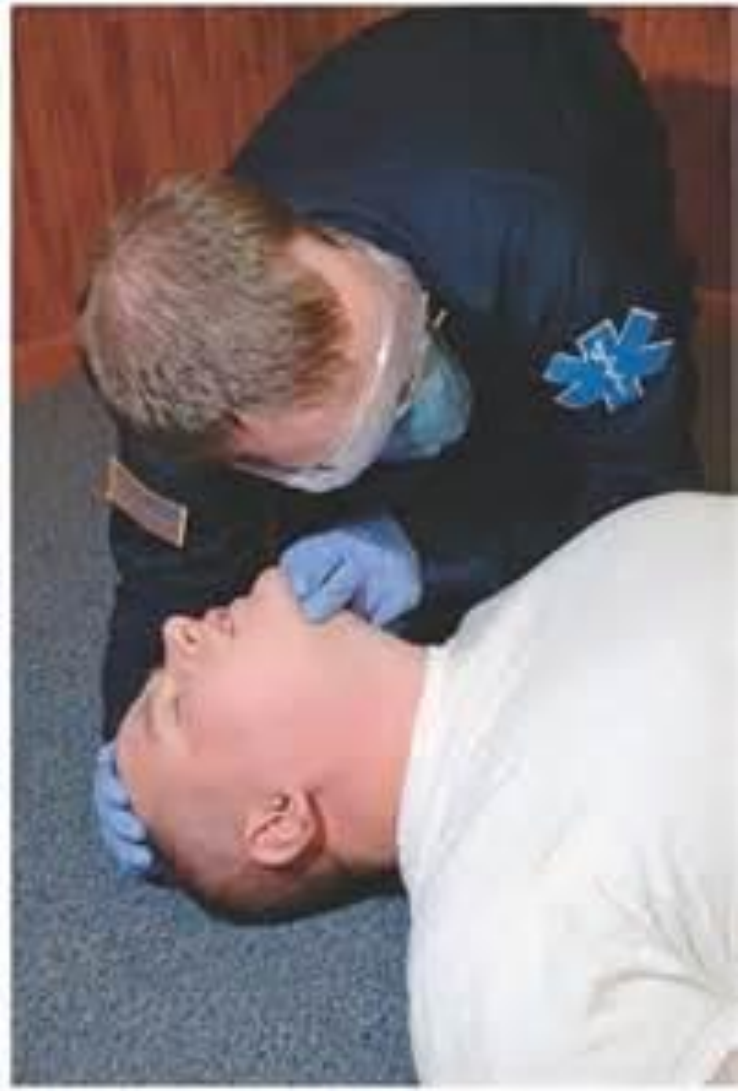
2. LEVEL OF RESPONSIVENESS

- Assess pt's responsiveness, level of distress, facial expressions, age, ability to talk, skin color
- If pt appears unresponsive, tap their shoulder and ask "Are you ok?"



3. ASSESS THE AIRWAY

- Is the pt's airway open?
- If the pt is awake, alert, and talking to you, the airway is open, the pt is breathing and has a pulse
- If the pt is unresponsive, open the airway using head tilt-chin lift or jaw thrust



4. ASSESS BREATHING

- Is the pt breathing adequately?
- If there is no breathing, prepare to provide rescue breaths
- If there is inadequate breathing, the pt may need oxygen or breathing assistance using a bag-valve-mask

5. ASSESS CIRCULATION

- Does the pt have a pulse?
- Do you see any serious external bleeding?
- What is the pt's skin color?
- If there is no pulse or signs of impaired circulation, start chest compressions
- Apply direct pressure to any serious bleeding

6. ASSESS PRIORITY

- Determine the priority and urgency of the pt's condition
- Seek immediate and appropriate transport to a medical facility

FOCUSED HISTORY & PHYSICAL EXAM

- After initial assessment has been done & any life-threatening problems treated, continue on to the focused history & physical exam
- In 90 seconds check head, eyes, neck, chest, abdomen, pelvis, arms, legs and back
- Take a set of VS & assess the skin color & temperature
- Take SAMPLE history, if time permits

FOCUSED HISTORY & PHYSICAL EXAM

During the 90 second assessment, assess for the following:

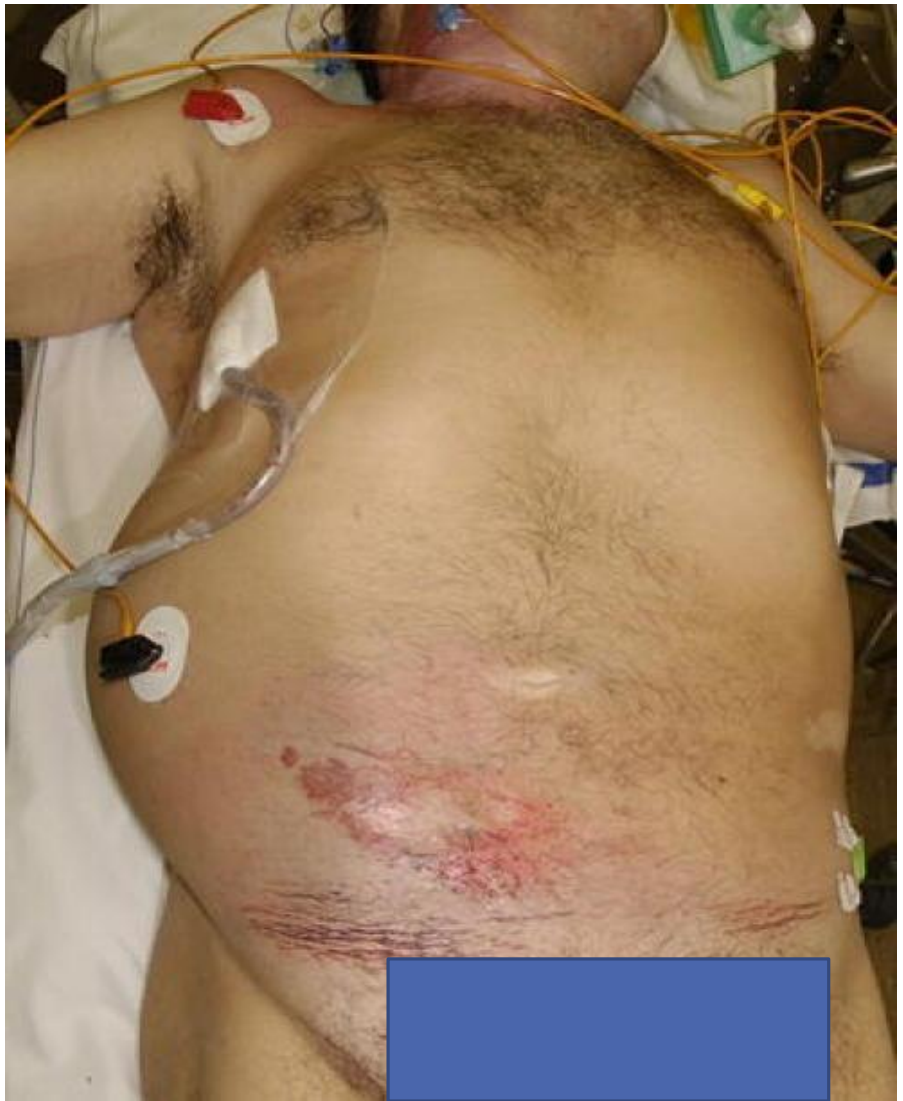
1. Head=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling. Check the ears & nose for blood & CSF. Check the mouth for bleeding, loose teeth, or foreign bodies
2. Eyes=check for same size pupils

FOCUSED HISTORY & PHYSICAL EXAM

3. Neck=look & feel for deformities, bruises, depressions, open wounds, tenderness, & swelling. Check for a medical alert necklace/bracelet

FOCUSED HISTORY & PHYSICAL EXAM

4. Chest=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling
5. Abdomen=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling

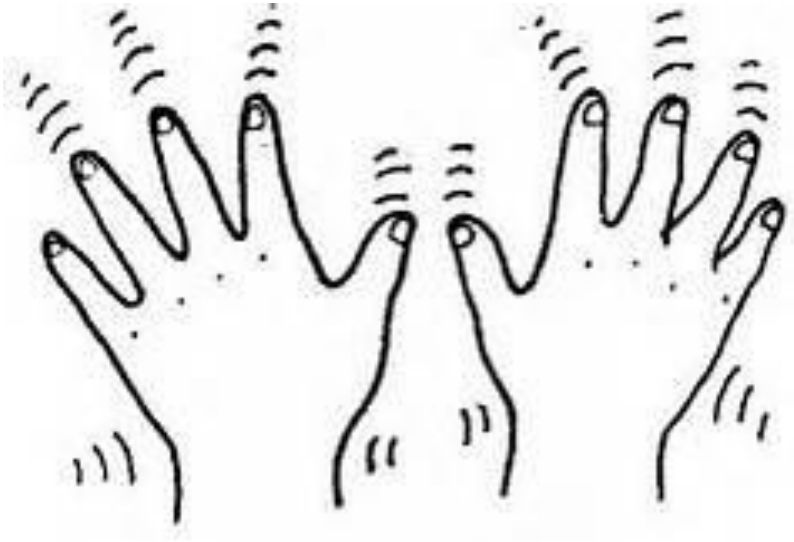


FOCUSED HISTORY & PHYSICAL EXAM

6. Pelvis=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling. Gently press downward on the pelvis for pain. Gently grab the upper thighs & press inward for pain.

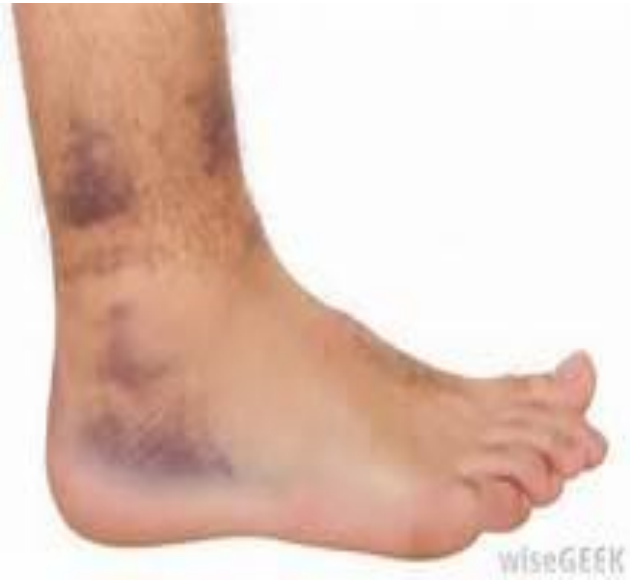
FOCUSED HISTORY & PHYSICAL EXAM

7. Arms=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling. If possible check for movement & sensation by having pt wiggle fingers, touch a finger & have them identify which finger was touched



FOCUSED HISTORY & PHYSICAL EXAM

8. Legs=look & feel for deformities, bruises, open wounds, tenderness, depressions, & swelling. If possible check for movement & sensation.
9. Back=slide your hand under back as far as it will go without moving the pt to feel for any deformities, open wounds, tenderness, depressions, or swelling



FOCUSED HISTORY & PHYSICAL EXAM

Obtain SAMPLE history if time permits:

- **S** *Signs and Symptoms* (What is wrong?)
- **A** *Allergies* (Are you allergic to any medications?)
- **M** *Medications* (What medications are you taking?)
- **P** *Pertinent Past Medical History* (What other medical problems do you have?)
- **L** *Last Oral Intake* (When was the last time you ate/drank?)
- **E** *Event Preceding* (What were you doing when this happened?)

DETAILED ASSESSMENT

- Done to identify further injury or illness
- Includes careful and systemic looking and feeling for signs of injury and illness
- Done when time permits such as in the back of the ambulance once en route to the hospital

ONGOING ASSESSMENT

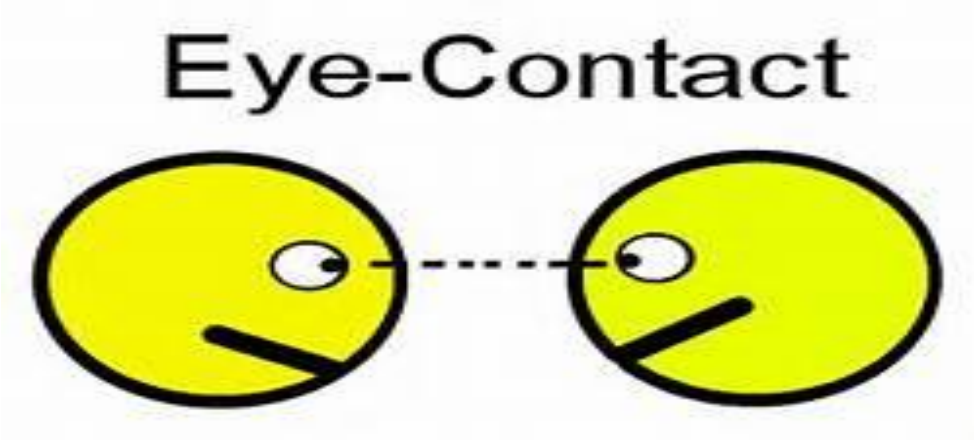
- No assessment is ever complete
- When taking care of an injured/ill patient, always reevaluate the initial assessment, vital signs, and history
- Continuously note any changes

COMMUNICATIONS

- Obtain the patient's first and last name
- Address patients by their last name unless permission has been given by the patient to use the first name
- Never call patients slang terms or use the terms honey, sweetie, gramps, sugar, or partner
- Be considerate and respectful – care for the patient like you want to be cared for
- Be aware of your body language and position

COMMUNICATIONS

- If possible position yourself at or below the eye level of the patient, it is less intimidating
- Use eye contact to let your patient know you are interested and attentive to their needs



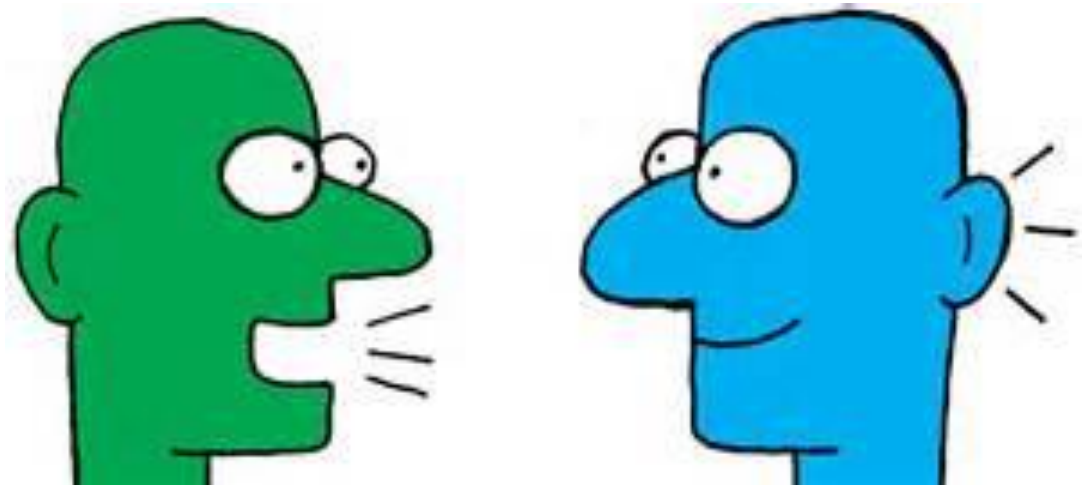
- Be honest – attempt to answer patient's questions honestly without scaring them. Let them know you are doing everything possible to help

COMMUNICATIONS

- Keep the patient/family informed - Keep them informed of any procedures you are doing. If you are going to cause pain, let everyone know but tell them you will be as gentle as possible
- Listen – to the patient and family members, don't interrupt unless necessary

COMMUNICATIONS

- Communication happens between the responder & the client (and their family)
- Communication also happens between the responder & dispatchers via radio/cell phone report and also a verbal report (hand-off) to the hospital staff



DOCUMENTATION

Written report that describes:

1. Physical findings of an exam
2. Procedures performed
3. Mediations given
4. Vital signs
5. Name, age, and address of the client