

Patient Assessment Ch 7



Patient Assessment Sequence

- Assessment of the scene and pt affects the level of care requested.
- The pt assessment sequence allows you to systematically gather information you need.
- Safely approach an emergency scene.
- Determine the need for additional help.

Untrained bystanders

The Initial Assessment

Step I: Scene Size-up

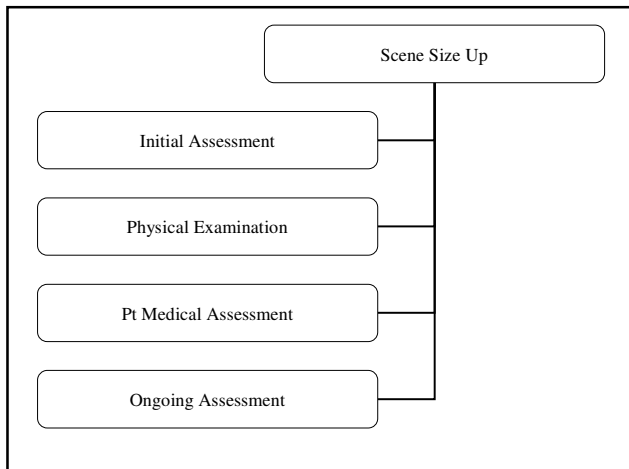
- A general overview of the incident and its surroundings
- Review dispatch information.
 - Anticipate possible conditions.
- Observe BSI precautions.
 - Always have gloves available.

(1 of 2)

Step I: Scene Size-up

- Ensure scene safety.
 - Scan the scene for hazards.
 - If scene is unsafe, keep everyone away until specially trained teams arrive.
- Mechanism of injury or nature of illness
 -

(2 of 2)



The initial assessment

- A closer look
 - Form a general impression of the pt
 - Assess responsiveness
 - Check the pt's airway
 - Check the pt's breathing
 - Check the pt's circulation (including severe bleeding)

Step II: Perform Initial Assessment

- Form a general impression of the patient.
- Assess responsiveness.
 - Introduce yourself.
 - Determine level of consciousness.



Step II: Perform Initial Assessment

- Describe level of consciousness using AVPU scale:
 - A = Alert –
 - V = Verbal –
 - P = Pain –
 - U = Unresponsive –

Step II: Perform Initial Assessment

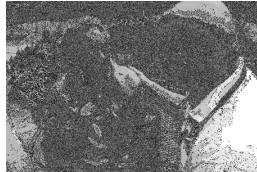
- Check airway:
 - Use head tilt–chin lift or jaw thrust in unconscious patients.
 - Inspect airway for foreign bodies.
- Check breathing:
 - Assess rate and quality.
 - If breathing is absent, open airway and perform rescue breathing.

Step II: Perform Initial Assessment

- Check circulation:
 - Find a pulse.
 - Check for severe bleeding.
 - Assess patient's skin color and temperature.
- Skin color may be:
 - Pale, flushed, cyanotic, or yellow

Step II: Perform Initial Assessment

- Acknowledge the patient's chief complaint.
 - Form an impression of the primary complaint.
- Update responding EMS units.



The Physical Examination

- A closer look

Step III: Physical Examination

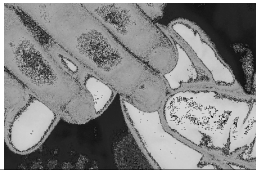
- Check patient from head to toe for non-life-threatening conditions.
- Purpose of exam is to locate and begin initial management of injury or illness.

Signs and Symptoms

- What is a sign? examples
- What is a symptom? examples
- Vital signs?

Capillary Refill

- Ability of circulatory system to return blood to capillaries after blood is squeezed out
- Done on patient's fingernails or toenails
- Will be delayed or absent if patient:
 - Has lost a lot of blood
 - Blood vessels to limb are damaged
 - Is very cold



Skin Condition

- Check for color and moisture.
- Check temperature.
- Skin may be:
 - Hot and dry
 - Hot and moist
 - Cold and dry
 - Cold and moist

Pupil Size and Reactivity

- Unequal size: Can indicate stroke or brain injury
- Remain constricted: Often present in person who is taking narcotics
- Remain dilated: Indicate a relaxed or unconscious state



Level of Consciousness

- Observe and note changes.
- Determine using the AVPU scale.

Head-to-Toe Exam

- Look and feel for signs of injury.

- Conduct a thorough examination in a logical, systematic manner.

Examine Patient's Head and Eyes

- Examine head:
 - Use both hands.
 - Do not move patient's head.
 - Remove eyeglasses.
 - Remove wig if necessary.
- Examine eyes:
 - Cover one eye for 5 seconds.
 - Watch for pupil contraction.

Examine the nose and mouth

- Look for deformities of the nose
- Blood or fluids
- Clear any objects from the mouth

Examine Patient's Neck

- Examine each side; check for pain.
- Check neck veins – maybe a heart px

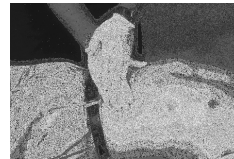


Examine Patient's Chest

- Check for pain on inhalation/exhalation.
- Look for signs of difficult breathing.
- Note injuries, bleeding, or abnormal, unequal, or painful movement.
- Check for collarbone or rib fractures.

Examine Patient's Abdomen

- Look for signs of external bleeding, penetrating injuries, or protruding parts.



Examine Patient's Pelvis

- Check for obvious bruising, bleeding, or swelling.
- Check for pain if no pain has been reported.



Examine Patient's Back

- Stabilize head and neck.
- Check one side of the back at a time.



Examine the Extremities

- Observe the extremity.
- Examine for tenderness.
- Check for movement.
- Check for sensation.
- Assess the circulatory status.

Patient's Medical History

- Check medical ID
 - Obtain Hx
- Obtain SAMPLE Hx

Step IV: Patient's Medical History

- Gather important facts about pt's general medical hx.
- ? pt in a clear and systematic manner.



Step IV: Patient's Medical History

- Signs/symptoms
- Allergies
- Medications
- Pertinent, past medical history
- Last oral intake
- Events associated with or leading to the injury

Ongoing Assessment

- A closer look
 - Repeat the initial assessment
 - Repeat the physical exam as prn
 - Check the effectiveness of the Rx
 - Calm the pt
 - Provide a hand-off report

Step V: Ongoing Assessment

- Monitor patient's vital signs:
 - Every
 - Every
- Maintain an open airway.
- Monitor breathing and pulse.
- Monitor skin color and temperature.

"Hand-off" Report

- Provide age and sex of pt.
- Describe incident and c/c.
- Describe pt's level of responsiveness.
- Report vital signs and examination results.
- Report pertinent medical condition in SAMPLE format.
- Report interventions provided.

Trauma vs. Medical Patients

- Patients can generally be divided into two categories:
 - Those who suffer from trauma
 - Those who have sudden illness
- Change sequence when dealing with an illness:
 - Obtain medical history before physical examination.

When to call

- Unconscious
- Breathing Px
- Persistent chest pain
- Cardiac arrest
- Severe bleeding
- Vomiting/passing blood
- seizures
- Severe headaches
- Slurred speech
- Injury to spine
- Obvious deformity