Chapter 7
Patient Assessment

Learning Objectives

- Identify components and importance of an initial (primary) assessment
- Explain importance of determining scene safety before entering
- Discuss common mechanisms of injury and nature of illness
- Discuss the reason for identifying the total number of patients at the scene
- Identify components of an initial (primary) history

Learning Objectives

- Discuss methods of assessing altered mental status
- Explain the importance of forming a general impression of the patient
- State reasons for management of the cervical spine once the patient has been determined to be a trauma patient
- Discuss methods of assessing airway and breathing in the adult, child, and infant
- Describe methods used to assess a pulse in an adult, child, and infant
Learning Objectives

- Discuss the need for assessing the patient for external bleeding
- Describe normal and abnormal findings when assessing skin condition and capillary refill
- Differentiate among assessing AMS, child, infant
- Compare methods of providing airway care to adult, child, infant
- Explain the reason for prioritizing a patient for care and transport
- Differentiate between sign and symptom

Learning Objectives

- Describe unique needs for assessing individuals with a specific chief complaint with no known prior history of the problem
- Differentiate between history and physical exam performed for responsive patients with no known prior history and for responsive patients with a known prior history of the problem
- Identify the components and importance of the SAMPLE history
- Differentiate between the assessment performed for a patient who is unresponsive or has an altered mental state and other medical patients requiring assessment

Learning Objectives

- Describe the needs for assessing an individual who is unresponsive
- Identify components, purpose, and importance of a focused (secondary) assessment
- Identify the components of vital signs
- Explain the value of performing the baseline vital signs
- Defend the need for obtaining and recording an accurate set of vital signs
Learning Objectives

- Describe methods to obtain a breathing rate, pulse, and BP
- Identify characteristics that should be evaluated during a breathing assessment
- Differentiate among shallow, labored, and noisy breathing
- Identify the information obtained in the assessment of the pulse
- Differentiate among a strong, weak, regular, and irregular pulse
- Define systolic pressure and diastolic pressure.

Learning Objectives

- Explain the difference between auscultation and palpation for obtaining a blood pressure (BP)
- Describe the methods used to assess the pupils
- Identify normal and abnormal pupil size
- Differentiate between dilated and constricted pupil size, reactive and nonreactive pupils, and equal and unequal pupils

Learning Objectives

- State the reasons for performing a rapid trauma assessment
- Determine when the rapid assessment may be altered to provide patient care
- Discuss reasons for reconsidering the mechanism of injury
- State reasons for performing a head-to-toe survey
- Describe areas included in the head-to-toe survey, and discuss what to evaluate
Learning Objectives

- Describe the components and importance of the ongoing assessment or reassessment
- Describe trending of assessment components
- Recognize, respect, and respond to the feelings that patients might experience during assessment

Patient Assessment

- Overview
  - Foundation of emergency medical care - comprehensive, systematic patient assessment
    - Scene size-up
    - Initial (primary) assessment
    - Focused (secondary) assessment

Scene Size-Up

- Critical actions
  - Police respond, secure scene
  - Identify potential for hazmat
  - Assist in disentanglement, extrication
  - Consider weather, environmental threats
  - Direct additional EMS units to severely injured
  - Once scene is safe, begin triage and initial assessment
Scene Size-Up

- Scene size-up & patient assessment
  - Assess scene, surroundings
  - Ongoing process
  - Patient assessment

Scene Size-Up

- Standard precautions
  - Protect against exposure/contact
    - Blood
    - All body fluids
    - Secretion/excretion
    - Nonintact skin
    - Mucous membrane
Scene Size-Up

- Personal protection

- Protective gear
  - Head gear
  - Eye protection
  - Respiratory protection (if required)
  - Gloves
  - Boots
  - Coat

Scene Size-Up

- Scene safety
  - Crash/rescue scenes
    - Most common hazard - surrounding traffic

Scene Size-Up

- Scene safety
  - Crash/rescue scenes
    - Scene survey: approach to crash scene
      - Stop 100 ft away, uphill, upwind
      - Look, listen
      - Assess resources
      - Determine if rescue attempt poses undue risk
      - Approach vehicle, survey victims
      - During approach, look for downed electrical wires
      - Evaluate vehicle stability
Scene Size-Up

- Scene safety
  - Crash/rescue scenes
    * Traffic delineation devices
  - Crime scenes
    * Do not enter until police have secured scene

- Scene safety
  - Do not block escape or challenge individual
  - Identify yourself as a medical provider
  - If person is upset, acknowledge, emphasize that you are there to help
  - Explain exactly what is being done in a calm, reassuring voice
  - Do not make quick moves; maintain safe distance
  - Encourage person to state problems; respond honestly to questions
Scene Size-Up

- Scene safety
  - Environmental hazards
    - Consider various potential environmental conditions
    - Is it safe to approach patient?

Scene Size-Up

- Scene safety
  - Protection
    - Patients
    - Bystanders

Scene Size-Up

- MOI/NOI
  - Manner in which injury occurred (MOI)
  - Type of medical symptoms patient exhibits (NOI)
Scene Size-Up

• MOI/NOI
  - Trauma patients
  - Determine MOI from inspection of scene and from patient, bystanders
  - Determine number of patients
  - Initiate mass casualty plan, as needed
  - Consider spinal precautions, begin primary assessment, triage

Scene Size-Up

• MOI/NOI
  - Significant MOI
  - Search for clues on body
  - Speed at impact

Scene Size-Up

• MOI/NOI
  - Significant MOI
  - Look for injury patterns
Scene Size-Up

- MOI/NOI
  - Hidden injuries

Scene Size-Up

- MOI/NOI
  - Hidden injuries

Scene Size-Up

- MOI/NOI
  - Infants, children
    - Bicycle collisions
    - Struck by vehicles
    - Fall from small heights
Scene Size-Up

- MOI/NOI
  - Medical patients
    - Determine why EMS was activated
    - Number of patients
    - Ask about NOI
    - Scene may offer clues

Scene Size-Up

- MOI/NOI
  - Multiple patients
    - Call for additional help before patient contact
    - Identify need for advanced life support (ALS) intercept early
    - Triage
    - Consider initiating MCI plan

Initial (Primary) Assessment

- Rapid means of assessing patient condition, life threats, priority of care
Initial (Primary) Assessment

- General impression
  - Based on immediate assessment of environment, patient’s general appearance

- Life-threatening conditions
  - Treat immediately
    - Airway management, positive-pressure ventilation
    - Supplemental O₂
    - CPR
    - Defibrillate
    - ALS intercept
    - Bleeding control
    - Determine if rapid transport appropriate
Initial (Primary) Assessment

- Spinal immobilization
  - Immobilize appropriately

- Assessment of mental status
  - Central nervous system (CNS) function evaluated by assessing level of consciousness (LOC)
  - Patient’s mental state - most sensitive indicator

Skill 7-1: Establishing Responsiveness

- For suspected trauma, 1 EMT maintains inline manual immobilization of head & neck, while 2nd EMT performs initial assessment.

Skill 7-1: Establishing Responsiveness

- If no response to verbal stimuli, tap on patient’s chest. Vigorously rub sternum or firmly pinch neck muscles.
Skill 7-1: Establishing Responsiveness

- Unresponsive patient should be placed in supine position. If spinal injury is suspected, do this while maintaining alignment of spine.

Initial (Primary) Assessment

- Airway assessment
  - Head-tilt/chin-lift
  - Jaw thrust without head tilt
  - Tongue-jaw lift
  - Opening airway is a priority over spinal injury

Skill 7-2: Supine Position

One-Person Procedure

- Support patient’s c-spine; hold arm next to chest
- Carefully rotate patient while maintaining spinal alignment
Skill 7-2: Supine Position
One-Person Procedure

- Place patient in supine position

Skill 7-2: Supine Position
Two-Person Procedure

- 1st EMT maintains c-spine alignment, while 2nd EMT supports shoulder and hips
- Both EMTs smoothly rotate patient to lateral position on command of 1st EMT

Skill 7-2: Supine Position
Two-Person Procedure

- Carefully rotate patient to supine position
Skill 7-3: Opening the Airway

**Head-Tilt/Chin-Lift**

- Place 1 hand on forehead and fingers of other hand along patient’s jawbone
- Apply gentle, tilting force to forehead while lifting chin upward; do not close mouth

**Jaw Thrust**

- Place both thumbs on maxilla and index & middle fingers on both sides of mandible where it angles
- Apply upward pressure with your fingers to displace jaw forward without tilting head

- Grasp lower jaw with your thumb and index & middle fingers, placing thumb inside lower teeth and fingers along margin of mandible inferriorly
- While stabilizing head with other hand, pull jaw forward
Initial (Primary) Assessment

Breathing assessment
- Evaluate adequacy of ventilation, oxygenation
  - Responsive patient, breathing may be normal or rapid
    - Rapid (more than 24 breaths/min)
    - Slow (less than 8 breaths/min)
  - Breaths may be shallow or deep
- Look, listen, and feel
  - If inadequate breathing:
    - Provide supplemental O₂
    - Determine need for airway adjuncts, ventilatory assistance

Skill 7-4: Assessing Breathing

Look, listen, feel
- Look for breathing: chest/abdominal movement, use of accessory muscles, retractions
- Feel for warm breath

Respiratory distress:
- Maintain open airway, administer high-concentration O₂, determine need for assisted ventilations

Initial (Primary) Assessment

Circulation assessment
- Pulse check
  - Unresponsive patient: carotid pulse
  - Responsive patient: radial pulse
  - Child younger than 1 year: brachial pulse; if faint/absent, femoral pulse
  - If no pulse:
    - Start cardiopulmonary resuscitation (CPR), attach AED
Initial (Primary) Assessment

- Circulation assessment
  - Pulse check

Identify life-threatening bleeding:
- Rapid external blood loss must be controlled
  - Direct pressure
  - Elevation
  - Pressure points (in extremity)
  - Tourniquet as last resort

Signs of perfusion:
- Examine skin
  - Assess by inspection, palpation
    - Skin color
    - Skin temperature
    - Moisture
    - Capillary refill time
Initial (Primary) Assessment

- Circulation assessment
  - Skin color
    - Inspect nail beds, oral mucosa, conjunctiva
    - Abnormal skin color:
      - Pale, poor perfusion - reduced blood flow/low hemoglobin
      - Cyanotic (blue-gray) - inadequate oxygen in blood/poor perfusion
      -Flushed - sign of exposure to heat/carbon monoxide
      - Jaundiced (yellowish tint) - liver abnormalities
Initial (Primary) Assessment

- Circulation assessment
  - Skin color
    - Cyanosis
  - Jaundice

- Skin temperature & condition
  - Assess temperature, moisture
    - Normal, described as warm
    - Hot indicates fever
    - Cool, cold, clammy indicates poor perfusion
    - Assess capillary refill time
Initial (Primary) Assessment

- Circulation assessment
  - Skin temperature & condition
  - Assess capillary refill time

Initial (Primary) Assessment

- Infants & children
  - Alter assessment techniques

Initial (Primary) Assessment

- Identification of priority patients
  - Provide lifesaving treatments as needed during initial assessment
  - Patients in unstable condition should be transported immediately
Patient History

- Patient’s chief complaint, signs/symptoms
  - Rapid assessment of conditions that require emergency care, rapid transport
  - Determine history of present illness
  - Signs/symptoms
  - Patient complaint
  - Observable evidence (e.g., OPQRST)
  - SAMPLE history
  - Rapid assessment of body regions
  - Baseline vital signs

Patient History

- Sources of a history
  - Best: Alert, competent patient
  - If patient is unable to communicate - closest family member
  - If necessary, friend, bystanders at scene, public safety workers

Patient History

- Reliability of history
  - History only as good as truth it reveals about current, past history of patient
  - In some circumstances, patients, family members, others provide false/inaccurate information
  - Unsure/concerned about accuracy of data, notify physician/nurse on arrival
Patient History

- **Chief complaint**
  - History key to assessing, managing patient
  - Identifies areas of body that require examination
  - Chief complaint with no prior history of problem:
    - Need condition explored to identify underlying problem
  - Patients with ongoing illness may know chief complaint, underlying problem

Patient History

- **History of present illness**
  - Most significant part of assessment for medical patient
    - Signs, symptoms
    - Allergies
    - Medications
    - Pertinent past medical history
    - Last oral intake
    - Events leading to present illness
Patient History

- Signs/symptoms of present illness
  - Onset
  - Provocation
  - Quality
  - Radiation
  - Severity
  - Time

Patient History

- Signs/symptoms of present illness
  - Allergies & medications
    - Inquire about allergy history, including allergic reactions
    - Current medications
    - Bring medications to hospital

Patient History

- Signs/symptoms of present illness
  - Pertinent past medical history
    - Always ask about history
    - Note any hospitalizations, surgeries, current medications, currently under physician care
    - General questions about overall health status
Patient History

- Signs/symptoms of present illness
  - Last oral intake
    - Information may provide indication of patient’s underlying condition
    - Note compliance/noncompliance in taking prescribed medications

Patient History

- Signs/symptoms of present illness
  - Not clear from answers to previous questions?
    - Ascertain chronology of events leading to call for help
  - Unresponsive patients - determine if recent trauma occurred

Patient History

- Signs/symptoms of present illness
  - History according to type of patient
    - Questions asked depend on specific complaint/situation
    - OPQRST format for complaints of pain/respiratory distress; other situations may require additional questions
Patient History

- Responsive patient
  - History, physical examination directed toward chief complaint

Patient History

- Unresponsive patient or patient with altered mental status
  - Head-to-toe survey
  - Be sure trauma not playing role
  - Inspect, feel for injuries, other signs
  - If unresponsive, ask family, bystanders

Patient History

- Unresponsive patient or patient with altered mental status should be placed in recovery position
Patient History

- Respecting privacy & patient autonomy
  - Be sensitive to right to privacy during questioning, physical examination
  - Inform patient about your intentions before beginning physical examination

- Challenging issues related to histories
  - Silent
  - Overly talkative
  - Anxious
  - Angry, hostile
  - Intoxicated
  - Crying
  - Depressed

Focused (Secondary) Assessment

- Reconsider mechanism of injury to determine patient needs
  - Head-to-toe survey
  - Focused physical examination
Focused (Secondary) Assessment

- Baseline vital signs
  - Measurements of functions of vital body systems
  - Good indicators of abnormal conditions
  - Central role in determining prehospital management
  - Observe trends
  - Know norms

- Respirations
  - Normal breathing
  - Rate
  - Quality

- Quality
  - Normal
  - Shallow
  - Labored
  - Noisy
Focused (Secondary) Assessment

Baseline vital signs
- Pulse
  - Alternating expansion, contraction of artery caused by rhythmic propulsion of blood with each heartbeat
  - Pulse evaluated by rate, quality
    - Radial
    - Brachial
    - Femoral
    - Dorsalis pedis, posterior tibial
    - Carotid

Focused (Secondary) Assessment

Checking a Radial Pulse
Focused (Secondary) Assessment
Checking a Brachial Pulse

Focused (Secondary) Assessment
Checking a Femoral Pulse

Focused (Secondary) Assessment
Checking a Dorsalis Pedis Pulse
Focused (Secondary) Assessment
Checking a Posterior Tibial Pulse

Focused (Secondary) Assessment
Checking a Carotid Pulse

Focused (Secondary) Assessment

- Baseline vital signs
  - Skin
    - Examination of skin gives clues for perfusion, oxygenation
    - Inspect, palpate to assess color, temperature, moisture, capillary refill time
    - Assess nail beds, oral mucosa, conjunctiva

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Focused (Secondary) Assessment

- Baseline vital signs
  - Skin - pale
    - Poor perfusion - impaired blood flow to skin surface
    - Loss of blood volume
    - Decreased BP
    - Blood flow constriction, cold environment
    - Blockage/tear of vessel supplying area of skin tissue
    - Pale skin on face, conjunctiva - hypoperfusion

Focused (Secondary) Assessment

- Baseline vital signs
  - Skin
    - Cyanotic
    - Poor oxygenation
    - Flushed
      - Increased blood flow
    - Jaundiced
Focused (Secondary) Assessment

- Baseline vital signs
  - Skin temperature
    - Temperature
    - Moisture
    - Capillary refill time
  - Blood pressure
    - Measure of force blood exerts on artery walls
    - Factors
      - Amount of blood ejected from heart each minute
      - Space within arteries that blood occupies
      - Measurement of BP reflects phases of heart’s cycle: systole (contraction), diastole (relaxation)
    - Blood pressure cuff
      - Various sizes available, correct size important
        - Adult: 1/3 to 1/2 arm circumference
        - Children: encircle 3/4 of arm
Focused (Secondary) Assessment

Baseline vital signs
- Blood pressure
  - Methods for measuring BP
    - Auscultation
    - Palpation
Skill 7-5: Measuring Blood Pressure
Auscultation

- Place BP cuff on arm just above elbow with bladder portion of cuff centered over brachial artery
- Locate brachial pulse point in crease of anterior side of elbow

- Place stethoscope over pulse point. Close valve above valve on BP cuff, pump air into cuff until dial on gauge undulates as it moves upward (approximately 150 to 200 mm Hg).
- Release valve slowly and listen for soft pulsating sounds. 1st sound heard – systolic BP.

- Continue to release pressure & listen until sounds disappear – diastolic BP.
- Record measured values (systolic reading over diastolic reading) using diagonal line to divide them.
Skill 7-6: Measuring Blood Pressure
Palpation

- After applying cuff, monitor radial pulse & pump up pressure until pulse disappears.
- Slowly release pressure until pulse first appears (systolic BP).

Focused (Secondary) Assessment

- Normal/abnormal BP readings
  - Vary in adults
    - Systolic BP – 100 mm Hg + patient's age (max 140 to 150 mm Hg)
    - Diastolic BP - 60 to 90 mm Hg
    - Women – 8 to 10 mm Hg lower than men of same age
  - Children/young adults – lower than adults
  - Many factors and diseases affect BP
  - Question patients about their normal BP

Focused (Secondary) Assessment

- Baseline vital signs
  - Pupils
    - Central, round, black portion of eye, normally changes diameter in light
    - Measure:
      - Diameter
      - Reactivity to light
      - Equality of size
      - PERRL
Focused (Secondary) Assessment

- Baseline vital signs
  - Vital signs assessment
    - Continually monitor vital signs on scene, during transport
      - Stable – every 15 min
      - Unstable - every 5 min
      - Reassess after any intervention
      - Compare changes during treatment & transport

Focused (Secondary) Assessment

- Rapid assessment
  - Approach varies by severity of MOI
    - Minor injury - focus on injury
    - Serious injury - head-to-toe assessment
Focused (Secondary) Assessment

- Reconsidering MOI
  - One of the 1st details to determine when arriving on scene
    - Anticipate injury patterns
  - Hidden injuries
    - Were safety devices used? Used properly?
    - "Lift & look" - airbag deployment

Focused (Secondary) Assessment

- Reconsidering MOI
  - Infants, children
    - Bicycle collisions
    - Impact from vehicles
    - Falls from lesser heights
  - Elderly patients
    - Can be seriously injured by lesser MOI
    - Different response than younger people

Focused (Secondary) Assessment

- Detailed physical examination
  - Head-to-toe survey on all patients with significant MOI, looking for signs, symptoms of injuries
  - If potential for spinal/head injury, maintain spinal stabilization while conducting head-to-toe survey
  - Determine if rapid transport/ALS intercept are warranted
Focused (Secondary) Assessment

- DCAP/BTLS
  - Deformities
  - Contusions
  - Abrasions
  - Punctures/penetrations
  - Burns
  - Tenderness
  - Lacerations
  - Swelling
Focused (Secondary) Assessment

- DCAP/BTLS
  - Abrasions

Focused (Secondary) Assessment

- DCAP/BTLS
  - Punctures/penetration

Focused (Secondary) Assessment

- DCAP/BTLS
  - Burns
    - Superficial
    - Partial-thickness
    - Full-thickness
Focused (Secondary) Assessment

- DCAP/BTLS
  - Tenderness

Focused (Secondary) Assessment

- DCAP/BTLS
  - Lacerations

Focused (Secondary) Assessment

- DCAP/BTLS
  - Swelling
Focused (Secondary) Assessment

- Head-to-toe survey
  - Examination ensures all body parts included
  - Look for and note signs of injury using DCAP/BTLS
    - Head
    - Neck
    - Chest
    - Abdomen
    - Pelvis
    - Lower & upper extremities

Focused (Secondary) Assessment

- Head-to-toe survey
  - Head
    - Always examine for injuries
    - Trauma patient - assume neck injury
    - Observe & palpate skull; face carefully/gently
    - Avoid compressing bone fragments into brain if skull fracture present

Focused (Secondary) Assessment

- Head-to-toe survey
  - Neck
    - Palpate for signs of injury
    - Active neck muscles
    - Check neck veins
Focused (Secondary) Assessment

- Head-to-toe survey
  - Chest
    - Observe & palpate on anterior, posterior, lateral planes
    - Identify open wounds, seal with airtight dressing
    - Watch for paradoxical/symmetrical movement
    - Look for use of accessory muscles
    - Listen to lungs

- Abdomen
  - Inspect for injury, distention, bloated appearance
  - Assess for abdominal masses, possible bowel obstruction/abdominal aneurysm
Focused (Secondary) Assessment

- Head-to-toe survey
  - Pelvis
    - Inspect, palpate hip region

Focused (Secondary) Assessment

- Head-to-toe survey
  - Lower extremities
    - Observe & palpate bilaterally; compare one leg to other
    - Evaluate for circulation, nerve function

Focused (Secondary) Assessment

- Head-to-toe survey
  - Upper extremities
    - Inspect & palpate bilaterally
    - Check for sensation
    - Evaluate motor function
    - Check radial pulse
Focused (Secondary) Assessment

- Head-to-toe survey
  - Log roll patient
  - Using spinal precautions, roll to inspect & palpate posterior surface of body for injuries when transferring patient to long spine board

Skill 7-7: Head-to-Toe Survey

- Inspect and palpate the head for injuries and signs of injuries (DCAP/BTLS)

Skill 7-7: Head-to-Toe Survey

- Inspect & palpate the neck
Skill 7-7: Head-to-Toe Survey

- While palpating trachea, look & feel for:
  - Crepitation
  - Tracheal deviation
  - Neck vein distention
- Apply cervical collar

Skill 7-7: Head-to-Toe Survey

- Inspect & feel chest; note any crepitation or paradoxical motion

Skill 7-7: Head-to-Toe Survey

- Auscultate breath sounds on anterior chest wall
Skill 7-7: Head-to-Toe Survey

- Auscultate breath sounds on lateral chest wall

Skill 7-7: Head-to-Toe Survey

- Inspect & palpate abdomen; note if firm, soft, or distended
- Inspect & palpate pelvis; if no pain, gently compress to detect tenderness or motion

Skill 7-7: Head-to-Toe Survey

- Inspect & palpate lower extremities
- Inspect and palpate the lower leg, checking for DCAP/BTLS
Skill 7-7: Head-to-Toe Survey

- Check distal pulse; palpate dorsalis pedis
- Palpate posterior tibial pulse

Skill 7-7: Head-to-Toe Survey

- Check motor ability; ask the patient to flex his/her foot against your hand

Skill 7-7: Head-to-Toe Survey

- Ask the patient to extend his/her foot
Skill 7-7: Head-to-Toe Survey

- Check sensation; instruct patient close his/her eyes & state when you touch the legs & feet
- Check motor ability; ask the patient to move his/her hands

Skill 7-7: Head-to-Toe Survey

- Have the patient spread his or her fingers and squeeze your fingers; ask the patient to pull & push your hands

Skill 7-7: Head-to-Toe Survey

- Check the radial pulse
Skill 7-7: Head-to-Toe Survey

- Log-roll patient and check the back

Ongoing Assessment (Reassessment)

- Reevaluation of patient
  - Look for changes in condition
  - Observe dynamic status changes
  - Document changes

Ongoing Assessment (Reassessment)

- Emotional needs
  - Be sensitive to feelings patient might experience
  - Be honest; do not draw conclusions beyond your scope of practice
Ongoing Assessment (Reassessment)

- Components
  - Repeat initial assessment
  - Reassess mental status
  - Maintain open airway
  - Monitor breathing for rate, quality

Ongoing Assessment (Reassessment)

- Components
  - Reassess pulse for rate & quality
  - Monitor skin color, temperature
  - Reestablish priority patients
  - Reassess & record vital signs

Ongoing Assessment (Reassessment)

- Components
  - Repeat focused (secondary) assessment
  - Check interventions
Summary

- EMT determines:
  - If scene/situation is safe
  - Uses appropriate PPE
  - Determines MOI/NOI
  - Determines number of patients
  - Requests additional help if necessary
  - Begins triage
  - Considers spinal stabilization

Summary

- General impression – 1st step of initial (primary) assessment, when you note patient's age & gender, NOI/MOI, and any obvious life-threatening conditions

Summary

- Lifesaving treatments include:
  - Controlling bleeding
  - Opening & maintaining airway
  - Providing supplemental O₂, positive-pressure ventilations
  - AED
  - CPR
Summary

- Assess mental status quickly during initial (primary) assessment using AVPU mnemonic:
  - Alert
  - Verbal stimuli
  - Painful stimuli
  - Unresponsive

Summary

- Assess airway with appropriate technique: head-tilt/chin-lift for medical patients and jaw thrust for trauma patients with suspected spinal injury

- Assess breathing - "look, listen, and feel" method:
  - Look for chest and abdominal movements, accessory muscle use, retractions
  - Listen for air movement, abnormal sounds of breathing
  - Feel for warm air from lips, mouth

Summary

- Assess circulation pulse check:
  - Radial pulse - children/adults
  - Brachial pulse – infants
  - Carotid pulse - unresponsive patients

- Assess circulation & perfusion by assessing skin, nail bed, conjunctivae, mucous membranes for color, temperature, and condition (moisture)
Summary

- Focused (secondary) assessment - reconsider MOI/NOI to guide scope of the evaluation
- MOI guides the physical examination. If MOI is significant, conduct a head-to-toe survey. If the MOI is limited, a focused physical examination of affected part may be sufficient
- DCAP/BTLS can guide you during the head-to-toe survey

Summary

- Responsive medical patient - perform focused (secondary) physical examination based on chief complaint, history of present illness, SAMPLE history
- Unresponsive medical patient - perform head-to-toe survey, and then obtain as complete a history as possible from family/bystanders
- OPQRST can be used to guide you during collection of history of present illness to clarify complaints and factors surrounding the event.

Questions?