Patient Assessment Skills Practice

Receive EMS Call – Initial Information / Preparation
Respond to EMS Call – Street Knowledge, Location, Frequent Flyer, Parking, Positioning, Staging
Scene Survey – *Is the scene SAFE? *MOI / NOI? *# of Patients? *Do we need HELP?
Body Substance Isolation Precautions prior to Patient Contact
General Impression of the scene / patient – Mental Status and Immediate Life Threat's (Major Arterial Bleeding)
C-Spine Control (if indicated)
Level of Consciousness (A&O x ___,V,P,U)
"My name is _____, we are here to help you. What happened?"

AIRWAY – Is it clear and unobstructed? (Broken teeth, vomit, blood, dentures, etc.)
Open airway if necessary: ***Head Tilt Chin Lift or Jaw Thrust***

BREATHING – Yes/No If breathing, Rate/Regularity/Quality (RRQ)
Ventilation / Oxygenation Instructions

CIRCULATION – Check Carotid and Bilateral Radials (RRQ)

SKIN – Color, Condition, and Temperature

Transport Decision – Load and GO **or** Stay and Play

L&G Criteria – **1)** Altered Mental Status **2)** Respiratory Distress **3)** Hemodynamic Instability (Shock) *4) MOI/NOI*

MEDICAL		**TRAUMA**	
Serious S/S	*No serious S/S*	**Serious S/S**	*No serious S/S*
|	|	|	|
Rapid Trauma Assessment	Focused H&PE	Rapid Trauma Assessment	Focused H&PE
Head to Toe Exam	Chief Complaint	Head to Toe Exam	Chief Complaint

Head – DCAP-BLS or TIC? Battle Signs, Raccoon Eyes, Blood or Cerebral Spinal Fluid, Eyes (PERRL)
Neck – DCAP-BLS or TIC? Jugular Venous Distention, Trachea Midline ***Place C-Collar if indicated***
Chest – DCAPParadoxical Motions-BLS or TIC? Breath Sounds X 4 quads (percuss if unequal)
Abdomen – DCAP-BLS? All quads (Rigidity, tenderness, distention)
Pelvis – DCAP-BLS or TIC? Stability, Check Symphysis Pubis, Incontinence
Lower Ext. – DCAP-BLS or TIC? Pulse, Motor, Sensation? (PMS)
Upper Ext. – DCAP-BLS or TIC? PMS? Grip strengths, Arm Drift
Prepare for placement on BB or Stretcher
Back – DCAP-BLS or TIC? Exit wounds?

Obtain SAMPLE (if possible) prior to leaving scene if patient is not able to provide information.
Baseline set of VITALS (Blood Pressure, Heart Rate, Resp. Rate, Temp.)

Recheck / Perform Interventions – Ventilation/Oxygenation, Bleeding Control, Bandaging/Splinting, IV, EKG, etc.
Detailed Physical Examination – Repeat Head to Toe (more complete with interventions; i.e. Band/Splint etc.)
Contact ED – Clear and concise radio report (Findings, treatments, responses, Estimated Time of Arrival)
Ongoing Assessment – Constant Reevaluation, Interventions, Note Responses to Treatment
Documentation – Document fully and completely. Details are important.

D=Deformity C=Contusion A=Abrasion P=Puncture/Penetration B=Burns L=Lacerations S=Swelling T=Tenderness I=Instability C=Crepitus