Patient Assessment –Medical

1 - Scene Size-Up

- Body Substance Isolation [INCLUDES, BUT NOT LIMITED TO: GLOVES, MASK, GOWN, HEPA MASK]
- Assess for scene safety [IF THE SCENE IS UNSAFE RETREAT TO A SAFE DISTANCE - HAZMAT, WMD]
- Identify Nature of Illness (NOI)
- Identify number of patients
- Determine need for additional resources [OTHER BLS, ALS, FD, PD, ETC.]
- Application of cervical spine immobilization, as necessary

Age, gender and race information may be used to identify a patient whose name cannot be determined.

2 - Initial Assessment

- **General Impression**
  - Age, gender, race, position found
  - Determine NOI, if not already done
  - Locate and treat life threats/quick *CPR Check* [EXSANGUINATING BLEEDING, NO PULSE OR RESPIRATIONS, ETC.]
  - Verbalize a general impression of patient ["PALE 35 Y/O MALE, APPEARS VERY ILL WITH OBVIOUS RESP DISTRESS"]
- **Mental Status**
  - Check for responsiveness, if not readily apparent
  - Determine mental status/level of consciousness (LOC) on AVPU Scale
    - **A**lert - correctly answers three questions related to Person, Place and Time
    - **V**erbal - does not correctly answer all of above questions **OR** the patient only responds to verbal commands
    - **P**ain - only responds to painful stimuli
    - **U**nresponsive - does not respond to any stimuli
  - Determine chief complaint, if possible
- **Airway**
  - Can patient speak or cry?
  - Are there any unusual breathing sounds? [STRIDOR, WHEEZING, ETC]
  - Can the patient maintain his/her own airway?
    - Suction, as necessary
    - Modified jaw-thrust, as necessary
    - If not, insert an Oropharyngeal Airway (OPA) or Nasopharyngeal Airway (NPA)

A patient's dentures may block the airway if they are not securely in place.

To better assess the chest during the Initial Assessment, listen for lung sounds at the mid-axillary line.

- **Breathing**
  - Is the patient breathing?
  - Is the patient complaining of difficulty breathing?
  - Inspect the chest for obvious deformities [PARADOXICAL MOTION - RULE OUT TRAUMA]
  - Palpate the chest for unstable segments, crepitation & equal expansion of the chest [RULE OUT TRAUMA]
  - Is the breathing adequate? Is the rate & quality adequate to sustain life? [OBTAIN A QUICK RESPIRATORY RATE & QUALITY]
    - Ventilate if: respiratory rate is <10 and/or signs of inadequate oxygenation are present. Connect to oxygen as soon as possible.
    - Provide oxygen via Non-Rebreather if pt. exhibits SOB or difficulty breathing, or via nasal-cannula PRN

Use the following mnemonic to remember the steps of a good breathing assessment
***I** inspect*
***P**-palpate*
***A**-auscultate (listen)*
***O**-O_2 decision*

- **Circulation**
  - Is there life-threatening hemorrhage?
    - Control it if possible [DO NOT CONTROL MINOR BLEEDING AT THIS TIME]
  - Assess pulses for presence and quality:
    - Carotid if unresponsive, radial if responsive (Brachial pulse if patient ≤ 1 year of age)
    - If radial pulse is weak, or absent, compare it to/check carotid pulse
  - Assess patient's perfusion by evaluating the skin color, temperature and condition (CTC)
    - The patient's conjunctivae and lips may also be used to assess perfusion
    - Assess capillary refill in patient's < 6 years of age
  - Treat for hypoperfusion (shock) as necessary
    - Position patient supine, elevate legs, maintain body temperature (cover with a blanket)

Life-threatening bleeding may occur with GI bleeds. This may result in hematemesis, melena or show no external signs of bleeding other that the S & S of shock.

- **Identify Priority Patients**

Systolic blood pressure estimates may be obtained as follows:
Radial=80mmHg
Femoral=70mmHg
Carotid=60mmHg

HIGH PRIORITY: BEGIN PACKAGING AND TRANSPORT AS SOON AS POSSIBLE			FURTHER ASSESSMENT MAY BE PERFORMED
Critical	**Unstable/Potentially Unstable**		**Stable**
•Cardiac or respiratory arrest	•Poor general impression	•Complicated childbirth	•Minor illness
•Ventilated patients	•Unresponsive-no gag/cough reflex	•Uncontrolled bleeding	•Uncomplicated extremity injury
	•Responsive, but can't follow commands	•Severe pain anywhere in body	•Any patient that cannot be categorized as C, U or P
	•Difficulty breathing	•Severe chest pain, especially with systolic < 100 mmHg	
	•Signs of hypoperfusion	•Inability to move any body part	

Look for signs of incontinence when examining the pelvis..

Leave the B/P cuff in place when treating patients requiring constant monitoring.

Have a long spineboard ready when log-rolling the patient to check the posterior. When you're done checking for bleeding and DCAP-BTLS secure the patient to the board.

When performing a focused physical exam, it is also a good idea to look at areas associated with the chief complaint, i.e.: For chest pains, also look for JVD, swollen ankles and clubbing of the fingers.

If your patient has a non-rebreather mask on you can use it to obtain a respiratory rate by counting the number of times the reservoir bag partially deflates, or the mask fogs up, in 30 seconds and multiply by 2.

*** For each of the medical emergencies listed, bold text denotes questions specified by New York State.**

3 - Focused History and Physical Examination

3a - Focused Medical Assessment

Performed if the patient is ***CONSCIOUS AND CAN ADEQUATELY RELATE THEIR CHIEF COMPLAINT***

For each of the following Medical Emergencies ask the following OPQRSTI/pertinent and SAMPLE questions *

Onset - what were you doing when the symptoms started?
Provocation - what makes the symptoms better or worse?
Quality - what does the pain/discomfort feel like?
Radiation - does the pain/discomfort radiate, or move? If YES, where?
Severity - on a scale on 1-to-10 how severe is this episode?
Time - how long has the problem been going on? Has it changed over time?
Interventions - have you taken anything to alleviate the pain/symptoms?

Cardiac & Respiratory	Ob/Gyn	AMS
OPQRSTI	**How long have you been pregnant?**	**Describe episode**
Interventions	Do you have to move your bowels?	**Associated symptoms**
	Are you pregnant? **Has water broken?**	**Evidence of trauma?**
	Previous pregnancies? If **YES**, How many?	**Seizures?** **Fever?**
	When was last period? **Pain/contractions?**	**Onset?** **Duration**
	Bleeding or discharge? Pre-natal care?	Compliant with meds?
	Do you need to push?	**Interventions**

Behavioral	Environmental	Poisoning	Allergic Reaction
How do you feel?	**Source (hot/cold)?**	**Substance?**	**What was exposure?**
Suicidal?	**Environment?**	**How much ingested/inhaled?**	**History of allergies?**
Is patient a danger to self/others?	**Loss of consciousness?**	**When exposed?**	**Method of exposure?**
Any medical problems?	**General or localized?**	**Over what time period?**	**Effects?**
Psych history?	**Duration?**	**Estimated weight?**	**Progression?**
Compliant with meds?	Alcohol use?	**Interventions**	Difficulty breathing?
Interventions	Shivering?		**Interventions**

Signs and symptoms - what is the patient feeling/what have you seen?
Allergies - to medications, foods, etc.
Medications - prescription (Rx), over-the-counter (OTC) and herbal
Past medical history - medical problems, hospitalizations and surgeries
Last oral intake - what and when?
Events leading up to this incident

Perform a **Focused Assessment** based on the patient's specific area of complaint/chief complaint. Follow the steps for the Rapid Medical Assessment (seen to the right and above), but geared toward the chief complaint.

3b - Rapid Medical Assessment

Performed if the patient is ***UNCONSCIOUS, CONFUSED OR UNABLE TO RELATE THEIR CHIEF COMPLAINT***.

Inspect/palpate each area of the body for the following (in addition to DCAP-BTLS):

Head Blood/fluid from ears, nose or mouth
Keep airway clear

Neck Jugular venous distention (JVD)
Crepitation
Apply CSIC, if necessary not already done

Chest Paradoxical motion
Crepitation
Breath sounds (apices of mid-clavicular line, mid-axillary at nipple line, and at bases)

Abdomen Pain
Firm/soft
Distention

INSPECT THE ABDOMEN ONE QUADRANT AT A TIME

Pelvis If no pain, gently compress iliac crests to determine instability

Extremities Crepitation
Distal pulses, sensory & motor function

Posterior Log-roll the patient while maintaining c-spine immobilization

4. Obtain **Vital Signs** (see below)
5. Obtain SAMPLE history from relatives/bystanders (see left)
6. Perform **Detailed Physical Exam** (see below)

4 – Baseline Vital Signs

Obtain a full set of vital signs, including:

- **Respirations** - rate, quality and rhythm [COUNT FOR 30 SECS AND MULTIPLY BY 2. IF IRREGULAR, COUNT FOR A FULL MINUTE]
- **Pulse** - rate, quality and rhythm [COUNT FOR 30 SECS AND MULTIPLY BY 2. IF IRREGULAR, COUNT FOR A FULL MINUTE. IF HYPOTHERMIC, COUNT FOR 30 - 45 SECS]
- **Blood Pressure** [NOT REQUIRED IN PATIENTS UNDER THREE YEARS OF AGE]
- **Level of Consciousness (LOC)** [USE AVPU]
- **Skin** - color, temperature and condition [CAPILLARY REFILL IN PATIENTS UNDER SIX YEARS OF AGE]
- **Pupils**

5 – Provide Treatment and Re-evaluate Transport Decision

Administer treatment appropriate to patient condition [MAY INCLUDE: MEDICATION ADMINISTRATION/ASSISTANCE, DELIVERY OF NEWBORNS, ETC.

Re-evaluate transport decision based on new information: i.e. vital signs, effects of medications, etc.

6 – Detailed Physical Examination

Performed to gather additional information regarding the patient's condition after attending to life-threatening conditions. **DO NOT DELAY** transport to perform this assessment. Perform during transport, or on scene if transport is delayed. Not necessarily performed on all patients. Performed in a head-to-toe manner as is the Rapid Medical Assessment, but with the following additions:

Face
Ears - Drainage, Battle's signs
Eyes - discoloration, equality of pupils, blood in anterior chamber, foreign bodies
Nose - drainage, bleeding
Mouth - broken teeth, unusual odors, discoloration
Neck - tracheal deviation
Genitalia/perineum - priapism, bleeding or discharge

7 - On-Going Assessment (for all patients)

Performed during transport to hospital. Consists of repeating the Initial Assessment, vital signs, Focused Assessment and interventions. Record any findings.

Repeat On-Going Assessment every 5 minutes for High Priority (Rapid Transport) Patients and every 15 minutes for Stable Patients.