

Cognitive Objectives

- 3-1.1 Discuss the components of scene size-up.
- 3-1.2 Describe common hazards found at the scene of a trauma and a medical patient.
- 3-1.3 Determine if the scene is safe to enter.
- 3-1.4 Discuss common mechanisms of injury/nature of illness.

Cognitive Objectives

- 3-1.5 Discuss the reason for identifying the total number of patients at the scene.
- 3-1.6 Explain the reason for identifying the need for additional help or assistance.
- 3-1.7 Summarize the reasons for forming a general impression of the patient.

Cognitive Objectives

- 3-1.8 Discuss methods of assessing mental status.
- 3-1.9 Differentiate between assessing mental status in the adult, child, and infant patient.
- 3-1.10 Describe methods used for assessing if a patient is breathing.
- 3-1.11 Differentiate between a patient with adequate and inadequate breathing.

Cognitive Objectives

- 3-1.12 Describe the methods used to assess circulation.
- 3-1.13 Differentiate between obtaining a pulse in an adult, child, and infant patient.
- 3-1.14 Discuss the need for assessing the patient for external bleeding.

Cognitive Objectives

- 3-1.15 Explain the reason for prioritizing a patient for care and transport.
- 3-1.16 Discuss the components of the physical exam.
- 3-1.17 State the areas of the body that are evaluated during the physical exam.

Cognitive Objectives

- 3-1.18 Explain what additional questioning may be asked during the physical exam.
- 3-1.19 Explain the components of the SAMPLE history.
- 3-1.20 Discuss the components of the ongoing assessment.
- 3-1.21 Describe the information included in the First Responder “hand-off” report.

Affective Objectives

- 3-1.22 Explain the rationale for crew members to evaluate scene safety prior to entering.

- 3-1.23 Serve as a model for others by explaining how patient situations affect your evaluation of the mechanism of injury or illness.
- 3-1.24 Explain the importance of forming a general impression of the patient.

Affective Objectives

- 3-1.25 Explain the value of an initial assessment.
- 3-1.26 Explain the value of questioning the patient and family.
- 3-1.27 Explain the value of the physical exam.

Affective Objectives

- 3-1.28 Explain the value of an ongoing assessment.
- 3-1.29 Explain the rationale for the feelings that these patients might be experiencing.
- 3-1.30 Demonstrate a caring attitude when performing patient

assessments.

Affective Objectives

- 3-1.31** Place the interests of the patient as the foremost consideration when making any and all patient care decisions during patient assessment.
- 3-1.32** Communicate with empathy during patient assessment to patients as well as with family members and friends of the patient.

Psychomotor Objectives

- 3-1.33** Demonstrate the ability to differentiate various scenarios and identify potential hazards.
- 3-1.34** Demonstrate the techniques for assessing mental status.
- 3-1.35** Demonstrate the techniques for assessing the airway.
- 3-1.36** Demonstrate the techniques for assessing if the patient is

breathing.

Psychomotor Objectives

- 3-1.37** Demonstrate the techniques for assessing if the patient has a pulse.
- 3-1.38** Demonstrate the techniques for assessing the patient for external bleeding.
- 3-1.39** Demonstrate the techniques for assessing the patient's skin color, temperature, condition, and capillary refill (infants and children only).

Psychomotor Objectives

- 3-1.40** Demonstrate questioning a patient to obtain a SAMPLE history.
- 3-1.41** Demonstrate the skills involved in performing the physical exam.
- 3-1.42** Demonstrate the ongoing assessment.

Knowledge and Attitude Objectives

- Discuss the importance of each of the following steps in the patient assessment sequence:
 - Scene size-up
 - Initial patient assessment
 - Examining the patient from head to toe
 - Obtaining the patient's medical history
 - Performing an ongoing assessment

Knowledge and Attitude Objectives

- Discuss the components of a scene size-up.
- Describe why it is important to get an idea of the number of patients at an emergency scene as soon as possible.

Knowledge and Attitude Objectives

- List and describe the importance of the following steps of the initial patient assessment:
 - Forming a general impression of the patient
 - Assessing the patient's responsiveness and stabilizing the spine if necessary
 - Assessing the patient's airway
 - Assessing the patient's breathing
 - Assessing the patient's circulation
 - Updating responding EMS units

Knowledge and Attitude Objectives

- Describe the differences in checking airway, breathing, and circulation when the patient is an adult, a child, or an infant.
- Explain the significance of the

- following signs: respiration, circulation, skin condition, pupil size and reactivity, and level of consciousness.
- Describe the sequence used to perform a head-to-toe physical examination.

Knowledge and Attitude Objectives

- State the areas of the body that you should examine during a physical examination.
- Describe the importance of obtaining the patient's medical history.
- State the information that you should obtain when taking a patient's medical history.

Knowledge and Attitude Objectives

- List the information that should be addressed in your hand-off report

- about the patient's condition.
- List the differences between performing a patient assessment on a trauma patient and performing one on a medical patient.
- Describe the components of the ongoing assessment.

Skill Objectives

- Perform the following five steps of the patient assessment sequence given a real or simulated incident:
 - Scene size-up
 - Initial patient assessment
 - Examination of the patient from head to toe
 - Obtaining the patient's medical history using the SAMPLE format
 - Performing an ongoing assessment

Skill Objectives

- Identify and measure the following signs on adult, child, and infant

patients: respiration, pulse, capillary refill, skin color, skin temperature, skin moisture, pupil size and reactivity, level of consciousness.

Patient Assessment

- Assessment of the scene and patient affects the level of care requested.
- The patient assessment sequence allows you to systematically gather information you need.

Patient Assessment Sequence

- Safely approach an emergency scene.
- Determine the need for additional help.
- Examine the patient to determine if injuries or illnesses are present.
- Obtain the patient's medical history.
- Report the results of your 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.

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
 - Look for clues and ask for additional information.
- Determine need for additional resources.

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, blue, or yellow

Step II: Perform Initial Assessment

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

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

- **Sign:** A condition you can feel or see
- **Symptom:** A condition the patient tells you
- **Important signs:**
 - Respirations
 - Pulse
 - Capillary refill

Respiration

- Respiratory rate indicates how fast the patient is breathing.
- Normal adult resting rate is 12 to 20 breaths per minute.
- Check rate and quality:
 - May be rapid and shallow or slow

- May be deep, wheezing, gasping, panting, snoring, noisy, or labored

Pulse

- Indicates speed and force of heartbeat
- Use radial, carotid, brachial, or posterior tibial pulse points.
- Note whether pulse is:
 - Regular or irregular
 - Strong (bounding)
 - Weak (thready)

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.

- Deformities
- Open injuries
- Tenderness
- Swelling
- Conduct a thorough examination in a logical, systematic manner.

Examine Patient's Head and Eyes

Examine Patient's Neck

Examine Patient's Chest

Examine Patient's Abdomen

Examine Patient's Pelvis

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.

Step IV: Patient's Medical History

- Attempt to gather important facts about patient's general medical history.
- Question patient in a clear and systematic manner.
- SAMPLE history provides framework to ask needed questions.

Step IV: Patient's Medical History

- **S**igns/symptoms
- **A**llergies
- **M**edications
- **P**ertinent, past medical history
- **L**ast oral intake
- **E**vents associated with or leading to

the injury

Step V: Ongoing Assessment

- Monitor patient's vital signs:
 - Every 5 minutes if unstable
 - Every 10 minutes if stable
- Maintain an open airway.
- Monitor breathing and pulse.
- Monitor skin color and temperature.

“Hand-off” Report

- Provide age and sex of patient.
- Describe incident and chief complaint.
- Describe patient'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.