

## **Testing Orientation**

- **Person** - His or her name
- **Place** - His or her current location
- **Time** - Current year, month, and approximate date
- **Event** - Describe what happened  
MOI/NOI

# Caring for Abnormal Mental Status

- Complete initial assessment.
- Provide high-flow oxygen.
- Consider spinal immobilization based upon MOI/NOI.
- Initiate transport.
- Support ABCs.
- Reassess.

## **Assessing the Airway**

- Look for signs of airway compromise:
  - Two to three - word dyspnea
  - Use of accessory muscles
  - Nasal flaring and use of accessory muscles in children
  - Labored breathing

## **Signs of Airway Obstruction in the Unconscious Patient**

- Obvious trauma, blood, or other obstruction
- Noisy breathing such as bubbling, gurgling, crowing, or other abnormal sounds
- Extremely shallow or absent breathing

## **Assessing Breathing**

- **Choking**
- **Rate**
- **Depth**
- **Cyanosis**
- **Lung sounds**
- **Air movement**

# Assessing Breath Sounds



## **High-Flow Oxygen Administration**

- Breathing faster than 20 breaths/min
- Breathing slower than 12 breaths/min
- Breathing too shallow
- Decreased level of consciousness
- Respiratory distress
- Poor skin color

## **Positioning the Patient**

- **Position of comfort**
  - **Sitting up with feet dangling**
  - **High Fowler's position**
- **Spinal precautions if possible spinal injury**

## **Assessing the Pulse**

- **Presence**
- **Rate**
- **Rhythm**
- **Quality - Strength**

# Normal Pulse Rates in Infants & Children

| <i>Age</i>                  | <i>Range<br/>(beats/min)</i> |
|-----------------------------|------------------------------|
| Infant: 1 month to 1 year   | 100 to 160                   |
| Toddler: 1 to 3 years       | 90 to 150                    |
| Preschool-age: 3 to 6 years | 80 to 140                    |
| School-age: 6 to 12 years   | 70 to 120                    |
| Adolescent: 12 to 18 years  | 60 to 100                    |

# **Assessing and Controlling External Bleeding**

- Assess after clearing the airway and stabilizing breathing.
- Look for blood flow or blood on floor/clothes.
- Controlling bleeding
  - Direct pressure
  - Elevation
  - Pressure points

## **Assessing Perfusion**

- **Color**
- **Temperature**
- **Skin condition**
- **Capillary refill**

## **Priority Patients**

- Difficulty breathing
- Poor general impression
- Unresponsive with no gag reflex
- Severe chest pain
- Signs of poor perfusion
- Complicated childbirth
- Uncontrolled bleeding
- Responsive but unable to follow commands
- Severe pain
- Inability to move any part of the body

## **Transport Decision**

- **Patient condition**
- **Availability of advanced care**
- **Distance to transport**
- **Local protocols**

Scene Size-up

Initial Assessment

Trauma Patients

Medical Patients

### Focused History and Physical Exam

#### Reconsider Mechanism of Injury

| Significant Mechanism of Injury | No Significant Mechanism of Injury                 |
|---------------------------------|--|
| Rapid Trauma Assessment         | Focused Trauma Assessment Based on Chief Complaint |
| Baseline Vital Signs            | Baseline Vital Signs                               |
| SAMPLE History                  | SAMPLE History                                     |
| Reevaluate Transport Decision   | Reevaluate Transport Decision                      |

### Focused History and Physical Exam

#### Evaluate Responsiveness

| Responsive  | Unresponsive                  |
|---|-------------------------------|
| History of Illness                                  | Rapid Medical Assessment      |
| SAMPLE History                                      | Baseline Vital Signs          |
| Focused Medical Assessment Based on Chief Complaint | SAMPLE History                |
| Baseline Vital Signs                                | Reevaluate Transport Decision |
| Reevaluate Transport Decision                       |                               |

Detailed Physical Exam

Ongoing Assessment

Trauma Patients

Medical Patients

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## Medical Patients



# Focused History and Physical Exam

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| History of Illness                                     | Rapid Medical Assessment      |
| SAMPLE History   | Baseline Vital Signs          |
| Focused Medical Assessment<br>Based on Chief Complaint | SAMPLE History                |
| Baseline Vital Signs                                   | Reevaluate Transport Decision |
| Reevaluate Transport Decision                          |                               |



## Focused History and Physical Exam

- Understand the circumstances surrounding the chief complaint.
- Obtain objective measurements.
- Perform physical exam.

# **Components of Focused History and Physical Exam**

- **Medical history**
- **Baseline vital signs**
- **Physical exam**

# Rapid Physical Exam

- 60-90 second head-to-toe exam
- Performed on:
  - Significant trauma patients
  - Unresponsive medical patients
- Identifies undiscovered conditions



## DCAP-BTLS

- **D** Deformities
- **C** Contusions
- **A** Abrasions
- **P** Punctures/  
Penetrations
- **B** Burns
- **T** Tenderness
- **L** Lacerations
- **S** Swelling

# Components of a Rapid Physical Exam (1 of 3)

- Maintain spinal immobilization while checking patient's ABCs.
- Assess the head.
- Assess the neck.
- Apply a cervical spine immobilization collar.



# Components of a Rapid Physical Exam (2 of 3)

- Assess the chest.
- Assess the abdomen.
- Assess the pelvis.



## Components of a Rapid Physical Exam (3 of 3)

- Assess all four extremities.
- Roll the patient with spinal precautions.



## **Focused Physical Exam**

- Used to evaluate patient's chief complaint
- Performed on:
  - Trauma patients without significant MOI
  - Responsive medical patients

## **Head, Neck, and Cervical Spine**

- Feel head and neck for deformity, tenderness, or crepitation.
- Check for bleeding.
- Ask about pain or tenderness.



## **Chest**

- Watch chest rise and fall with breathing.
- Feel for grating bones as patient breathes.
- Listen to breath sounds.



## **Abdomen**

- Look for obvious injury, bruises, or bleeding.
- Evaluate for tenderness and any bleeding.
- Do not palpate too hard.



## **Pelvis**

- Look for any signs of obvious injury, bleeding, or deformity.
- Press gently inward and downward on pelvic bones.



## **Extremities**

- Look for obvious injuries.
- Feel for deformities.
- Assess
  - Pulse
  - Motor function
  - Sensory function



## **Posterior Body**

- Feel for tenderness, deformity, and open wounds.
- Carefully palpate from neck to pelvis.
- Look for obvious injuries.



## **Specific Chief Complaints**

- Chest pain
- Shortness of breath
- Abdominal pain
- Pain associated with bones or joints
- Dizziness



## **Significant Mechanism of Injury**

- Ejection from vehicle
- Death in passenger compartment
- Fall greater than 15'-20'
- Vehicle rollover
- High-speed collision
- Vehicle-pedestrian collision
- Motorcycle crash
- Unresponsiveness or altered mental status
- Penetrating trauma to the head, chest, or abdomen

## **Assessment Steps for Significant MOI**

- Rapid trauma assessment
- Baseline vital signs
- SAMPLE history
- Reevaluate transport decision

## **Assessment Steps for Trauma Patients Without Significant MOI**

- **Focused assessment**
- **Baseline vital signs**
- **SAMPLE history**
- **Reevaluate transport decision**

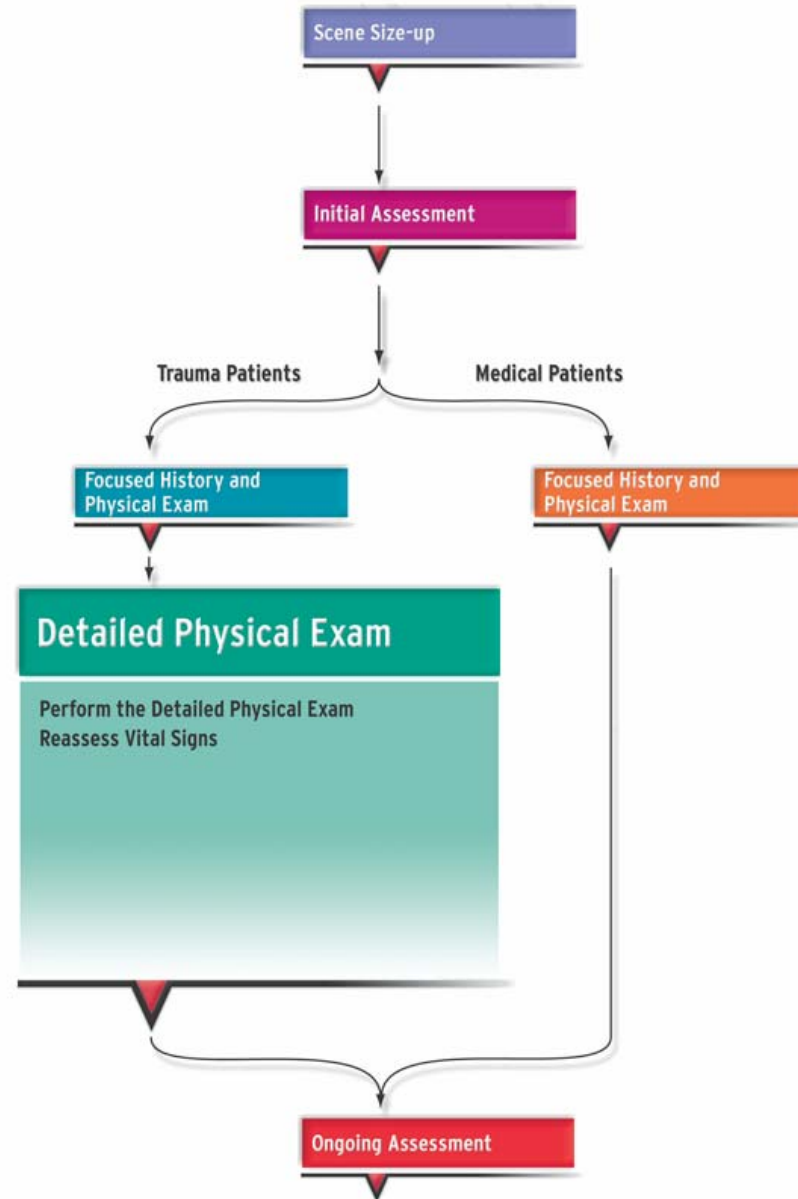
## **Responsive Medical Patients**

- History of illness
- SAMPLE history
- Focused assessment
- Vital signs
- Reevaluate transport decision

## **Unresponsive Medical Patients**

- **Rapid medical assessment**
- **Baseline vital signs**
- **SAMPLE history**
- **Reevaluate transport decision**

# Patient Assessment Process



## Detailed Physical Exam

- More in-depth exam based on focused physical exam
- Should only be performed if time and patient's condition allows
- Usually performed en route to the hospital

## Performing the Detailed Physical Exam (1 of 10)

- Visualize and palpate using DCAP-BTLS.
- Look at the face.
- Inspect the area around the eyes and eyelids.
- Examine the eyes.



## **Performing the Detailed Physical Exam** (2 of 10)

- Pull the patient's ear forward to assess for bruising.
- Use the penlight to look for drainage or blood in the ears.



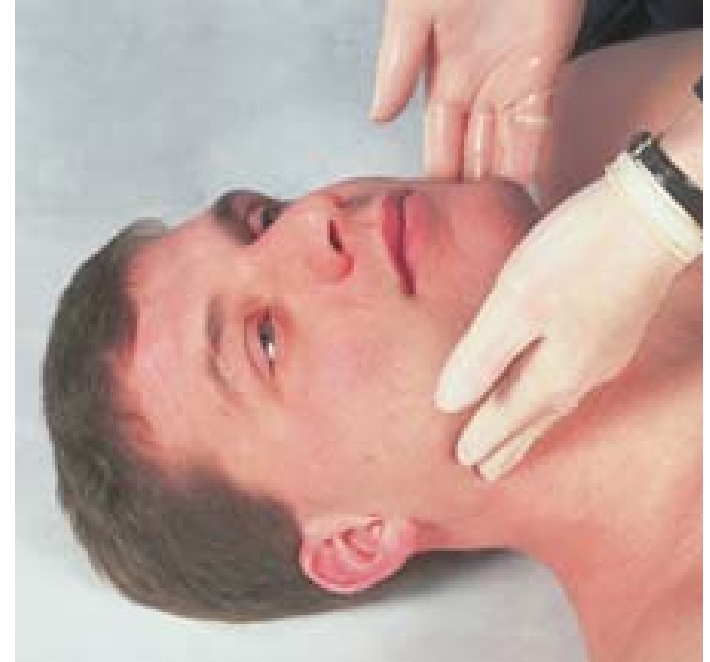
## Performing the Detailed Physical Exam (3 of 10)

- Look for bruising and lacerations about the head.
- Palpate the zygomas.



**Performing the Detailed Physical Exam (4 of 10)**

- Palpate the maxillae.
- Palpate the mandible.



## **Performing the Detailed Physical Exam (5 of 10)**

- Assess the mouth and nose for obstructions and cyanosis.
- Check for unusual odors.



## Performing the Detailed Physical Exam (6 of 10)

- Look at the neck.
- Palpate the front and the back of the neck.
- Look for distended jugular veins.



## Performing the Detailed Physical Exam (7 of 10)

- Look at the chest.
- Gently palpate over the ribs.



## Performing the Detailed Physical Exam (8 of 10)

- Listen for breath sounds.
- Listen also at the bases and apices of the lungs.



## **Performing the Detailed Physical Exam (9 of 10)**

- Look at the abdomen and pelvis.
- Gently palpate the abdomen.
- Gently compress the pelvis.



## **Performing the Detailed Physical Exam** (10 of 10)

- Gently press the iliac crests.
- Inspect all four extremities.
- Assess the back for tenderness or deformities.

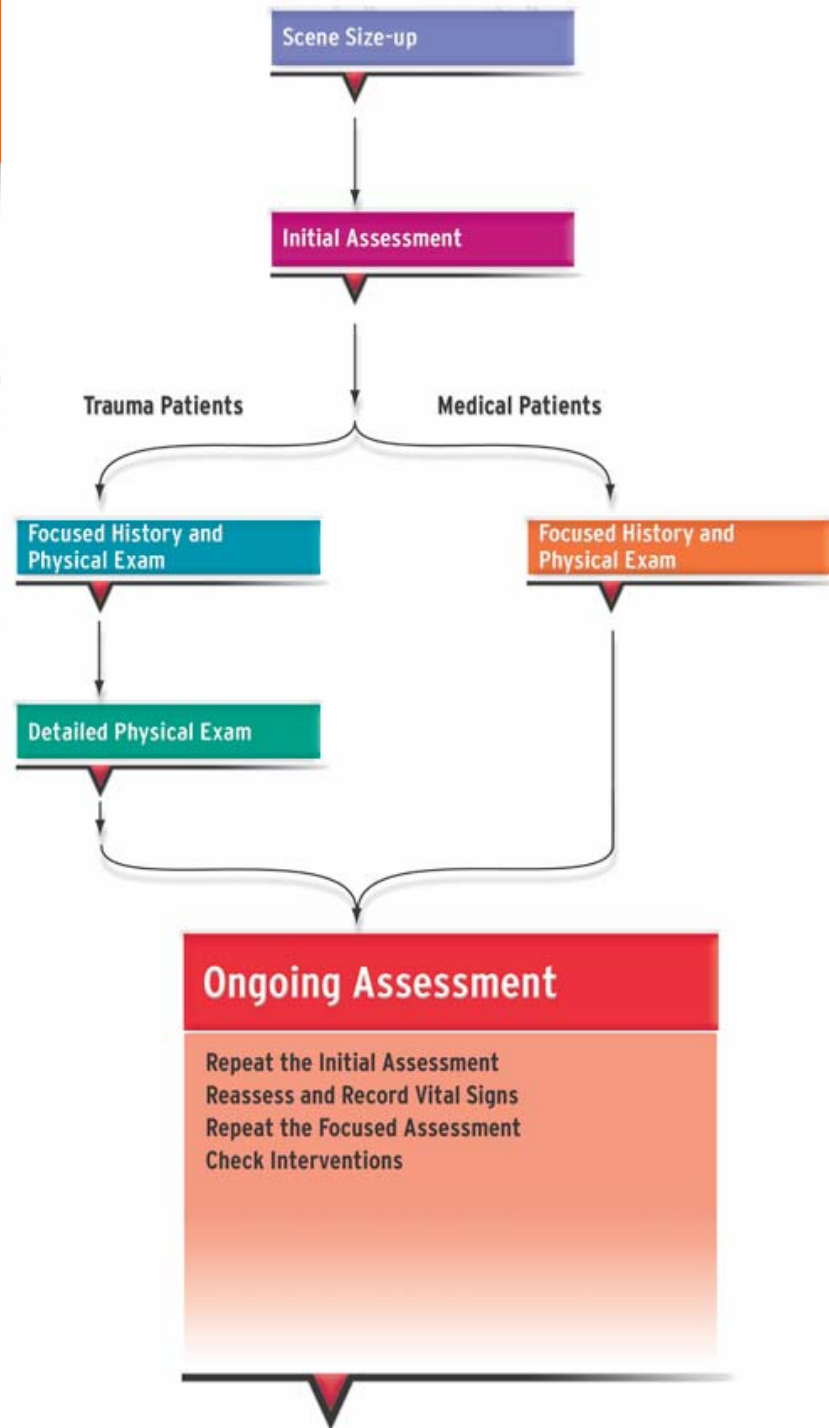


## Patient Assessment

# Patient Assessment Process

### Ongoing Assessment

- Repeat the Initial Assessment
- Reassess and Record Vital Signs
- Repeat the Focused Assessment
- Check Interventions



### Ongoing Assessment

- Repeat the Initial Assessment
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- Check Interventions

## Ongoing Assessment

- Is treatment improving the patient's condition?
- Has an already identified problem gotten better? Worse?
- What is the nature of any newly identified problems?

# Steps of the Ongoing Assessment

- Repeat the initial assessment.
- Reassess and record vital signs.
- Repeat focused assessment.
- Check interventions.

