**Medical Assessment Guide 1st draft**

These sheets are intended to explain the different aspects of the Medical Assessment, how to interview your patient and also how to communicate with the proctor. The gray highlight phrases are taken directly from the EMT Medical Assessment sheet.

**Takes or verbalizes appropriate PPE precautions.**

**Scene Size Up**

**Determines the Scene/Situation is safe**

**Consider Mechanism of Injury/Nature of illness**

**Determine number of patients**

**Determine additional EMS assistance if necessary**

**Consider spinal stabilization –** *based on the MOI, state whether or not you need to take spinal precautions. This line DOES NOT mean that you need to place the patient on a backboard and begin preparing them for transport at this time (this is often referred to as packaging. Focus on the assessment and do not spend time verbalizing the entire process spinal immobilization.*

**Primary Assessment**

**Verbalizes the general impression** *state patient’s position, activity, do they appear to be responsive, life threats)*

**Determines Responsiveness/Level of Consciousness (AVPU)**

 *Hi can you tell me your name?*

 *Hi \_\_\_\_\_\_\_\_\_, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_, I’m an EMT, may I check your pulse?*

 *I’m going to ask you a few more question and these next two are going to sound a bit*

 *strange, but can you tell me what city you’re in right now? Can you tell me what year it*

 *is? Why did you call 911?*

**Determines Chief Complaint/Apparent Life Threats**

*Examples of a life threat would be an arterial bleed, fluid/secretions in an unresponsive patient’s airway, etc.*

*During your general impression if you see that the patient has outward signs of major bleeding/trauma this could be an ideal time to do a* ***rapid exam****. Delegating your partners to remove clothing while you check pulse and breathing is recommended. Once your patient is exposed you can commence your rapid exam.*

*During the ABCs you are getting what is referred to as “snap shot vitals.” You need to quickly determine if the rate and quality of breathing and pulse are adequate and if not, immediate interventions are to be performed in effort to correct ABCs. During this time it is not expected that you give an exact number for heart rate or respiratory rate. The goal here is for you to quickly look, listen, feel and identify what is normal and what is not. Exact numbers that you can obtain via delegation during ABCs would be pulse oximetry, temp and glucose. These are the only vital signs that can be delegated to your partners and they should not take priority over YOU assessing ABC’s by examining the patient.*

**Airway & Breathing**

**Assessment** – *verbalize that you are assessing the patient’s chest rise and fall to determine rate and quality of respirations. Other points you can ask/verbalize are if there is accessory muscle use, retractions, abnormal noises etc. Ask yourself: Is my patient able to effectively move air and have good tidal volume, or do I need to move the air for them with positive pressure? It is highly recommended that you obtain a SPO2.*

**Assures adequate ventilation –** *verbalize the rate and quality of ventilation. Ex “ventilations are rapid and shallow or slow and deep.”*

**Initiates appropriate O2 therapy-***state how you would deliver O2 (NC, NRB, BVM, CPAP) to your patient and the specific flowrate in liters per minute (LPM)*

**Circulation**

**Assesses/Controls major bleeding –** *correct any bleeding that was not corrected in life threats. For unresponsive medical patients this is an ideal time to do a* ***rapid exam*** *if you have not already done so****.*** *State that you would remove clothing and examine your patients for any additional life threats or clues such as track marks, med tags, scars, dialysis access, medication patches, medical device implants, etc.*

**Checks Pulse** *– state the rate and quality (strength, regularity) of the pulse.*

**Assess skin** *(color, temperature, and condition (dry, clammy, diaphoretic))*

**Identifies patient priority and makes transport decision.** *Even if you don’t package the patient at this time, be sure to state your intention to transport.*

**Determines History of Chief Complaint:**

*Think of this section as where you do your EMT detective work. The NREMT sheet only provides the OPQRST mnemonic which is ideal for assessing pain but not as helpful Most patients fit into one or more of the three complaint categories of patients. The complaint categories are:*

* ***Pain*** *- assess with OPQRST*
* ***Respiratory Distress -*** *assess with PASTES*
* ***Altered Mental Status (AMS) -*** *assess with AEIOUTIPS*

*Some patients will fit into more than one category. For example, a patient who has chest pain but is also short of breath or a stroke patient who is altered but also complaining of a headache. As long as you ask questions that are relevant to the chief complaint and you are organized you will receive points for each of your questions. If your patients is unconscious or too altered to answer utilize the bystander if present or be aware of scene clues such as alcohol bottles, insulin in the fridge, odors, medications. When you ask about scene clues this will also give you points during the assessment if they are relevant.*

*Below are the mnemonics you can use to investigate the chief complaint. If you are not sure what mnemonic to use, you can always start with SAMPLE and get medical history first.*

**For PAIN use OPQRST**

**O - Onset:** Did the pain come on suddenly or gradually?

**P - Provocation:** *Does anything make the pain better or worse? (Pressure, inhalation, position)*

**Q - Quality*:*** *Can you describe how it feels?*

**R - Region:** *Point to where it hurts.*

 **Radiation:** *Does the pain travel anywhere else*?

 **Reoccurrence:** *Have you ever had this type of pain before?*

**S - Severity:** *On a scale of 1 to 10, 10 being the worse pain, how would you rate the pain?*

**T: - Time:** *What time did the pain start?*

**Two special questions related to OPQRST:** *Ask any questions that are relevant to the chief complaint and/or any pertinent negatives such as checking for pregnancy.**Ruling out recent history of trauma or other illnesses is also helpful. Ex. “In the last few weeks have you experience any trauma from a fall or accident? In the last few weeks have you had any other illness, especially any respiratory symptoms?”*

**Determines History of Chief Complaint: For Respiratory Distress use PASTES**

**P - Provocation** - *What provoked the episode? Or how did it start?*

**A - Associated Chest Pain:**  *Do you have an increase of pain of inhalation or exhalation?*

**S - Speech, Sputum, Skin, Swelling**: *Does the patient have broken speech? Are they coughing anything*

 *up?* What color is it. Does the patient have any hives or swelling to

 the face

**T – Temp, Tubed before?** *For anaphylaxis and asthma it’s important to know if the patient has been*

 *intubated. This can give you an idea of how severely the episode can progress.*

**E - Exacerbation:** - *Anything make it better or worse?*

**S – Sounds, Lung Sounds:** - *Stridor, Snoring, Wheezing, Barking, Whooping. Don’t forget to take lung*

 *sounds. (Not getting lung sounds for a respiratory call can be considered*

 *Incompetent.)*

**Determines History of Chief Complaint: For Altered Mental Status**

**A - Alcohol** **-** *ask patient or bystander, look for paraphernalia, be aware of smell of ETOH*

**E - Epilepsy -** *ask about tonic/clonic activity (convulsions), aura. Look for med tags, incontinence, oral*

*trauma (bites on the tongue), check medications*

 **Environment** **-** *Heat exhaustion, heat stroke, hypothermia*

  **Electrolytes** **–** *Dehydrations, Dialysis (does the patient have a dialysis access on the arm, chest,*

 *abdominal cavity)*

 **Envenomation -** *Bee sting, snake bite, spider bite, jelly fish, sting ray, etc*

**I – Insulin -** *Ask patient of bystander if patient is a diabetic? Look for med tag, insulin pump, insulin in fridge?*

**O - Overdose, Odors**- *check pupils, track marks, paraphernalia: smells for signs of neglect, ketones, UTI*

**U - Underdose, Uremia** *(HTN meds, psych meds, insulin) Kidney issues (pedal edema, crackles, blood in urine)*

**T – Trauma –** *do a rapid exam*

 **I** - **Infection –** *Take a Temp* *be aware of temps under 96.8 or over 100.4*

**P** - **Psych, Pulmonary Embolus –** *ask about psychiatric history; be aware if your patients has had any recent*

 *extremity surgeries*

**S - Stoke: Do BE-FAST**

 **Sepsis: Take Temp, Infection Smells**

 **Seizure:**

 **Surgeries?:**

 **Syncope (fainting):**

**Secondary Exam - Assess Affected Body Part/System(s)**

Th*is section is where you do more physical examination of the patient and you should examine the systems that are being currently affected. As you are examining the patient you can also ask more questions involving the system being examined as long as they are relevant. Before you physically touch your patient ask permission and explain exactly what you are doing.*

*Ex. If you had a patient experiencing anaphylaxis you would examine Cardiovascular, pulmonary, integumentary and GI/GU system.*

*. FYI, on real Patient Care Reports the Cardiovascular (BP and pulse check, Pulmonary (lung sounds) and Neurological System (eyes), Integumentary (Skin) will have a drop down menu that is mandatory to complete the report.*

**Psychological/Psychiatric**

**Neurological**

**Cardiovascular**

**Pulmonary**

**Gastro-intestinal/Gastro-urinary**

**Reproductive**

**Musculoskeletal**

**Integumentary**

Vital Signs

The highlighted vital signs are listed at certain points during the assessment, however, depending on the chief complaint other vital signs can be a necessary part of the assessment.

Ex If your patient is having respiratory distress, it’s imperative you get a SpO2 and check lung sounds

For all AMS patients it is recommended that you delegate an SpO2, blood glucose and temperature to your partner while you assess the ABCs. During your assessment you have to prioritize vital signs meaning some will be more important to obtain than others. For instance for an patient who is conscious and A&O x 4 with abdominal pain, lung sounds are not necessarily a priority that needs to be moved up into your primary but they should be checked during your vital signs section. In the real world all the vital signs listed below are to be completed on a PCR except for Blood Glucose and Stroke Scale unless the chief complaint and sign and symptoms indicate it.

**Vital Signs**

**P - Pulse**

**R - Respiratory Rate & Quality**

**O - O2 Sat**

**B - Blood Pressure**

**B** - **Blood Glucose**

**E - Eyes**

**L - Lung Sounds**

**L- Level of Consciousness –** general impression

**S - Skin (color, temp, condition) –** *ABCs circulation*

**S - Stroke Scale –** *not necessarily a vital sign but helpful to add to your check list of assessment tools*

**States Field Impression of Patient**

**Interventions (verbalizes proper interventions/treatment –** *Interventions that manage/correct ABCs should be performed as soon as the ABC threat is identified. i.e suction, oxygen, direct pressure, tourniquets. Medication Interventions such as Epinephrine, Narcan, and Glucose should be administered/assisted as soon as the indicated emergency is identified. Epinephrine and Narcan in particular are ABC interventions so waiting to deliver these medications till the end of your assessment would constitute not correcting an ABC problem immediately. The medication 5 rights should be verbalized before treating with any medication. If the NOI is identified and treated relatively early in the assessment the EMT still needs to complete all phases of the call and do a thorough assessment. If your patient was previously altered or not able to speak due to a severe respiratory issue, and now because of the intervention they can communicate, ask the questions you were not able to previously get answers to.*

**ReAssessment:**

**Determines how and when to re access the patient to determine changes in condition -**state whether you would reassess the patient every 5 minutes (unstable) or 15 minutes (stable).

**Provide accurate verbal report to arriving EMS unit**