EMT Skill Sheet

Skill #2 - Primary Assessment with Airway Skills

Student Name: _____ Pass date - _____

Evaluator Name_____ Signature: _____
(Sign if Student Passes Skill)

In this Skill you are a lone EMT performing this skill on a Manikin Date

Time Start: _____	Complete Time: _____		
Information on this skill can be found in the Text Book and on the class D2L website			**Comments**
SCENE SIZE-UP – Starts prior to Patient contact but continues throughout the call			
Takes, or verbalizes, body substance isolation precautions of Gloves and Eye Protection **(Critical Fail!)**			
Verbalizes Scene Size-up (Information from Dispatch and EMRs) – Safety **(Critical Fail!)**, Mechanism of Injury (MOI) – C-spine needed, Nature of Illness (NOI), Additional Resources, # of Patients			
PRIMARY ASSESSMENT (Primary Survey/Initial Assessment) - Done On Scene			
General Impression of the scene, patient & gathers information from EMRs or bystanders. Must observe: ✓ Unusual Environmental Factors (Hazards, Odors/Temperature, Lighting, Entrances/Exits, People) ✓ Patient's approximate Age, Sex, and Mental Status/ LOC (Level of Consciousness) ✓ Patient's Positioning, Level of Distress (Breathing/Pain), and any Gross Injuries seen ✓ Looking for Arterial Bleeding and ***≈If necessary*** - applying bleeding control as soon as possible			
Considers C-spine (Spinal Motion Restriction) for the Patient **(Critical Fail!)** – When in doubt – C-spine EMT should evaluate the scene for MOI (Mechanism of Injury). Does patient meet any of the following; • Significant MOI (MVC at high speed, Falls>20 feet) with Neck/Back Pain or Neurological deficit • Unresponsive/AMS (Altered Mental Status or Drugs/ETOH) patients with unknown history of event • Water related accidents, head/neck injuries, hangings If Yes to the above - Tell patient not to move and directs an EMT to hold manual stabilization (Skill #4)			
Note: The Evaluator states C-spine is NOT needed			
Identifies self by Name, Level of Medical training, Agency & gets Patient's Consent (Expressed/Implied)			
Determines responsiveness of Patient by AVPU - May visualize for signs of Breathing at this time ✓ Awake - If patient is Alert must ask Person, Place, Time and Event orientation questions ✓ Responses to Verbal – check to see if patient can follow commands or answer questions ✓ Physical then Pain - check to see if patient can follow commands, open eyes or answer questions ✓ Unresponsive – **NO** response to Painful stimulus (Do no harm – neck/ear pinch, push bone above eye)			
Note: The Evaluator states patient is unresponsive to pain			
Determines patient's Chief Complaint considers calling for ALS and AED if necessary			
≈If necessary - If patient is Unresponsive to Pain start with Circulation not Airway (2015 ECC)			
Circulation - Assesses and Fixes **(Critical Fail!)** ✓ Pulse **(Verbalize the Strength, Speed-fast/slow, and Regularity)** assess for up to 10 seconds ✓ Checks Skin signs (**Moisture/Color/Temperature**) and Cap Refill if patient has a pulse • Signs or symptoms of Shock must be treated in Primary assessment (Skill #5)			
Note: The Evaluator states patient has a pulse			
Airway – Opens (Head tilt/Chin lift – no trauma) Assesses and Fixes **(Critical Fail!)** ✓ Listen for noise – snoring, stridor, gurgling, wheeze ✓ Smell for odors – ETOH (alcohol), emesis, ketones, unusual odors (must be within 3 feet of Head) ✓ Ask if patient if they are nauseated or had emesis if awake Considers if Airway is Good (Adequate) or Bad (Inadequate) ➢ **Signs/Symptoms (s/s) that Airway is Patent/Adequate** – Patient is awake and maintaining their own airway, no abnormal noises heard (stridor, snoring, gurgling), Patient can speak clearly, No oral trauma or obstructions (blood, vomit, fluid, swelling) are noted ➢ **Signs/Symptoms that Airway is Inadequate** – Diminished level of responsiveness, Abnormal noises heard (stridor, snoring, gurgling), Drooling, Difficulty talking or speaking clearly, Actively vomiting ✓ If Airway is Inadequate or Patient with Altered Mental Status (AMS) - Open mouth and look for Obstruction – broken teeth, dentures, edema, emesis, blood (use light pen)			

Verbalizes indications and contraindications for a OPA - ✓ Unresponsive Patients without a Gag reflex ✓ Apneic patients being ventilated by BVM		
Selects and measures correct OPA **(Critical Fail!)** ✓ Measures OPA from Corner of Mouth to Earlobe (or Center of Mouth to Angle of Jaw) ✓ Re-opens patient's mouth and inserts airway without pushing the tongue posteriorly • Open the patient's mouth – tongue depressor/cross finger technique/mandible traction • Invert OPA in mouth and insert while turning 180 degrees (adults only) OR • Uses tongue depressor and then inserts OPA (preferred method in Child/Infant, AHA guideline) ➢ OPAs that are to large or small may block the airway and may stimulate the gag reflex (emesis)		
Note: The Evaluator must advise the candidate that the patient is gagging		
If patient gags the EMT will - ✓ Re- opens patient's mouth and removes the OPA following the contour of the airway ✓ Assess the patient's airway for emesis by opening the patient's Airway and visualizes (light Pen)		
Note: The Evaluator must advise the candidate that Emesis is noted in oral pharynx		
Must clear patient's Airway by – Gravity (log rolling the Patient) is the primary means of clearing a patient's airway. **May be Verbalized** ✓ EMT must suction the patient – **In this skill we will be suctioning the patient supine to demonstrate the general principals of suctioning.** May turn head to the side slightly as stated in the book. May use portable battery operated suction unit or hand powered suction unit (V-Vac). 1. Turn on the assembled suction unit and test for suction 2. Measure the suction catheter (Corner of mouth to earlobe) 3. Open the patient's mouth – tongue depressor/cross finger technique/mandible traction 4. Insert catheter without suctioning to premeasured distance or back of mouth, base of tongue 5. Suction for no more than 15/10 seconds for adult (10/5 seconds child, 5 seconds infant) 6. Verbalizes the consideration of oxygen for the patient because suctioning causes hypoxia ✓ Uses Rigid (tonsil tip, Yankauer) or Soft (French, whistle tip) suction catheters ➢ Suctioning may stimulate the gag reflex ➢ If suction unit becomes clogged with secretion use water to clear the line		
Verbalizes and assess patient for indications and contraindications for a NPA Indications for a NPA are the following; ✓ Unresponsive or Semi-Responsive Patients with or without a Gag reflex ✓ Patients that do not tolerate an OPA (Gag reflex, Clenched teeth) Contraindications for a NPA are the following; ✓ Severe Head or Facial Trauma (Must Exam and Palpate Head, Facial Bones for deformity and check for Bleeding out of ears) ✓ Nose Bleeding (epistaxis) – (Must Check with light in nares) ➢ History of nasal surgery or previous fractures is a relative contra-indication in some books		
Selects and measures correct NPA ✓ Measure from Tip of nose to Earlobe (or Nare to angle of Jaw or Earlobe) ✓ Apply water soluble lubrication (**use manikin airway spray for skill station**) ✓ Insert NPA with bevel toward septum and gently rotate or twist it in (Stop if resistance is felt) ✓ Invert 180 degrees if inserting in Left nare ✓ Flange should rest on outside of nare • Document nare used for NPA. If NPA needs to be removed - follow contour of the airway • NPAs may stimulate the patient which may temporary increase patient's level of conscious ➢ Some Providers evaluate NPA size by diameter of patient's largest nare or patient's pinky finger		
Note: The Evaluator states patient accepts NPA		
Breathing - Assesses and Fixes **(Critical Fail!)** – This may be done in Mental status assessment Considers if Airway is Good (Adequate) or Bad (Inadequate) ✓ Looks for bilateral chest rise/Listens for Noisy breathing/Feels for chest rise (AMS patients) ➢ **Breathing is Adequate** – Equal rise and fall of chest bilaterally, Non-labored, Patient is Awake with good mental status, no abnormal noise heard, breathing is full, appears to be a good rate (12-20), Pink dry skin, patient can speak in full sentences ➢ **Breathing is Inadequate** – Labored breathing, Abnormal noises (stridor, wheezes, coughing, or noisy breathing), Bad rate (<12 or > 20), Shallow breathing, Patient is tripoding, using accessory muscles, Pale /cyanotic skin, unable to speak full sentences, (Nasal flaring, Grunting, Retractions, or Seesaw breathing - Kids) – patients with Decreased mental status should be carefully assessed • If Breathing is labored - Describes level of Dyspnea as Mild, Moderate or Severe (**get SpO2**)		

Note: The Evaluator advises that the patient is not breathing or breathing shallow or slow		
***≈If patient has* - Signs of Inadequate Breathing** ✓ Opens airway with Head-Tilt Chin-Lift/Jaw-Thrust and uses EC clamp for mask seal ✓ Provides positive pressure ventilation - starts with 2 initial breaths with visible bilateral chest rise • Reposition airway if breath/ventilation does not produce viable chest rise Rescue Breathing (Continues BVM ventilation as they complete the primary assessment) ✓ Adult – 1 ventilation every 5 to 6 seconds with each ventilation lasting 1 second ✓ Infant/Child - 1 ventilation every 3 to 5 seconds with each ventilation lasting 1 second ✓ Hooks up BVM to Oxygen - Oxygen flow to no less than 15 liters/minute (may be performed at any time in the skill as long as oxygen is used in the first 1 minute of BVM ventilation) ✓ BVM ventilations must produce visible bilateral rise and fall of patient chest **(Critical Fail!)**		
***≈If patient has* - Signs of Adequate Breathing but life threating chief complaint/signs of Hypoxia** Provides appropriate oxygen therapy by - • NRM (Non Rebreather Mask) at 15 LPM or NC (Nasal Cannula) at 1-6 LPM or CPAP		
***NOTE* - Student should continue to ventilate the patient until instructed informs student to stop**		
<u>D</u>eformities - Assesses and Fixes (**Arterial Bleeding**) by; Rapid Scan (Medical Patients) ✓ Visualize (***≈If necessary*** - Touch as needed) of Patient to check for arterial bleeding, deformities (chest injuries, gross deformities), or incontinence (urine/feces). ***≈If necessary*** - Provides appropriate bleeding control (Direct pressure, Considers use of a Hemostatic sponge/dressing (based on local Protocol), Elevation, Tourniquet)		
<u>Expose and Examine</u> - To the appropriate level (Age, Mental status, Injury, Environment) ✓ Head and Chest should be exposed in the Primary Assessment (Head Coverings/Shirt) – based on complaint and severity of the patient (Other exposing can be done later in the secondary assessment)		
Consider and verbalizes to EMT partner(s) the following – Patient Priority (Life Threats) – 1. Appears – Stable (Little Sick); ➢ Mental Status & ABCDs normal and no life threating complaint(s) 2. Appears - Potentially Unstable (possible Big Sick); ➢ Mental Status and ABCD good but has life threating complaint(s) 3. Appears – Unstable (Big Sick); ➢ Any abnormal Mental Status or abnormal ABCDs and/or has life threating complaint(s) ✓ Inform team of Transport Decision. Stay & Play or Load & Go • **<10 min on scene for Critical patients** ✓ Calls for ALS or any other additional resources that may be needed ✓ Assign Tasks to Team Members (sometimes done in Scene Size up) • EMT #1 - Patient Treatments of Airway and Breathing, • If have EMT #2 - Vital Signs and gets gurney setup for patient extrication, Physical Assessment and Patient History (From patient and bystanders/caregivers)		
***NOTE* - Student should continue to ventilate the patient until instructed informs student to stop**		
Contacts Medical Control and/or documents Standing Orders/Protocols followed		
Note: The student is advised to stop BVM ventilation and demonstrate and explain cricoid pressure on the manikin/model		
Student explains and demonstrates Cricoid Pressure (also called Sellick maneuver) on model/manikin <u>2015 ECC guideline for Cricoid Pressure</u> Cricoid pressure might be used in a few special circumstances (patient unresponsive to pain) (e.g. to aid in viewing the vocal cords during tracheal intubation) ***However, the routine use of cricoid pressure in adult cardiac arrest is not recommended*** 		
Note: The Evaluator tells student to remove NPS and reset the station for the next student		
More than 4 missed points results in Failure	Total Missed Points	

✓	Actions performed and/or verbalized by student when doing skill
➢	Additional information on the procedure
•	Key Points that student should know but do not need to verbalized/do unless asked

Evaluator Comments:

This Page is Blank