EMT Skill Sheet

Skill #5 - Bleeding and Shock with Vital Signs/Neurovascular Assessment

Student Name: _____ Pass date - _____

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

Dispatched:	Patient Contact:	Transport:	End of Call:		
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 the patient has severe arterial bleeding and no Significant MOI					
Identifies self by Name, Level of Medical training, Agency and gets Patient's Consent (Expressed/Implied)					
Applies direct pressure to the wound with sterile dressing after exposing wound **(Critical Fail!)** ✓ May utilize elevation with Direct Pressure (Do Not utilize elevation if suspected musculoskeletal injuries are in the injured extremity) – if limited resources and/or severe arterial bleeding go to tourniquet ➢ Elevation in Bleeding control is controversial in some Textbooks ➢ Pressure points with Bleeding control are no longer utilized					
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)					
If patient is Awake and alert the EMT should ask Patient about the Trauma (falls, accidents, assaults or head strikes). If so do they have any neck/back pain or weakness or numbness to their extremities?					
Note: The Evaluator states the patient denies head/neck/back pain					
Asks Patient – Name, Age and Chief Complaint • Determines patient's condition and considers calling for ALS if necessary					
<u>A</u>irway - 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, 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) ***≈If necessary*** – Fixes Airway (Skill #2) • Suctions patient as needed • Open and maintain airway with Head-Tilt Chin-Lift/Jaw-Thrust if patient is not maintaining Airway • Considers Airway Adjunct for all Patient's with AMS - OPA or NPA					

Breathing - Assesses and Fixes **(Critical Fail!)** – This may be done in Mental status assessment Considers if Breathing is Good (Adequate) or Bad (Inadequate) ✓ Looks for bilateral chest rise/listens for noisy breathing (Feels for chest rise in 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**)		
Considers Ventilation and Oxygen for the Patient –- **(Critical Fail!)** (Skill #1) **≈*If patient has* - Adequate Breathing & No life threating Complaint &/or signs of Hypoxia/Shock** ✓ Oxygen therapy may not be required **≈*If patient has* - Adequate Breathing but life threating signs of Hypoxia or Shock** Directs an EMT to provide O2 therapy and place SpO2 on patient (**keep SpO2 greater or equal to 94%**) ✓ NC 1-6 LPM – Little Sick without Life Threating Complaints or only mild Respiratory distress ✓ NRM 15 LPM – Big Sick, Hypoxic, AMS, CO poisoning, Shock, or Respiratory distress (>Mild) ✓ Considers CPAP for moderate to severe Respiratory distress. Considers contraindications of CPAP **≈*If patient has* - Signs of Inadequate Breathing (Slow, Shallow, Unequal/Inadequate chest rise)** ✓ Directs 2 EMT/EMRs to provide positive pressure ventilation with BVM (Oxygen at 15 LPM)		
Circulation - Assesses and Fixes **(Critical Fail!)** **** May forgo Pulse check if arterial bleeding is not controlled – should note signs of circulation** • Pulse (Verbalize the Strength, Speed-fast/slow, and Regularity) assess for up to 10 seconds • Unresponsive Patient – Adult/Child use Carotid pulse, Infant use Brachial pulse • Responsive Patient – Adult/Child use Radial pulse, Infant use Brachial or Pedal pulse ✓ Notes Skin signs (**Moisture/Color/Temperature**)		
Deformities - Assesses and Fixes life threating injuries (arterial bleeding/open chest injury); Rapid Scan for Awake Patients - Anterior & Posterior with Visualization/Palpation (< 60 seconds) Visualize Patient to check for Arterial bleeding and deformities ✓ Check Head for symmetry, Neck for JVD, trauma or abnormalities ✓ Check Chest for equal rise and fall – check for pleuritic chest pain by movement and deep breathing ✓ Check pelvis for incontinence (urine/feces) ✓ Checks Extremities for trauma or deformities or edema		
Expose and Examine - To the appropriate level (Age, Mental status, Injury, Environment) ✓ Site of Bleeding should be exposed prior to placing dressing Other exposing can be done later in the secondary assessment ✓ All Jewelry on extremity that is injured should be removed (Verbalize only!) • 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 – Provides Bleeding control, shock management, Patient History and Demographics • EMT #2 – Vital Signs and Patient Packaging and Physical Assessment if patient is stable		
Note: The Evaluator states Bleeding is not controlled and has bleed through your dressing		
Applies more sterile dressings to wound and does not remove dressings (ITLS states differently)		
Holds direct pressure till bleeding is controlled – at least 10 minutes		
Considers use of a Hemostatic sponge/dressing (based on local SOP)		
Note: The Evaluator states Bleeding is now controlled		
Bandages the wound with Pressure dressing ✓ Makes sure extremity is exposed prior to dressing		
Considers a splint and other bleeding control measures (air splits are preferred)		

Note: The Evaluator states - What would you do is bleeding is not easily controlled with Direct Pressure?		
Demonstrate the use of a Tourniquet on a manikin arm - **DO NOT use Tourniquets on students!** ✓ Tourniquets should not be used over joints and should be placed proximal (2 inches) to bleeding ✓ Do not remove a Tourniquet once it is in place without orders from Medical control ✓ Use wide padding under Tourniquet if possible to protect tissues and assist with arterial pressure ✓ May use commercial Tourniquets or Blood Pressure cuffs (No BP cuff in some counties) ➢ Tourniquets may be used at any time in bleeding control and also may be used as a first step for critical patients or limited responders ➢ Patients with a Dialysis Shunt and arterial bleeding the tourniquet must be placed proximal (NOT OVER) to the fistula/shunt and only as a last resort if other bleeding control means are not working		
Places date and time of Tourniquet application on Patient or Tourniquet		
Assesses distal CMS* or motor, sensory and circulatory function in the injured extremity after bleeding has stopped **(Critical Fail!)** ➢ If tourniquet is used should not feel distal pulse in injured extremity		
Verbalizes signs and/or symptoms of compensatory/early shock (Must state 6) **(Critical Fail!)** ✓ Agitation, Anxiety or Restlessness ✓ Feeling of Impending Doom ✓ Dizziness ✓ Weak, rapid (thready) pulses – tachycardia (narrow pulse pressure) ✓ Clammy (pale/cool/moist) skin signs ✓ Pallor and cyanosis at lips or distal extremities ✓ Rapid Breathing or Shortness of Breath ✓ Nausea or vomiting ✓ Delayed Capillary Refill ✓ Marked Thirst ✓ Altered mental Status (Confusion)		
Note: The Evaluator informs student that patient has S/S of Hypoperfusion		
Shock Management Treatments **(Critical Fail!)** ✓ Properly positions the patient (supine) Note Trauma or Breathing issues ✓ Applies high concentration oxygen ✓ Initiates steps to prevent further heat loss from the patient (Blanket and heat on) ✓ Indicates the need for immediate/rapid transportation		
Reassess and Bleeding control measures (treatments) 1. Tourniquet 2. Bandage 3. Splint		
Special Considerations (if asked); ➢ All Neck arterial bleeding must be covered with an Occlusive dressing to prevent air embolisms. If direct pressure is not controlling aerial bleeding from the neck you might find it necessary to apply pressure both above and below the penetrating wound to control life-threatening bleeding from the carotid artery (above) and the jugular vein (below). ➢ Epistaxis • Position Patient leaning forward • Pinch soft tissue of nostrils together (hold for 10 minutes) • Alternative method - May use gauze between upper lip and gum • Use Ice pack over bridge of nose Considers causes of Epistaxis – • Skull fracture • Facial injuries • Sinus Infections • Drug use • Bleeding disorders • Medication use (**blood Thinners – Coumadin/warfarin**, Edoxaban, Pradaxa, Xarelto, Eliquis) • Hypertension		
EMT #2 should be acquiring Baseline Vital Signs at same time bleeding control is being done		
Informs patient of vital signs assessment and get consent (informed/implied) ✓ Checks Vital Signs in uninjured (without Dialysis shunt or on Mastectomy side) extremity		
Checks patients pulse – ✓ Rate of Beats per Minute - Number of beats in 30 seconds X 2 (1 minute for Slow/Irregular pulses)		

✓ Quality – Bounding, Strong, Weak or Absent ✓ Rhythm - Regular or irregular • Must document (even numbers) both rate and quality and rhythm (66 Strong and Regular). If unable to get distal pulses bilaterally then move up to brachial pulse checks.		
Checks patient's SpO2 ✓ Pulse Oximetry heart rate must match patients pulse. Green light or multiple bars on Pulse Oximetry must signal good readings. The below list may cause inaccurate readings of the Pulse Oximetry; * Dirty or oily fingers or Nail polish * Cold or hot extremities * Hypoperfusion * Poisoning – CO, cyanide, cigarettes * Movement/Shivering * Anemia * Skin tone (dark) * Equipment issues (batteries) * IV medical injected dyes * Genetic conditions * Outside interference (MRI) * *Students do not need to verbalize this list* ✓ Document SpO2 as % and if Patient on Oxygen (LPM) or Room Air (RA)		
Checks patient's respirations – ✓ Rate of Breaths per Minute - Number of breaths in 30 seconds X 2 (1 minute for Slow or Irregular breathing) ✓ Quality - Character of breathing (Labored/Non-labored) ✓ Rhythm - Regular or irregular ✓ Noisy respiration or Cough (non/productive (color)) - Normal, stridor, wheezing, snoring, gurgling ✓ Depth - Shallow or deep / Adequate or inadequate tidal volume • Document (even #s) both Rate, Quality and/or Rhythm and/or noise and/or depth (16 Non-labored)		
Checks patient's blood pressure (If BP needs to be repeated let arm rest 1 minute in-between attempts) Document in even numbers ➢ Non-Invasive Blood Pressure can be used AFTER manual Blood pressure but can give Erroneous readings – guideline by NHTSA and manufactures of the NIBP equipment		
Checks patient's pupils - P – Pupils, E – Equal, A – and, R – Round, R – Regular size, L – react to Light • Must document pupils reaction (PERL/PEARL/PEARRL, unequal, delayed/sluggish, nonreactive, dilated, pinpoint) – Pupil size not required to be documented by EMTs		
Checks breath sounds in apex & bases bilaterally (**2 breaths per field – under shirt**) ➢ Anterior or Posterior may be assessed (both not required) ➢ EMTs not required to distinguish lung sounds (Clear, Bad lungs sounds or Absent is all EMTs required to hear)		
Reassesses skin signs and cap refill ✓ Color - Pink, pale, blue, red, or yellow (check mucus membranes, palms hands/feet) ✓ Temperature - Warm, hot, or cool (check forehead with back of hand) ✓ Moisture - Dry, moist (sweat on palms of hands or forehead), or wet (diaphoretic) • Must document all 3 types of assessments (Pink, Warm, Dry) and Cap Refill		
≈If necessary - Other Vital Assessments (Based on State/Local SOP) – End title CO2 detector, CO detector, Temperature, Blood Glucose monitoring		
Student documents vital signs and time taken		
Prepares Gurney and patient for packaging and extrication to the ambulance		
EMTs Obtains History, Physical Exam & Demographics – Done on Scene most of Time unless patient unstable		
#2 EMT Gets Get Patient's Demographical Info (legal name, age, birthday, full address, phone #, insurance/hospital) Patient ID and Insurance Cards (if at medical facility must get copy of patient's medical record)		
#2 EMT Gets and Documents SAMPLE and OPQRST		
Physical Assessment (Head to Toe) may be deferred till enroute for Unstable patients		
Contacts Medical Control and/or documents Standing Orders/Protocols followed		
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

* CMS – Circulation, Motor and Sensory Function (also called Neurovascular Function and PMS – Pulse/Motor/Sensory)

Evaluator Comments: