EMT Skill Sheet

Skill #9 - Patient Assessment – Trauma (Patients with Altered Mental Status)

Student Name: ____________________________ Pass date - ___________

Evaluator Name______________________ Signature: ___________________________________

(Sign if Student Passes Skill)

* Students may have pen, light pen, stethoscope, blank Note Book/Clipboard and First Out equipment 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		
Uses body substance isolation precautions of Gloves and Eye Protection **(Critical Fail!)**		
Scene Size-up Evaluation (Information from Dispatch or 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 - Evaluator states Patient involved with Trauma of Significant MOI		
Informs patient not to move and directs an EMT to maintain manual immobilization of head in a neutral in-line position – Verbalizes patient will be placed in C-spine after primary assessment (Skill #4)		
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)		
≈***If necessary*** - If patient is Unresponsive to Pain start with Circulation not Airway (2015 ECC BLS)		
Asks Patient – Name, Age and Chief Complaint • Determines patient's condition and considers calling for ALS if necessary		
Airway - 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) ≈***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 due to decreased mental status • 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!)**

- ✓ Pulse **(Considers the Strength, Speed-fast/slow, and Regularity)** assess for up to 10 seconds
- ✓ Checks Skin signs (**Moisture/Color/Temperature**) and Cap Refill
- Signs or symptoms of Shock must be treated in Primary Assessment (Skill #5)

Deformities - Assesses and Fixes this assessment should take no more than 30-60 seconds

Anterior Rapid Scan in all Patients with decreased LOC;

- ✓ Head - Palpate head for deformities, Visualize ears, nose & open mouth for trauma or bleeding or ecchymosis with light pen, checks facial symmetry
- ✓ Neck – Visualize for JVD, swelling or bleeding. Palpate the midline neck if not already done
- ✓ Chest – Visualize equal rise & fall of chest. Expose chest and then Visualize then Palpate anterior Sternal and Lateral by Palpation
  - Cover penetrating thoracic injuries with gloved hand until an occlusive dressing applied
  - EMT may consider checking Lung Sounds (Bases & Apexes) for Critical patients/Chest trauma
- ✓ Abdomen – Expose and Palpate for guarding, tenderness, distention or rigidity in 4 quadrants
- ✓ Pelvis – Visualize for incontinence of urine/feces (for significant Trauma Patients the EMT must palpate pelvis laterally and anteriorly/posterior). Checks for priapism.
- ✓ Extremities – Visualize/Palpate for arterial bleeding and gross injuries. Check CMS* in Arms/Legs

*CMS – Circulation, Motor & Sensory function (Neurovascular function or PMS - Pulse/Motor/Sensory)

Posterior Rapid Scan for Sitting/Standing Patients with decreased LOC;

- ✓ Expose and then Visualize/Palpate – Midline Back, Scapulae, Kidneys

Posterior Rapid Scan for Supine Patients with decreased LOC;

- ✓ Rub hands posteriorly (behind patient) on bilateral sides of Patient to check for Arterial Bleeding

***≈If necessary* - Provides bleeding control or occlusive dressing (Critical Fail!)**

Some EMTs may just do a quick Visual Scan without Palpation on Awake Medical/Trauma Patients

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Expose and Examine - To the appropriate level (Age, Mental status, Injury, Environment)

- ✓ Head and Chest should be exposed in Critical Patients (Head Coverings/Shirt)

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 - Vital Signs, Patient Treatments and gets C-spine/gurney setup for patient extrication
  - EMT #2 - Physical Assessment and Patient History (From patient and bystanders/caregivers)

VITAL SIGNS (Some books place this in the Secondary Assessment) – Should be done On Scene ➢ **Assigns and EMT/EMR to complete if available (for skills practice must complete yourself)**		
Informs an EMT to get the patient's Baseline vital signs with consent (informed/implied) ✓ Checks Vital Signs in Uninjured extremity (without Dialysis shunt or on Mastectomy side)		
Checks patient's pulse – (Critical Trauma may use 10/15 second pulse checks) • Must document (even numbers) both Rate and Quality and Rhythm (66 Strong and Regular)		
• Checks patient's SpO2 - **Pulse Oximetry heart rate must match patient's pulse**. SpO2 (Skill #1)		
Checks patient's respirations – (Critical Trauma may use 10/15 second respiration checks) • Document (even #s) both Rate, Quality and/or Rhythm and/or noise and/or depth (16 Non-labored)		
Checks patient's blood pressure (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		
Checks lung sounds in apex & bases bilaterally (**2 breaths per field – under shirt**)		
Reassesses skin signs (Moisture/Color/Temperature) and cap refill		
Considers Blood Glucose monitoring in AMS/diabetic patients (may be done enroute for Critical Patients)		
Student documents vital signs and time taken (Writes down and tells Team Leader)		
Vital signs should be reassessed - Anytime patient condition changes or ✓ Every 5 minutes for critical patients ✓ Every 15 minutes for stable patients		
PATIENT HISTORY - Investigates the Chief Complaint – Done on Scene and in any order		
Gathers information from EMRs, bystanders, caregivers, family members and/or the patient • Looks for medical alert tags or information sheets (DNR – POLST Form)		
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)		
Obtains SAMPLE History – Done on Scene most of Time		
Signs and symptoms that occurred at onset of Complaint (any medical complaints prior to trauma)		
Allergies to Medications or Food or Latex		
Medications (**dose and how often it is taken**) including Over the Counter, Birth control and ED meds		
Pertinent Past Medical History (diabetes, hypertension, cardiac disease, COPD, asthma) Surgeries, Hospitalizations, ER Visits (where/when/why), Smoking and Recreational Drugs or Alcohol (ETOH)		
Last meal and fluid intake, Last menstrual period or pregnancy for females of childbearing age		
Events associated with the patient's chief complaint – Patient describes what they were doing in a detailed description of the event and what happened right before, during, after event Get details of MOI – Speed of vehicle (Helmets/Leathers or Seatbelts/Airbags used), Damage to vehicle (intrusion/ejection/windshield spidering), Type of collision, Height of fall, Surface fell onto, Description of weapon(s) and the distance, AMS or LOC with MOI, Patient moved prior to arrival		
Gets O.P.Q.R.S.T. questions – Done on Scene most of time		
✓ **O**nset of Complaint – if possible ✓ **P**rovoke the complaint – if possible ✓ **Q**uality of complaint – if possible ✓ **R**adiation – where is the complaint – if possible ✓ **S**everity – 1 to 10 discomfort scale – if possible ✓ **T**ime – time the pain or event started/occurred **(All calls must get Time of Event)**		
Packages Patient (C-spine) – Done On Scene		
Checks CMS* in arms and legs - CMS must be checked Prior to moving the Patient (Critical Fail!) ✓ Patients not following commands EMT should use Pain in Hands/Feet for Motor/Sensory response ➢ If CMS checked checked in Rapid Assessment of Primary Assessment not needed to reassess		
C-spines the Patient - (Critical Fail!) ✓ Palpates cervical vertebrae for deformities/tenderness & directs an EMT to apply a cervical collar. ✓ Logrolls the Patient and Assess Patient's Posterior – Inspects/Fix injuries or abnormalities. Visualize then Palpates occipital head, cervical/thoracic/lumbar vertebrae, scapula, kidneys (Costovertebral angle), flank area, buttock (incontinence), and posterior legs Places Patient on backboard, slides into position & directs an EMT to secure Patient in Full C-spine		
Rapid (Code 3) Patient Transport to Hospital/Trauma Center (10 minute scene time) **(Critical Fail!)**		

SECONDARY ASSESSMENT – Enroute for Critical Trauma ➢ **Stable Patients may be assessed on scene and UNSTABLE MUST BE ASSESSED ENROUTE**		
Note - Evaluator states you have a 45-minute transport to the closest Trauma center.		
Physical Assessment of the Patient by a Full-Body Scan (Head to Toe Assessment) is required for the skill ***Note - Focused Assessments may be done in the field for some awake and alert patients <u>but not for this skill!</u>*** • **This is done by Inspecting (Looking), Palpating (Feeling), and Auscultation (Listening) – Look before you touch** • **This assessment may be done in any order but often done Head to Toe**		
Assesses patient looking for DCAP-BTLS – Informs patient of physical assessment and get consent (Deformities, Contusions, Abrasions, Punctures/ Penetrations, Burns, Tenderness, Lacerations, Swelling)		
Head – ✓ Visualize then Palpates whole Head and all of Face for deformities (Battles sign/Raccoon eyes). ✓ Visualize Ears and Nose with light pen for trauma or bleeding (epistaxis) ✓ Visualize Eyes with light pen for PEARL and checks sclera (redness or jaundice) and conjunctiva ✓ Visualize/Smell/Listens to Airway with light pen (opens mouth) and checks for emesis, blood, unusual odors, swelling, trauma, or sounds of snoring/gurgling/stridor		
Neck – ✓ Visualizes Neck for Rash, Scars, JVD, tracheal placement, swelling or subcutaneous emphysema ✓ Visualizes lateral and anterior neck. Palpates cervical vertebra for deformity or tenderness.		
Chest – should be exposed in primary assessment ✓ Visualize for scars, rash, implanted medical devices, injury or abnormality, subcutaneous emphysema and equal bilateral rise & fall of chest. Do not palpate if injuries are noted to chest. ✓ Palpates clavicles, sternum stress (AP), bilateral rib stress (paradoxical chest wall movement) ✓ **Auscultate Lung Sounds in apices and bases** ≈***If necessary*** - Checks for pleuritic chest pain by movement and deep breaths if patient is awake		
Abdomen – should be exposed ✓ Visualize then Palpates (4 Quadrants) - bruising, tenderness, guarding, rigidity, distention, or masses ➢ Do not palpate abdomen if pain or injury has already been determined		
• **Back** – Assessed with C-spine treatment.		
Pelvis – Expose and examine (Remove pants and underwear – manikins only in class) ✓ Visualize for incontinence (urine/feces) or priapism ✓ Palpates pelvis (laterally on Iliac crest, anteriorly/posterior on Iliac crest, & pubic symphysis)		
Arms/Legs – Expose and examine (Remove shoes and socks) ✓ Visualize then Palpates all extremities for injury or abnormalities (entire extremity with feet/hands) ✓ Checks CMS* in arms and legs **(Critical Fail!)** ✓ Checks for full range of motion in all uninjured extremities (check CMS before moving) *CMS – Circulation, Motor & Sensory function (Neurovascular function or PMS - Pulse/Motor/Sensory)		
Provides appropriate treatment to injuries or abnormal findings at appropriate time • Shock - (**Critical Fail!) –** Keep patient warm (cover with Blanket), Rapid Transport, Oxygen • C-spine immobilization **(Critical Fail!)** • Bleeding Control **(Critical Fail!)** – direct pressure, hemostatic dressing, elevation, tourniquet • Occlusive Dressings **(Critical Fail!) –** penetrating neck or chest injuries • Splinting/Traction splinting • Moist sterile dressings (exposed bone, eye, eviscerations, female genitalia soft tissue injuries) ✓ Dry sterile dressings (burns, soft tissue injuries)		
≈If necessary - Assesses Patient's chief complaint in a more detail assessment		
REASSESSMENT – Done Enroute – These should be verbalized and explained		
Repeat the Primary Assessments on the patient		
Reassessment and Recording of Vital Signs – Stable every 15 minutes, Unstable every 5 minutes or if the patient condition changes.		
Reassess chief complaint and Evaluation of Treatments and Interventions provided		
Contacts Hospital/Medical Control and/or documents Standing Orders/Protocols followed		
More than 6 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: