



# ADVANCED ASSESSMENT

## Approach To The Patient

2014 Ontario Base Hospital Group

# ADVANCED ASSESSMENT

## Approach to the Patient

### AUTHORS

**Mike Muir AEMCA, ACP, BHSc**

Paramedic Program Manager  
Grey-Bruce-Huron Paramedic Base Hospital  
Grey Bruce Health Services, Owen Sound

**Kevin McNab AEMCA, ACP**

Quality Assurance Manager  
Huron County EMS

References – Emergency Medicine

### REVIEWERS/CONTRIBUTORS

**Lori Smith AEMCA, ACP**

Kitchener-Waterloo-Wellington Base Hospital

**Rob Theriault EMCA, RCT(Adv.), CCP(F)**

Peel Region Base Hospital

**Donna L. Smith AEMCA, ACP**

Hamilton Base Hospital

# SCENE ASSESSMENT – INITIAL APPROACH

The first step in patient assessment is to STOP and evaluate the scene for the following

- **Environmental Hazards** (Is it safe for you, your partner and patient?)
- **Mechanism of Injury** (Note the series of events that caused the injury, if applicable)
- **Casualties** (How many patients are you working with?)
- **Additional Resources** required (ambulance or other emergency services)
- **Personal Protection Equipment** (gloves, eye protection)
- **Introduce** yourself and your partner
- **Advise** patient to limit movement to reduce further harm when appropriate

# PARAMEDIC ROLES ON SCENE DEFINED

## ATTENDING PARAMEDIC

LEVEL OF DISTRESS  
ASSESS LOA (AVPU)  
C-SPINE CONTROL IF INDICATED

ASSESS  
AIRWAY  
BREATHING  
CIRCULATION

GATHER CHIEF COMPLAINT

CHEST AUSCULTATION

HISTORY OF CURRENT CONDITION

PAST MEDICAL CONDITION  
MEDICATIONS  
ALLERGIES

PHYSICAL EXAM  
(PERTINENT TO PATIENT PRESENTATION)

INTERVENE  
IF REQUIRED  
(OXYGENATION/VENTILATION)

## TECHNICAL PARAMEDIC

REMOVE EQUIPMENT OFF AND  
PREPARE STRETCHER

ATTACH CARDIAC  
MONITOR

ATTACH SPO<sub>2</sub> MONITOR

OBTAIN VITAL  
SIGNS

OBTAIN BLOOD GLUCOSE

REPORT ALL FINDINGS TO PARTNER  
AS FOUND

ASSIST PARTNER IN ANY TREATMENTS

TREATMENT DECISION  
APPROXIMATELY 5 MINUTES

# ASSESSING THE PATIENT



**SICK – NOT SICK**

# Does the Patient Pass the “look” Test?

- first impressions are critical
- observations and instincts are key elements for a savvy clinician
- first impressions may lead to “load & go”

# DETERMINING LEVEL OF AWARENESS

## Utilize the AVPU Scale

- **A** – Alert - does the patient look at you when you walk in the room
- **V** – Does the patient respond to your verbal commands
- **P** – Does the patient only respond to painful stimulus
- **U** – Unresponsive (patient does not respond to painful stimuli)

## ASK – closed questions at first to determine LOA

- What is your name?
- Where are you?
- What month is it?



# Assess C-Spine

- Does the mechanism of injury suggest trauma?
- Do you have any discomfort in your head or neck region?

# DETERMINING LEVEL OF DISTRESS

**(mild, moderate, severe)**

## **Evaluate 4 Areas**

- 1) What is patients level of awareness
- 2) Workload of breathing
- 3) Position
- 4) Skin (color, condition, temperature)

# Assess Airway

- Patent or not
- Manageable
- Correct if needed

# Assess Breathing

- Rate
- Volume
- Workload
- Correct if needed (Oxygenation / Ventilation)

# Circulation

- Pulses-rate, where found (radial, brachial, carotid)
- Does the pulse match monitor (pulse deficit)
- Capillary refill

# Chief Complaint

- The complaint that troubles the patient the most (Reason for calling the Ambulance) Is the patient complaining of any SOB (always ask)

# Chest Auscultation

- Assess all lung fields (optimum is auscultation on the back)
- Assess for breath sounds apices to bases
- Equality
- Adventitious Sounds

# **GATHER HISTORY OF CURRENT CONDITION**

**(Expand upon Chief Complaint and Look for Associated Symptoms)**  
**Concentrate on this area**

- **ONSET** (when did C/C start)
- **ACTIVITY** (what were you doing when C/C started)
- **DURATION** (length of time of c/c, is it constant, increasing in severity)
- **DESCRIBE CHIEF COMPLAINT** (type of discomfort, location, radiation, scale, similar discomforts, aggravating relieving factors)
- **ASSOCIATED COMPLAINTS** (always assess chest, head, abdo for pain or discomfort)
- ANY WEAKNESS OR DIZZINESS
- ANY NAUSEA OR VOMITING
- ANY HISTORY OF COUGH COLD OR FEVER, FLU Symptoms
- ANY RECENT ILLNESSES
- HOW HAVE YOU BEEN EATING AND DRINKING
- BOWEL AND URINE OUTPUT



# Past Medical History

## (examples)

- MI, angina, hypertension, diabetic, respiratory disorders, CVA/TIA

# Medication

- What medications? Are you taking them regularly?
- As prescribed? Any new medications?
- Any over the counter medications?
- **LOOK AT MEDICATIONS – WRITE DOWN NAMES & DOSAGES, OR OPTIMALLY, TAKE THEM WITH YOU TO THE HOSPITAL!**

# Allergies

- Do any pills make you sick? Are you allergic to any medications?
- What happens to you when you come into contact with the medicine or products that you are allergic to?

# SECONDARY SURVEY

- Keep assessment pertinent to call - focused on specific organ systems on medical calls compared with trauma calls where a broader assessment is performed
- Keep it organized as you work your way down from head to toe

# General Appearance

- Distress level, LOA, skin color condition, facial expression
- Neural exam, person, place, time
- Take an overall view, communicate
- Visual assessment look first then palpate

# Head

- Skin condition, mucous membranes, facial droop, pupil size, equality reaction, unilateral stare( staring to one side only)
- Take a better look at the airway (possible/potential) problems e.g. dentures, partial plates
- Discharge from ears or nose (can palpate fontanelles lightly)

# Neck

- JVD while patient sitting @ 45 degrees > 3 cm above clavicle= abnormal
- can block jug to see if distal pressure disappears, lowest pressure in the body, if jug vein needed lift legs
- tracheal deviation, palpate suprasternal notch, approx. 1 finger either side
- subcutaneous emphysema
- palpate C-spine for tenderness, step deformity
- carotid artery palpate both to see if difference in pressure
- auscultate for Carotid Bruits (swishy sound on auscultation caused by atherosclerosis)
- carotid endarterectomy = removal of plaque, look for scar (contraindication of CSM)

# Chest

- Look first **CLAPS**, Paradoxical movements
- Auscultate (reassess for changes)
- Palpate for **TICS** (tenderness, instability, crepitus, subcutaneous emphysema)



# Abdomen

**(proper assessment patient must be supine)**

- Look before touching, masses, bruising, symmetry, discoloration, scarring
- Size: obvious distention (normal or not) Gas? Bleeding?
- Do not palpate masses or pulsations
- Peritonitis: guarding, rigidity
- Pain near diaphragm: think abdomen as well as chest (heart problem)
- Child bearing years think ectopic pregnancy
- Look for previous surgeries (scars)

# Pelvis

- No need to assess if medical
- Trauma is critical (large amount of blood loss) needs rapid transport
- Palpate at least 2 planes for stability, crepitus

# Extremities

## If medical go distal

- Edema: pitting or not, how far up legs, duration, changes
- Cap refill, sensation, movement equal or not
- Arms (assess bilateral B/P if chest pain)
- Dialysis Patient: shunt (never start an I.V in same arm)
- PICC line?

# PATCHING FORMAT

# Patch Format

- Introduction of yourself, name, medic # , run #
- How you are patching (cell phone, radio, landline)
- Make sure they can hear you (confirm reception)
- Where you are (location, e.g. 25th floor)
- Age, weight, sex, LOA, level of distress
- Chief complaint
- Incident history
- Vitals, ECG, SpO<sub>2</sub>
- Exam findings
- Past medical history, Medications, Allergies
- Treatment & Response

# Patch Format (Details)

- Pulse, respirations, blood pressure, skin, pupils
- Rhythm on the monitor
- Physical assessment
- Head, neck, patency of airway, cyanosis, JVD
- Chest- Breath sounds, trauma
- Abdomen (assessed not assessed) report findings if any
- Extremities- pulses present, Edema pitting or not location
- Treatment done so far & response, any change
- What receiving hospital, amount of time to have patient receive transfer of care
- Modify patch format to give report at emergency room
- Follow same structure

# Question # 1

What is the purpose of obtaining a patient history?

- A** to detect signs of injury
- B** to establish priorities of patient care
- C** to make the patient feel comfortable
- D** to see if you can “no service” the patient

# Answer # 1

What is the purpose of obtaining a patient history?

- A** to detect signs of injury
- B** to establish priorities of patient care
- C** to make the patient feel comfortable
- D** to see if you can “no service” the patient



## Question # 2

When gathering information from the elderly, it is important to:

- A** speak loudly since most are deaf
- B** refer to the patient as “dear”
- C** anticipate numerous medications
- D** not expect any variation in the exam

## Answer # 2

When gathering information from the elderly, it is important to:

- A** speak loudly since most are deaf
- B** refer to the patient as “dear”
- C** anticipate numerous medications
- D** not expect any variation in the exam

## Question # 3

From the following list, in which situation is important to determine the last oral intake?

- A** patient with a welding flash burn to the eye
- B** patient with a nail through his foot
- C** dizzy patient
- D** adult with dental pain

## Answer # 3

From the following list, in which situation is important to determine the last oral intake?

- A** patient with a welding flash burn to the eye
- B** patient with a nail through his foot
- C** dizzy patient
- D** adult with dental pain

## Question # 4

The approach to the pediatric patient should include:

- A** Establishing a rapport with the parents
- B** Calm and confident approach
- C** Observing the patient prior to physical examination
- D** All of the above

## Answer # 4

The approach to the pediatric patient should include:

- A** Establishing a rapport with the parents
- B** Calm and confident approach
- C** Observing the patient prior to physical examination
- D** All of the above

## Question # 5

In which of the following cases is the paramedic most likely to perform a detailed physical examination?

- A** 34 year old patient in status seizure
- B** 40 year old shot in the chest
- C** 80 year old in cardiac arrest
- D** 59 year old weak and diaphoretic

## Answer # 5

In which of the following cases is the paramedic most likely to perform a detailed physical examination?

- A** 34 year old patient in status seizure
- B** 40 year old shot in the chest
- C** 80 year old in cardiac arrest
- D** 59 year old weak and diaphoretic





# Well Done!

Ontario Base Hospital Group  
Self-directed Education Program

SORRY,  
THAT'S NOT THE CORRECT ANSWER

