Patient Assessment Script

BSI, Scene Size-Up, and Primary Assessment Script

-BSI

Scene Size-Up

1. Scene/Situation Safe
   a. Is the scene safe?
   b. What do I see?

2. Determine MOI/NOI
   a. What happened?
   ***Listen for the chief complaint!!***

3. Number of Patients
   a. Is this my only patient?

4. Requests additional help/Resources
   a. Based on scene safety, MOI/NOI, and number of patients

5. Consider C-Spine Immobilization
   a. Based on MOI/NOI

Ask the EXAMINER these questions one at a time.

If the patient is able to respond, ask the PATIENT. If there is a manikin and not a “real patient, ask the EXAMINER.

Help = EMS (ALS) - Resources = Law enforcement, fire, HAZMAT, etc. VERBALLY request help/resources to the EXAMINER

Ask the EXAMINER, “Is there any suspicion of trauma?”

YES = ask partner to initiate c-spine stabilization IMMEDIATELY

NO = no need for c-spine precautions

If your patient is found to be unresponsive with no bystanders, family, or any other witnesses available to recount the events that led to the patient requiring EMS, and with no OBVIOUS signs of trauma present, you must immediately instruct your partner to maintain manual c-spine stabilization and then perform a rapid head to toe exam to find clues as to what is wrong with the patient. You should also immediately check a blood sugar after completing the primary assessment and rapid head to toe, or have another crew member check the sugar during the rapid head to toe.

Primary Survey/Assessment

***PURPOSE: To identify and treat LIFE THREATS.***

LIFE THREATS = Brain, Heart, Airway/Breathing (Lungs)

-Brain- Altered Mental Status, Decreased LOC?

-Heart- Too fast, Too Slow, or absent?

-Airway- Is it open? Will it stay open? Can the patient keep his airway open on his own?

-Breathing- Inadequate, too fast, too slow, absent, irregular pattern or noisy?
1. **General Impression**
   a. Based on potential life-threats, scene size-up, and chief complaint (MOI/NOI)

   \[\text{Verbalize to the EXAMINER if the patient is STABLE or UNSTABLE.}\]

2. **Responsiveness/LOC** *(Responsiveness = AVPU) (LOC only applies to A and V patients)*
   a. AVPU
   b. If alert,
      i. Name (Hello. What is your name?)
      ii. Date, Day, Time (Do you know what day of the week it is?)
      iii. Place (Do you know where you are right now?)
      iv. Events (Could you please tell me what happened before we arrived?)
   c. If UNRESPONSIVE, or RESPONSIVE ONLY TO PAINFUL STIMULI
      i. ALS is required
      ii. Rapid head to toe exam looking for life threats and/or trauma that could cause unresponsiveness
      iii. Have partner look for Medical Alert jewelry
      iv. Have partner check blood sugar
      v. Rapid transport
   d. If the patient is altered:
      i. Altered = Alert and oriented x 1 or 2
      ii. Altered = Alert, but will not respond verbally
         1. ALS is required
         2. Rapid head to toe
         3. Medical Alert Jewelry
         4. Blood Sugar
         5. Rapid transport

   \[\text{Go through the steps of determining AVPU. Verbalize your finding to the EXAMINER. If the patient is A or V, then ask the PATIENT the 4 questions listed. Then verbalize to the EXAMINER the patient’s LOC. LOC = Alert and oriented x 0, 1, 2, 3, or 4.}\]

   \[\text{Perform all listed skills and verbalize to the EXAMINER why and what you are doing.}\]

   \[\text{Perform all listed skills and verbalize to the EXAMINER why and what you are doing.}\]
3. **Determines Chief Complaint (Responsive Patients)**
   a. Why did you call for an ambulance today?
   b. **LIFE THREATS = Brain, Heart, Lungs**

4. **Determines Chief Complaint (Unresponsive Patients)**
   a. Use bystanders, friends, or family members, and rapid head-to-toe findings for sources of chief complaint information.

5. **Assess Airway/Breathing**
   a. **Airway**
   b. Is it open?
   c. Is it going to stay open?

   d. **Breathing**
      i. Rate – 12 – 20 in adults
      ii. Rhythm – Regular or Irregular
      iii. Quality – Normal, Shallow, Deep, Noisy, Labored

   e. **Does the patient require oxygen?**
      i. Based on
         1. AVPU
         2. Chief Complaint
         3. Tripod position?
         4. Airway
         5. Breathing (Rate, Rhythm, Quality)
         6. Pulse Oximetry/Capnography
         7. Cyanosis?

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**Restate the chief complaint to the PATIENT for confirmation and understanding and ask if he/she has any other complains.**

**Verbalize the chief complaint to the EXAMINER.**

**Reconfirm with the EXAMINER possible chief complaint info for unresponsive patients. The EXAMINER will give you bystander info.**

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**1. Ask yourself Question B. If the patient is alert and speaking, their airway is open. Verbalize to the EXAMINER that the airway is open because the patient is alert and speaking. If the patient is P or U, the airway is NOT open. You then need to open the airway using the HTCL or Jaw Thrust.**

**2. Ask yourself Question C. If the patient is P or U, the airway will NOT remain open. Place an OPA or NPA. If the patient is A or V, there is no need for an adjunct.**

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1. **Ask the EXAMINER for the patient’s breathing Rate, Rhythm, and Quality. Use that information to assist in the next 2 steps.**

2. **A and V patients will only need O2 if the chief complaint warrants it. (Heart, brain, lung CC require O2. (Refer to O2 admin chart for route and dosage.)**

3. **P and U patients will ALWAYS require O2. (Refer to O2 admin chart for route and dosage.)**

4. **Perform or verbalize the need for O2, the route, and the dosage to the EXAMINER.**
6. Assess Circulation
   a. Pulse (A and V patients = radial; P and U patients = carotid)
      i. Rate – 60 to 100 in adults
      ii. Rhythm – Regular or Irregular
      iii. Quality – Strong, Bounding, Weak, Thready
      iv. Major bleeding

   b. Skin
      i. Color – Pink, Pale, Cyanotic, Mottled, Jaundiced
      ii. Temperature – Warm, Cool, Hot, Cold
      iii. Condition – Moist, Dry, Diaphoretic, Clammy, Normal

7. Determines Priority (Load and Go or Stay and Play)
   a. Based on:
      i. Scene size-up
      ii. Need for ALS
      iii. MOI/NOI
      iv. General Impression
      v. AVPU/LOC
      vi. Life threats?
      vii. ABC’s
      viii. Chief Complaint
   b. Rapid head to toe, ALS, medical control, unresponsive, life threats = LOAD AND GO!!
Secondary Assessment (History-Taking, OPQRST, SAMPLE, Vital Signs, and Body Region Assessment) and Reassessment Script (Medical)

***If enough crew members are present, baseline vital signs and history-taking (OPQRST and SAMPLE) can be done simultaneously.***

1. **OPQRST** (for patients NOT experiencing pain)
   a. O = Onset = “What were you doing when the **(chief complaint)** started?”
   b. P = Provocation = “Does anything you do make the **(chief complaint)** better or worse?”
   c. Q = Quality = “Can you describe how the **(chief complaint)** feels?”
   d. R = Radiation = “Do you have any other symptoms anywhere else that could be associated with the **(chief complaint)**?”
   e. S = Severity = “Please rate the **(chief complaint)** on a scale from 1 to 10 with 1 being not bad at all and 10 being the worst you have ever felt in your life.”
   f. T = Time = “What time did the **(chief complaint)** begin? Have you ever experienced **(chief complaint)** before? If so, how many times before?”

2. **OPQRST** (for patients who ARE experiencing pain)
   a. O = Onset = “What were you doing when the pain started?”
   b. P = Provocation = “Does anything make your pain better or worse?”
   c. Q = Quality = “Can you describe the pain for me?”
   d. R = Radiation = “Do the pain move anywhere else in your body?”
   e. S = Severity = “On a scale of 1 to 10, please rate your pain with 10 being no pain at all and 10 being the worst pain you have ever felt.”
   f. T = Time = “What time did your pain begin? Have you ever experienced pain like this before? If so, how many times before? Was there a diagnosed cause?”

3. **SAMPLE** (for ALL patients, medical, trauma, both, pain, no pain, etc…)
   i. **IF NO FAMILY OR BYSTANDERS ARE AROUND, YOU NEED TO VERBALIZE TO THE EXAMINER THAT IF ANYONE WERE THERE, YOU WOULD OBTAIN A SAMPLE HISTORY.**
   b. S = Signs and Symptoms = From your notes, verbalize all of the signs and symptoms you have gathered so far. Verbalize them to the patient. Then ask the patient, “Is there anything else that you would like to add?”
   c. A = Allergies = “Are you allergic to any medication?”
   d. M = Medications = “Do you take any prescription medication on a daily basis?”
   e. P = Pertinent Post Medical History = “Could you please list any medical conditions you have?”
   f. L = Last Oral Intake = “When was the last time you had anything to eat or drink? What did you eat or drink?”
      Last Menstrual Period = (For child-bearing age women you need to ask, “When was your last menstrual cycle? Is there any possibility that you are pregnant?”
   g. E = Events Leading to Call to 911 = From your notes, verbalize all of the signs, symptoms, and events you have gathered so far. Verbalize them to the patient. Then ask the patient, “Is there anything else that you would like to add?”

4. **Focused Assessment of Affected Body Part(s)/System(s)**
   a. Cardiovascular = See cardiovascular (cardiac compromise) reference sheet
   b. Pulmonary = See pulmonary (respiratory compromise) reference sheet
   c. Neurological = See neurological (AMS, seizure, etc...) reference sheet
   d. Musculoskeletal = DACP-BTLS-IC of affected body part(s)
e. **Integumentary** = Color, temp, condition, lacerations, abrasions, any other skin abnormalities
f. **GI/GU** = See GI/GU (abdominal pain) reference sheet
g. **Reproductive** = See OB/GYN emergencies reference sheet
h. **Psychological/Social** = See behavioral emergency reference sheet

5. **Baseline Vital Signs**
   a. Blood Pressure
   b. Respirations
   c. Pulse
   d. Pupils
   e. SpO2 and CO2
   f. Blood Glucose Level (BGL)
   g. Skin

6. **Reassessment**
   a. Verbalize to the examiner how often you would reassess the patient.
   b. When prompted by the examiner, give a full verbal report just as if you were transferring care to a higher level EMT or RN at the ER.
Secondary Assessment (History-Taking, OPQRST, SAMPLE, Vital Signs, and Body Region Assessment) and Reassessment Script (Trauma)

***If enough crew members are present, baseline vital signs and history-taking (OPQRST and SAMPLE) can be done simultaneously. YOU will perform the physical exam (either rapid head-to-toe or focused exam) while another crew member assess vital signs and asks the OPQRST and SAMPLE questions.***

1. Decide if the patient requires a **Rapid Head-to-Toe Exam or Focused (Detailed) Exam**.
   a. **AV Patients with no significant MOI** = Focused Exam of injured body part(s)
   b. **PU Patients** = AUTOMATIC RAPID HEAD-TO-TOE EXAM regardless of MOI
   c. **Significant MOI** = Rapid Head-to-Toe regardless of mental status

2. **Rapid Head-to-Toe Exam**
   a. Instruct your partner to maintain manual c-spine immobilization.
   b. State to the examiner, “I will now make the patient trauma naked.” Trauma naked = cutting off the clothes to expose the patient fully so that no injuries are missed during the assessment.
   c. Position yourself close to the patient’s head without hindering the person holding c-spine.
   d. State to the examiner, “I am now going to assess each body region for deformities, contusions, abrasions, punctures and penetrations, burns, tenderness, lacerations, swelling, instability, and crepitus.”
   e. Palpate all regions of the body starting with the head and work your way down to the feet. For each body region, ask the examiner, “What do I see? What do I feel?” Wait for the examiner’s response. If the examiner gives you an answer that is a life-threat, you must stop and treat that life-threat. If there is nothing you can do to treat the injury/problem within your scope of practice, respond to the examiner with, “Noted.” Make a mental note of the injury so that you can include it in your transfer of care report.

   i. **BODY REGIONS TO BE EXAMINED (IN THIS ORDER)**
      1. Skull and cranium
      2. Eyes
      3. Nose
      4. Mouth
      5. Nose
      6. Ears (Halo test, if needed)
      7. Posterior neck
      8. Anterior neck (Trachea midline? JVD?)
      a. Once you have completed assessing the neck, measure and apply a c-collar.
      9. Clavicles and shoulders
      10. Anterior chest
      11. Sternum
      12. Lateral chest walls bilaterally
      13. Lung Sounds
      14. Abdomen
      15. Pelvis
      16. Genitals and rectum
      17. Right or left upper leg (circumferentially)
      18. The opposite upper leg (circumferentially) of #17
      19. Right or left lower leg (circumferentially)
20. The opposite lower leg (circumferentially) of #19
21. Ankles and feet to include PMS
22. Right or left upper extremity (circumferentially)
23. The opposite upper extremity (circumferentially) of #22
   a. **LOG ROLL THE PATIENT**
24. The posterior of the patient and the buttocks

3. Move the patient to the long backboard and prepare for transport.

4. **Reassessment**
   a. Verbalize to the examiner how often you would reassess the patient.
   b. When prompted by the examiner, give a full verbal report just as if you were transferring care to a higher level EMT or RN at the ER.

5. **Focused (Detailed) Exam**
   a. Expose the injured body part/region
   b. Inspect and palpate the injured area in order to determine if there is any DCAP-BTLS-IC
   c. Appropriately treat any DCAP-BTLS-IC found
   d. Prepare for transport.

6. **Reassessment**
   a. Verbalize to the examiner how often you would reassess the patient.
   b. When prompted by the examiner, give a full verbal report just as if you were transferring care to a higher level EMT or RN at the ER.