

Tempe Fire Department Policies and Procedures
Patient Assessment
210.01
Rev 9-28-06

POLICY

To provide the best possible emergency medical service (EMS) to all patients encountered.

PURPOSE

The objective of all EMS operations is to provide appropriate assessment and treatment to individual patients within the capabilities of personnel and the resources available.

The officer in command is responsible for the provision and deployment of resources to meet that objective. Personnel are responsible for the assessment and treatment of individual patients, within their capabilities, as assigned by the officer in command.

Paramedics are responsible for advanced life support (ALS) of individual patients. When operating at an EMS incident, the paramedic, in consultation with a physician or by standing orders, will determine and direct appropriate treatment. The officer in command of the incident remains responsible for scene management and resource allocation as well as deployment of ALS units.

All Department policies and procedures are in effect for EMS incidents, to the extent applicable to the situation, unless modified or superseded specifically by an EMS procedure. Command will be established at all incidents requiring the resources of more than two companies, ambulances excluded. All Fire Department personnel will follow patient assessment and treatment procedures as outlined.

Patient assessment and treatment procedures are intended to provide general guidelines for patient care. When procedures appear to conflict with patient care, personnel are expected to exercise medical judgment and take action in the best interest of the patient.

Subject to the individual needs of each incident and the applicable training for such incident, patient care will be provided by personnel in an active manner, anticipating problems where possible and considering treatment with a pessimistic outlook for the patient.

PROCEDURE

Patient assessment includes obtaining relevant information that is reasonably available to aid in overall patient care. Much of the information obtained during the patient assessment can be used to determine the appropriate treatment plan for the patient.

Personnel must utilize appropriate proper universal precautions when in contact with the patient or working in close proximity to the patient.

Below are listed the areas of patient assessment that must be completed on every patient.

- Primary Survey Assessment and Treatment
 - A. Provide for patient and scene safety or removal from immediate danger, if indicated.

- B. AIRWAY - Provide and maintain airway utilizing manual techniques and/or airway adjuncts, including suction units, while giving early consideration to potential cervical spine injuries.
- C. BREATHING - Check for adequate breathing, assist and provide optimum ventilation with supplemental oxygen and equipment as indicated.
- D. CIRCULATION - Check for adequate circulation (pulse), initiate chest compressions when indicated. Control severe hemorrhage, apply MAST/PASG as necessary.
- E. DISABILITY - Assess patient's level of consciousness (LOC).
- F. EXPOSURE - For examination (remove clothing as necessary).
- G. Continue provision of cervical spine immobilization when indicated.

- Determine Chief Complaint

- Obtain Initial Vital Signs

- A. Observe respirations for rate and quality, assess lung sounds.
- B. Palpate pulse for rate, quality, and regularity.
- C. Auscultate blood pressure, palpate if necessary.
- D. Observe and palpate skin color, temperature, and condition.
- E. Observe capillary refill status.
- F. Observe size, equality, and reaction of both pupils to light.

- Secondary Survey Assessment

Determine the patient's level of consciousness as follows:

- Alert - Normally interactive with their environment. This assessment is, in part, subjective and, many times, obvious. However, there is a definite difference between being awake and being alert. For instance, if an intoxicated patient is awake, answers questions appropriately, but has slurred speech and a staggering gait, their reflexes and coordination are impaired so it would be difficult to describe this patient as being "alert" in the context of this manual. It would be more accurate to describe this patient as being awake, responding to verbal questions appropriately but with slurred speech and an unsteady gait.
- Non Alert - Not awake and requires verbal, tactile, or painful stimulus to illicit a response. Documentation should identify the stimuli attempted and the responses, if any. Evaluation of the patient's level of consciousness must be completely objective without assumption of cause. Three methods of stimulus are available for use in a specific order and are as follows:
 1. Verbal - Talking to a patient. If the patient can answer questions, determine the orientation by asking their name, the day of the week, location, and reason for being there. If the patient answers all questions correctly, he/she is oriented X 4. If the patient answers only some of the questions correctly, spell out what he/she is oriented to and what he/she is not oriented to. Determine if the patient can follow simple commands and document the response.
 2. Tactile - Gently shaking or otherwise gentle physical stimulus. Again, document the stimulus and response.
 3. Painful - Sternal rub, pinching a fold of skin, etc., utilized when the patient has no response to verbal or tactile stimuli. Document the specific stimulus and response.
- Unresponsive - Does not respond to any stimuli.

Other reflexes, such as presence or absence of gag and corneal reflex might also be appropriate in the description of the patient with an altered level of consciousness (ALOC).

The following areas (head, eyes, ears, nose, throat, neck, chest, abdomen, pelvis, extremities, and back) of patient assessment conducted during the secondary survey must be completely objective and describe specific topographical areas and their underlying organ systems and anatomical structures. This information is obtained using three simple methods of examination. These methods of examination are as follows:

- Inspection - Looking at the various topographical areas.
- Auscultation - Listening over the chest and abdomen with a stethoscope.
- Palpation - Feeling the various topographical areas and their underlying structures.

Document the normal as well as abnormal findings. Documentation of normal findings is necessary to establish if the EMT/paramedic met the standard of care and conducted a thorough assessment. Thorough assessment leads to better decision making.

1. Head, Eyes, Ears, Nose, and Throat

- Inspect the head and face for:
 - Airway patency - presence of partial/complete airway obstruction.
 - Any odors present at the airway.
 - Any soft tissue injuries and their location, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Presence of fluid or blood from the ears, nose, and/or mouth.
 - Any facial droop.
 - Dysconjugate gaze.
 - Check pupils if not already completed.
- Palpate the head and face and determine the location of any:
 - Deformities.
 - Tenderness.
 - Crepitus.

2. Neck

- Inspect the neck and determine:
 - Any soft tissue injuries and their location, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Presence of tracheal shift.
 - Presence of jugular venous distension.
 - Use of accessory muscles to breath.
- Palpate the neck and determine the location of any:
 - Deformity.
 - Tenderness.
 - Subcutaneous air (subcutaneous emphysema).

3. Chest

- Inspect the chest and determine the location of:
 - Any soft tissue injuries, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Any deformity.
 - Any abnormal rise and fall of the chest wall (paradoxical motion).
 - Presence of retractions.
- Auscultate the chest and determine the:
 - Presence/absence of breath sounds bilaterally (includes after intubation).
 - Equality of breath sounds (decreased or absent on one side?).
 - Sounds heard (clear, crackles, wheezes).

- Palpate the chest wall and determine the location of:
 - Any deformity.
 - Any tenderness.
 - Any crepitus.
 - The presence of subcutaneous air (subcutaneous emphysema).

4. Abdomen

- Inspect the abdomen and determine the location of any:
 - Soft tissue injuries, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Distension.
- Auscultate the abdomen and determine the presence/absence of:
 - Bowel sounds - if possible, if pertinent.
- Palpate the abdomen wall and determine the location of any:
 - Tenderness.
 - Guarding or rigidity.
 - Masses.

5. Pelvis

- Inspect the pelvis and determine the location of:
 - Any soft tissue injuries, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Any blood from urethra, vagina, or rectum.
 - Urinary/fecal incontinence.
 - Any deformity.
- Palpate, compress, and rock the pelvis and determine the location of any:
 - Deformity.
 - Tenderness.
 - Hip tenderness.
 - Crepitus.

6. Extremities

- Inspect the extremities and determine the location of:
 - Any soft tissue injuries, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Any deformity.
 - Any edema.
 - Skeletal injuries.
- Palpate the extremities and determine the location of:
 - Any deformity.
 - Any tenderness.
 - Motor, sensory, and distal pulse status x 4 (MSP x 4).
 - Grips and pushes.

7. Back

- Inspect the back and determine the location of any:
 - Soft tissue injuries, i.e. bruising, lacerations, swelling, and similar such injuries.
 - Deformity.
- Palpate the back and determine the location of any:
 - Deformity.
 - Tenderness.

- General Assessment
 1. Determine name, age, sex and weight.
 2. Determine the chief complaint in detail.
 3. Determine the history of present illness or the mechanism of injury.
 4. Obtain the past medical history.
 5. Determine current medications and any allergies to medication.
 6. Determine patient's physician or insurance group, if any.
- Obtain complete second set of vital signs if the then existing circumstances reasonably permits it-
- Complaint Specific Assessments
 1. Chest Pain
 - Determine what patient was doing at onset of chest pain (exertional or nonexertional).
 - Determine location of pain and any radiation of pain to other parts of the body.
 - Obtain patient's description of chest pain (dull, sharp, crushing).
 - Determine time of onset and duration of pain.
 - Determine what relieves pain or aggravates pain (medications, movement, and similar such items).
 - Obtain patient description of pain intensity on 1-10 scale with 10 being most severe.
 - Is patient nauseous or vomiting?
 - Is patient diaphoretic?
 - Is pain constant or does it come and go?
 - Is patient experiencing shortness of breath?
 - Did patient experience a loss of consciousness, altered level of consciousness?
 - Does patient have pedal edema?
 - Does patient have JVD?
 2. Difficulty Breathing
 - Determine any immediate need for supplemental oxygen or ventilatory assistance.
 - Determine if the onset was sudden or progressive and the duration of the difficulty breathing.
 - Observe the number of words the patient can speak between breaths.
 - Consider associated signs/symptoms.
 - Determine what patient was doing prior to onset.
 - Determine if patient has previous similar episodes or hospitalizations for difficulty breathing/shortness of breath.
 - Is patient using accessory muscles to breathe?

MEDICAL EMERGENCIES THAT REQUIRE PARAMEDIC ASSESSMENT

The following medical emergencies require paramedic assessment:

- Any medical emergency that in the reasonable judgment of the EMT or Paramedic suggests consultation with a base hospital physician is appropriate.
- Cardiac or respiratory arrest.
- Near drowning.
- Chest pain.
- Respiratory distress or breathing at less than 8/min or greater than 24/min.
- Any acute cardiac arrhythmias.
- Serous blunt or any penetrating chest and/or abdominal injuries/wounds.

- Hypotension with evidence of inadequate tissue perfusion.
- Hypertension, symptomatic.
- All facial burns and/or any second degree or third degree burns covering more than 10% of the body; all electrical burns, burns to hands, feet, genitalia.
- Any patient with an altered state of consciousness.
- Cerebrovascular accident (stroke) patients.
- Overdose or accidental poisoning.
- Imminent or post childbirth, including miscarriages or complications relating to the pregnancy or labor.
- Excessive body temperatures with convulsions or deliriums, including heat/cold-related disorders.
- First time seizure or repeated seizing (status epilepticus) or failure to fully recover from the post ictal state.
- Severe orthopedic emergency, multiple fractures, open fractures.
- Cancer patients (terminal) in distress.
- Possible recent death that does not meet 901H criteria.
- Any injury to the spine in which there are any symptoms of neurological deficit or injury to the spinal cord.
- Any child under the age of 18 months exhibiting any of the above and/or:
 - Evidence of dehydration.
 - Hyperthermia/hypothermia.
 - Poor muscle tone.
 - Failure to feed.
- Diabetic related emergencies.
- Vomiting blood or serious hemorrhaging.
- Any patient with any of the above medical conditions who refuses treatment and/or transportation.

Subsequent consultation with the paramedic's base hospital physician will be completed when the then existing circumstances reasonably permit it.

POSSIBLE RECENT DEATH/DO NOT RESUSCITATE (DNR) ORDERS

In the absence of a valid DNR, basic and advanced life support should be initiated for all victims of sudden death. Exceptions include those patients who have been decapitated, have rigor mortis, post mortem gravity dependent lividity, or are in advance stages of tissue decompositions. When in doubt, continue basic life support until a thorough assessment can be made, and a paramedic consults his/her base hospital physician for direction in further resuscitation efforts.