

VIRGINIA DEPARTMENT OF HEALTH - OFFICE OF EMERGENCY MEDICAL SERVICES

BASIC LIFE SUPPORT - PRACTICAL SKILL TEACHING SHEET

**PATIENT ASSESSMENT - TRAUMA / MEDICAL**

<b>SCENE SIZE-UP</b>										
<b>Assess:</b> Need for body substance isolation, Scene safety, Trauma(MOI) or Medical(NOI) nature and Number of patients										
<b>INITIAL ASSESSMENT</b>										
<p><b>General Impression of patient</b> - Chief complaint, trauma or medical, age and sex, check for obvious life threatening problems.</p> <p><b>Level of Consciousness</b> - Spinal immobilization (if needed) and AVPU (Alert, Verbal,Painful,Unresponsive)</p> <p><b>Airway Status Assessment</b> - Responsive patient: IS BREATHING ADEQUATE? (Normal rate 8 to 24) Unresponsive patient: IS AIRWAY OPEN? IF NOT, OPEN AND CLEAR</p> <p><b>Breathing Assessment</b> - Responsive patient: If adequate, Consider oxygen Unresponsive patient: If adequate, Apply oxygen, Consider airway adjuncts If inadequate, ASSIST VENTILATIONS, APPLY OXYGEN, USE AIRWAY ADJUNCTS</p> <p><b>Circulatory Assessment</b> - Rapid Pulse check, Bleeding check, Skin CTC (Color/Temperature/Condition) Capillary Refill check (&lt; 2 seconds is normal) Use for children &lt; 6 years old ONLY</p> <p><b>Identification of Priority Patients</b> - Stable/Unstable, Transport decision, Need for Advanced Life Support back-up</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Poor general impression</td> <td style="width: 33%;">Difficulty breathing</td> <td style="width: 33%;">Chest pain with BP &lt; 100</td> </tr> <tr> <td>Unresponsive patient - No gag or cough</td> <td>Shock (Hypoperfusion)</td> <td>Uncontrolled bleeding</td> </tr> <tr> <td>Responsive - not following commands</td> <td>Complicated Childbirth</td> <td>Severe pain anywhere</td> </tr> </table>		Poor general impression	Difficulty breathing	Chest pain with BP < 100	Unresponsive patient - No gag or cough	Shock (Hypoperfusion)	Uncontrolled bleeding	Responsive - not following commands	Complicated Childbirth	Severe pain anywhere
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<b>FOCUSED HISTORY AND PHYSICAL EXAM (Rapid Assessment)</b>										
<p><b>Mechanism of Injury (MOI) - TRAUMA</b> ALL PATIENTS: Ejection from Vehicle Death of another passenger Fall over 20 feet Roll over of vehicle High speed vehicle crash Vehicle/Pedestrian crash Motorcycle crash Unresponsive or altered mental status Penetrations of Head/Chest/Abdomen Hidden Injuries (Seat belt/airbag)</p> <p>INFANTS AND CHILDREN: Falls over 10 feet Medium speed vehicle crash Bicycle crash</p>	<p><b>Nature of Illness (NOI) - MEDICAL</b> Assess complaint, signs and symptoms: (O-P-Q-R-S-T)</p> <p><b>O</b> = Onset (When/How did symptoms start?) <b>P</b> = Provocation (What caused or makes symptoms change?) <b>Q</b> = Quality (Describe symptoms/sensations/pain) <b>R</b> = Radiation (Does sensation move to other body area(s)?) <b>S</b> = Severity (How severe is discomfort?/Scale of 1-10) <b>T</b> = Time (How long have symptoms lasted?)</p> <p><b>IF UNRESPONSIVE OR PRIORITY NOI:</b></p> <p>Reassess airway and airway protection Perform Rapid Assessment</p>									

(over)

**Rapid Assessment - IF UNRESPONSIVE OR PRIORITY MECHANISM OF INJURY / NATURE OF ILLNESS**

Reassess mental status  
Spinal stabilization  
Head-to-Toe Exam (D-CAP/BTLS)

**D** = Deformity                      **B** = Burns  
**C** = Contusions                    **T** = Tenderness  
**A** = Abrasions                     **L** = Lacerations  
**P** = Punctures/Penetrations   **S** = Swelling

ROLL PATIENT TO ASSESS POSTERIOR BODY

**Assess Baseline Vital Signs -**

Breathing: Rate, Rhythm, Depth  
Pulse: Rate (Rapid/Slow)  
Quality (Strong/Weak - Regular/Irregular)  
Pupils: Size (Normal/Dilated/Constricted) Equal size?  
Reactivity (Reactive/Non-reactive) Equal reaction?  
Blood Pressure: (Systolic/Diastolic) All patients over 3 years old.  
Capillary Refill: (< 2 seconds is normal) Use for children < 6 years old ONLY.

**Assess SAMPLE HISTORY -**

**S** = Signs and Symptoms  
**A** = Allergies (Medications, food, bee stings, etc.)  
**M** = Medications (Prescribed or Over-the-counter)  
**P** = Past Pertinent Medical History  
**L** = Last Oral Intake (Fluid or Solid)  
**E** = Events leading to history of present illness (HPI)

DETAILED ASSESSMENT

**Complete Head-to-Toe Assessment -** Perform full body assessment of areas not previously examined.

Purpose is to identify previously unknown wounds/injuries and manage secondary problems.

Assess head (DCAP/BTLS)  
Assess neck (DCAP/BTLS, Jugular vein distention, Crepitation)  
Assess chest (DCAP/BTLS, Paradoxical motion, Crepitation, Breath sounds)  
Assess abdomen (DCAP/BTLS, Swelling, Firm/Soft)  
Assess pelvis (DCAP/BTLS, If no pain, Compress)  
Assess extremities (DCAP/BTLS, Pulse/Motor/Sensation)  
Assess posterior body (DCAP/BTLS)

Performance is patient and injury specific - Used to gather more detailed patient information in addition to Initial and Focused Assessments. Patient injury/illness will guide EMT as to whether to perform this assessment or not.

[Performed only after priority treatments have been performed and patient condition and team member availability allows.]

ON-GOING ASSESSMENT

**Repeat of Initial Assessment -**

Reassess mental status  
Monitor airway status  
Monitor breathing  
Reassess pulse (Rate/Quality)  
Monitor skin CTC (Color/Temperature/Condition)  
Adjust patient priorities as needed  
Reassess vital signs  
Repeat Focused Exam regarding complaint or injuries (HPI)  
Check interventions

**Stable patient:** repeat every 15 minutes

**Unstable patient:** repeat every 5 minutes