

NREMT EMT Patient Assessment 2014 - TRAUMA



OCAP BTLS

1 SCENE SIZE-UP

Scene safe?

BSI (gloves, mask etc.)

MOI & NOI mechanism of injury
nature of illness?

Number of patients?

EMS assistance needed?

Hello, my name is _____
I'm an EMT, we're here to help you.

Consider Manual C-spine
Application Here!

2 PRIMARY SURVEY/ RESUSCITATION

Verbalize general
impression of the
patient

(What do you see?)

L.O.C

level of consciousness?

x @ "What's your name?"

x @ "Where are you right now?"

x @ "What day is it?"

x @ "Tell me what happened?"

Alert - responsive

Verbal - responds to verbal

Pain - responds to pain

Unresponsive - to all stimulation

? What is/ are the
Chief Complaint or
Apparent Life-threats?

A Check Airway

Opens & assess airway Section Needed?
Inserts adjunct as indicated

B Check Breathing

Assess breathing
Assesses adequate ventilation
Oxygen therapy (O₂-15LPM)
Manage injuries that compromise
breathing/ventilation EMT POC Pressure Cx?

C Check Circulation

Checks pulse - Rate & Quality
Assess skin Color, Temp, Condition
Assess & control major bleeds
Blood timeseg Now!

Shock ?

- Initiate shock management
(position patient - conserves body heat)
(Mylar Space Blanket Wrap Here)

Transport ?

- Patient Priority
(critical/ stable)(contact hospital)
Identifies patient priority & makes treatment/
transport decision (based on calculated GCS)

3 History

Signs & Symptoms - What can you see? What is the Chief Complaint?

Allergies - What have you come in contact with? Meds, Insects, Pollen, Food, Latex?

Medications - S.H.O.P. - Street, Herbal, OTC, Prescriptions

Past Medical History - Has this happened before, is this a pre-existing condition?

Last Oral intake- When did you eat last? What was it? Nausea or Vomiting?

Events - What were you doing when you started to feel this way?

4 SECONDARY ASSESSMENT

Head

Inspect mouth, nose & facial area
Inspect & palpate scalp & ears
Assess eyes

Neck

Check position of trachea
Check jugular veins
Palpate cervical spine
Apply CERVICAL COLLAR Now!

Chest

Inspect & palpate chest
Auscultate chest

Abdomen/pelvis

Inspect & palpate abdomen
Assess pelvis

Verbalize assessment of
genitalia/perineum as needed

Lower extremities

Inspect, palpate & assess
motor sensory & distal circulatory
functions

Upper extremities

Inspect, palpate & assess
motor, sensory & distal circulatory
functions

Log Roll & Backboard Now!

Posterior thorax, lumbar & buttocks

Inspect & palpate posterior thorax
Inspect & palpate lumbar &
buttocks areas

5 VITAL SIGNS

Baseline Vitals

Blood Pressure
Respiration (Rate & Quality)
Heart rate (Rate & Quality)
Skin (Color, Temp & Condition)
Pupils (PERRL)
SPO₂ (oxygen saturation)

Manage secondary
injuries & wounds

6 Reassessment

Mental status ?

Airway
Breathing
Circulation

Re-check vitals

Re-check interventions
(O₂, bandages, splints etc.)

Repeat every

5 minutes for **Critical Patient**

Repeat every

15 minutes for **Stable Patient**



Transfer Care
and Document
The Call!

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K Payea

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