PATIENT ASSESSMENT

TIME ALLOWED FOR SKILL PERFORMANCE - 15 MINUTES FOR PHYSICAL SURVEY
5 MINUTES FOR VITAL SIGNS

PERFORMANCE OBJECTIVE

1. **PHYSICAL SURVEY** - Given a human "patient," a stethoscope, a blood pressure cuff, a pen light and a scenario describing the circumstances of the patient's illness or injury, the candidate shall, within the allotted station time, perform an assessment of the patient, including the scene size-up, initial assessment and focused history and physical examination or detailed physical examination and state appropriate interventions for the patient's problems, using the criteria herein prescribed..

2. **VITAL SIGNS** - Given a human "patient" the candidate shall, within the allotted station time, determine the pulse, respirations, and palpated and auscultated blood pressure.

TESTING CONDITIONS

1. Examiner shall insure that the session is conducted as a testing station and ***NOT*** as a teaching session.

2. Examiner shall prompt the candidate only as indicated by the criteria.

3. Candidates shall be tested in private and one candidate at a time.

4. A non-candidate or a previously tested candidate ***MUST*** be used as the "patient." If it is necessary to use a candidate who has not yet tested this skill, that candidate shall ***NOT*** be tested using the same scenario. The Examiner shall determine that the patient has readily palpable radial pulses. Examiner shall ***NOT*** be used as the "patient."

5. The patient shall ***NOT*** "cue" the candidate being examined but may assist to the extent that an actual patient would be able. The patient shall be cooperative.

6. Based on the scenario, the candidate should talk to the "patient" and/or Examiner as the candidate progresses through the test.

7. Examiner shall require candidate to take or verbalize body substance isolation precautions before station time begins.

8. Examiner shall require candidates to have pen or pencil and a piece of paper on which to chart vital signs and other observations. Other methods such as writing on gloves, etc. are also acceptable.

9. **The scenario(s) will be based on protocols established by the Course Medical Director and/or Course Coordinator that are appropriate to the skill level of the course and shall have been submitted as part of the course approval documents.** Scenarios must include both medical and trauma patients.

STATION EQUIPMENT:

1. A human "patient"
2. A watch with a second hand or a digital watch (provided by candidate).
3. Pen or pencil and paper (provided by candidate).
4. A blood pressure cuff of appropriate size.
5. A stethoscope
6. A teaching stethoscope
7. A penlight
8. A watch or clock with readings in seconds (for Examiner)

INSTRUCTIONS TO THE EXAMINER

1. The Course Coordinator, lead Instructor and Examiner are responsible for insuring the presence of all necessary equipment; and also for insuring that all equipment is in working order prior to beginning the test session.

2. Examiner will ***NOT*** remove or hide equipment required to complete the skill.

3. Before the test session begins, the candidate shall be allowed to familiarize with the equipment. During this time Examiner shall answer any questions the candidate has about the equipment.

4. Once vital sign values are given, no further attempts will be allowed.

5. Vital sign reports will be compared to values obtained by Examiner.

6. Once a test session has begun, it must be completed within the allotted time with ***NO*** restarts allowed.

7. Station time shall ***NOT*** be restarted or extended for any reason.

8. Station time shall begin immediately after Examiner finishes examination instructions, reads the scenario to the candidate, and informs candidate to begin.

9. Examiner shall record starting and ending times in the appropriate section of the score sheet.

10. If station time limit is exceeded, Examiner shall end the test, record skill as failure.

11. Sequence errors shall ***NOT*** be penalized unless specified by the grading criteria.

12. The candidate shall be assigned a scenario ***randomly***. Examiner will read the scenario to the candidate, giving the candidate the dispatch information and what the candidate can see upon arrival at the scene. The candidate then is expected to continue the assessment of the patient as would be appropriate in a real situation.

13. ***ONLY*** scenarios submitted with the course approval application are to be used.

14. Documentation by narrative is required on all steps awarded a "0" and on all skills failures.

15. Candidate shall ***NOT*** fail because of Examiner or “patient” error.

PHYSICAL SURVEY GRADING CRITERIA
[STATION TIME 15 MINUTES]

*1. **Performs scene size-up**
   a. Determines scene safety before beginning initial assessment
   b. Determines mechanism of injury/nature of illness
   c. Determines number of patients
   d. Requests additional help, if necessary

   2 = Performs above criteria
   1 = Omits “c” or “d”
   0 = Omits step
   Omits “a” or “b”

*2. **Performs initial assessment**

a. Determines general impression of patient (Candidate should ask, “How does the patient look?” or make some other inquiry regarding the patient’s general appearance
b. Assesses mental status (AVPU)
c. Assesses airway
d. Assesses breathing
e. Assesses presence/quality of perfusion (radial/carotid pulse, skin color/temperature/condition or capillary refill
f. Assesses for major bleeding, if applicable

2 = Performs above criteria
0 = Omits “a”, “b”, “c”, “d” or “e” in any patient
Omits “f” in trauma patient
Performs detailed or focused physical examination, takes baseline vital signs, or attempts to obtain SAMPLE history before completing initial assessment

*3. **Describes interventions for problems found during initial survey**
a. Provides immediate manual immobilization of C-spine if indicated by mechanism of injury
b. Opens airway appropriately
c. Assures adequate oxygenation/ventilation
d. Controls major bleeding, if applicable

NOTE: Verbalization of interventions is acceptable.

2 = Performs above criteria
0 = Does not perform above criteria
Performs detailed or focused physical examination, takes baseline vital signs, or attempts to obtain SAMPLE history before providing care for problems found during initial survey
Attempts to manage less serious problems before life threats and potential life threats have been identified and corrected
Opens airway inappropriately

*4. **Identifies patient priority; makes transport decisions**

2 = Correctly determines if patient requires immediate transport or continued on-scene evaluation and stabilization
0 = Does not correctly determine if patient requires immediate transport or continued on-scene evaluation and stabilization

NOTE: If not obvious from the scenario, the Examiner should ask the candidate to justify rationale for transport decision.

*5. **Performs focused physical examination**

a. Trauma patients (Serious injuries or mechanisms of injury): Performs rapid detailed physical exam (head-to-toe exam) (DCAP-BTLS); examines neck for distended jugular veins and tracheal deviation; examines chest for crepitation, paradoxical motion, equality of breath sounds, examines abdomen for rigidity or distension
b. Trauma patients (Isolated injury and no significant mechanism of injury): Evaluates local injury or injuries
c. Medical patients (Responsive): Performs exam guided by patient's chief complaint
d. Medical patients (Unresponsive): Performs rapid detailed physical exam (head-to-toe exam) as for unstable trauma patients

2 = Performs above criteria
1 = Performs above criteria but exam is not organized
0 = Does not perform rapid head-to-toe exam when indicated by patient condition or mechanism of injury/ nature of illness

*6. **Obtains baseline vital signs** (The candidate will simulate assessing the pulse, respirations, and blood pressure. The Examiner will then provide the:

a. pulse, rate, rhythm, and quality
b. respiratory rate, rhythm, and quality
c. blood pressure

2 = Performs above criteria
0 = Does not perform above criteria

*7. **Obtains SAMPLE history from patient or others**

2 = Attempts to obtain signs and symptoms (history of present illness), allergies, medications, past history, last oral intake, and events leading up to emergency
1 =Does not attempt to obtain information about last oral intake
0 = Does not attempt to obtain signs and symptoms (history of present illness), allergies, medications, past history, or events leading up to emergency

*8. **Describes interventions for problems identified during history and focused examination**

NOTE: Verbalization of interventions is acceptable.

2 = Provides appropriate care for problems identified during focused history and physical examination
1 = Omits care or provides inappropriate care which would **NOT** have resulted in significant deterioration of patient's condition and/or injury
0 = Omits care or provides inappropriate care which would have resulted in significant deterioration of patient's condition and/or injury
Performs interventions on-scene with priority patient who should have been treated enroute to hospital
Does not provide spinal protection when indicated

*9. **Performs detailed physical examination, as indicated**

a. Head: Inspects/palpates scalp; inspects/palpates face; inspects nose, mouth, ears; inspects eyes/pupils
b. Neck: Inspects/palpates; assesses for jugular vein distension; assesses for tracheal deviation
c. Chest: Inspects/palpates; auscultates for equality of breath sounds
d. Abdomen: Inspects/palpates all four quadrants
e. Pelvis: Palpates for instability; verbalizes assessment of genitalia/perineum, as needed
f. Extremities: Inspects/palpates all four extremities; assesses circulation, motor and sensory function
g. Back: Inspects/palpates thoracic/lumbar spine; inspects/palpates entire back

2 = Performs above criteria
Step not required in this scenario
1 = Does not inspect nose, mouth, ears
Does not assess extremity circulation, motor and sensory function in all four extremities
0 = Does not perform detailed physical examination when indicated
Omits any portion of detailed physical examination **EXCEPT** failing to inspect nose, mouth, ears or does not assess extremity circulation and motor/sensory function

10. **Reports to hospital after obtaining appropriate information**

a. Age/gender of patient and problems found in primary assessment, if any
b. Patient's chief complaint
c. Estimate of severity of patient's condition
d. Brief history of present illness/injury
e. Vital signs
f. Allergies, medications, past history, last oral intake, and events leading up to incident
g. Physical exam findings
h. Pertinent treatment provided
i. Anticipated time of arrival

NOTE: A required sequence of reporting information is not implied. "Disorganized" means that candidate fails to obtain all information before beginning report and interrupts report to obtain patient information.

2 = Performs above criteria
1 = Radio traffic disorganized
Radio report omits "a", "f", or "i"
0 = Radio report omits "b", "c", "d", "e", "g" or "h"

*11. **Describes ongoing assessment** (Examiner should ask candidate to describe how candidate would manage the patient during the remainder of the transport to the hospital.)

a. Repeats initial assessment (AVPU, ABC's)
b. Repeats vital signs (every 5 minutes for unstable patients; every 15 minutes for stable patients)
c. Repeats focused assessment regarding patient complaint or injuries
d. Checks interventions

NOTE: Verbalization of interventions is acceptable.

2 = Performs above criteria
0 = Does not perform above criteria

VITAL SIGNS GRADING CRITERIA
[STATION TIME 5 MINUTES]

*1. **Calculates and reports pulse**
a. Avoids using thumb
b. Reports rate within 10% of Examiner's value
c. Describes quality (strong, weak, thready, etc.)
d. Describes regularity (regular or irregular)

2 = Performs above criteria
1 = Fails to report "c" and/or "d"
0 = Omits step
Uses thumb
Reports value that is in error greater than 10% from Examiner's value

*2. **Calculates and reports respiratory rate**
a. Reports rate within plus or minus two (2) of Examiner's value
b. Describes quality (shallow, labored, etc.)
c. Describes regularity (regular or irregular)

2 = Performs above criteria
1 = Fails to report "b" and/or "c"
Reports rate within three (3) of Examiner's value
0 = Omits step
Reports rate that is in error greater than three (3) from Examiner's value.

NOTE: Examiner shall direct candidate to palpate blood pressure before auscultating blood pressure.

*3. **Palpates and reports systolic blood**
a. Uses brachial or radial pulse
b. Locates pulse before cuff inflation
c. Reports palpated systolic within 10 mm Hg of Examiner's palpated value
d. Deflates cuff completely prior to reinflation (if 2nd or 3rd attempt performed)

2 = Performs above criteria
1 = Reports value differing 11-16 mm Hg from Examiner's palpated value
Omits "a", "b" and/or "d"
0 = Omits step
Reports value that is in error greater than 16 mm Hg from Examiner's palpated value

NOTE: Examiner shall NOT palpate at the same time as the candidate

*4. **Auscultates and reports auscultated blood pressure**
a. Systolic over diastolic
b. Reports each value within 8 mm Hg of Examiner's values
c. Deflates cuff completely prior to reinflation (If 2nd or 3rd attempt performed)

2 = Performs above criteria
1 = Reports any value differing 9-12 mm Hg from Examiner's value
Omits "c"
0 = Omits step
Requires more than 3 attempts
Reports any value that is in error greater than 12 mm Hg from Examiner's values
Reports diastolic over systolic

SUGGESTED FORMAT FOR PATIENT ASSESSMENT SCENARIOS

NOTE: This is a ***SUGGESTED*** format. If you are already using a scenario format it is ***NOT*** necessary to reformat your scenarios to an identical format.

Scenario: (Describe the scene, including the situation, information about the patient to include age, position, etc., clues to mechanism of injury, and scene safety or lack thereof.)

Initial Assessment: Level of Consciousness:
(Primary Survey) Airway:
Breathing:
Circulation:

Vital Signs: Pulse: (To include rate, regularity, strength, and location, if applicable)
Blood Pressure:
Respirations: (To include rate, regularity & quality)

Detailed Physical Exam: Head:
(Head-to-toe Exam) Neck:
Chest:
Abdomen: (To include pelvis in trauma patients)
Back:
Extremities:

SAMPLE: Signs & Symptoms:
Allergies:
Medications:
Past History:
Last Meal:
Events:

Management: (Intervention that should be verbalized by the candidate to include: interventions for problems found during initial survey; transport decision; interventions for problems found during history and focused examination.)

Report: (Information that MUST be reported to hospital.)

PATIENT ASSESSMENT
PATIENT CARE PROVIDED

YES	NO	N/A	BASIC CARE
____	____	____	Activated Charcoal
____	____	____	Airway, Manual
____	____	____	Anti-Shock Measures
____	____	____	Bag-Valve-Mask
____	____	____	Bandaging
____	____	____	Cervical Collar
____	____	____	Cervical Immobilization Device
____	____	____	Control Bleeding
____	____	____	Extrication
____	____	____	Flow Restricted Oxygen Powered Ventilation Device
____	____	____	Foreign Body Airway Obstruction Management
____	____	____	Glucose
____	____	____	Irrigation
____	____	____	Long Spinal Immobilization Device
____	____	____	Mouth-to-Mask Resuscitator (Pocket Mask)
____	____	____	Nasopharyngeal/Oropharyngeal Airway
____	____	____	Oxygen: ____Nasal Cannula ____ Non-Rebreather Mask
____	____	____	Short Spine Immobilization Device
____	____	____	Splinting
____	____	____	Suctioning
____	____	____	Tourniquet
____	____	____	Traction Splint
____	____	____	Other:
____	____	____	Other:

NOTE: This is an optional sheet that ***MAY*** be used by the Examiner to assist in grading this skill.