

Module 5:
Patient Assessment

OBJECTIVES

At the completion of this lesson, the student will be able to:

COGNITIVE OBJECTIVES

- 5-1 Recognize hazards/potential hazards
- 5-2 Describe common hazards found at the scene of a trauma and a medical patient
- 5-3 Determine if the scene is safe to enter
- 5-4 Explain the reason for identifying the need for additional help or assistance
- 5-5 Assess mechanism of injury
- 5-6 Discuss common mechanisms of injury/nature of illness/# of patients
- 5-7 Summarize the reasons for forming a general impression of the patient.
- 5-8 Define each letter of AVPU.
- 5-9 Describe the patient characteristics for each letter of AVPU.
- 5-10 Discuss methods of assessing altered mental status.
- 5-11 Discuss methods of assessing the airway in the adult, child and infant patient.
- 5-12 Compare the methods of providing airway care to the adult, child and infant patients.
- 5-13 Describe methods used for assessing if a patient is breathing.
- 5-14 Differentiate between a patient with adequate and inadequate breathing.
- 5-15 Distinguish between methods of assessing breathing in the adult, child and infant patient.
- 5-16 Differentiate between obtaining a pulse in an adult, child and infant.
- 5-17 Discuss the need for assessing the patient for external bleeding.
- 5-18 Discuss the value of removing some of the patients clothing during assessment.
- 5-19 Describe normal and abnormal findings when assessing skin color, temperature and condition.
- 5-20 Describe normal and abnormal findings when assessing skin capillary refill in the infant and child.
- 5-21 Explain the reason for prioritizing a patient for care and transport.
- 5-22 Obtain a SAMPLE history (Signs and Symptoms of the present illness/injury, Allergy, Medications, Past medical History, Last oral intake, Events leading to present illness/injury)
- 5-23 Identify the components of a SAMPLE history
- 5-24 State the reasons for performing a rapid trauma assessment
- 5-25 Recite examples and explain why patients should receive a rapid trauma assessment
- 5-25 Discuss the reason for performing a focused history and physical examination.
- 5-26 Differentiate between the history and physical examination that are performed for responsive patients with no known prior history and responsive patients with a known history.
- 5-27 Differentiate between the assessment that is performed for a patient who is unresponsive or has an altered mental status and other medical patients requiring assessment.
- 5-28 State the areas of the body that are evaluated during the detailed physical examination.
- 5-29 Explain what additional care should be provided while performing the detailed physical examination.

- 5-30 Discuss the reasons for repeating the initial assessment as part of the on-going assessment.
- 5-31 Describe the components of the on-going assessment.
- 5-32 Complete a prehospital care report on a programed patient.
- 5-33 Apply the components of the essential patient information in a written report.
- 5-34 Discuss the communication skills that should be used to interact with the patient.
- 5-35 Discuss the communication skills that should be used to interact with the family, bystanders, individuals from other agencies while providing patient care and hospital personnel, and the difference between skills used to interact with the patient and those used to interact with others.
- 5-36 Explain the importance of effective communication of patient information.

AFFECTIVE OBJECTIVES

- 5-37 Explain the value of performing an each component of the prehospital patient assessment.
- 5-38 Recognize and respect the feelings that patients might experience during assessment.
- 5-39 Explain the rationale for providing efficient and effective radio and written patient care reports.

PSYCHOMOTOR OBJECTIVES

- 5-40 Demonstrate the steps in performing a scene size-up.
- 5-41 Demonstrate the steps in performing an initial assessment.
- 5-42 Demonstrate the rapid trauma assessment that should be used to assess a patient based on mechanism of injury.
- 5-43 Demonstrate the steps in performing a focused history and physical on a medical and a trauma patient.
- 5-44 Demonstrate the skills involved in performing a detailed physical examination.
- 5-45 Demonstrate the skills involved in performing an on-going assessment.
- 5-46 Complete a prehospital care report.

PREPARATION

Motivation: The EMT-Basic will encounter patients who require emergency medical care. It is important to identify those patients who require rapid assessment, critical intervention and immediate transport. The components of the assessment will assist the EMT-Basic in making patient intervention decisions.

MATERIALS

AV Equipment: Utilize various audio-visual materials relating to emergency medical care. The continuous design and development of new audio-visual materials relating to EMS requires careful review to determine which best meet the needs of the program. Materials should be edited to assure the objectives of the curriculum are met.

EMS Equipment: Exam gloves, airway management equipment, stethoscope, blood pressure cuff and a penlight.

PERSONNEL

Primary Instructor:

One EMT-Basic instructor knowledgeable in scene management and patient assessment.

Assistant Instructor:

The instructor-to-student ratio should be 1:6 for psychomotor skills practice. Individuals used as assistant instructors should be knowledgeable in scene management and patient assessment.

PRESENTATION

Declarative (What)

1. Scene Size-up/Assessment
 1. Definition - an assessment of the scene and surroundings that will provide valuable information to the EMT-Basic.
 2. Body substance isolation (BSI) review
 3. Scene safety
 1. Definition - an assessment to assure the safety and well-being of the EMT-Basic.
 2. Personal protection - Is it safe to approach the patient?
 1. Crash/rescue scenes
 2. Toxic substances - low oxygen areas
 3. Crime scenes - potential for violence
 4. Unstable surfaces: slope, ice, water
 3. Protection of the patient - environmental considerations
 4. Protection of bystanders - if appropriate, help the bystander avoid becoming a patient
 5. If the scene is unsafe, make it safe. Otherwise, do not enter.
 4. Mechanism of injury/nature of illness.
 1. Medical
 1. Nature of illness (NOI) - determine from the patient, family or bystanders why EMS was activated.
 2. Determine the total number of patients
 - (1) If there are more patients than the responding unit can effectively handle,
 - (1) Obtain additional help prior to contact with patients: law enforcement, fire, rescue, ALS, utilities. The EMT-Basic is less likely to call for help if involved in patient care.
 - (2) Begin triage
 - (2) If adequate resources are available at the scene, proceed to the initial assessment
 2. Trauma
 1. Mechanism of injury - determine from the patient, family or bystanders and inspection of the scene what is the mechanism of injury
 - (1) Ejection from vehicle
 - (2) Death in the same passenger compartment
 - (3) Falls > 20 feet
 - (4) Roll-over of vehicle
 - (5) High-speed vehicle collision
 - (6) Vehicle pedestrian collision
 - (7) Motorcycle crash

- (8) Bicycle crash
- 2. Determine the total number of patients
 - (1) If there are more patients than the responding unit can effectively handle,
 - (1) Obtain additional help prior to contact with patients. The EMT-Basic is less likely to call for help when involved in patient care.
 - (2) Begin triage
 - (2) If the responding crew can manage the situation, consider spinal precautions and continue care.

2. Initial Assessment

1. General Impression of the Patient

1. Definition

- 1. The general impression is formed to determine priority of care and is based on the EMT-Basic's immediate assessment of the environment and the patient's chief complaint.
- 2. Determine if ill (medical) or injured (trauma). If injured, identify mechanism of injury
- 3. Age
- 4. Sex

2. Assess patient and determine if the patient has a life threatening condition

- 1. If a life threatening condition is found, treat immediately
- 2. Assess nature of illness or mechanism of injury

2. Assess patient's mental status. Maintain spinal immobilization if needed.

- 1. Begin by speaking to the patient. EMT-Basics should state their names, tell the patient that they are emergency medical technicians, and explain that they are here to help.
- 2. Levels of mental status - (AVPU)
 - 1. **A**lert
 - 2. Responds to **V**erbal stimuli
 - 3. Responds to **P**ainful stimuli
 - 4. **U**nresponsive - no gag or cough

3. Assess the patient's airway status

- 1. Responsive patient - Is the patient talking or crying?
 - 1. If yes, assess for adequacy of breathing
 - 2. If no, open airway
- 2. Unresponsive patient - Is the airway open?
 - 1. Open the airway. Positioning of the patient is age and size specific
 - (1) For medical patients, perform the head-tilt chin-lift
 - (1) Clear
 - (2) Not clear
 - 1) Noisy respirations
 - 1) Crowing

- 2) Audible wheezing
 - 3) Gurgling
 - 4) Snoring
 - 5) Stridor
 - 2) Clear the airway
 - 1) Open the airway
 - 2) Suction the airway as needed
 - 3) Insert airway adjuncts
 - (2) For trauma patients or those with unknown nature of illness, the cervical spine should be stabilized/immobilized and the jaw thrust maneuver performed
 - (1) Clear
 - (2) Not clear
 - 1) Noisy respirations
 - 1) Crowing
 - 2) Audible wheezing
 - 3) Gurgling
 - 4) Snoring
 - 5) Stridor
 - 2) Clear the airway
 - 1) Open the airway
 - 2) Suction the airway as needed
 - 3) Insert airway adjuncts
4. Assess the patient's breathing
 - 1. If breathing is adequate and the patient is responsive, oxygen may be indicated.
 - 2. All responsive patients breathing >24 or <8 should receive high flow oxygen (defined as a 15 LPM non-rebreather mask).
 - 3. If the patient is unresponsive and the breathing is adequate, open and maintain the airway and provide high concentration oxygen.
 - 4. If the breathing is inadequate, open and maintain the airway, assist the patients breathing and utilize ventilatory adjuncts. In all cases oxygen should be used.
 - 5. If the patient is not breathing, open and maintain the airway and ventilate using ventilatory adjuncts. In all cases oxygen should be used.
5. Assess the patient's circulation
 - 1. Assess the patient's pulse
 - 1. The circulation is assessed by feeling for a radial pulse.
 - (1) In a patient one year old or less, palpate a brachial pulse
 - (2) If no radial pulse is felt, palpate carotid pulse
 - (1) If pulse less, medical patient $>$ or $=$ 12 years old, start CPR and apply automated external defibrillator (AED)

- (2) Medical patient < 12 years old or < 90 lbs, start CPR.
 - (3) Trauma patient, start CPR if consistent with state or local protocol
 - 2. Assess if major bleeding is present. If bleeding is present, control bleeding
 - 3. Assess the patient's perfusion by evaluating skin color, temperature and condition.
 - 1. The patient's skin color is assessed by looking at the nailbeds, lips and eyes
 - (1) Normal - pink
 - (2) Abnormal conditions
 - (1) Pale
 - (2) Cyanotic or blue-gray
 - (3) Flushed or red
 - (4) Jaundice or yellow
 - 2. Assess the patient's skin temperature by feeling the skin
 - (1) Normal - warm
 - (2) Abnormal skin temperatures
 - (1) Hot
 - (2) Cool
 - (3) Cold
 - (4) Clammy - cool & moist
 - 3. Assess the patient's skin condition. This is an assessment of the amount of moisture on the skin.
 - (1) Normal - dry
 - (2) Abnormal - moist or wet
 - 4. Assess capillary refill in infant and child patients under six years old.
 - (1) Normal capillary refill is less than two seconds
 - (2) Abnormal capillary refill is greater than two seconds
- 6. Identify priority patients
 - 1. Poor general impression
 - 2. Unresponsive patients - no gag or cough
 - 3. Responsive, not following commands
 - 4. Difficulty breathing
 - 5. Shock (hypoperfusion)
 - 6. Complicated childbirth
 - 7. Chest pain with BP <100 systolic
 - 8. Uncontrolled bleeding
 - 9. Severe pain anywhere
- 7. Expedite transport of the patient. Consider ALS backup
- 8. Proceed to the appropriate focused history and physical examination (trauma or medical)

3. Focused History and Physical Examination

1. Trauma

1. Perform rapid trauma assessment on patients with significant mechanism of injury to determine life threatening injuries. In the responsive patient, symptoms should be sought before and during the trauma assessment. The rapid trauma assessment is important in order to:
 1. Estimate the severity of injuries.
 2. Make transport decisions.
 3. Consider ALS intercept.
 4. Consider platinum ten minutes and golden hour.
2. Rapid assessment should be interrupted to provide life saving interventions.
 1. Airway
 2. Breathing
 3. Circulation
3. Continue spinal stabilization
4. Consider ALS request
5. Assess mental status
6. Inspect and palpate, looking and feeling for the following examples of injuries or signs of injury - DCAP-BTLS
 1. **D**eformities
 2. **C**ontusions
 3. **A**brasions
 4. **P**unctures/penetrations
 5. **B**urns
 6. **T**enderness
 7. **L**acerations
 8. **S**welling
7. Assess the head, inspect and palpate for injuries, signs of injury, or crepitation
8. Assess the neck, inspect and palpate for injuries or signs of injury
 1. Jugular vein distention (JVD)
 2. Crepitation
9. Apply cervical spinal immobilization collar (CSIC)
10. Assess the chest, inspect and palpate for injuries or signs of injuries
 1. Paradoxical motion
 2. Crepitation
 3. Breath sounds in the apices, mid-clavicular line, bilaterally and at the bases, mid-axillary line, bilaterally
 - (1) Present
 - (2) Absent
 - (3) Equal
 4. Assess the abdomen, inspect and palpate for injuries or signs of injury
 - (1) Firm

- (2) Soft
- (3) Distended
- 5. Assess the pelvis, inspect and palpate for injuries or signs of injury. If no pain is noted, gently compress the pelvis to determine tenderness or motion.
- 6. Assess all four extremities, inspect and palpate injuries or signs of injury
 - (1) Distal pulse
 - (2) Sensation
 - (3) Motor function
- 7. Roll patient with spinal precautions and assess posterior body, inspect and palpate, examining for injuries or signs of injury
- 8. Assess baseline vital signs
- 9. Assess **SAMPLE** history
 - (1) **S**igns and symptoms of present illness or injury
 - (2) **A**llergies
 - (3) **M**edications
 - (4) **P**ertinent past history
 - (5) **L**ast oral intake: solid or liquid
 - (6) **E**vents leading to the injury or illness
- 11. For patients with no significant mechanism of injury, e.g., cut finger
 - 1. Perform focused history and physical exam of injuries based on the components of the rapid assessment. The focused assessment is performed on the specific injury site.
 - 2. Assess baseline vital signs
 - 3. Assess **SAMPLE** history

2. Responsive Medical Patients

- 1. Assess history of present illness
- 2. Assess complaints and signs or symptoms
 - 1. **O-P-Q-R-S-T**
 - (1) **O**nset
 - (2) **P**rovocation
 - (3) **Q**uality
 - (4) **R**adiation
 - (5) **S**everity
 - (6) **T**ime
 - 2. Assess **SAMPLE** history
 - 3. Perform rapid assessment
 - (1) Assess the head if necessary
 - (2) Assess the neck if necessary
 - (3) Assess the chest if necessary
 - (4) Assess the abdomen if necessary
 - (5) Assess the pelvis if necessary
 - (6) Assess the extremities if necessary
 - (7) Assess the posterior body if necessary
 - 4. Assess baseline vital signs

5. Provide emergency medical care based on signs and symptoms in consultation with medical direction
3. Unresponsive Medical Patients
 1. Perform rapid assessment
 1. Assess the head
 2. Assess the neck
 3. Assess the chest
 4. Assess the abdomen
 5. Assess the pelvis
 6. Assess the extremities
 7. Assess the posterior aspect of the body
 2. Assess baseline vital signs
 3. Position patient to protect airway
 4. Obtain SAMPLE history from bystander, family, friends prior to leaving
 4. Detailed Physical Exam (contains components of the former "secondary survey")
 1. Patient and injury specific; e.g., cut finger would not require the detailed physical exam
 2. Perform a detailed physical examination on the patient to gather additional information
 1. As you inspect and palpate, look and/or feel for the following examples of injuries or signs of injury - DCAP-BTLS
 1. **D**eformities
 2. **C**ontusions
 3. **A**brasions
 4. **P**unctures/penetrations
 5. **B**urns
 6. **T**enderness
 7. **L**acerations
 8. **S**welling
 2. Assess the head, inspect and palpate for injuries or signs of injury
 3. Assess the face, inspect and palpate for injuries or signs of injury.
 4. Assess the ears, inspect and palpate for injuries and signs of injury, or drainage
 5. Assess the eyes, inspect for injuries or signs of injury
 1. Discoloration
 2. Unequal pupils
 3. Foreign bodies
 4. Blood in anterior chamber
 6. Assess the nose, inspect and palpate for injuries or signs of injury
 1. Drainage
 2. Bleeding
 7. Assess the mouth, inspect for injuries or signs of injury
 1. Teeth
 2. Obstructions

3. Swollen or lacerated tongue
 4. Odors
 5. Discoloration
 8. Assess the neck, inspect and palpate for injuries or signs of injury
 1. Jugular vein distention
 2. Crepitation
 9. Assess the chest, inspect and palpate for injuries or signs of injury
 1. Crepitation
 2. Paradoxical motion
 3. Breath sounds in the apices, mid-clavicular line, bilaterally and at the bases, mid-axillary line, bilaterally
 - (1) Present
 - (2) Absent
 - (3) Equal
 10. Assess the abdomen, inspect and palpate for injuries or signs of injury
 1. Firm
 2. Soft
 3. Distended
 11. Assess the pelvis, inspect and palpate for injuries or signs of injury. If the patient does not complain of pain or is unresponsive, gently flex and compress the pelvis to determine stability.
 12. Assess all four extremities, inspect and palpate for injuries or signs of injury
 1. Distal pulses
 2. Sensation
 3. Motor function
 13. Roll with spinal precautions and assess posterior aspect of body, inspect and palpate for injuries and signs of injury
 14. Reassess vital signs
3. Ongoing Assessment
 4. Repeat initial assessment. For a stable patient, repeat and record every 15 minutes, for an unstable patient, repeat and record at a minimum every 5 minutes.
 1. Reassess mental status
 2. Maintain open airway
 3. Monitor breathing for rate and quality
 4. Reassess pulse for rate and quality
 5. Monitor skin color and temperature
 5. Re-establish patient priorities
 6. Reassess and record vital signs
 7. Repeat focused assessment regarding patient complaint or injuries
 8. Check interventions
 1. Assure adequacy of oxygen delivery/artificial ventilation

2. Assure management of bleeding
 3. Assure adequacy of other interventions
5. Verbal communication
1. After arrival at the hospital, give a verbal report to the staff
 2. Introduce the patient by name (if known).
 3. Summarize the information given over the radio:
 1. Chief complaint
 2. History that was not given previously
 3. Additional treatment given en route
 4. Additional vital signs taken en route
 5. Give additional information that was collected but not transmitted.
6. Interpersonal communication
1. Make and keep eye contact with the patient.
 2. When practical, position yourself at a level lower than the patient.
 3. Be honest with the patient.
 4. Use language the patient can understand.
 5. Be aware of your own body language.
 6. Speak clearly, slowly and distinctly.
 7. Use the patient's proper name, either first or last, depending on the circumstances. Ask the patient what he wishes to be called.
 8. If a patient has difficulty hearing, speak clearly with lips visible.
 9. Allow the patient enough time to answer a question before asking the next one.
 10. Act and speak in a calm, confident manner.
7. Prehospital care report
1. Functions
 1. Continuity of care - a form that is not read immediately in the emergency department may very well be referred to later for important information.
 2. Legal document
 1. A good report has documented what emergency medical care was provided and the status of the patient on arrival at the scene and any changes upon arrival at the receiving facility.

2. The person who completed the form ordinarily must go to court with the form.
 3. Information should include objective and subjective information and be clear.
 3. Educational - used to demonstrate proper documentation and how to handle unusual or uncommon cases.
 4. Administrative
 1. Billing
 2. Service statistics
 5. Research
 6. Evaluation and continuous quality improvement
2. Use
1. Types
 1. Traditional written form with check boxes and a section for narrative.
 2. Computerized version where information is filled in by means of an electronic clipboard or a similar device.
 2. Sections
 1. Run data - date, times, service, unit, names of crew
 2. Patient data - patient name, address, date of birth, insurance information, sex, age, nature of call, mechanism of injury, location of patient, treatment administered prior to arrival of EMT-Basic, signs and symptoms, care administered, baseline vital signs, SAMPLE history and changes in condition.
 3. Narrative section (if applicable)
 - (1) Describe, don't conclude.
 - (2) Include pertinent negatives.
 - (3) Record important observations about the scene, e.g., suicide note, weapon, etc.
 - (4) Avoid radio codes.
 - (5) Use abbreviations only if they are standard.
 - (6) When information of a sensitive nature is documented, note the source of that information, e.g., communicable diseases.
 - (7) Be sure to spell words correctly, especially medical words. If you do not know how to spell it, find out or use another word.
 - (8) For every reassessment, record time and findings.
 4. Other state or local requirements
 3. Confidentiality - the form and the information on the form are considered confidential in many states. Check state and local laws.
 4. Distribution - local protocol and procedures will determine where the different copies of the form should be distributed.

3. Falsification issues
 1. When an error of omission or commission occurs, the EMT-Basic should not try to cover it up. Instead, document what did or did not happen and what steps were taken (if any) to correct the situation.
 2. Falsification of information on the prehospital care report may lead not only to suspension or revocation of the EMT-B's certification/license, but also to poor patient care because other health care providers have a false impression of which assessment findings were discovered or what treatment was given.
 3. Specific areas of difficulty
 1. Vital signs - document only the vital signs that were actually taken.
 2. Treatment - for example, if a treatment like oxygen was overlooked, do not chart that the patient was given oxygen.

4. Documentation of patient refusal
 1. Competent adult patients have the right to refuse treatment.
 2. Before the EMT-Basic leaves the scene, however, he should:
 1. Try again to persuade the patient to go to a hospital.
 2. Ensure the patient is able to make a rational, informed decision, e.g., not under the influence of alcohol or other drugs, or illness/injury effects.
 3. Inform the patient why he should go and what may happen to him if he does not.
 4. Consult medical direction as directed by local protocol.
 5. If the patient still refuses, document any assessment findings and emergency medical care given, then have the patient sign a refusal form.
 6. Have a family member, police officer or bystander sign the form as a witness. If the patient refuses to sign the refusal form, have a family member, police officer or bystander sign the form verifying that the patient refused to sign.
 7. Complete the prehospital care report.
 - (1) Complete patient assessment.
 - (2) Care EMT-Basic wished to provide for the patient.
 - (3) Statement that the EMT-Basic explained to the patient the possible consequences of failure to accept care, including potential death.
 - (4) Offer alternative methods of gaining care.
 - (5) State willingness to return.

5. Special situations/reports/incident reporting
 1. Correction of errors
 1. Errors discovered while the report form is being written
 - (1) Draw a single horizontal line through the error, initial it and write the correct information beside it.
 - (2) Do not try to obliterate the error - this may be interpreted as an attempt to cover up a mistake.

2. Errors discovered after the report form is submitted
 - (1) Preferably in a different color ink, draw a single line through the error, initial and date it and add a note with the correct information.
 - (2) If information was omitted, add a note with the correct information, the date and the EMT-Basic's initials.
2. Multiple casualty incidents (MCI)
 1. When there is not enough time to complete the form before the next call, the EMT-Basic will need to fill out the report later.
 2. The local MCI plan should have some means of recording important medical information temporarily, e.g., triage tag, that can be used later to complete the form.
 3. The standard for completing the form in an MCI is not the same as for a typical call. The local plan should have guidelines.
3. Special situation reports
 1. Used to document events that should be reported to local authorities, or to amplify and supplement primary report.
 2. Should be submitted in timely manner.
 3. Should be accurate and objective.
 4. The EMT-Basic should keep a copy for his own records.
 5. The report, and copies, if appropriate, should be submitted to the authority described by local protocol.
 6. Exposure
 7. Injury
4. Continuous quality improvement
5. Information gathered from the prehospital care report can be used to analyze various aspects of the EMS system.
6. This information can then be used to improve different components of the system and prevent problems from occurring.

SUGGESTED APPLICATION

Procedural (How)

Demonstrate all components of patient assessment.

Review methods of questioning to determine history of present illness - (SAMPLE history).

Demonstrate proper methods for providing a verbal and a written patient care report.

Contextual (When, Where, Why)

Size-up represents the very beginning of patient assessment. It requires the EMT-Basic to evaluate several aspects concerning the situation in a very short period of time. It is the essence in assuring the safety of the crew and the patient. This information may be obtained as part of dispatch, but should always be reassessed upon arrival at the scene. For some situations, size-up is an on-going process. As additional information is obtained, modification is performed to the size-up of the patient and the situation overall.

Perform initial assessment on all patients after assuring scene and personal safety. If the scene is safe and the environment permits, perform the assessment prior to moving the patient. The initial assessment is a rapid means of assessing patient condition and priorities of care.

The focused history and physical exam is performed following the initial assessment and correction of immediate threats to life. The focused history and physical exam differs for medical and trauma patients. During this process, obtain additional information regarding the patient's condition. This assessment may be performed at the same location as the initial assessment, unless the scene or patient's condition requires movement. This assessment is the second hands-on approach to gain information to continue providing patient care.

The detailed physical exam is performed following the focused history and physical exam. It will be performed after all critical interventions have been completed. It is situation and time dependent. Depending upon the severity of the patient's injury or illness, this assessment may not be completed. During this process, additional information regarding the patient's condition is obtained. Typically this assessment will be performed while en route to the receiving facility.

The on-going assessment should be performed on all patients after assuring completion of critical interventions. Ideally, it is completed following the detailed physical exam. However, the patient condition may preclude performance of the detailed physical exam. In these cases, the on-going assessment is extremely valuable. The on-going assessment is a means of determining changes in the patient's condition.

STUDENT ACTIVITY

Auditory (Hear)

Student should hear simulations of various safe and unsafe scenes.

Students should hear recordings of various patient situations to listen for clues concerning the general impression.

Students should hear information input from a simulated patient or others regarding symptoms for patients with altered mental status.

Students should hear questions to assist in determining the history of the present illness.

Visual (See)

Students should see simulations of various safe and unsafe scenes.

Students should see visual aids or materials of various patient situations.

Students should see the inspection and palpation of programmed patients for various injuries and patterns of injury.

Students should see the entire assessment completed for each patient category.

Kinesthetic (Do)

Students should practice role playing the actions taken at various safe and unsafe scenes.

Students should practice all components of the assessment.
Students should practice examining interventions to assure that they continue to be effective.
Students should practice recording assessment findings.

Instructor Activities

Supervise student practice.
Reinforce student progress in cognitive, affective, and psychomotor domains.
Redirect students having difficulty with content.

EVALUATION

- Written: Develop evaluation instruments, e.g., quizzes, verbal reviews, and handouts, to determine if the students have met the cognitive and affective objectives of this lesson.
- Practical: Evaluate the actions of the EMT-Basic students during role play, practice or other skill stations to determine their compliance with the cognitive and affective objectives and their mastery of the psychomotor objectives of this lesson.

REMEDIATION

Identify students or groups of students who are having difficulty with this subject content.

SUGGESTED ENRICHMENT

What is unique in the local area concerning this topic?