First Aid Response

Recognise and Assess

Module 1 – Patient Assessment

First Aid Response

Patient Assessment

Learning Outcomes

Knowledge Objectives (by the end of this Unit, you will be able to…)

1. State the purpose of a Primary Survey and identify when it should be conducted
2. State the purpose of a Secondary Survey and identify when it should be conducted
3. Identify the key anatomical areas to be examined during a “Survey”
4. Describe the procedure for patient assessment – primary and secondary
5. State the 6 Vital Signs – circulation, breathing, blood pressure (cap refill), skin colour, skin temperature, and conscious level
6. State the normal/abnormal characteristics of the 6 vital signs
7. Define the term ‘sign’ and ‘symptom’
8. Identify the components of a patient’s history based on the mnemonic SAMPLE: Signs & Symptoms, Allergies, Medication, Pertinent medical history, Last oral intake, Event (SAMPLE)

Learning Outcomes

Attitudinal Objectives (by the end of this Unit, you will be able to…)

1. Recognise and respond to the feelings the patient may experience during examination in a non-judgemental and compassionate manner
2. Communicate with empathy during examination to patient/s as well as with family members, friends and bystanders showing appreciation and understanding for the effects of pain and fear

Skills Objectives (by the end of this Unit, you will be able to…)

1. Demonstrate how to conduct a Primary Survey
2. Demonstrate how to conduct a Secondary Survey
3. Demonstrate how to obtain a SAMPLE history
4. Demonstrate how to record the findings of patient assessment

Topics

Primary Survey

1. Initial Response
2. Catastrophic Bleeding
3. Mechanism of Injury
4. Assess Responsiveness
5. ABCDE

Secondary Survey

1. Vital Signs
2. Signs & Symptoms
3. SAMPLE History
4. Head-to-Toe Examination

Primary Survey

What is it?

1. Method used to identify the presence of any life threatening injuries
2. We use a Primary Survey with every patient we meet
3. First step in the Care Management of any patient

What does it consist of?

1. Initial Response
2. Catastrophic Bleeding
3. Mechanism of Injury
4. Assess Responsiveness
5. ABCDE

1. Initial Response

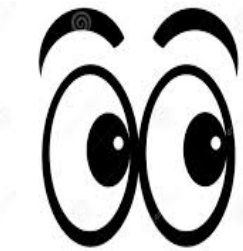
- Scene Safety
- Scene Survey
- Scene Situation

Question:

What elements might we be focusing on here?

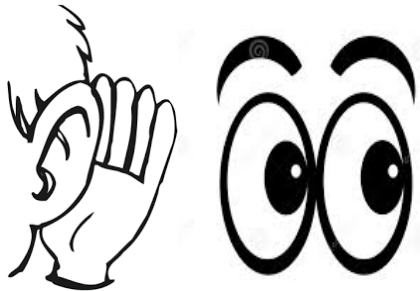
Scene Safety

- Look and listen for immediate dangers to yourself & others
- Any hazards at the scene?
- Is it safe to approach?
- Take standard infection control precautions and COVID-19 specific precautions.



Scene Survey

- Look at the incident – what happened?
- Examine the Mechanism of Injury
- Look at the position of the patients
- Number of patients?
- Are there bystanders/onlookers?



Scene Situation

- Will you need additional help?
  - Responders
  - EMS (999/112)
- Establish priority patient/s
- Listen to information being provided
- Be calm and confident (the patient is relying on you)
- Be caring, compassionate & non-judgemental

3. Mechanism of Injury

Linking Mechanism of Injury to suspected injuries of the head and spine

- Any trauma patient with altered level of consciousness
- Blunt trauma with associated injuries above the collar bones
- Penetrating trauma to head, neck and torso
- Falls from height
- Shallow water diving accidents
- Hangings
- Gunshot wounds

C-Spine

If the Mechanism of Injury suggests a spinal injury you must control c-spine

4. Assess Responsiveness

- Shake & Shout
- Gently tap the patient's shoulders and ask if he/she can hear you
- Unresponsive? **(999/112 & AED)**

Open the Airway & check for normal Breathing

5. ABCDE

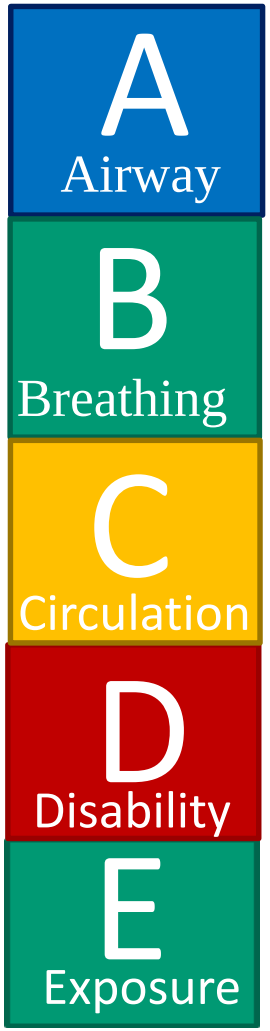
AIRWAY

BREATHING

CIRCULATION

DISABILITY

EXPOSE AND EXAMINE



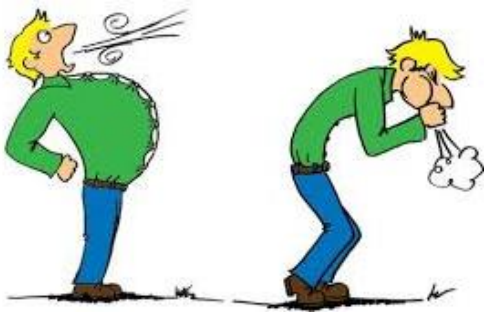
Airway

- The first step is to ensure the patient has an adequate Airway

WHY?

No airway = no means of breathing

Result: Life threatening complications



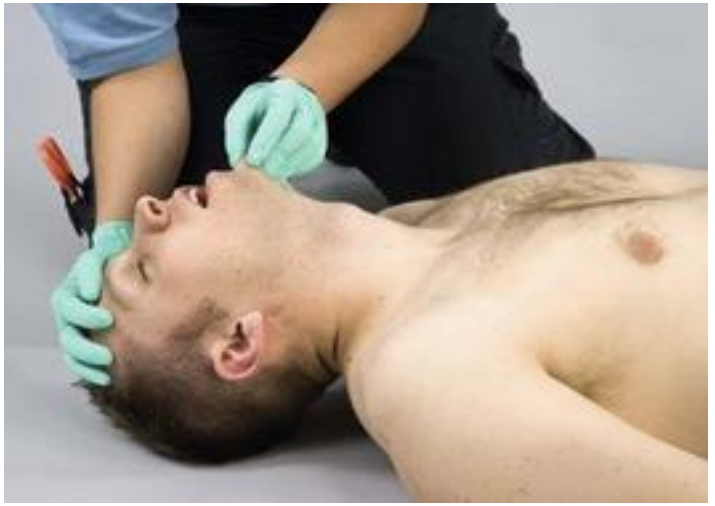
Airway

Q. Does anyone know the most common cause of an airway obstruction?

- The Tongue

Q. How do we fix an inadequate airway?

- Head-Tilt, Chin-Lift method
- Lifts the tongue from the back of the mouth and opens the airway



Breathing

- After we have ensured the patient has an airway – we need to ask a very important question:

<u>Are they breathing?</u>

<u>YES – is it normal?</u>

- Depth (shallow or deep)
- Speed (fast or slow)
- Regularity (regular or irregular)

<u>NO</u>

- We need to breathe for them
- Start CPR
- Call for help

Circulation

- Key Components:
  - Pulse
    - Have they a pulse?

YES – is it normal?

- Rate (fast or slow)
- Regularity (regular or irregular)
- Strength (strong or weak)

NO

- No breathing + No Pulse = CPR

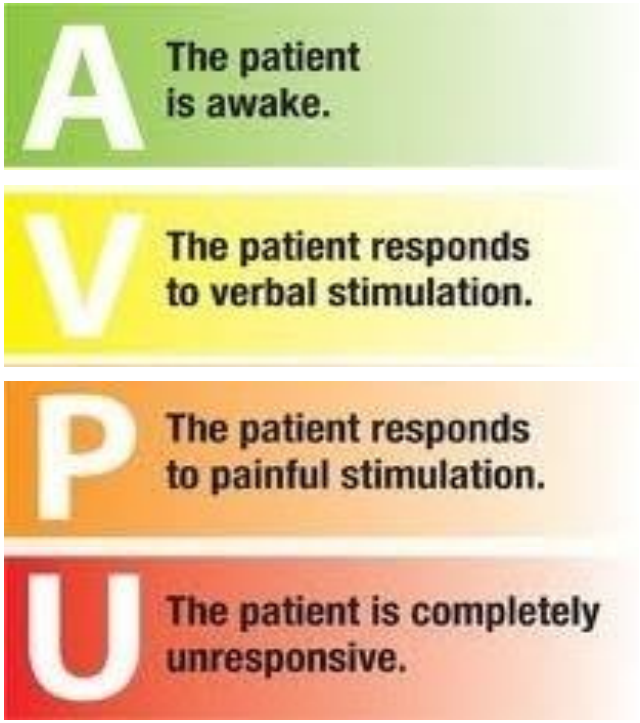
Circulation

- Key Components:
  - Cap Refill
    - Is it less than 2 seconds?
  - Skin Colour and Temperature
    - Pale?
    - Flushed? (Red)
    - Cyanosed? (Blue)

Disability

In order to assess a patients responsiveness we use the AVPU scale

- **Alert** – is the patient alert?
- **Voice** – do you have to raise your voice to get response from patient?
- **Pain** – does the patient only respond to a pain stimulus?
- **Unresponsive** – is the patient completely unresponsive?



Expose & Examine

- The final step of the Primary Survey is to expose and examine
- A common mistake people have is thinking this is only for trauma patients, but we should do it for all patients
- What are we looking for?
  - Deformities
  - Open Wounds
  - Tenderness
  - Swelling
  - Also looking out for rashes, sources of infection, etc.

PHECC CPGs

- FAR CPGs (2017)
  - Primary Survey

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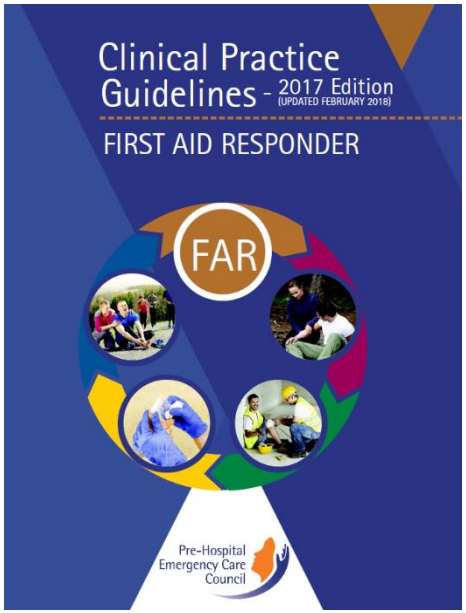


Secondary Survey

What is it?

- Method used to establish any other injuries and look for signs & symptoms

- We can classify it as either ‘Medical’ or ‘Trauma’

What does it consist of?

- Vital Signs
- Signs & Symptoms
- SAMPLE History
- Head-to-Toe Examination

Vital Signs

- Circulation
- Breathing
- Blood Pressure (Cap Refill)
- Skin Colour
- Skin Temperature
- Conscious level

Assessing Pulse (Circulation)

Radial Pulse

Normal Rates:
60 to 100 Adult

Count for
30 seconds x 2

Assessing Pulse (Circulation)

Carotid Pulse

Normal Rates:
60 to 100 Adult

Count for
30 seconds x 2

Don’t press too hard!

No to be used for patients with suspected head or neck injuries

Assessing Pulse (Circulation)

Pulse		
Rate:	Fast	Slow
Rhythm:	Regular	Irregular
Quality:	Strong	Weak

Q1. What might a rapid strong pulse be a sign of?

Q2. What might a fast & weak pulse be a sign of?

Q3. What would no pulse be a sign of?

Assessing Breathing (Resp. rate)

Normal Rates:
12 to 20 Adult

Count for
30 seconds x 2

Assessing Breathing

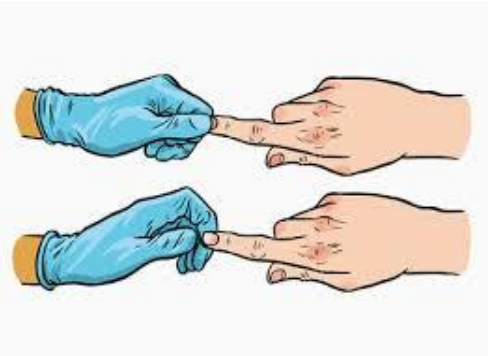
Breathing		
Rate:	Fast	Slow
Rhythm:	Regular	Irregular
Quality:	Deep	Shallow
	Quiet	Noisy
	Laboured	Normal

Q1. What might a slow or fast breathing rate be a sign of?

Q2. What might irregular breathing be a sign of?

Blood Pressure (Cap Refill)

Cap Refill	
Fast Refill	**Slow Refill**
Palpable Pulse	**Non-Palpable Pulse**



Pressure is applied to the nail bed until it turns white. This indicates that the blood has been forced from the tissue

Pink colour should return in less than 2 seconds after pressure is removed

Skin Condition

- Colour – white (pale), red, blue, yellow, black/blue, flushed
- Temperature – warm/cool, hot/cold
- Condition – clammy, sweaty, dry, wet

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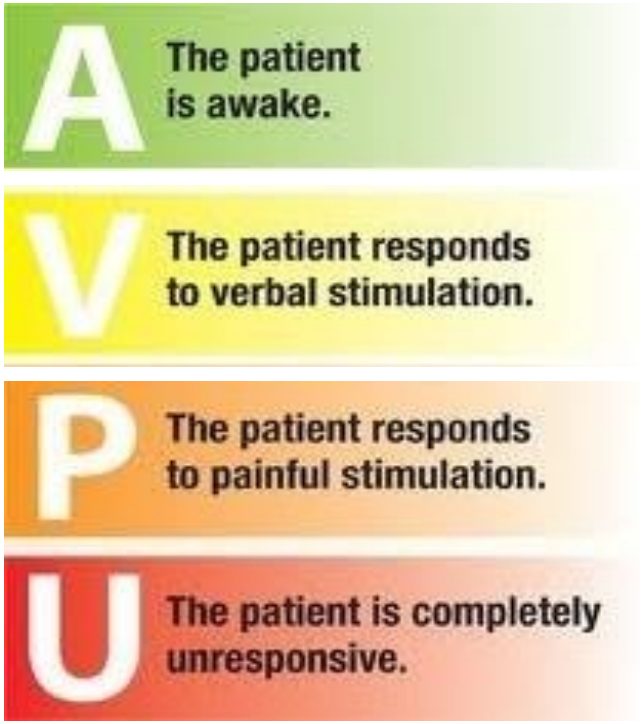
Conscious Level – AVPU

- **Alert** – is the patient alert?
- **Voice** – do you have to raise your voice to get response from patient?
- **Pain** – does the patient only respond to a pain stimulus?
- **Unresponsive** – is the patient completely unresponsive?



Sign or a Symptom?

Sign

- An indicator of the patient's condition that you can see, smell, feel or hear (e.g. vomiting, coughing, deformity)

Symptom

- An indicator of the patient's condition that they tell you and that only they can feel (e.g. nausea, back pain, stomach-ache)

Sign or a Symptom?

Mix & Match	
1. “I feel sick”	8. Tightness of the chest
2. A fractured arm	9. Tenderness
3. Swelling	10. Patient says they feel unwell
4. Fatigue	11. Breathing rate of 10 p.min
5. Smell of alcohol off patient	12. Wheezing
6. Abnormal breathing	13. Headache
7. Weak pulse	14. Bleeding

Pick out the Signs & Symptoms

SAMPLE History (Hx)

- **S** – signs and symptoms
- **A** – allergy
- **M** – medications taken or medications on
- **P** – past medical history
- **L** – last intake including drugs or alcohol
- **E** – events leading to and including event

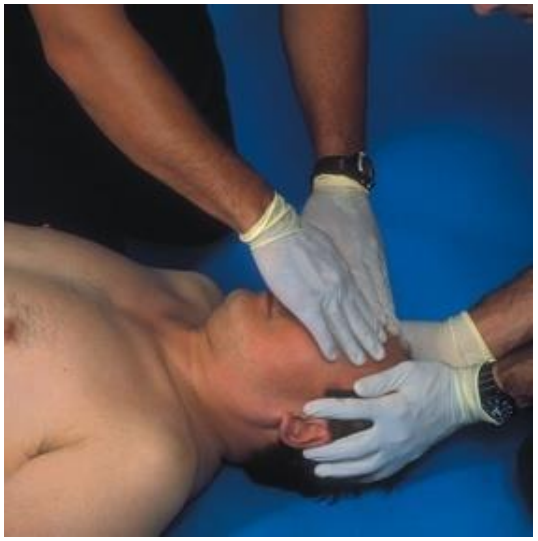
Why is it important to find out about allergies?

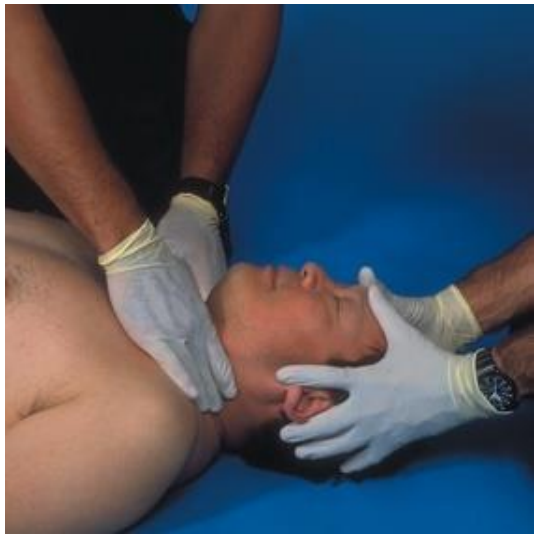
What might "events leading up the incident" include?

What can past medical history tell us?

Head-to-Toe Examination

- Head, Neck, and Cervical Spine
  - Feel head and neck for deformity, tenderness, or crepitus
  - **Check** for bleeding & **Ask** about pain or tenderness





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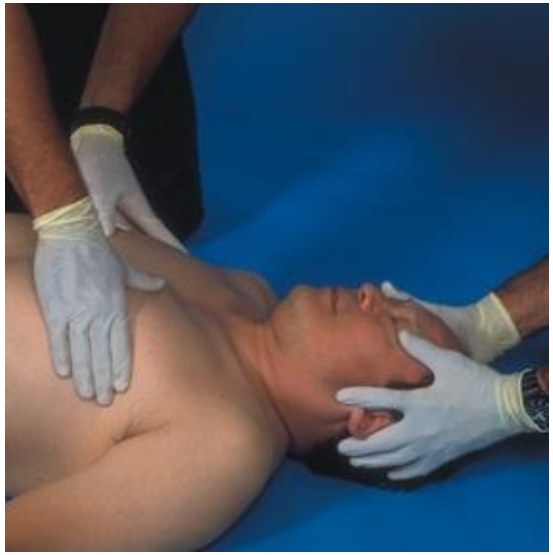
Head-to-Toe Examination

- Chest
  - Watch chest rise and fall with breathing.
  - Feel for grating bones as patient breathes.
  - Listen to breath sounds.



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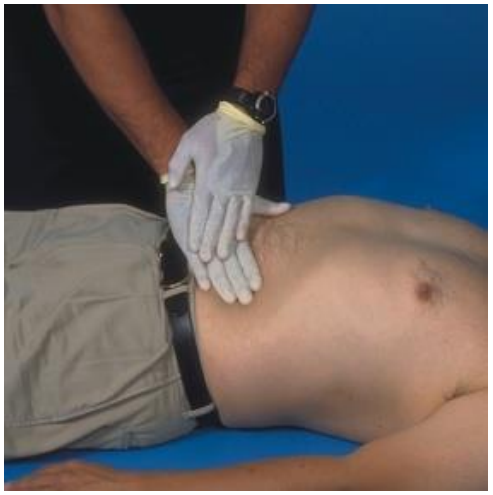
Head-to-Toe Examination

- Abdomen
  - Look for obvious injury, bruises, or bleeding.
  - Evaluate for tenderness and any bleeding.
  - Examine the area very gently.



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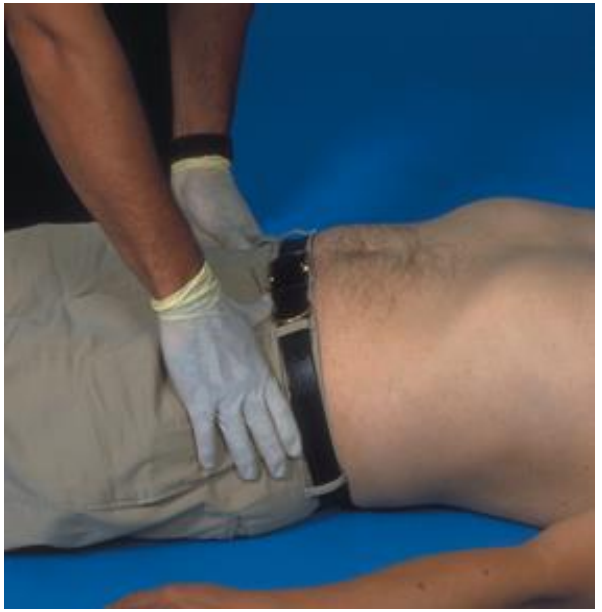
Head-to-Toe Examination

- Pelvis
  - Look for any signs of obvious injury, bleeding, deformity
  - Do not apply pressure to the pelvis



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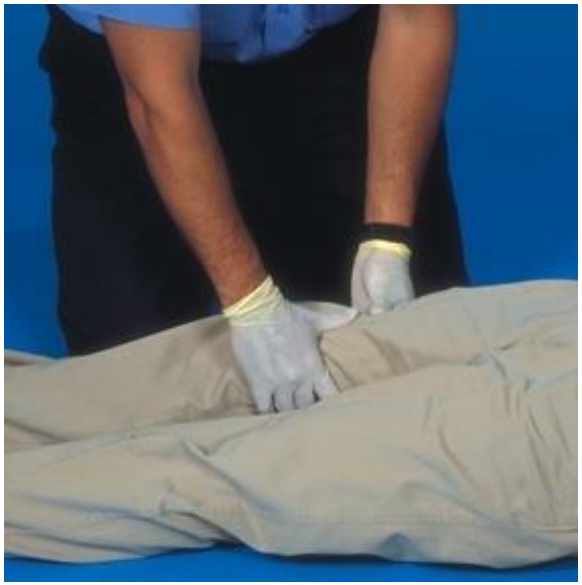
Head-to-Toe Examination

- Extremities – Arms & Legs
  - Look for obvious injuries
  - Feel for deformities
  - Look for Medic alert tags
  - Assess
    - Cap Refill



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Assessment

Q. Describe the procedure for carrying out a Primary Survey

Q. Describe the procedure for carrying out a Secondary Survey

Summary

Primary Survey

1. Initial Response
2. Catastrophic Bleeding
3. Mechanism of Injury
4. Assess Responsiveness
5. ABCDE

Secondary Survey

1. Vital Signs
2. Signs & Symptoms
3. SAMPLE History
4. Head-to-Toe Examination