Chapter 8

Patient Assessment

Introduction

- As an EFR, you must be able to:
  - Rapidly assess the scene
  - Size up potential hazards and determine the need for additional resources
  - Rapidly assess patients for life-threatening (critical) conditions and begin treatment

Introduction

- Assessment is learned as a series of separate skills, but in reality you will be doing many of these things at the same time
  - In the assessment process you rapidly take in information and sort it to make decisions

Introduction

- Assessment is the most important skill
  - Includes the following stages:
    - Scene size up
    - Primary assessment
    - Physical examination
    - Patient history
    - Ongoing assessment
    - Hand-off report

Scene Size-up

- Quick determination of the entire scene before you actually touch the patient; this includes:
  - Safety of the scene
  - Personal protection
  - Assessment of mechanism of injury or nature of illness

Scene Size-up

- Begins the moment you receive initial request for aid
  - Information provided by dispatch should give you an idea of:
    - What to expect when you arrive
    - What resources you may need to obtain
    - Security of the scene

Scene Size-up

- While traveling to the scene look at weather conditions
  - Bad weather = adjust travel speeds
  - Weather = extreme hot or cold conditions

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Scene Size-up

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Scene Size-up

- Scene safety
  - Specialty Training areas:
    - Tactical situations
    - Fire
    - Hazardous materials
    - Vehicle extrication
    - Other types of special rescue

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Scene Size-up

- Nature of the event
  - Is this a TRAUMA call or a MEDICAL call?
    - A trauma patient is one who has sustained an injury as the result of an external force
    - A medical patient is a patient who appears to have an illness or complains of symptoms of an illness

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Scene Size-up

- Nature of the event
  - MOI
    - You can predict likely injuries to the patient by considering the impact site and tracing destructive energy through the body
    - You cannot see the forces that occurred, but you can learn to look at a trauma incident

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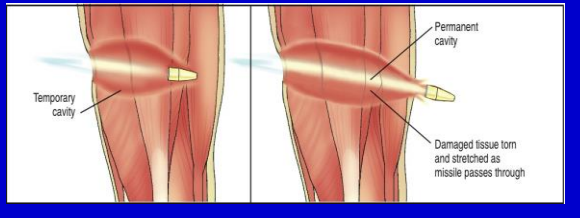
Scene Size-up



- Penetrating trauma can create both a permanent cavity and temporary cavity
- In blunt trauma, the energy applied also creates a temporary cavity

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Scene Size-up

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Scene Size-up

- Nature of the event (Illness)
  - NOI
    - With a medical emergency, try to learn the NOI
      - Talk directly with the patient whenever possible
      - Look around the scene to uncover clues about the NOI

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Scene Size-up

- Number of patients involved
- Additional resources
  - * Police, Fire, Hazmat, Extrication, Utility
- Find everyone involved in the incident
- Prepare to triage in MCI situations

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Primary Assessment

- Called either the primary survey or initial assessment
- Performed to identify and treat any life-threatening problems
- Has three main parts:
  - Form a general impression of the patient
  - Assessing the patient's responsiveness
  - Checking the patient's airway, breathing, circulation, and disability (ABCD)

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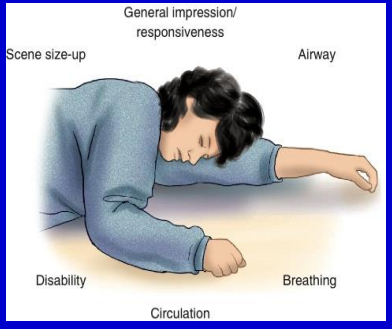
Primary Assessment



Entering a scene:

- Look at the patient
- Think about what happened
- Begin to evaluate the patient's condition
- Notice the patient's responsiveness, level of anxiety, breathing, and skin

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Primary Assessment

- General Impression
  - Is formed before you have touched/started to assess the patient
  - Helps you decide how to act and gauge the seriousness of the scene
  - To form a general impression of the emergency you need to quickly evaluate the scene and think about what is happening, what you have been told, and what you observe

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Primary Assessment

- Level of consciousness

A – Alert before you attempt to talk to them
V – Response to verbal stimuli from you
P – Respond to a painful stimuli (pinch, sternum rub)
U – Unresponsive to all commands

Primary Assessment

- Airway
  - A patient who is responsive and can speak has an open (or patent) airway
    - Continue to reassess the airway FREQUENTLY!
      - Noisy breathing indicates a partially obstructed airway
      - A patient who is trying to speak or cough but cannot make any noise has a completely obstructed airway

Primary Assessment

- Airway
  - Unresponsive: assess the patient's airway and look, listen, and feel for breathing
    - Open the airway if breathing is noisy or if you do not hear breathing at all
      - Medical: Head tilt, chin lift
      - Trauma: Jaw Thrust

Primary Assessment

Primary Assessment

- Breathing and ventilation
  - Look at and listen to the patient as they breathe
  - If patient is responsive and alert, ask yourself the following questions:
    - Is the patient able to speak in full sentences without having to stop to take a breath?
    - How hard is patient working to breathe?
    - Is breathing adequate?
    - Is patient sitting upright?

Primary Assessment

- Breathing and ventilation
  - Also look for:
    - What is patient's color?
    - Is patient showing signs of hypoxia such as cyanosis?
    - How fast and deep is patient breathing?
    - Is patient using accessory muscles in the chest (between the ribs) or neck or abdominal muscles to breath?
    - Can patient speak and carry on a normal conversation?

Primary Assessment

- Breathing and ventilation
  - To assess the patient look at and listen to them as they breath
    - If patient is responsive and alert, ask yourself the following:
      - Is the patient sitting upright?
      - What is the patient's color?
      - Is the patient showing signs of hypoxia, cyanosis?
      - How fast and how deep is the patient breathing?

Primary Assessment

- Breathing and ventilation
  - If patient is unresponsive, look, listen, and feel for breathing
    - If patient is breathing adequately, continue to reassess
    - If patient is not breathing adequately, open airway and ventilate using either mouth-to-mask, mouth-to-barrier, or bag-mask device

Primary Assessment

What does this position tell you?

Primary Assessment

- Breathing and ventilation
  - Supplemental O_2 should be given to any patient with signs of inadequate breathing and/or ventilation
    - Assist breathing with bag-mask and supplemental O_2 if patient is breathing too fast (>24 breaths per minute) or too slow (<8 breaths per minute) or has signs of cyanosis

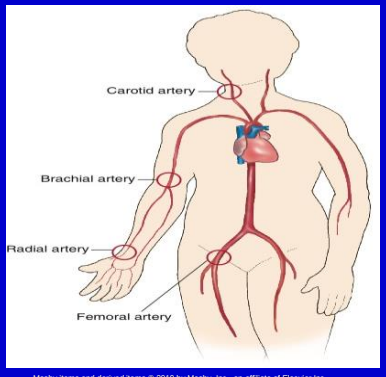
Primary Assessment

- Breathing and ventilation
  - If patient is showing signs/symptoms of inadequate ventilation and oxygenation, start ventilation assistance
    - Regardless of his/her level of consciousness
  - If patient has no respiration or very slow respirations, start rescue breathing

Primary Assessment

- Circulation
  - To determine effectiveness of a patient's circulation
    - Look for major bleeding
    - Assess the pulse
    - Quickly assess the skin

Assessment of the Pulse



Primary Assessment

How do you properly feel for a carotid pulse?

Primary Assessment

Demonstrate how to properly feel for a brachial pulse

Primary Assessment

What patients do you often check a radial pulse on?

Primary Assessment

- Circulation
  - Femoral pulse
    - Found in groin area
    - Used to assess circulation in responsive children if brachial or radial pulse cannot be found
    - Carotid or femoral pulse should be assessed in an unresponsive child
    - In newborns, assess central pulse by palpitating the base of the umbilical cord between your thumb and index fingers

Primary Assessment

- Circulation
  - When you check a pulse, determine:
    - Whether it is present or not present
    - Is it slow or fast
      - Normal pulse rates for an adult will be between 60 and 100 beats/minute and regular
    - If no pulse, start CPR

Primary Assessment

- Circulation
  - Major bleeding
    - As part of the primary assessment, assess patient for major bleeding (hemorrhage)
    - Look at both the patient and scene for:
      - Any visible active bleeding
      - Pool of blood anywhere at the scene
      - Blood collected in the ground
      - Feel around the back of the patient to see if any blood has collected underneath the patient

Primary Assessment

- Circulation
  - Major bleeding
    - Active hemorrhage must be controlled immediately
      - Be aware of how much blood patient has potentially lost
      - If patient has lost significant blood, possible shock occurs
    - Do not let bleeding distract you from the priorities of assessing and maintaining airway, breathing, and circulation

Primary Assessment

- Circulation
  - Skin Assessment
    - Skin color and temperature can also be indications of the adequacy of circulation

    > A bluish (cyanotic) discoloration indicates a lack of O_2 at the cellular level

    > Pale skin may indicate a low body temperature, blood loss, or shock

Primary Assessment

- Circulation
  - Abnormal Skin
    - Flushed or red, patient's temperature may be elevated
    - Cool skin may indicate a low body temperature/shock
    - Wet/sweaty skin may indicate physical exertion, severe pain, or shock
    - If color is pale, mottled, and cool to the touch, patient may be in shock

Primary Assessment

- Circulation
  - Check capillary refilling time for circulation assessment of infants and children <6 years
    - Press on area of the skin or thumb and nail & release
      - Once released, color should return to the area within 2 seconds
      - If it takes longer than 2 seconds for color to return to the depressed area, it may indicate possible decreased circulation
      - Delayed capillary refill by itself is not a reliable indicator

Primary Assessment

- Disability
  - An additional step in the initial assessment is sometimes designated as D for disability
    - Provides more of an assessment of a patient's brain (mental) function (neurological assessment)
    - Assess the patient's mental function along with the ability to move and control all extremities

Primary Assessment

- Disability
  - Glasgow Coma Scale (GCS)
    - One of the most complete ways to assess a patient's mental status (disability)
    - GCS score is used by other prehospital providers to assess the patient's mental function
    - The earlier an assessment can be done on a patient, the earlier a baseline value can be set

Glasgow Coma Scale

Best eye response (E)	Spontaneous--open with blinking at baseline	4
	Opens to verbal command, speech, or shout	3
	Opens to pain, not applied to face	2
	None	1
Best verbal response (V)	Oriented	5
	Confused conversation, but able to answer questions	4
	Inappropriate responses, words discernible	3
	Incomprehensible speech	2
	None	1
Best motor response (M)	Obeys commands for movement	6
	Purposeful movement to painful stimulus	5
	Withdraws from pain	4
	Abnormal (spastic) flexion, decorticate posture	3
	Extensor (rigid) response, decerebrate posture	2
	None	1

Primary Assessment

- Disability
  - GCS
  - Reporting of the GCS Score
    - After assessing each component of the GCS (E, V, M) the points received for each component are added together to get a total GCS score
      - Ranges from 3 to 15 points

Primary Assessment

- Disability
  - GCS
    - Reporting of the GCS Score
      - A total GCS of 3 = unresponsive patient
      - A total GCS of 15 = conscious and alert
      - If patient's GCS score is something other than 3 or 15, the score should be broken down by category and its awarded points

Primary Assessment

- Prioritizing patients
  - The primary assessment helps separate/triage critical/serious patients from noncritical ones
    - With critical/serious patients you must continue to reassess the airway, breathing, and circulation and care for any life-threatening conditions until the patient is stable or more advanced care arrives

Skill 8-1
Primary Assessment (Unresponsive Patient)

- General impression
  Assess responsiveness

- Assess airway and breathing

Skill 8-1
Primary Assessment (Unresponsive Patient)

- Assess for pulse

- Assess for major bleeding

Skill 8-1
Primary Assessment (Unresponsive Patient)

- Assess the skin
- Determine disability & assess priority

Skill 8-2
Primary Assessment (Responsive Patient)

- General impression

- Assess responsiveness, airway, and breathing

Skill 8-2
Primary Assessment (Responsive Patient)

- Assess circulation

- Determine disability and assess priority

Primary Assessment

- Communication
  - If patient is unresponsive during initial assessment, call for additional help immediately
  - If patient is responsive, wait until initial assessment is complete before calling for additional help
  - Once you have prioritized the patient, update the responding EMS unit with a brief radio/cellular telephone report if possible

Secondary Assessment

- Performed after ensuring all life threatening conditions have been identified and correctly managed during the primary assessment
- Obtain complete set of vital signs
- Perform detailed physical examination based on patient's present condition
- Gather past medical history
- Perform a systematic and organized physical examination of the patient

Secondary Assessment

- Vital signs
  - Consists of patient's pulse rate, respiratory rate, and, if allowed, blood pressure
  - Provides starting point for judging effectiveness of prehospital care
  - Taken every 15 minutes for noncritical patients and at least every 5 minutes for critical patients or whenever their condition changes

Secondary Assessment

- Physical examination
  - Inspect (look) and palpate (feel) for signs of injury
  - Use mnemonic DOTS for physical examination
    - *D*eformities
    - *O*pen wounds
    - *T*enderness
    - *S*welling

Secondary Assessment

Secondary Assessment

Secondary Assessment

- Physical examination
  - Always compare one side of patient's body to the other side to help identify abnormalities
  - Done in a systematic and orderly manner
  - Practice assessment skills often so you can quickly identify normal/abnormal findings
  - If a patient has a specific injury or complaint, start there and then expand the examination as needed
  - Purpose of the physical examination is to identify other injuries not found in your initial assessment

Skill 8-3
Secondary Assessment-Physical Head to Toe Examination

- Inspect and palpate the scalp

- Inspect and palpate the face

Skill 8-3
Secondary Assessment-Physical Examination

- Look for eye injuries and pupil response; do not palpate eye injuries

- Look for fluid leaking from ears

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Skill 8-3
Secondary Assessment-Physical Examination

- Check the mouth for any bleeding or injuries

- Remove clothing from patient's upper body

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Skill 8-3
Secondary Assessment-Physical Examination

- Inspect and palpate the front and back of the neck

- Inspect and palpate the chest

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Skill 8-3
Secondary Assessment-Physical Examination

- Compare both side of the chest for any abnormality

- Auscultate the chest

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Skill 8-3
Secondary Assessment-Physical Examination

- Inspect and palpate the abdomen

- Palpate the back and inspect for signs of bleeding

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Skill 8-3
Secondary Assessment-Physical Examination

- Remove clothing from patient's lower body

- Palpate the pelvis

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Skill 8-3
Secondary Assessment-Physical Examination

- Inspect and palpate each upper leg

- Inspect and palpate each lower leg

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Skill 8-3
Secondary Assessment-Physical Examination

- Assess movement and sensation in each foot

- Assess pulses in each foot

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Skill 8-3
Secondary Assessment-Physical Examination

- Inspect and palpate each upper arm

- Inspect and palpate each lower arm

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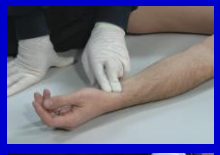
Skill 8-3
Secondary Assessment-Physical Examination

- Assess radial pulse in each arm



- Assess movement and sensation in each hand

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Skill 8-3
Secondary Assessment-Physical Examination

- If possible, log roll patient and assess back

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Secondary Assessment

- Physical examination
  - Head
    - To examine the head run your fingers over the face and scalp to gently palpate for deformities or depressions in bones of the face and skull
      - Be gentle, so you do not force pieces down into the brain, in case of skull fracture

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Secondary Assessment

- Physical examination
  - Neck
    - If the patient is injured, keep head and neck stabilized while you use gently pressure to palpate for deformities
    - Check position of the trachea (midline) and any open wounds to the neck
      - Open wounds in the neck can be dangerous; the neck holds the trachea and has very large blood vessel
      - If you discover an open wound, cover it completely with an airtight occlusive dressing

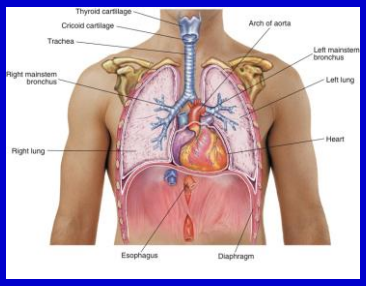
Secondary Assessment

- Physical examination
  - Neck
    - If patient complains of tenderness when you palpate, there may be damage to the spine/soft tissue that supports the neck
    - Swelling can obstruct the airway
    - Palpate not only front of the neck but also vertebrae and skin on back of the neck

Secondary Assessment

- Physical examination
  - Chest
    - As you examine the chest remember the major organs that the thoracic cavity holds
    - Always compare the two sides of the chest to help identify abnormalities
    - Inspect and palpate the chest for any deformity, which may indicate broken ribs

Secondary Assessment



Secondary Assessment

- Physical examination
  - Chest
    - Assess both anterior (front) and posterior (back) of the chest for open wounds
      - Open chest wounds can let air flow into the chest and around the lungs, potentially causing a life-threatening injury
      - If you find an open chest wound, immediately apply direct pressure with a gloved hand and then apply an airtight (occlusive) dressing
      - Tape the dressing on three sides, maintaining one side open for air to escape

Secondary Assessment

Secondary Assessment

- Physical examination
  - Abdomen
    - Gently palpate for any injuries/tenderness
    - You may feel/see deformities
    - If you discover any open injuries to the skin and fatty tissue, cover them with an occlusive dressing such as plastic food wrap to keep air from entering the abdomen
      - If contents are spilling out of the wound, cover area with a sterile, moist dressing

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Secondary Assessment

- Physical examination
  - Abdomen
    - It is important to note location of any tenderness because it may provide a clue about underlying organ damage
    - Patient may tighten the muscles of an injured area (called “guarding”) when you palpate the abdomen
    - Report swelling/distention in the abdomen by quadrant locations

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Secondary Assessment

- Physical examination
  - Back
    - If there are enough providers available when you are assessing a trauma patient, do a log roll to inspect the patients back
    - Inspect and palpate the back for any obvious deformities, open wounds, tenderness/swelling

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Secondary Assessment

- Physical examination
  - Pelvis
    - To assess, apply gentle but firm pressure to the pelvic girdle to check for deformities
    - As you are palpitating you may feel a crunching/crepitus
    - Injury can cause extensive bleeding both internally and externally from the large blood vessels in this area
    - Tenderness and swelling may indicate a fracture or dislocation
    - If you need to move a patient, fully support the legs if you suspect a fracture in the pelvic area

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Secondary Assessment

- Physical examination
  - Extremities
    - Inspect and palpate each extremity for deformities of the bones, soft tissue, and joints
    - Look for open wounds and control any bleeding
    - Injuries can be dramatic
    - Tenderness/swelling may result from a fracture, dislocation, or sprain

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Secondary Assessment

- Physical examination
  - Extremities
    - To assess for numbness, ask the patient to identify areas you touch
    - Palpate radial pulses in arms and pedal pulses in legs to evaluate circulation
    - Compare each extremity to the opposite extremity to help identify possible injuries/abnormalities

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Secondary Assessment

- History
  - Important to collect patient's complaint, past medical history, and event history as you assess the patient
    - Primary complaint is a very brief description of the reason for summoning assistance
    - In the best circumstances, the patient will be able to answer all questions about his/her medical history
    - You can gather most relevant medical history by using the mnemonic SAMPLE

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Secondary Assessment

- SAMPLE
  - S-signs and symptoms
    - What you "see" and what you "hear"
  - A-allergies
    - Important to note anything pertinent (latex, medical tags)
  - M-medications
    - What prescribed medications, over the counter, herbs, vitamins
  - P-pertinent past history
    - Cardiac, respiratory, surgeries, etc.
  - L-last oral intake
    - What have you ate and drank recently
  - E-events prior
    - What occurred before the call

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Reassessment

- While caring for your patient perform a reassessment until additional EMS personnel arrive and take over care
- Repeat primary assessment (ABCD) and vital signs at continuous intervals

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Reassessment

- Reassesses airway, breathing, circulation, and possible disability to gauge effectiveness of your treatment and to correct any identified problems
  - Reassess airway to ensure it is open and maintained
  - Monitor patient's breathing and pulse for rate and quality
  - Recheck skin color, temperature, and condition
  - Calm patient as you wait for EMS to arrive
- Anytime a patient's condition changes, reassess

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Hand-off Report

- When EMS responders arrive, be ready to give a hand-off report
- This report describes your assessments and interventions
- With multiple patients, start with most critical patients so they get immediate care and transport

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Hand-off Report

- The report should include the following:
  - Age and gender
  - Primary complaint
  - Responsiveness
  - Airway and breathing status
  - Circulation status
  - Physical findings
  - SAMPLE history
  - Interventions provided
  - Patient's current condition

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Vital Signs

- As part of the healthcare team it is beneficial for you to know how to take and report vital signs and how to accurately triage patients
- You may be required to evaluate/help evaluate the patient's vital signs if time permits

Vital Signs

- Include:
  - Breathing
  - Pulse
  - Skin
  - Pupils
  - Blood pressure

Vital Signs

- As you assess a patient's vital signs the initial numbers you obtain will be important, but even more important will be trends you identify as you reassess vital signs
  - Vital signs are usually taken at a minimum of every 5 minutes in critical patients and every 15 minutes in noncritical patients

Vital Signs

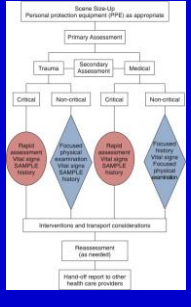
- Breathing
  - When evaluating, assess rate, quality, and in some situations breath sounds
  - To assess breathing observe rise and fall of patient's chest
    - You may find it easier to look at/feel the upper abdomen to count the respiratory rate
      - To measure rate you should count the number of breaths in 30 seconds and multiply this number by 2

Vital Signs

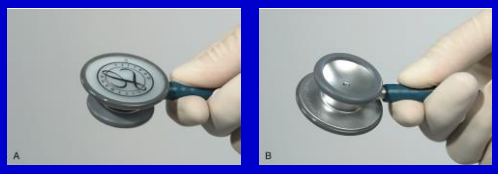
- Breathing
  - To assess quality of breathing, evaluate how much energy the patient is using to breathe
    - Whether the patient is using accessory muscles to breathe
    - How deep respirations are
    - Whether breathing is noisy

Vital Signs

- Breathing
  - To assess breath sounds you may also auscultate or listen to the chest with a stethoscope
    - Place the stethoscope in your ears with earpieces facing forward and use diaphragm of the stethoscope to listen from side to side on the chest
    - You are comparing sounds and quality of respiration in each lung field in order to identify abnormalities



Vital Signs



Vital Signs

Vital Signs

- Pulse
  - Indicator of patient's circulatory function
  - Assess radial pulse on both adult and child patients
    - A radial pulse should be measured with 2/3 fingers of your hand
      - Do not use your thumb to feel for a pulse because a thumb has its own pulse, which may be measured instead
      - If radial a pulse cannot be found, assess a carotid pulse on adults and brachial pulse on children
      - Brachial pulse should always be assessed on infants

Vital Signs

- Pulse
  - Once you feel the pulse assess it for rate, regularity, and quality
    - To determine pulse rate, count the number of beats in 30 seconds and multiply by 2
    - Also determined by counting the number of beats in 15 seconds and multiplying by 4
    - Normal pulse occurs at regular intervals
    - If the pulse is irregular, it may be a sign of cardiac problems

Vital Signs

- Pulse
  - When you assess the quality of the pulse, you are feeling to see if the pulse is weak or strong
    - If pulse is rapid and weak, patient may be in shock
    - If pulse is rapid and bounding, it may indicate that the patient is anxious or has high blood pressure

Vital Signs

- Skin signs
  - Assessing patient's skin can tell you a lot about a patient
    - Not only will you see injuries, assessment will give you clues about how well the heart and lungs are working
  - When evaluating the skin, assess for color, temperature, condition, and in children, capillary refill time

Vital Signs

- Skin signs
  - To assess color you should look at:
    - Overall skin color
    - Mucous membranes of the mouth
    - Nail beds
    - Conjunctiva of the eye

Vital Signs

- Skin signs
  - Abnormal skin colors may include the following:
    - Pale
    - Cyanotic
    - Flushed
    - Jaundiced
    - Mottled

Vital Signs

- Skin signs
  - Skin temperature
    - Assess by placing the back of your ungloved hand on patient's skin
    - Normal skin: temperature is warm
    - Abnormal skin: temperature suggests decreased perfusion, infection, or heat and cold emergencies

Vital Signs

- Skin signs
  - Condition of the skin
    - Skin is normally dry
      - Wet, moist, or clammy skin may be associated with shock

Vital Signs

- Skin signs
  - Capillary refill time
    - Capillary refill in conjunction with other findings is a reflection of how well the circulatory system is working
    - Delayed capillary refill time can be caused by decreased perfusion to an area

Vital Signs

Capillary Refill Time

Press on patient's skin/fingernail until skin under depressed area turns white
* Once area turns white the pressure is released
* Note how long it takes for the color to return to the white area

Vital Signs

- Pupils
  - Assessed for size, equality, and reaction to light
    - To assess, look at pupils and then shine a light into them
      - Normally pupils react by constricting equally to light
      - Pupils of both eyes are normally the same size
      - Size, equality, and reaction to light give you clues about possible problems

Vital Signs

Vital Signs

- Blood pressure
  - Reflects status of heart and blood vessels
  - To assess you need a stethoscope and properly fitting blood pressure cuff/sphygmomanometer
  - Represented by two numbers, systolic and diastolic blood pressures
  - Values will vary depending on age of the patient

Vital Signs

- Blood pressure
  - Can be obtained by two methods, auscultation and palpation
    - When you auscultate the blood pressure, you will be using a stethoscope and listening for systolic and diastolic sounds

Skill 8-4
Auscultating a Blood Pressure

- Place blood pressure cuff on patient and place stethoscope in your ears

- Palpate for the brachial artery

Skill 8-4
Auscultating a Blood Pressure

- Place diaphragm of stethoscope over brachial artery and hold in place

- Tighten valve on bulb and inflate the cuff by squeezing on the bulb

Skill 8-4
Auscultating a Blood Pressure

- Slowly let the air out of the cuff and listen to the sounds
- The first sound is the systolic pressure

Skill 8-4
Auscultating a Blood Pressure

- Where the sound stops is the diastolic pressure
- Record the blood pressure as systolic/diastolic

Skill 8-5
Palpating a Blood Pressure

* When you palpate a blood pressure, you will be feeling for the return of a pulse as the cuff is deflated

  You will not obtain a diastolic pressure when you palpate

- Place blood pressure cuff on patient

Skill 8-5
Palpating a Blood Pressure

- Place your index and middle fingers over the radial pulse

Skill 8-5
Palpating a Blood Pressure

- Tighten the valve on the bulb and inflate the cuff by squeezing the bulb

Skill 8-5
Palpating a Blood Pressure

- Slowly let the air out of the cuff and feel for a pulse
- Systolic pressure is when a pulse can be felt
- Record a “systolic/palp.”

Vital Signs

- Blood pressure
  - Documented with systolic pressure over diastolic pressure (e.g., 120/90). When palpated, you will record as 120/P
  - There are many factors that can affect accuracy of a blood pressure reading
    - When taking a blood pressure reading it is very important to use the proper cuff size

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Vital Signs

- Blood pressure
  - Take blood pressure readings in all patients who are ≥ 3 years
  - Vital signs tell you how your patient is doing; they are most useful when assessed repeatedly for trends

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Vital Signs

- Triage
  - Process of sorting patients
  - Used when you have more patients than personnel or resources to care for them
  - Being aware of how to perform triage and the importance of triage is of vital importance to EFRs because they may be the first on the scene at a multicasualty incident

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Questions?

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