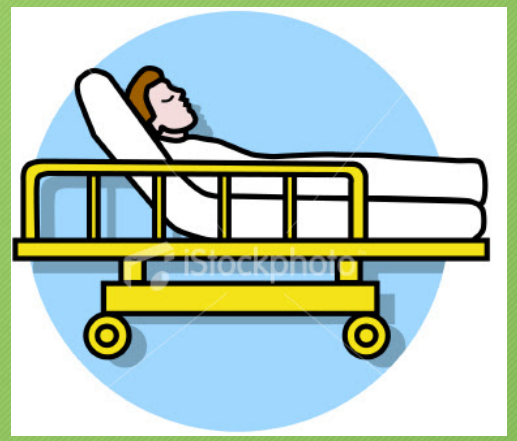
Patient Assessment

Katie Good-Opdahl, RN

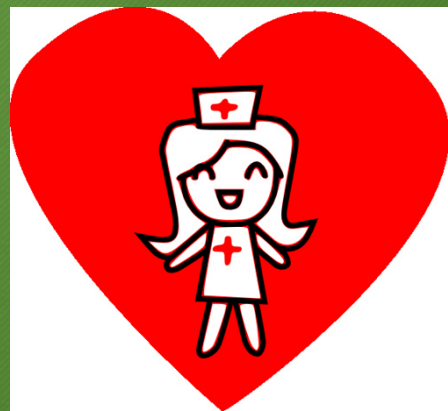


Objectives

- Following the presentation, individuals should be able to:
  - Complete a thorough head to toe assessment of the ED patient
  - Withhold knowledge for early recognition of the critical ED patient

“The competent emergency nurse must be a ‘jack-of-all-trades’, master of most”

- Patients present to the ED with every possible medical, surgical, traumatic, social and behavioral health condition.
- Subjective vs Objective Data

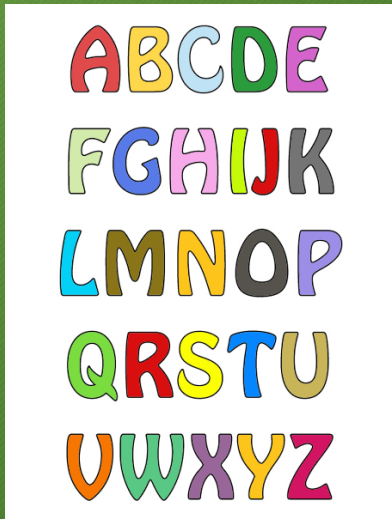


Back to the Basics

- Gown every patient, every time
- A-I mnemonic for assessment
- Primary vs Secondary Assessments
  - Both can be completed within minutes unless resuscitative measures are required.

Primary Assessment

- Utilized to identify and address potentially life-threatening conditions
- ABCDE
  - Airway
  - Breathing
  - Circulation
  - Disability
  - Exposure



Secondary Assessment

- Identify all clinical indicators of illness or injury
- FGHI mnemonic
  - Full set of vitals
  - Give comfort measures
  - History and head-to-toe assessment
  - Inspect posterior surfaces

Airway

Assessment Actions include:

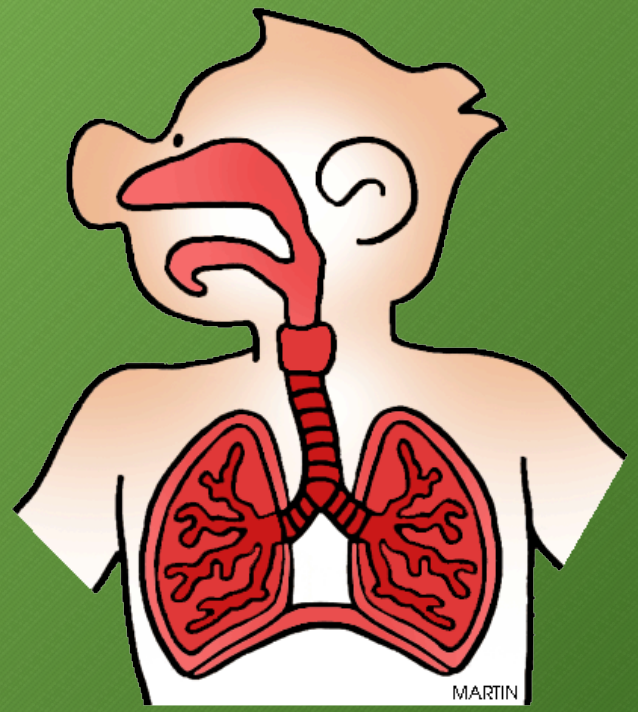
*Identifying and removing any partial or complete airway obstruction;

*Position airway to maintain patency

Interventions:

*Insert oropharyngeal or nasopharyngeal airway

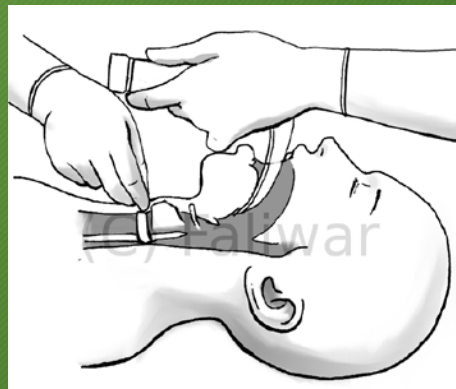
*Protect cervical spine



Breathing

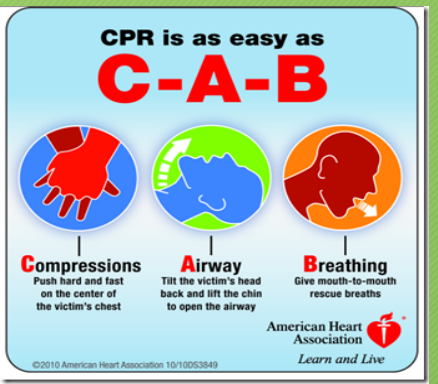
- Assessment Actions include:
  - Assist breathing with oxygen therapy, mouth to mask ventilations, or bag-mask ventilation as needed
  - Intubate when necessary

- Interventions:
  - Assist in providing ventilations and supplemental oxygen as needed
  - Relieve tension pneumothoraces may be necessary to support breathing efforts



Circulation

- Assessment Actions include:
  - Evaluate pulse presence and quality, character, and equality
  - Assess capillary refill, skin color and temperature
  - Assess for diaphoresis and skin turgor
- Interventions:
  - If no palpable pulse is present, initiate CPR and resuscitation efforts



Disability

Response	Score
Eye opening	
Opens eyes spontaneously	4
Opens eyes in response to speech	3
Open eyes in response to painful stimulation (eg, endotracheal suctioning)	2
Does not open eyes in response to any stimulation	1
Motor response	
Follows commands	6
Makes localized movement in response to painful stimulation	5
Makes nonpurposeful movement in response to noxious stimulation	4
Flexes upper extremities/extends lower extremities in response to pain	3
Extends all extremities in response to pain	2
Makes no response to noxious stimuli	1
Verbal response	
Is oriented to person, place, and time	5
Converses, may be confused	4
Replies with inappropriate words	3
Makes incomprehensible sounds	2
Makes no response	1

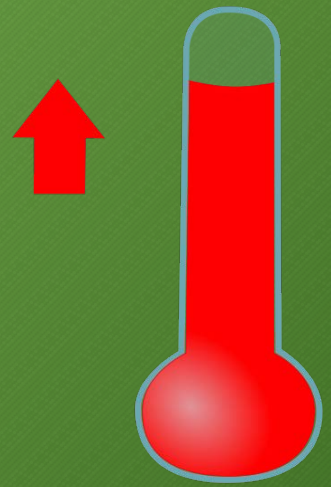
- Assessment Actions include:
  - Determine level of consciousness
- Interventions:
  - If altered level of consciousness, further assessment needs to be completed in order to investigate cause.

Exposure and Environmental Control

*All patient's should be in a gown

-Provide a blanket

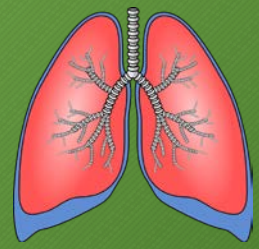
-Trauma patient's meet requirements to have warmed rooms



Secondary Assessment – Full Set of Vitals

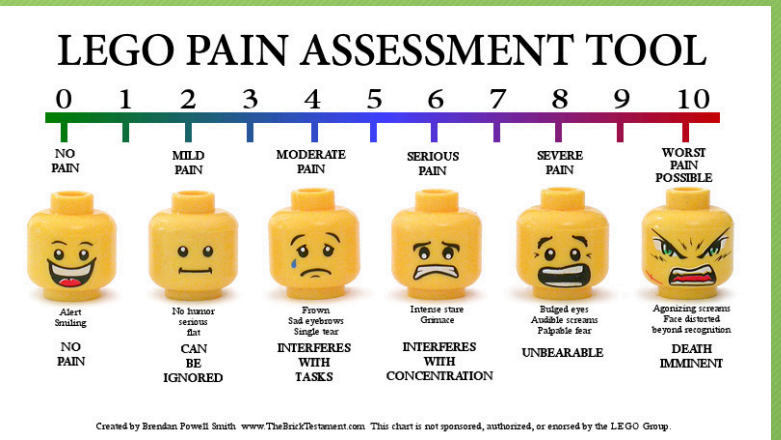
- Temperature
  - Core temperature recommended
    - Rectal
    - Urinary catheter thermistors
- Pulse
  - Palpate central pulses
  - A change is indicatory of compensatory mechanisms
- Respirations
  - Count respirations for a full minute
  - Chest must raise equally on both sides
- Oxygen Saturation
  - Good pleth
  - Observe with clinical appearance
- Blood Pressure
  - Proper cuff size
  - Cardiac monitor vs manual BP

*Weight, Height, and head circumference



Give Comfort Measures

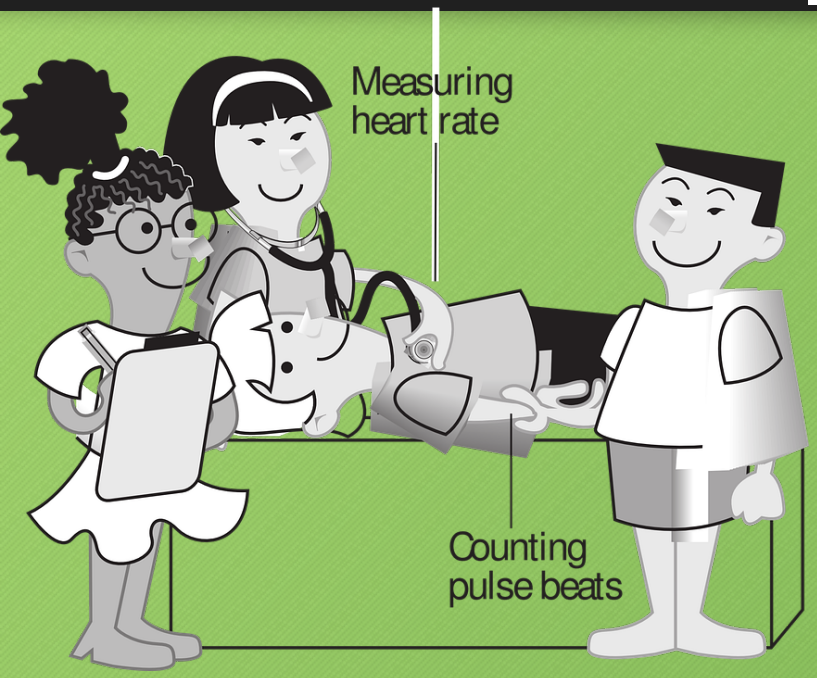
- Pain is referred to as the 5th VS
  - Age-appropriate standardized tool
  - FACES Pain Rating Scale
  - FLACC – face, legs, activity, cry and consolability
- Comfort measures initiated based on chief complaint and obvious injury



History

- AMPLE
  - Allergies
  - Medications
  - Past health history
  - Last meal eaten
  - Events leading to the illness/injury

Head-to-Toe Assessment



- Head and Face
- Neck
- Chest
- Abdomen
- Pelvis/Perineum
- Extremities
- Posterior Surfaces

The End

"You were nursing in your sleep again. You checked my vitals, gave me an imaginary shot, then mumbled something about doing paperwork."

"The bad thing about Halloween is that I don't know what injuries are real, and which ones are part of their costume."