Patient Assessment

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Emergency Assessment Overview

Patients who present to the ED have every possible complaint from Medical, Surgical, Traumatic, Social, and Behavioral. ER nurses need to be able to handle a broad spectrum of patients spanning all ages from newborn to centenarians. A competent ER nurse must be a “jack-of-all trades” master of “most”, and constantly prepared for EVERY conceivable scenario.

Types of Information

Subjective Data

- Information verbally provided by the patient
- Is the patients perception of the problem
- Often put in “Quotes”
- And referred to as the Chief Complaint

Objective Data

- Data considered Factual
- Things you can see and/or Measure
- Obtained from
  - Inspection
  - Palpation
  - Auscultation
  - Percussion
  - Smell
- Used to validate the patients subjective complaint

Essential Assessment tools for ER

- Interpersonal Skills
- Knowledge of Anatomy and Physiology
- Physical assessment skills
- And the ability to apply critical thinking to each patients unique situation

Initial Assessment

Primary Phase (ABCDE)

- Ensures that potentially life threating conditions are identified and addressed
- Evaluates
  - Airway
  - Breathing
  - Circulation
  - Disability
  - Exposure

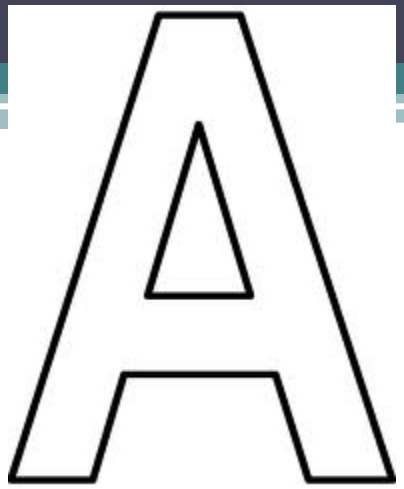
Secondary Phase (FGHI)

- Done after primary exam and primary threats addressed
  - Measurement of VS
  - Pain Assessment
  - History
  - Head to Toe
  - Posterior surface inspection

Primary Assessment

During Primary Assessment in initial impression of the patient is formed, determining them to be “sick” or “not sick”.

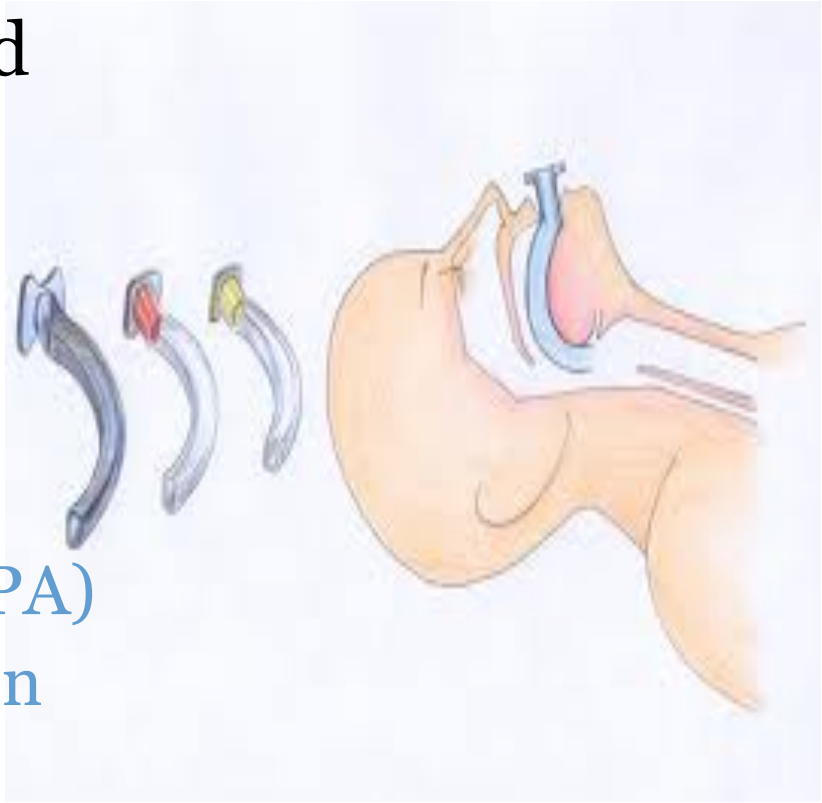
Primary Assessment
Airway



- Is pt vocalizing sounds appropriate for age?
- Check for obstruction or foreign material visible in the oropharynx (blood, emesis, teeth, debris)
- Look for swelling or edema to lips, mouth, tongue, or neck
- Is the pt drooling or dysphasic?
- Listen for stridor or abnormal sounds

Primary Assessment
Airway

- If the airway is obstructed what do you do?
  - Head tilt- chin lift (if no trauma)
  - Jaw Thrust
  - Suction
  - Airway Adjunct (OPA, NPA)
  - Preparation for intubation



Primary Assessment
Breathing

- Assess for the following:
  - Spontaneous breathing
  - Rate and Pattern
  - Symmetrical Rise and Fall
  - Increased work of breathing (nasal flaring, retractions)
  - Use of accessory muscles
  - Chest wall stability/integrity
  - Skin color

Primary Assessment
Breathing

- What if breathing is significantly compromised?
  - Assess Lung Sounds
  - Bag-mask device assistance
  - Oxygen
  - Position Airway Open
  - Occlude Open chest wounds
    - Intervene to relieve PTX if applicable
- If not compromised?
  - Assess lung sounds

Primary Assessment
Circulation

- Assess skin for:
  - Color
  - Temperature
  - Moisture
  - Cap Refill (central-on head or chest)
  - Uncontrolled bleeding or Trauma

Primary Assessment
Circulation

Compromised

- Palpate Pulse (central/periph)
  - Rate and Quality
- Place on Cardiac Monitor
- Establish Vascular Access

No Pulse

- Begin Resuscitation
  - BLS, or ACLS

Primary Assessment
Disability

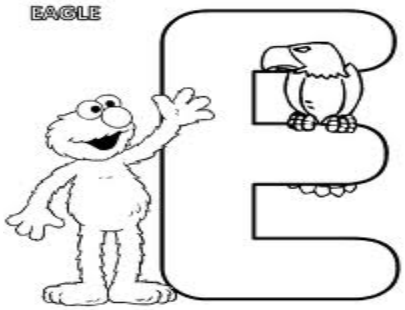
A helpful mnemonic exists to assist in a brief neurologic assessment

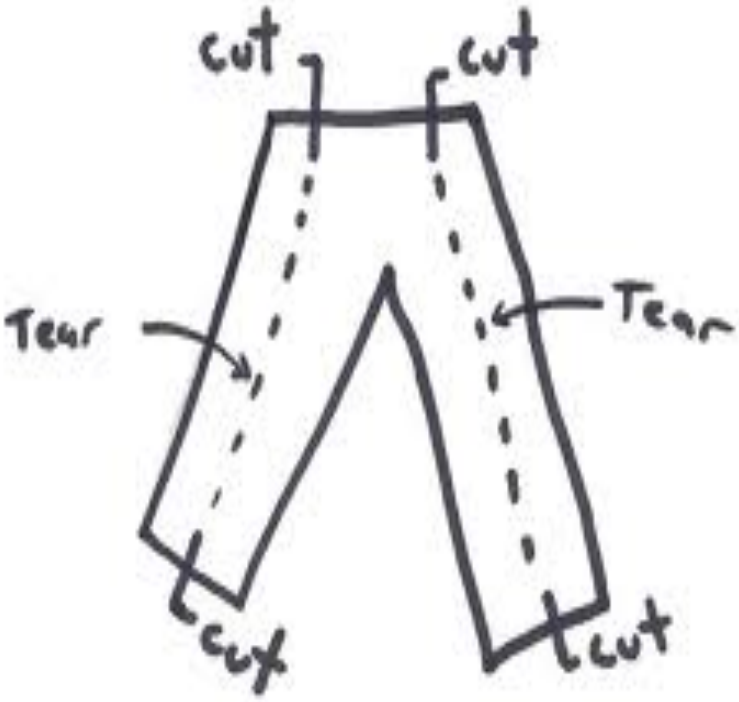
- **A**- Alert: Pt is awake, alert, responsive to voice and is oriented to person, time, and place
- **V**- Verbal: Pt responds to voice but is not fully oriented to person, time, or place
- **P**- Pain: Pt does not respond to voice but does respond to painful stimulus
- **U**- Unresponsive: Pt does not respond to voice or painful stimulus

Primary Assessment
Disability

- What if they have ALOC?
  - Check pupils-
    - Size, equality, and reactivity to light
  - Further investigate during your secondary assessment

Primary Assessment
Exposure





- Remove the patients clothing to thoroughly examine and identify any underlying cause of illness or injury
- Covering the patient maintains privacy and prevents heat loss

Secondary Assessment

Once emergent threats are addressed, your secondary assessment can be completed (FGHI)

Secondary Assessment
Full Set of Vital Signs

- Temperature
  - Oral, Tympanic, Temporal, Axillary, Rectal
- Pulse
  - Rate and Rhythm (regular or irregular)
  - Quality (Bounding, Weak, Thready)
- Respiratory Rate
  - Rate, Rhythm, Depth, and WOB
- Blood Pressure
  - Proper size cuff is important
- Oxygen Saturation
  - Proper placement of probe is key
- Weight
  - Must be done on ALL children/infants

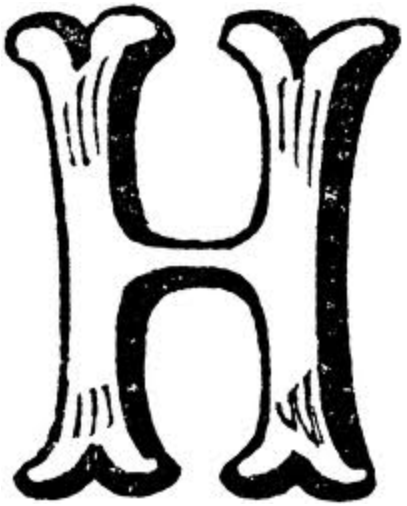
Secondary Assessment
Give Comfort Measures

Pain- "the 5th vital sign"

- PQRST (Provoked, Quality, Radiation, Severity, Time)
- 0-10 scale
- FACES pain scale
- FLACC Infant pain scale

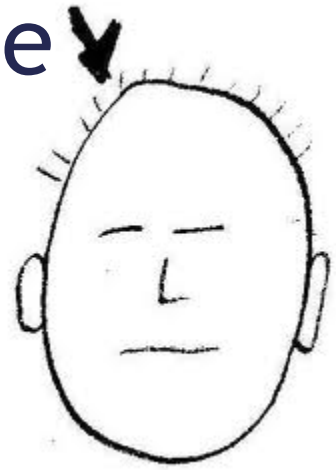
*More on pain later

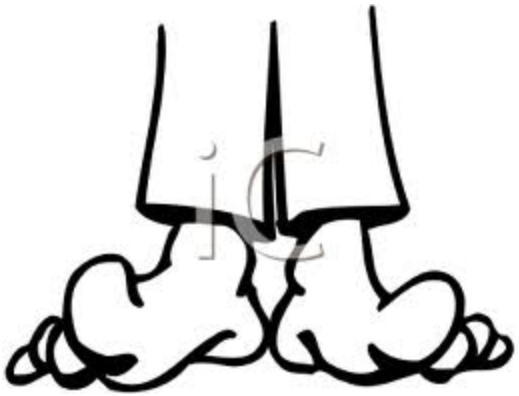
Secondary Assessment History



- AMPLE mnemonic
  - **A**- Allergies
    - Record severity and type of reaction
  - **M**- Medications
    - Rx, OTC, Herbal, Recreational, unprescribed
  - **P**- Past Health History
  - **L**- Last Meal Eaten
  - **E**- Events leading to injury/illness

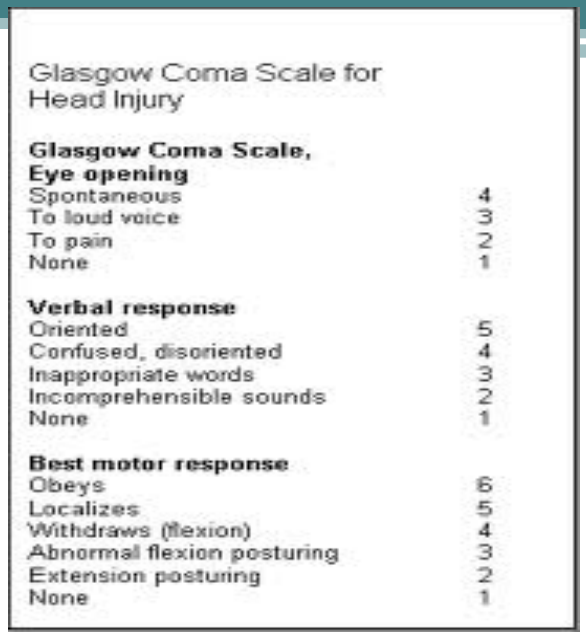
Secondary Assessment
Head to Toe





- Head and Face
  - Inspect
    - Lacerations, abrasions, avulsions, puncture wounds, foreign objects, burns, rash, ecchymosis, edema
    - Oral mucosa for hydration, swelling, bleeding, loose teeth
    - Eyes, lids, vision status,
  - Palpate
    - Feel for broken bones, crepitus, asymmetry and tenderness
  - Perform Detailed neuro exam if applicable

Secondary Assessment Head to Toe



Glasgow Coma Scale for Head Injury

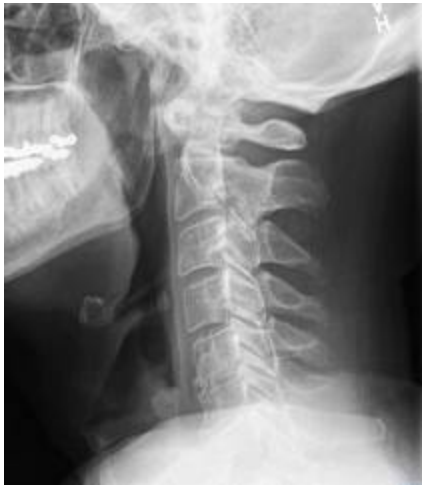
Glasgow Coma Scale,	
Eye opening	
Spontaneous	4
To loud voice	3
To pain	2
None	1
Verbal response	
Oriented	5
Confused, disoriented	4
Inappropriate words	3
Incomprehensible sounds	2
None	1
Best motor response	
Obeys	6
Localizes	5
Withdraws (flexion)	4
Abnormal flexion posturing	3
Extension posturing	2
None	1

- Neurologic
  - GCS- Glascow Coma Scale (3-15)
    - Common Scale, used to describe patient neurologic status, allows for easy communication between disciplines
  - NIH Stroke Scale (0-60)
    - Used to score stroke patients and in determining need for fibrinolytic therapy, and provides easy method of communication among providers

AEIOUTIPPS

- Causes of ALOC
  - A- Alcohol
  - E- Epilepsy/electrolytes
  - I- Insulin (hypo/hyperglycemia)
  - O- Opiates
  - U- Uremia
  - T-Trauma
  - I- Infection
  - P- Poison
  - P- Psychosis
  - S- Syncope

Secondary Assessment Head to Toe



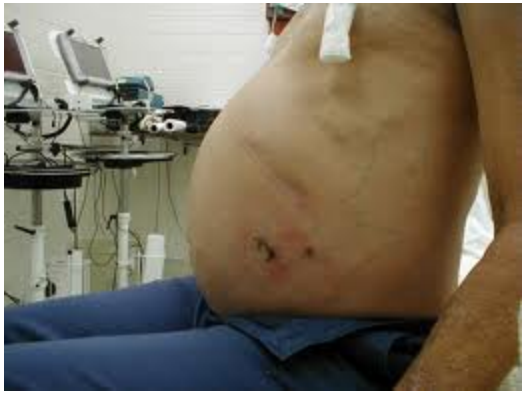
- Neck
  - Inspect
    - For injury, deformity, crepitus, edema, rash, lesions, and masses
    - Jugular veins
  - Palpate
    - Tracheal position, for SQ emphysema, and areas of tenderness
    - C-spine for Tenderness, step-off, bony crepitus

Secondary Assessment Head to Toe

Chest (pulmonary and Cardiac)

- Inspect
  - Rate and depth of respirations (paradoxical movement), trauma or rash, lesions, pacemakers, medication patches etc.
- Palpate
  - Bony deformity, crepitus, tenderness etc
- Auscultate
  - Lung sounds, adventitious sounds, heart sounds

Secondary Assessment Head to Toe



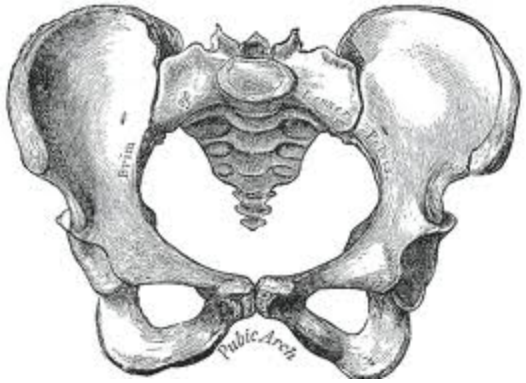
Abdomen

- Inspect
  - Contour of abd, ascites, trauma, scars, tubes, stomas
- Palpate
  - Away from the site of any reported pain
  - For any Rebound Tenderness
- Auscultate
  - Bowel sounds

Secondary Assessment
Head to Toe

Pelvis/Perineum

- Inspect
  - Trauma, edema, lesions, edema, bleeding, drainage or discharge (and quantity)
- Palpate
  - Pelvis for bony stability, sphincter tone



Secondary Assessment Head to Toe

Extremities

- Inspect
  - All 4 (if present) for redness, edema, rash, lesions, trauma, wounds, movement
- Palpate
  - Pulses, pain, tenderness, temperature, cap refill, sensation

Secondary Assessment
Inspect Posterior Surface

- Inspect
  - Bleeding, abrasions, wounds, hematomas, ecchymosis, rash, lesions, and edema
  - Pattern injury, or injury in different stages of healing (indicator of maltreatment-require further follow up)
- Palpate
  - Rectal tone- check character of stool, and for presence of blood

REVIEW

- A- Airway
- B- Breathing
- C- Circulation
- D- Disability
- E- Exposure/ Environment
- F- Full Set of Vitals, Facilitate Family presence
- G- Give Comfort Measures
- H- History and Head to Toe
- I- Inspect posterior Surfaces

Ongoing Assessment

- Should be done, if the patient has changes in condition, and upon assuming care of a new patient- other guidelines may apply specific to your facility
- Special situations may require more frequent monitoring and reassessment
  - Conscious sedation, blood transfusion, fibrinolytic therapy, pain medications, restraints, trauma, stroke etc.

Special Patient Populations

- Children and the elderly have unique anatomic and physiologic factors that must be considered in the assessment process. OB and Bariatric pts also present assessment challenges due to change in body habitus. Attention to these populations, and modification of assessment process may be necessary.