

## Patient Assessment

Patient assessment is generally something we do not even think about. We all assess patients on a regular basis and probably have our own system that we use perfected. The following is not intended to change anything we do, only to enhance or remind us to cover all areas and do have a thorough assessment on each and every patient.

The direction of our field diagnosis and treatments will be a direct result of our assessment process. Certain facts, when found will probably change the order or method of our questioning as we focus on the chief complaint. We will shorten or lengthen our assessment due to the severity of complaints found. As an example, a non-symptomatic complaint of chest pain versus a major trauma necessitates two different approaches to assessment.

A good interview sets the stage for patient care by creating confidence in the patient of the medic. By asking a series of well designed questions you begin to build a profile of your patients. You will develop a better understanding of their problems and a list of causes to explain signs and symptoms. Learning about your patient's history, medications and lifestyles will reveal clues as to an accurate field diagnosis.

The first impression is the lasting impression you will leave the patient, family and bystanders. You must quickly establish a positive and trusting relationship. Present yourself as caring, compassionate, competent and confident. Be aware of personal appearance suggesting professionalism and pride.

Voice, body language, gestures and eye contact should communicate that you care about your patient. The questioning process should make the patient comfortable. Position yourself at eye level and focus all attention on him. Make it a high priority to accommodate requests even if they are not medically significant. Should the patient be cold, cover patient with a blanket, this will help establish you do care about the patient and create confidence in you. If you cannot take care of a complaint immediately express concern for the complaint and address it later when time permits.

A calm reassuring voice and demeanor can put an apprehensive patient at ease. You are accustomed to handling emergency situations, he is not. You are not horrified by gory scenes, he is. You handle life threatening emergencies on a daily basis, he probably hasn't. Presenting as calm and collected during these times creates necessary confidence in the medic by patient.

Introductions should include immediate eye contact and maintain eye contact throughout patient care. Once you have established your personal safety is not at risk, you can enter the patient's personal space. (18 inches to 3 feet) Crouch or kneel so you can maintain eye level contact and also establish you are not attempting to take away his personal control. You do not want to appear threatening or indifferent.

Wear an identification badge or have your department and name clearly marked on your uniform that identifies who you are and whom you represent. Identify yourself by name and position such as "Hi, I am Joe and am a paramedic with Lubbock EMS. What is your name?" Find out what they like to be called- first name, Mr. or Mrs. and respect their wishes. Avoid slang names such as toots, dude, babe, sweetie, pops and gramps. The answers to the questions will establish a wealth of information as to patient condition such as mental status, respiratory difficulty, hearing and language barriers.

Be aware of non verbal communication. Facial expressions will tell the patients your attitude as much as voice tone. Touch establishes your feelings of compassion. Simply touching the wrist will establish your caring attitude while at the same time allowing you to check on pulse quality and skin tone. Always be sensitive as to a patient's attitude about touching. Avoid touching hostile, combative or paranoid patients. These patients can become violent and place the medic in danger. Unless the patient is critical, work efficiently but don't rush. You can delegate your partner or first responders to obtain vital signs and start initial treatments while you are taking a thorough history.

Take notes, you cannot possibly remember everything your patient tells you. Most patients will understand this. Do not ask personal questions in a public setting; wait until patient has been moved to a private setting for these. Teenage girls will probably not answer pregnancy questions truthfully with parents or guardians in the room. You need to be aware of when your patient becomes uncomfortable answering questions in a public setting and wait until a more appropriate time.

You can ask open ended or closed ended questions to find out information. An open ended question allows the patient to respond more freely and give details. This can give clues or directions you will take on treatments or for further questions. Sometimes a patient may get off course with their answers and you must steer them back to focusing on the current complaint. "Can you describe the pain?" or "Where does it hurt?" are examples of open ended questions. These type questions deal with generalizations and allow patient to give pertinent information that will assist patient care.

Closed ended questions elicit short answers to direct questions. They limit patient responses to one or two word answers. A patient in respiratory distress can only answer this way, phrase questions appropriately. "Does the pain move to your back?", "Shoulder?", "Do you take Lasix?" or "Have you had a heart attack before?" are examples of closed ended questions. This allows you to get to the problem quickly; however one can miss pertinent information that could be helpful by always asking closed ended questions of all patients.

Some people have difficulty describing their symptoms. Ask questions with multiple choice options. "Is the pain sharp, dull, pressure like, stabbing or like something else?" Some patients become easily confused, do not rush these patients. Have only one attendant asking questions if the patient is easily confused. You can become quite efficient with practice by knowing what questions can give the most information and maintaining your patient's attention.

Be aware of using appropriate language that patients can understand. Using medical terms much of the public is unfamiliar with confuses them. Sometimes simply phrasing the question "What is your medical history?" confuses some. Asking "What kind of medical problems have you had in the past?" is more easily understood by most people. Some people understand "Do you take diuretics?" while others understand "Do you take a water pill?" Medical terms can make the patient feel inferior and intimidated where simple language can make the patient comfortable and provide more information. Each patient is different; it is up to us to find the comfort range of terminology so we can effectively communicate with the patient.

Listen to your patient. This is a very important part of the interview process. Keep your eyes focused on him, this tells the patient you are listening to his responses. Listening also keeps one from developing "tunnel vision" from information dispatch gives attendants before arriving at the scene. Watch for subtle clues your patient may not be truthful. He may state the chest pain is gone but continues to rub his chest or grimace with pain. You may need to ask direct questions and confront what you see rather than accept the patients denial of signs/symptoms. Many people will simply deny problems because they are frightened of what the true cause can be. We need to listen with both ears and eyes to get to the actual problems with some patients.

The chief complaint would be the first fact to establish once patient contact has been made. The chief complaint can be found by questioning the patient if they are competent, from the caller if they have knowledge of the pertinent facts concerning the patient or a first responder should they make patient contact prior to you. Usually the simple question "What seems to be the problem?" will get to the point. Remember, the chief complaint may differ from the medical problem. "Right arm pain" may be the chief complaint, the primary medical problem could be a fractured arm from a fall. Asking the chief complaint establishes whether the patient is able to communicate at all. Should the patient present pulseless and apneic then asking a bystander events leading to this while you are going through the ABC's is advisable. "When was the last time you saw this person?", "Did they suddenly collapse?" can give insight as to how long the patient has been down. "Does the patient have asthma?", "Heart

problems?", "Any illness he has been treated for?" can give clues as to what caused the patient to be in this condition. Bystanders can give valuable information as to causes of traumas when the patient is unresponsive. Mechanism of injury is very important information both to relay to the receiving medical staff and to initiate immediate treatments.

Once the chief complaint has been established, you can then go into depth finding more information about the specific complaint. Most of us were trained with the AMPLE questions as a way to establish facts.

A--Allergies to medications

M--Medications

P--Previous pertinent medical history

L--Last oral intake

E--Events leading to the current problem

Allergies to medications are very important for initiating treatments. When one states they have allergies to certain medications that could be used for treatments, then go into depth as to the extent of the allergies. "Aspirin makes my throat swell and I can't breath" would be a clear contra indication to use aspirin. "Aspirin makes my arms itch but does not cause any other problems" would indicate a patient could be administered this medication in a suspected MI.

The medication one takes is very important information for both medic and receiving staff. This can give attendants clues as to previous medical problems the patient may not be forthcoming with. One can probe deeper with questions concerning reasons for taking a specific medication. Knowing current medications are necessary for receiving staff to provide the proper treatments and to be aware of potential drug interactions that may be detrimental to patients health.

The patient's previous medical history is one of the most important facts to establish. Having a seizure for the first time versus having another seizure with a history of seizures can tell one information that would lead to more intense questioning of events leading up to the current situation. Previous medical history is also important as to establish reasons patient may be in poor health at the present time. This allows us to establish a baseline as to the current health conditions and what the normal health is for the patient.

The last oral intake can give information as to the state of nourishment the patient has. It can also establish the current state of the GI tract and possible causes of the chief complaint.

The events leading to the current state has a wealth of information assisting in a field diagnosis. Was the patient resting, working, physically exerting himself or sleeping at onset of problems? Has the patient been under stress recently, been using recreational drugs or drinking excessively? Has a spouse been abusive to patient who caused the problem? Any pertinent information that can be obtained can and should be used in providing treatments and reports to receiving facilities.

One further word concerning patient assessment, always remember ABC's. Airway, Breathing and Circulation answers are always first with each and every patient. This can be established on initial contact. Severe traumatic injuries or medical problems may be such that one will not ever progress in patient care past the ABC's. Obtaining an adequate airway may be the only care you can provide from initial contact to presenting patient to the hospital. Assisting ventilations take precedent over minor complaints. Chest compressions on a pulseless patient are the patient's only chance of survival and also the ONLY way medications can be circulated to reach the patient's heart in cases of cardiac arrest. A complete assessment is impossible on many patients; experience will teach one how to obtain the best information you can with different patients.

Patient assessment is the first step in EMS care. A thorough assessment will provide a better field diagnosis and assist the receiving staff to continue those treatments. We all slightly vary our style; this is just a brief overview of reasons to have as complete an assessment of each and every patient as possible.