DEFINITIONS

- General Impression - EMT develops a plan of action from the time the call is received until the first few minutes of arrival.
- Scene Size Up - Immediately upon arrival the EMT looks for MOI/IOS, Safety, Number of Patients, and if Help Needed.
- Initial (Primary) Assessment - AVPU, CC, ABCDE. Used to find life threatening situations and treat them immediately when found.
- General (Secondary) Assessment - SAMPLE, Vitals, and Physical Assessment
- Ongoing Assessment - Start over at AVPU. Every 5 minutes for unstable, every 15 minutes for stable.
- Report - Give ID, Age, Sex, CC, ..., Care Given, ETA.
- Chief Complaint (CC) - Why the person called 911. In their words is the CC.
- Nature of Illness - is another term for CC.
- LOC stand for Level of Consciousness not Loss of Consciousness.
- BSI stands for Body Substance Isolation. All bodily fluids are contaminated.
- Paradoxical motion is when 3 or more consecutive ribs are broken in two or more places making the broken area move in an opposite direction as the rest.

- Crepitus are bone ends grinding as they rub against each other during CPR for example. Or air trapped under the skin and makes a popping sound.
- Edema means swelling.

BASE LINE VITALS

- Pulse, BP, Respirations, Temperature.
- Baseline vitals are the first ones taken.
- Trending is the comparison of other sets of vitals taken compared to the baseline.

RESPIRATIONS

- Ventilation is the act of the chest moving.
- Respirations are the act of getting air into the body and to tissue and out.
- Adult rate is 12 to 20 in a minute, Child is 15-30 and Infant is 25 to 50.
- Count the number of times a person takes a breath in a minutes for 30 seconds. Then double the number for breaths per minute. Number should always be even unless a machine has done it for you.
- Describe ventilations - noisy, quiet, deep, shallow, normal, effortless.
- Describe rhythms - regular or irregular.

Breathing Sounds

- Snoring - tongue has fallen back and is blocking the airway.
- Gurgling - fluid in the upper airway.
- Wheezing - reversible narrowing of the lower airway.
- Stridor - Partial upper airway obstruction. High pitched sound heard on inhalation.
- Rales - fine crackling bubbles in the alveoli.
- Rhonchi - fluid in the bronchioles.
- Wet Lung - Pulmonary edema.
- Note - Crackling lung sounds are not accurate. Not a true breath sound description word.

Perfusion (Pulse)

- Pulse is the contraction of the left ventricular.
- Count the number of pulses felt in 30 seconds and multiply by two for beats per minute.
- Even number unless a machine has been used.
- Pulse point is when the artery comes close to the surface and can be pressed against a bone.
- Carotid pulse is checked in unresponsive adults and children.
- Radial pulse is checked in responsive adults and children.
- Infants use the brachial.
- Central pulses are; carotid, femoral and apical.

- Apical pulse is listening to the heart pump.
- Describe the rhythms - regular or irregular.
- Describe the pulse - strong, weak, thready, absent, bounding.
- Normal pulse range for adult 60 to 100 per minute.
- At this time just know that child and infant hearts rates are faster.

Capillary Refill

- Should return in less than 2 seconds.
- Most reliable in patients under 6 years of age.
- If under 3 years old a BP can be replaced with Cap Refill.
- If between 3 and 6 years old try for BP and if cannot get us Cap Refill.
- May be used on adults but will not be as accurate.
- Cold and warm environments, raising or lowering the body part tested can falsify the test.

Blood Pressure

- Auscultation (listen) and Palpation (feel).
- Systolic is heart at work or pressure in vessels. 90 to 140mmHg. (YOUR BOOK STATES 100-150, IF YOU SEE THIS AS A QUIZ QUESTION THE CORRECT ANSWER IS 90 TO 140mmHg.
- Diastolic is heart at rest or neutral pressure in vessels. 60 to 90mmHg.

- Palpation is good in noisy environments and to find baseline for auscultation.
- Palpation can only find systolic number not diastolic.
- Auscultation can find both systolic and diastolic numbers and is more accurate.
- BP cuff should be 2/3 of the upper arm.
- Located the BP cuff 1 inch above the fold in the elbow.
- To Palpate; Find radial pulse and pump up until gone. Go about 30 more and slowly let air out of the cuff until pulse returns. The number is #/Palp
- To Auscultation; Take palpated number and add about 30 to it. Slowly let air out of cuff and listen for first sound and last sound. Then you are done. The first sound is systolic and the last sound is diastolic.
- Each line on the BP gauge is 2 points. Release air at a rate of 2 to 3 lines (4 to 6 points) a second.

Temperature

- 96.4 to 99.6 is normal range.
- Can take oral, axillary, rectal, tympanic, or touch
- If touch use back of hand on core - (chest/abdomen). 1) Is it hot, cool, cold, warm. 2) Is it dry, wet, cool/clammy. 3) Is the color pink, blue, gray, pale. In deep pigmented individuals is inside of eye, mouth
- The red probe goes in the "red eye".
- The blue probe goes in the mouth or other location.

Level of Consciousness (LOC)

- AVPU is used.
- Alert, Verbal, Pain, Unresponsive.
- Only one letter can be used.
- Unresponsive and coma mean the same.

SAMPLE History

- SAMPLE is used to ask questions and interview the patient.
- Sign and symptoms, Allergies, Medication, Pertinent past, Last intake, Events.

OPQRST

- Better defines the "S" in SAMPLE.
- Onset, Provocation, Quality, Radiation, Severity, Time.

DCAPBTLS

- Used to remember what we are looking for when touching a person during an assessment.
- Deformities, Contusions, Abrasions, Punctures, Burns, Tenderness, Lacerations, Swelling.

Detail Assessment

- Is performed in the general assessment

- It is a head to toe assessment.
- Do this in major injuries, young patients, unresponsive, intoxicated, under the influence patients. Also people who do not give a specific CC.
- Start at head, then - throat, chest, abdomen, pelvis, legs, arms, and back.
- Should take less than 90 seconds to complete.
- Note: do not compress the pelvis if unstable.

Sign and Symptom S/S

- Sign is something you see, feel or touch and can validate.
- Symptom is something the patient describes.

PUPILS

- Dilated, fixed, unequal, sluggish are common words to describe.
- Unequal are always stroke in this course.
- PEARL means Pupils Equal and Reactive to Light. This is normal.
- Pupils should dilate in dark and constrict in light.
- When flashing a light in one eye you should be testing the other eye.