

EMERGENCY ASSESSMENT

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Emergency Patient Assessment



Outline:

- What is emergency assessment (EA).
- Types of (EA).
- Standard of care guidelines.
- Triage.



Emergency Assessment:



- A systematic approach to the assessment of an emergency patient is essential.
- The most dramatic injury is not the most serious.
- The primary and secondary assessment provide the emergency nurse with a methodical approach to help identify and prioritize patient needs.

Primary Assessment:



- Primary assessment of the patient is meant to identify life-threatening problems.
- It is a initial, rapid, ABCD (airway, breathing, and circulation, as well as neurologic disability resulting from spinal cord or head injuries).

NOTE:

If conditions are identified that present an immediate threat to life, appropriate interventions are required before proceeding to the secondary assessment.



- **A (Airway):**
 1. Does the patient have an open airway?
 2. Is the patient able to speak?
 3. Check for airway obstructions such as loose teeth, foreign objects, bleeding, vomits or other secretions.
 4. Immediately treat anything that compromises the airway.

- **B (Breathing):**
 1. Is the patient breathing?
 2. Assess for equal rise and fall of the chest (check for bilateral breath sounds), respiratory rate and pattern, skin color, use of accessory muscles, integrity of the chest wall, and position of the trachea.
 3. All major trauma patients require supplemental oxygen via a non-rebreather mask.

- **C (Circulation):**
 1. Is circulation in immediate jeopardy?
 2. Can you palpate a central pulse? What is the quality (strong, weak, slow, rapid)?
 3. Is the skin warm and dry? Is the skin color normal?
 4. Obtain a blood pressure (in both arms if chest trauma is suspected).



- **D (Disability):**

1. Assess level of consciousness and pupils (a more complete neurologic survey will be completed in the secondary survey).

2. Assess level of consciousness using the AVPU scale:

- A: Is the patient alert?
- V: Does the patient respond to voice?
- P: Does the patient respond to painful stimulus?
- U: The patient is unresponsive even to painful stimulus.

Secondary Assessment (EFGH):



- It is a brief, but thorough, systematic assessment designed to identify all injuries.
- The steps include:
 1. E: Expose/environmental control.
 2. F: Full set of vital signs/Five interventions/Facilitate family presence.
 3. G: Give comfort measures.
 4. H: History and Head to Toe examination.

Expose/environmental control:



- It is necessary to remove the patient's clothing in order to identify all injuries.
- You must then prevent heat loss by using warm blankets, overhead warmers, and warmed I.V. fluids.

Full Set of Vital Signs/Five Interventions/Facilitate Family Presence:

- Obtain a full set of vital signs including blood pressure, heart rate, respiratory rate, and temperature.
- obtain blood pressure in both arms if chest trauma is suspected.
- **Five interventions:**
 1. Pulse oximetry to measure the oxygen saturation.
 2. Indwelling urinary catheter (do not insert if you note blood at the meatus, blood in the scrotum, or if you suspect a pelvic fracture).
 3. Gastric tube (if there is evidence of facial fractures, insert the tube orally).
 4. Laboratory studies frequently include type and crossmatching, hemoglobin and hematocrit, urine drug screen, blood alcohol, electrolytes, prothrombin time (PT) and partial thromboplastin time, and pregnancy test if applicable.

Continue.....Full Set of Vital Signs/Five Interventions/Facilitate Family Presence

- **Facilitate family presence:**
 1. It is important to assess the family's needs.
 2. If any member of the family wishes to be present during the resuscitation, it is imperative to assign a staff member to that person to explain what is being done and offer support.

Give Comfort Measures:

- These include verbal reassurances as well as pain management as appropriate.
- Do not forget to give comfort measures to the family during the resuscitation process.

History:

- Obtain prehospital information from emergency personnel, patient, family, or bystanders using the **mnemonic MIVT:**

- ❖ **M: Mechanism of injury:**

It is helpful to understand the mechanism of injury to anticipate probable injuries. It is particularly helpful in motor vehicle accidents to know such information as external and internal damage to the car and the period of time elapsed before the patient received medical attention.

- ❖ **I: Injuries sustained or suspected:**

Ask prehospital personnel to list any injuries that they have identified.

- ❖ **V: Vital signs:**

What were the prehospital vital signs?

- ❖ **T: Treatment:**

What treatment did the patient receive before arriving at the hospital and what was his response to those interventions?

Continue.....

- If the patient is conscious, it is essential to ask him what happened. How did the accident occur? Why did it happen? A fall, for example, may not be a simple fall perhaps the patient blacked out and then fell.
- Obtain past medical history from the patient or a family member or friend, including age, medical/surgical history, current medications, use of any illicit drugs, allergies, last menstrual period, last meal, and last tetanus shot.

NOTE:

To obtain a good descriptive history, do not ask questions that can be answered with a yes or no.

Head-to-Toe Assessment:

- The head-to-toe assessment begins with assessment of the patient's general appearance, including body position or any guarding or posturing.
- Work from the head down, systematically assessing the patient one body area at a time.

Focused Assessment:

Any injuries that were identified during the primary and secondary surveys require a detailed assessment, which will typically include a team approach and radiographic studies.

EMERGENCY TRAUMA ASSESSMENT

A
B
C
D
E
F
G
H
I

- AIRWAY
- BREATHING
- CIRCULATION
- DISABILITY
- EXAMINE
- FAHRENHEIT
- GET VITALS
- HEAD-TO-TOE ASSESSMENT
- INTERVENTION



STANDARDS OF CARE GUIDELINES

Emergency Assessment and Intervention

When a patient presents with a potentially life-threatening condition, proceed swiftly with the following:

- Remove the patient from potential source of danger, such as live electrical current, water, or fire.
- Determine whether patient is conscious.
- Assess airway, breathing, and circulation in systematic manner.
- Assess pupillary reaction and level of responsiveness to voice or touch as indicated.

STANDARDS OF CARE GUIDELINES

Emergency Assessment and Intervention

- If the patient is unconscious or has sustained a significant head injury, assume there is a spinal cord injury and ensure proper handling.
- Undress the patient to assess for wounds and skin lesions as indicated.
- Immediate intervention is needed for such conditions as compromised airway, respiratory arrest, compromised respirations, cardiac arrest, and profuse bleeding. Provide emergency airway management, cardiopulmonary resuscitation, and measures to control hemorrhage as needed.
- Call for help as soon as possible.
- Assist with transport and further assessment and care as indicated.

TRIAGE:

- Triage is a French verb meaning to sort.
- Most patients entering an emergency department (ED) are greeted by a triage nurse, who will perform a brief evaluation of the patient to determine a level of acuity or priority of care.
- The role of the triage nurse is to make acuity determinations and set priorities.



Priorities of Care and Triage Categories:

- Standardized triage categories are usually developed within each ED.
- Most common triage systems consist of five levels of acuity:
 1. Triage Level I - Resuscitation
 2. Triage Level II - Emergent.
 3. Triage Level III- Urgent.
 4. Triage Level IV -Less Urgent.
 5. Triage Level V –Non-urgent.

Level I	Resuscitation	see patient immediately
Level II	Emergency	within 15 minutes
Level III	Urgency	within 30 minutes
Level IV	Less Urgency	within 60 minutes
Level V	Non Urgency	within 120 minutes

Triage Level I – Resuscitation:

- Conditions requiring immediate nursing and physician assessment.
- Any delay in treatment is potentially life- or limb-threatening.
- **Includes conditions such as:**
 - ❖ Airway compromise.
 - ❖ Cardiac arrest.
 - ❖ Severe shock.
 - ❖ Cervical spine injury.
 - ❖ Multisystem trauma.
 - ❖ Altered level of consciousness (LOC) (unconsciousness).
 - ❖ Eclampsia.

Triage Level II – Emergent:

- Conditions requiring nursing assessment and physician assessment within 15 minutes of arrival.
- **Conditions include:**

❖ Head injuries.	❖ Severe asthma.
❖ Severe trauma.	❖ Abdominal pain in patients older than age 50.
❖ Lethargy or agitation.	❖ Vomiting and diarrhea with dehydration.
❖ Conscious overdose.	❖ Fever in infants younger than 3 months.
❖ Severe allergic reaction.	❖ Acute psychotic episode
❖ Chemical exposure to the eyes.	❖ Severe headache.
❖ Chest pain.	❖ Any pain greater than 7 on a scale of 10.
❖ Back pain.	❖ Any sexual assault.
❖ GI bleed with unstable vital signs.	❖ Any neonate age 7 days or younger.
❖ Stroke with deficit.	

Triage Level III- Urgent:

- Conditions requiring nursing and physician assessment within 30 minutes of arrival.
- **Conditions include:**
 - ❖ Alert head injury with vomiting.
 - ❖ Mild to moderate asthma.
 - ❖ Moderate trauma.
 - ❖ Abuse or neglect.
 - ❖ GI bleed with stable vital signs.
 - ❖ History of seizure, alert on arrival.

Triage Level IV- Less Urgent:

- Conditions requiring nursing and physician assessment within one hour.
- **Conditions include:**
 - ❖ Alert head injury without vomiting.
 - ❖ Minor trauma.
 - ❖ Vomiting and diarrhea in patient older than age 2 without evidence of dehydration.
 - ❖ Earache.
 - ❖ Minor allergic reaction.
 - ❖ Corneal foreign body.
 - ❖ Chronic back pain.

Triage Level V- Non-urgent:

- Conditions requiring nursing and physician assessment within two hours.
- **Conditions include:**
 - ❖ Minor trauma, not acute.
 - ❖ Sore throat.
 - ❖ Minor symptoms.
 - ❖ Chronic abdominal pain.



THE END