CLINICAL APPROACH TO THE PATIENT

HANDOUT
I am the most important part of patient care. How can you expect to treat a patient appropriately if you don’t follow through on basic primary care?

Remember:

- If you don’t look
- You won’t find
- You won’t treat
- You won’t be able to treat safely
Clinical Field Protocols

To complete this module, you will need to become familiar with the following clinical protocols:

- Clinical Approach to a Patient

…. and the following reference material:
- VAO RM01 – Perfusion Status Assessment
- VAO RM01 – Respiratory Status Assessment
- VAO RM01 – Sensory and Motor Examination

You should also ensure you understand the Graphic Guide and the Drug Presentation introduction (VAO D000) from the VAO Clinical Field Protocols.
The primary survey is always the first step in patient assessment taking priority over all other aspects of history taking and patient examination. It is necessary to attend to problems identified in the primary survey before any further assessment takes place. Once any problems have been managed the primary survey can be continued.

- **Dangers** to you or your partner, patient or others.
- **Response** is the patient responsive or not responsive?
  - **Airway** is it clear, can the patient manage their airway?
    - (If not, manage airway at this point.)
  - **Breathing** is the patient breathing effectively?
    - consider oxygen therapy or IPPV at this point.
  - **Circulation**
    - Do they have a pulse, carotid verses radial?
      - If not, immediate ECC
    - Is there any bleeding visible?
      - If yes, control haemorrhage as required at this point.

"CARDIAC ARREST? – GO TO PROTOCOL”

- **Debility** what is the level of consciousness? AVPU
  - Alert, to time place and purpose
  - Voice, responds to command
  - Pain, responds only to painful stimuli – pinch trapezius muscle
  - Unresponsive

The primary survey may be cleared within seconds as you approach the fully conscious patient or may take several minutes in response to any complications such as the need for airway management or haemorrhage control.

Performing a primary survey must become second nature to the volunteer as all good patient care is a direct result of quality **primary** and **secondary** surveys.

**First - the quick look**

Begin the primary survey as you approach the patient. Look for any risks that are present and don’t proceed until you are confident it is safe to do so.

A quiet question to the patient may give evidence of conscious state, airway and of their respiratory condition. The colour of the patient may indicate poor oxygenation or presenting shock. Bleeding may or may not be obvious.

**Checking the airway**

If the patient responded to your question in a clear voice then the airway is clear at that time. A clear voice, quiet respirations and a normal mental state rule out any significant obstruction.

Listen for noisy breathing as you continue your assessment, noisy resps indicate obstruction to some degree. Snoring suggests mechanical obstruction such as base of tongue, swelling or foreign matter. Hoarseness or throat pain may indicate or lead to swelling and therefore obstruction. Agitation may indicate poor oxygenation of the brain.
Breathing
First look at the upper chest and neck area and watch for respiratory motion, deviated trachea, open chest wounds, enlarged jugular veins and listen for breath sounds.
Place your cheek over the mouth of the patient looking down the chest and watching for rise and fall whilst feeling for warm expirations onto your cheek.
Place one hand with fingers spread across the lower sternum and ribs with the lower fingers protruding onto the upper abdomen. With your hand in this position feel for the rhythmical rise and fall of chest. Rates below 10 and above 30 and with low tidal volume in an adult may indicate IPPV. Are the accessory muscles involved and or intercostal recession present as this indicates respiratory distress and needs to be managed.

Stabilising respiration
All trauma patients must be placed on oxygen early, with flow rates of 8 litres per minute through a high concentration mask, whilst considering the need for IPPV. The patient who has inadequate airflow with altered conscious state must have ventilatory support by applying intermittent positive pressure ventilation.
Once respirations are managed continue with the primary survey.

Circulation
Pulses
If the patient is conscious and a good colour, check the radial pulse, taking note of the rate, strength and regularity of it.
If the patients is a poor colour and/or has an altered conscious state then go straight for the carotid pulse and if present follow up by checking the radial pulse.

- A radial pulse indicates that there is an adequate blood pressure at that time.
- A carotid pulse in the absence of a radial pulse indicates a low blood pressure.
- As for all vital signs pulses must be checked regularly, appropriate to the patient’s ongoing condition.

Revealed bleeding such as from wounds will be found easily but must be thoroughly checked for, i.e. expose the body and look closely for wounds and bleeding, but keep it relative to the presenting condition. Internal haemorrhage is less easily identified and will be displayed by, swelling, increases in pulses, changes in skin to clammy and pale, with the patient becoming apprehensive and anxious. As the condition worsens the skin may become bluish and mottled as in shock. Make sure the patient is well oxygenated to prevent hypoxic shock. If the patient has no respiratory or cardiac problems then assume that the cause of shock is a direct result of haemorrhage and treat accordingly.
Stabilising circulation
Apply direct pressure to external bleeding, using wet dressings and conforming bandages. (be cautious if foreign bodies are present or fractures underlie the injury)
Auto-transfusion – when appropriate elevate the legs to assist the return of excess blood from lower limbs into the central circulation. Be cautious with dyspnoea especially pulmonary oedema patients. In these cases semi sitting with legs dependent may help

Confirm paramedic backup has been dispatched

PERFUSION – DEFINITION

The ability of the cardiovascular system to provide tissues with an adequate blood supply to meet their functional demands at that time and to effectively remove the associated metabolic waste products.

PERFUSION - OBSERVATIONS
■ SKIN – colour, temperature, moistness
■ PULSE RATE
■ BLOOD PRESSURE
■ CONSCIOUS STATUS
■ CAPILLARY REFILL

SECONDARY SURVEY

Once the patient is stabilised it is time to move on to the secondary survey which involves taking a set of vital signs, a medical history and performing a physical examination.

Begins with a complete set of appropriate vital signs
For a patient this should include:
• Pulses
• Respirations
• (oxygen saturation)
• Blood pressure
• Skin moistness
• Capillary refill
• Pain level
• Temperature
• (ECG)
• Pupils
• Glasgow Coma Score
  o Eye opening
  o Verbal response
  o Motor response
• Skin appearance

<table>
<thead>
<tr>
<th>Skin colour</th>
<th>Possible causes</th>
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</thead>
<tbody>
<tr>
<td>Red</td>
<td>Fever, allergic reactions, carbon monoxide poisoning.</td>
</tr>
<tr>
<td>White / Pale</td>
<td>Poor perfusion as a result of blood loss</td>
</tr>
<tr>
<td>Blue / Mottled / Greyish</td>
<td>Poor perfusion as a result of respiratory failure or circulatory failure – shock</td>
</tr>
<tr>
<td>Blue cyanosis (common in asthma)</td>
<td>Hypoxemia (low O₂ in blood) peripheral vasoconstriction due to cold or shock</td>
</tr>
<tr>
<td>Mottled</td>
<td>Shock</td>
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</table>

• Skin temperature

<table>
<thead>
<tr>
<th>Skin</th>
<th>Possible causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot &amp; dry</td>
<td>Excessive body heat (heat stroke) hyperglycaemia</td>
</tr>
<tr>
<td>Hot &amp; wet</td>
<td>Reaction to increased internal or external temperature</td>
</tr>
<tr>
<td>Cool &amp; dry</td>
<td>Exposure to cold</td>
</tr>
<tr>
<td>Cool &amp; clammy</td>
<td>Shock or hypoglycaemia</td>
</tr>
</tbody>
</table>

Vital signs and the time they were taken should be recorded for entry into VACIS or written directly into the bottom left portion of the Ambulance Report Form. They should be done regularly, the more critical the patients condition the more often we should take vital signs.

Physical Examination
Learn to become methodical at doing these procedures as this will prevent you from missing essential checks. Always consider the mechanism of injury. Remember, examination of the neck and immobilisation of the cervical spine is essential with trauma patients and should be managed as part of the primary survey.

Examination of head and neck
Carefully check all regions of the head, including all orifices.
You must:

• Check the scalp for swelling, bleeding, other trauma
• Feel the scalp for depressions or fractures
• Check ears and nose for any discharge (blood or fluids)
• Inspect the mouth for trauma or foreign objects (loose teeth or dentures)
• Check eyes for trauma conjugacy (parallel directional movement)
• Check pupils for reaction to light, equality and shape
• Palpate the neck for tenderness (if indicated, apply C collar)
• Check the trachea is mid line
• Check for swollen jugular veins
Respiratory assessment
To be thorough you should:
• Measure the rate and rhythm of respirations
• Inspect the shape and equal movement of the chest
• Observe the respiratory cycle
• Listen to the patient talk
• Listen to the respirations for any wheezes, wet sounds or other obstructive sounds
• Check for shortness of breath (yes – go to SOB protocol)

Cardiovascular assessment
When doing this you should:
• Assess skin colour and condition
• Check for chest pain – present or recent (yes - go to chest pain protocol)
• Ask about cardiac history

Abdominal assessment
When performing the abdominal assessment you should:
• Look for distension, masses, swelling, bruising or trauma (do not apply pressure)
• Check for pain, nausea or vomiting
• Ask about recent bowel and bladder functions
• Possibility of pregnancy

Assessment of extremities and back
Compare left against right as a guide for normality. Start by quickly running hands down limbs as this will often identify major injuries, follow with a more thorough check. Assessing these areas involves:
• Check the back for signs of injury, deformity or loss of feeling in extremities (begin spinal injury management within the primary survey)
• Checking the pelvic area for stability, wetness or deformity
• Checking limbs for injuries, movement capabilities and deformity
• Check for strength, colour and circulation to extremities

Taking a patient’s history
The patient’s medical history has several sections (as per the ARF):
• Past medical history
• Presenting history
• Medications
• Allergies
• On arrival
• On examination

When this information can’t be given by the patient, it must be sought from reliable witnesses, friends and relatives.
The mnemonic “SAMPLE” is often used for basic care providers ie:

- Signs & Symptoms
- Allergies
- Medications
- Past medical history/injuries/illnesses
- Last meal/intake
- Events leading up to current injury/illness

Presenting History

“What happened today that meant you needed to call an ambulance?”

It is always good to ask “is this problem similar to your (known medical condition/s)” e.g. usual angina pain.

The mnemonic “NILDOOCARRF” is considered beneficial as a pain assessment guide and can be applied to any condition:

- Nature of pain – dull, sharp, cutting
- Intensity – get a score out of 10 (0 = no pain – 10 = extreme pain)
- Location – in what part of the body is the pain felt
- Duration – how long did the current episode last
- Onset – when did current episode start
- Offset – when did the current episode stop (if it has)
- Concomitant factors – is nausea, vomiting, sweating or other present
- Aggravating factors – what increases the pain (movement, vomiting, food, posture changes)
- Relieving factors – (food, drinks, posture, vomiting, other)
- Radiation – to other parts of the body (may not be felt as pain but as discomfort etc)
- Frequency – how often have they had the pain in past day, weeks or months

On Arrival
What you saw and heard … a brief assessment of the situation including any dangers, the patient’s position and appearance. Example: “Patient sitting on chair supporting left side of chest pale and clammy in appearance. Step ladder lying nearby.”

On Examination
The results of your primary and secondary survey.

Past Medical History
Once a patient’s current history has been established and managed it is time to review their past medical history. The following questions should be asked or considered.

- Are you currently under a doctors care – who? Last appointment
- What medical conditions do you have?
- What medication do you currently take? Or recent changes (take medications with patient or take list)
- Last Hospital admission
- What was it for?
- Do you have any allergies?
SUMMARY OF BASIC SUPPORT SESSION

• To manage any patient it is necessary to perform an adequate **primary** and **secondary** survey and to understand clinical approach as per CFP’s
• Always repeat the survey if there is a change in the patient’s conditions or if you become concerned.
• Practitioners at all levels (first aiders to surgeons) are required to follow this practice.
• Practice until these skills become second nature
• Adjust the assessment to suit the condition of the patient but don’t shortcut.
• Gather the appropriate past medical history to pass on.
• Self critique your performance at end of each case (discuss with someone responsible if you have concerns)

THE AIM IS TO:

• **COMPLETE THE PRIMARY AND SECONDARY SURVEYS**
• **TREAT THE PRESENTING SIGNS AND SYMPTOMS**
• **CONFIRM PARAMEDIC BACKUP HAS BEEN SENT**