

**Table 7-3** Methods for Assessing Mental Status

Glasgow Coma Scale		AVPU
Eyes	4 Opens eyes spontaneously	A Alert
	3 Opens eyes to verbal stimuli	V Unresponsive, but responds to verbal stimuli
	2 Opens eyes to pain	P Unresponsive, but responds to painful stimuli
	1 Does not open eyes	U Unresponsive to pain
Verbal	5 Speaks coherently	
	4 Speaks confusedly	
	3 Mutters words in response to pain	
	2 Moans in response to pain	
Motor	1 No verbal response to pain	
	6 Follows commands	
	5 Localizes pain	
	4 Withdraws from pain	
	3 Has a flexor response to pain	
	2 Has an extensor response to pain	
	1 Has no motor response to pain	

closed, talk to him. If the patient looks at you or merely opens his eyes, he is scored a “V” on the AVPU scale. If the patient does not respond to verbal stimuli, attempt to illicit a pain response in the patient using one of the techniques described in the next section. A patient that responds to pain is noted as “P” on the AVPU scale. If the patient does not respond to pain, then the patient is marked as “U” for unresponsive. Any score less than “A” is considered abnormal.

Another method to assess neurologic function is the Glasgow Coma Scale (GCS). Although more precise than the AVPU scale and more likely to uncover a neurologic abnormality, the GCS is more difficult to use than the AVPU scale and takes longer to perform. Use the AVPU scale for the initial assessment, and, if time permits complete a more detailed assessment using the GCS.

An OEC Technician should ideally calculate the GCS once the patient is in a more controlled environment such as a first aid room or transport vehicle. Alternatively, calculate the GCS in the field while waiting for transport to arrive. Even though the GCS provides valuable information, definitive care and transportation of the patient should never be delayed for the sole purpose of calculating the GCS. The GCS, which provides an objective measure of the patient’s overall neurologic condition, has three components (Table 7-3):

- ✦ The patient’s best eye response
- ✦ The patient’s best verbal response
- ✦ The patient’s best motor response

Each component consists of a range of physical responses; each response is assigned a numerical value. The patient is assessed for the best response for each component, and then the sum of the assigned values represents the GCS score.

To calculate the GCS, begin by assessing the patient’s eye response: select the description that best matches the patient’s response. If, for example, the patient’s eyes are initially closed but open as you first begin speaking to him, the score would be 3. If the patient’s eyes remain closed regardless of what you do, the score would be 1. Next, assess the patient’s best verbal response. As before, select the description that

If during the primary assessment you identify an abnormality in the ABCDs that in your judgment places the patient at imminent life-threatening risk, you should immediately expedite the rest of the assessment process and care. Focus on immediate life threats, and rapidly transport the patient to definitive care. Manage the ABCDs, protect the cervical spine, and initiate rapid transport.

## STOP, THINK, UNDERSTAND

### Multiple Choice

Choose the correct answer.

- A scene size-up includes all of the following components *except* \_\_\_\_\_.
  - using your senses to evaluate potential dangers.
  - determining the mechanism of injury (MOI).
  - obtaining a patient's vital signs.
  - determining how many victims there are.
- Which of the following statements regarding the primary assessment is *not* true? \_\_\_\_\_.
  - Its purpose is to quickly identify and correct any potential life-threatening problems that may be present.
  - It is conducted only on trauma patients.
  - It should take 30–60 seconds to complete.
  - Patient assessment and patient management often occur simultaneously.
- The ABCDs of primary assessment stand for \_\_\_\_\_.
  - airway, breathing, circulation, disability.
  - airway, bleeding, circulation, disability.
  - airway, breathing, circulation, deformity.
  - auscultation, blood pressure, correction, discovery.
- The most consistent of the earliest observations that warns an OEC Technician of possible problems with ABCD is a patient \_\_\_\_\_.
  - with uneven pupils.
  - who cannot stand up without assistance.
  - who cannot grip your hands with equal grip strength.
  - who is confused.
- The normal respiratory rate for an adult is \_\_\_\_\_.
  - 6–10 breaths per minute.
  - 12–20 breaths per minute.
  - 20–30 breaths per minute.
  - 32–38 breaths per minute.
- The normal respiratory rate for an infant is \_\_\_\_\_.
  - 6–10 breaths per minute.
  - 12–20 breaths per minute.
  - 25–50 breaths per minute.
  - 30–38 breaths per minute.
- The pulse of a child younger than 8 years of age should be checked at which pulse point? \_\_\_\_\_.
  - brachial
  - carotid
  - radial
  - femoral
- Normal capillary refill time is \_\_\_\_\_.
  - less than 2 seconds.
  - more than 2 seconds.
  - less 5 seconds.
  - immediate.
- "AAO × 4" means \_\_\_\_\_.
  - awake, alert and oriented, checked four times at 5-minute intervals.
  - awake, alert, and oriented to person, place, time, and situation.
  - awake, alert, and oriented to person, place, and time.
  - awake, alert, and oral answers are correct.
- The three components of the Glasgow Coma Scale are \_\_\_\_\_.
  - best eye, verbal, and motor responses.
  - assessment of pulse, respiration, and motor skills.
  - assessment of pulse, respiration, and mentation.
  - best response to grimace, circulation, and sensation.
- If during your primary assessment you identify a serious abnormality in the ABCD, you should \_\_\_\_\_.
  - stop and correct the problem, and then continue with your assessment as usual.
  - document the problem, expedite and continue with your assessment, and then correct the problem upon completion of the assessment.
  - stop and correct any threats to life, expedite the rest of the assessment process, manage the ABCDs, protect the cervical spine (if indicated), and transport the patient to definitive care.
  - stop the assessment, immediately treat threats to life, and transport the patient to definitive care.

### Fill in the Blank

- List the signs of respiratory distress: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.
- AVPU stands for \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.



## STOP, THINK, UNDERSTAND

## Multiple Choice

Choose the correct answer.

- What is the purpose of a secondary assessment? \_\_\_\_\_
  - To obtain additional information about the patient.
  - To ensure that no medical or traumatic problems that may need treatment are overlooked.
  - To obtain medical history, vital signs, and a physical exam.
  - All of the above
- The medical history exam includes all of the following data *except* \_\_\_\_\_.
  - diagnosis.
  - subjective complaints such as symptoms.
  - the chief complaint.
  - the nature of the illness.
- In which of the following situations is the resulting MOI likely to be considered significant? \_\_\_\_\_ (more than one may apply)
  - An adult climber who falls 22 feet off a ledge.
  - A 10-year-old climber who falls 12 feet.
  - A cross country skier struck by a snowmobile going 25 mph.
  - A cross country skier struck by a snowmobile going 15 mph.
  - A lift-operator struck by an out-of-control skier traveling at a high rate of speed.
- What is an associated symptom? \_\_\_\_\_
  - An additional complaint that may be related to the chief complaint.
  - A symptom you observe but that the patient may not be unaware of.
  - A cause and effect.
  - A symptom inadvertently caused by the rescuer's intervention.
- A patient fell out of a chair in the lodge cafeteria and your first judgment is that the patient suffered no significant injuries. However, the patient is complaining that his neck hurts and his fingers tingle. What is your *next* appropriate response? \_\_\_\_\_
  - Continue your assessment without being overly concerned about the complaint because no significant injuries are apparent.
  - Give the patient an ice pack and instruct him to see his physician if his neck still hurts in the morning.
  - Stop the assessment and initiate full spinal precautions, including putting this patient on a back board.
  - Have your partner stabilize the patient's head and neck, then rapidly continue your assessment.
- Which of the following about MOI is true? \_\_\_\_\_
  - If the patient has no complaints following a significant MOI, then an OEC Technician can safely assume that the patient is probably all right.
  - Even if the patient has no complaints following a significant MOI, an OEC Technician should assume that a significant injury may still have occurred.
  - An OEC Technician should never assume anything.
  - None of the above are true.
- Any trauma patient with an abnormal LOR or a significant head injury is automatically assumed to have what? \_\_\_\_\_
  - a compromised airway
  - a skull fracture
  - a cervical spine injury
  - an OEC Technician should never assume anything about a patient
- Decerebrate posturing is defined as \_\_\_\_\_.
  - a slumped-forward position.
  - a response in which a patient moves the hands toward the chest in response to painful stimuli.
  - a response in which a patient moves the hands away from the body in response to painful stimuli.
  - a situation in which a patient can hold the arms straight out in front of the body for 30 seconds.
- SAMPLE stands for which of the following? \_\_\_\_\_
  - Signs/symptoms, Allergies, Medications, Past medical history, Last oral intake, Events prior
  - Signs/symptoms, Allergies, MOI, Plan/pulse, Limitations, Environment
  - Subjective, Assessment, Medical history, Pain, LOR, Events
  - Symptoms, Associated signs, MOI, Plan/pulse, Limitations, Emesis
- What does the Q stand for in OPQRST?
  - Quality
  - Quiet
  - Quick
  - Quixotic
- Which of the following questions are appropriate to ask a patient regarding their medication(s)? \_\_\_\_\_
  - "Are you taking any herbs, supplements, or homeopathic remedies?"
  - "Which prescription medications are you taking?"
  - "Why are you taking this medication?"
  - Privacy laws prohibit OEC Technicians from asking any of these questions.
  - A, B, and C
- Why is it important to ask a patient what caused them to fall? \_\_\_\_\_
  - Dizziness or chest pains preceding or causing a fall could be indicative of a serious medical problem.
  - Knowing what caused a fall might prevent a law suit.
  - The cause of a fall is an indicator of a significant MOI.
  - The cause of a fall is not important for an OEC Technician to determine.

continued

13. Which of the following statements regarding assessment is *not* true? \_\_\_\_\_

- a. An assessment must be performed in the same sequence every time.
- b. Whenever possible, an OEC Technician should establish and follow the same sequence of assessment every time.

- c. An assessment should be stopped to correct any serious problems encountered.
- d. An assessment may be modified depending on existing circumstances, including environmental considerations and rescuer safety and well-being.

### Sequence

Number the following components of a physical exam in the correct sequence for performing it:

- \_\_\_\_\_ a. Assess the back of the neck.
- \_\_\_\_\_ b. Palpate the head/scalp.
- \_\_\_\_\_ c. Palpate the abdominal quadrants.
- \_\_\_\_\_ d. Look at the chest; assess for symmetry of breathing.

- \_\_\_\_\_ e. Look in the eyes and ears.
- \_\_\_\_\_ f. Assess papillary reaction and eye symmetry.
- \_\_\_\_\_ g. Palpate hips/pelvis.
- \_\_\_\_\_ h. Assess the face.
- \_\_\_\_\_ i. Examine the upper extremities.
- \_\_\_\_\_ j. Examine the lower extremities.
- \_\_\_\_\_ k. Examine the back/spine.

### Matching

Indicate whether each of the following items is a sign or a symptom by writing the correct letter in the blank.

- |                  |                              |
|------------------|------------------------------|
| _____ 1. sign    | a. pain                      |
| _____ 2. symptom | b. dilated pupils            |
|                  | c. nausea                    |
|                  | d. deformity                 |
|                  | e. audible wheezing          |
|                  | f. low blood pressure        |
|                  | g. shortness of breath (SOB) |
|                  | h. tripodding                |
|                  | i. elevated pulse            |
|                  | j. tightness in chest        |



## CASE UPDATE



You introduce yourself and ask permission to assess and treat the patient. The patient says, "Yes," so you perform a primary assessment while using spinal precautions because of the MOI. The patient is awake and speaks to you in two- or three-word sentences. You determine that his airway is open, but you are concerned that he appears to be having trouble breathing. You check his radial pulse, which is rapid (100/bpm) and strong. The patient is alert and oriented to person, place, and time. He opens his eyes spontaneously, speaks coherently, and is able to follow your commands.

In assessing his AVPU score, you assign him an "A" for "alert." The patient complains of a persistent pain on the left side of his chest. The history you take reveals that the patient was climbing approximately 6 feet off the ground when he began to feel weak and dizzy. He started having some pain in his chest and "lost my grip." He remembers hitting his lower back against a rock but does not believe that he lost consciousness. He describes the pain in his chest as "heavy." The pain does not radiate and is localized to the chest. He also reports being short of breath. He denies any other complaints. He reports no allergies to any medications but states that he takes aspirin on a daily basis because he had a heart attack ten years ago but has been doing quite well since then. He had been bouldering for about an hour and had taken several breaks during which he drank two bottles of a popular sports drink. His last rest break was about 15 minutes before he fell. He also ate a protein bar during that break. You obtain additional information using the OPQRST mnemonic.

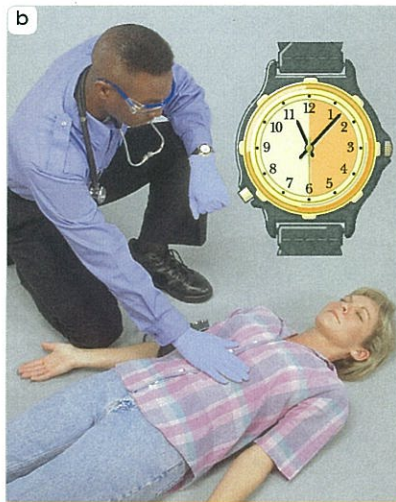
**What should you do now?**



**OEC SKILL 7-6****Assessing Respiration Rate**

Look and feel for the patient's chest to rise and fall.

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Assess the patient's respirations for rhythm, depth, effort, and noise to determine if the patient is breathing within normal limits.

**OEC SKILL 7-7****Obtaining a Blood Pressure by Auscultation**

Place the cuff on the upper arm with the arrow pointing over the brachial artery. Place the stethoscope tips to your ears.



Palpate the brachial artery pulse and place the diaphragm of the stethoscope on the pulse. Hold the stethoscope in place as you measure the pressure.

Primary Assessment

Assesses airway, breathing, circulation, disability (ABCDs).	1	(CPI)
Provides any necessary interventions related to airway/breathing.	1	(CPI)
Checks for and controls any major bleeding.	1	(CPI)
Confirms and monitors LOR (AVPU or GCS).	1	
Calls for transport, equipment, and/or additional assistance.	1	

Secondary Assessment

Performs detailed head-to-toe body assessment physical exam DCAP-BTLS.	1	(CPI)
Obtains SAMPLE history from patient and/or witness (if available).	1	(CPI)
Obtains baseline set of vitals.	1	(CPI)
Provides interventions per protocols.	1	
Treats for shock.	1	
Maintains spinal immobilization if applicable.	1	(CPI)
Prepares patient for transport.	1	
Reassesses vital signs and primary assessment.	1	

Must receive 17 out of 19 points.

Comments: \_\_\_\_\_

Failure of any of the CPIs is an automatic failure.

Evaluator: \_\_\_\_\_ NSP ID: \_\_\_\_\_

PASS      FAIL

## Skill Guide

Date: \_\_\_\_\_

(CPI) = Critical Performance Indicator

Candidate: \_\_\_\_\_

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

### Patient Assessment—Trauma Patient

**Objective:** To demonstrate the proper assessment of a trauma patient, to determine a baseline, and to select the appropriate transport method.

*continued*

SKILL GUIDE *continued*

Skill	Max Points	Skill Demo
<u>Scene Size-Up</u>		
Determines that scene is safe.	1	(CPI)
Introduces self, obtains permission to assist/treat.	1	
Initiates Standard Precautions.	1	(CPI)
Determines the MOI (mechanism of injury)—patient's chief complaint.	1	(CPI)
Identifies the number of patient(s) and the LOR of each.	1	
Forms general impression—evaluates any extrication issues for each patient(s); considers c-spine stabilization/immobilization.	1	
<u>Primary Assessment</u>		
Assesses airway, breathing, circulation, disability ( ABCDs).	1	(CPI)
Manages/treats life threats.	1	
Checks for and controls any major bleeding.	1	(CPI)
Confirms and monitors LOR (AVPU or GCS).	1	
Calls for transport, equipment, and/or additional assistance, EMS if needed.	1	
<u>Secondary Assessment</u>		
Performs head-to-toe detailed body assessment. DCAP-BTLS.	1	(CPI)
Exposes and inspects injury to identify level of emergency and formulate treatment plan.	1	(CPI)
Obtains SAMPLE history from patient and/or witness (if available).	1	(CPI)
Obtains baseline set of vitals.	1	(CPI)
Provides interventions per local protocols.	1	
Treats for shock.	1	
Maintains spinal immobilization if applicable.	1	(CPI)
Prepares patient for transport.	1	
Reassesses vital signs and primary assessment.	1	
Must receive 16 out of 20 points.		

Comments: \_\_\_\_\_

Failure to perform any of the CPIs is an automatic failure.

Evaluator: \_\_\_\_\_ NSP ID: \_\_\_\_\_

PASS    FAIL

## Skill Guide

Date: \_\_\_\_\_

(CPI) = Critical Performance Indicator

Candidate: \_\_\_\_\_

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

### Patient Assessment—Medical Patient

**Objective:** To demonstrate the proper assessment of a medical patient, to determine a baseline with a specific complaint.

Skill	Max Points	Skill Demo
<u>Scene Size-Up</u>		
Determines that the scene is safe.	1	(CPI)
Introduces self and obtains permission to examine/treat.	1	
Initiates Standard Precautions.	1	(CPI)
Determines NOI (nature of illness)—patient's chief complaint.	1	(CPI)
Identifies the number of patient(s) and the LOR of each.	1	
Forms general impression—evaluates any extrication issues and considers spinal precautions.	1	
<u>Primary Assessment</u>		
Assesses airway, breathing, circulation, disability (ABCDs).	1	(CPI)
Assists breathing, manages/treats life threats.	1	(CPI)
Confirms and monitors LOR (AVPU or GCS).	1	
Calls for transport, equipment, personnel, and EMS if needed.	1	
<u>Secondary Assessment</u>		
Performs detailed head-to-toe body assessment/physical exam.	1	
Obtains SAMPLE history.	1	(CPI)
Based on the chief complaint, gathers information by asking OPQRST questions.	1	(CPI)
Obtains baseline vital signs.	1	(CPI)
Provides interventions per local protocols.	1	(CPI)
Treats for shock.	1	
Maintains spinal immobilization if applicable.	1	(CPI)
Prepares patient for transport.	1	
Reassesses vital signs and primary assessment.	1	

*continued*



**Skill Guide**

Date: \_\_\_\_\_

(CPI) = Critical Performance Indicator

Candidate: \_\_\_\_\_

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

**Patient Assessment: Assessing Pulse**

Objective: To demonstrate the ability to locate, assess pulse, and obtain rate.

Skill	Max Points	Skill Demo
Initiates Standard Precautions.	1	(CPI)
Obtains permission from patient.	1	
Locates radial pulse (for child < 8 YOA, locate brachial pulse). Locates carotid pulse for unresponsive patient.	1	(CPI)
Notes quality of pulse (strength/regularity).	1	
Notes and verbalizes rate.	1	(CPI)
Acknowledges if rate obtained is WNL.	1	

Must receive 4 out of 6 points.

Comments: \_\_\_\_\_

Failure of any of the CPIs is an automatic failure.

Evaluator: \_\_\_\_\_ NSP ID: \_\_\_\_\_

PASS      FAIL

## Skill Guide

Date: \_\_\_\_\_

(CPI) = Critical Performance Indicator

Candidate: \_\_\_\_\_

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

**Assessing Respiration Rate**

Objective: To evaluate patient's respiration rate.

Skill	Max Points	Skill Demo
Initiates Standard Precautions.	1	(CPI)
Obtains permission to treat patient.	1	
Determines if patient can speak in complete sentences.	1	
Looks for chest rise and fall (On unresponsive patient, places hand on patient's chest or listen at mouth for respirations).	1	
Determines if patient has breathing problems.	1	
Assesses respirations for the following: <ul style="list-style-type: none"> <li>• Rhythm</li> <li>• Depth</li> <li>• Effort</li> <li>• Noise</li> </ul>	1	
Counts number of breaths for 30 seconds and multiplies by two for respirations per minute; determines if patient is breathing within normal limits (12–20 adult) (15–30 child) (25–50 infant).	1	(CPI)

Must receive 5 out of 7 points.

Comments: \_\_\_\_\_

Failure of any of the CPIs is an automatic failure.

Evaluator: \_\_\_\_\_ NSP ID: \_\_\_\_\_

PASS    FAIL

## Skill Guide

Date: \_\_\_\_\_

(CPI) = Critical Performance Indicator

Candidate: \_\_\_\_\_

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

### Obtaining a Blood Pressure by Auscultation

Objective: To measure a blood pressure by auscultation.

Skill	Max Points	Skill Demo	
Initiates Standard Precautions.	1		(CPI)
Obtains permission to treat patient.	1		
Applies the cuff snugly to the humerus above the elbow, ensuring that arrow on cuff points to brachial artery. Places the sphygmomanometer in position that is easy for you to read.	1		(CPI)
Palpates the brachial artery.	1		
Places the stethoscope diaphragm over the brachial artery and grasp the ball-pump. Turn the valve clockwise to close.	1		
Pumps a pressure of 160mmHg, if you can hear the pulse sound immediately inflate to 200mmHg. If you can still hear the heartbeat inflate in 20mm increments until no sound is heard. Open the valve counterclockwise and let the air escape slowly.	1		
Notes the number on the gauge where the first beat is heard (systolic pressure) as the needle descends.	1		(CPI)
Notes the number on the gauge where the last beat is heard (diastolic pressure).	1		(CPI)
Opens the valve, and quickly release remaining air.	1		

Must receive 7 out of 9 points.

Comments: \_\_\_\_\_

Failure of any of the CPIs is an automatic failure.

Evaluator: \_\_\_\_\_ NSP ID: \_\_\_\_\_

PASS      FAIL



- a. Heroes go where angels fear to tread.
  - b. It is acceptable to rush into an unsafe scene and quickly pull a patient to safety if it is a matter of life or death.
  - c. You do not owe a patient your life.
  - d. None of the above are true.
5. The assessment referred to as tandem gait checks for \_\_\_\_\_
- a. a subtle injury or neurological deficit.
  - b. whether or not the patient's arms move equally.
  - c. whether or not the patient's pupils react equally.
  - d. whether grip strength is equal in both hands.
6. A complete set of vitals consists of \_\_\_\_\_
- a. respiration rate, pulse rate, level of responsiveness, blood pressure, and temperature.
  - b. respiration rate, pulse rate, pulse oximetry (PSAT), blood pressure, and temperature.
  - c. MOI, NOI, pulse rate, and blood pressure.
  - d. PSAT, Glasgow Coma Scale, AVPU, and SAMPLE.
7. You are taking a patient's blood pressure by auscultation. As you release the cuff, you continue to hear the patient's pulse all the way to the "zero" reading on gauge. What should you do?
- a. Note that the patient has a diastolic reading of "0" and arrange for immediate transport to the closest medical facility.
  - b. Wait a few moments, reinflate the cuff, and listen again carefully to determine when the sound changes rather than disappears.
  - c. Wait a few moments and then reassess blood pressure because you obviously made a mistake.
  - d. Simply document the finding, because in some patients a diastolic reading of 0 is a normal condition known as hypophoresis.
8. Which of the following statements about taking a blood pressure reading is correct? \_\_\_\_\_
- a. If you release the cuff too quickly and miss the diastolic reading, go ahead and reinflate the cuff immediately, then reassess the BP.
  - b. Releasing the cuff very slowly will give you a more accurate reading.
  - c. It does not matter how quickly or slowly you deflate the cuff.
  - d. None of the above are correct.
9. Orthostatic hypotension is defined as \_\_\_\_\_
- a. a condition in which a patient has an abnormally low blood pressure.
  - b. a condition in which a patient's blood pressure increases when the patient stands up.
  - c. a condition in which a patient's blood pressure decreases suddenly when the patient stands up.
  - d. a condition in which blood pressure is controlled by taking antihypertension medication.
10. A drop in blood pressure during a postural BP check could indicate that \_\_\_\_\_
- a. the patient's blood pressure is too high.
  - b. the patient is hypotensive.
  - c. the patient is dehydrated or bleeding internally.
  - d. the patient has a normal reaction for when a person goes from sitting to standing.
11. Which of the following regarding orthostatic hypotension is true? \_\_\_\_\_
- a. It should only be performed on a patient who is not at risk for spinal cord injury.
  - b. The test should be discontinued if the patient begins to faint.
  - c. Some patients with orthostatic hypotension do not show a drop in pulse.
  - d. All of the above are true.
12. The most important thing an OEC Technician can do for an unresponsive patient with a pulse is \_\_\_\_\_
- a. monitor and maintain the airway.
  - b. transport the patient immediately to the nearest medical facility.
  - c. record the GCS value.
  - d. perform CPR.

13. Which of the following statements regarding vital signs is true?
- A stable patient's vitals should be taken and recorded every 10–15 minutes, whereas a seriously injured or unstable patient's vitals should be recorded every 3–5 minutes.
  - A patient's vitals should be taken every 5 minutes whether they are stable or not.
  - Vital signs should not be taken in the field and are best performed in an aid station or in the back of an ambulance.
  - A patient's temperature should be checked at the axilla (armpit) or using a forehead strip thermometer because these methods are the least invasive forms of recording temperature.
14. The normal respiratory rate for an adult is \_\_\_\_\_
- 8–24 breaths per minute.
  - 12–22 breaths per minute.
  - 12–20 breaths per minute.
  - highly variable from person to person.
15. The normal pulse rate for an adult is \_\_\_\_\_
- 60–100 beats per minute.
  - 50–90 beats per minute.
  - 20–40 beats per minute.
  - highly variable from person to person.
16. BP by auscultation is measured at which pulse point? \_\_\_\_\_
- Carotid
  - Brachial
  - Radial
  - Femoral
17. Which is the best answer regarding patient assessment? \_\_\_\_\_
- It is a dynamic, ongoing process.
  - It should be done systematically and by one rescuer only.
  - A typical complete exam (primary and secondary assessments) should take only a few minutes to complete.
  - All of the above are true.

## Matching

Match each of the following acronyms or mnemonics to its use.

- |                    |  |
|--------------------|--|
| _____ 1. AVPU      | a. used to assess a patient's chief complaint                              |
| _____ 2. OPQRST    | b. used to assess a patient's pupils                                       |
| _____ 3. PERRL     | c. used for conducting a trauma assessment                                 |
| _____ 4. SAMPLE    | d. used to obtain a medical history during the assessment process          |
| _____ 5. DCAP-BTLS | e. used to assess a patient's level of responsiveness                      |
| _____ 6. ABCD      | f. used to obtain critical information during a primary patient assessment |

## Scenario

*You receive a call that a visitor to the ski area is "down" in the cafeteria of the upper lodge. Upon arrival you find a 72-year-old man sitting on the floor holding his right wrist and arm. He appears to be slightly confused. The answers to your questions reveal that the patient had become dizzy and tripped and had landed on his right arm, that earlier today he drove 3 hours by car, and that he has left-sided dull chest pain (rated at 5 out of a possible 10, or "5/10") and mild difficulty breathing. The patient does not have a history of cardiac problems. He does take warfarin (blood thinner) for a clotting problem in his legs. Breakfast was at 7 a.m. The scene is secure. The patient's pulse rate is 90 per minute, and respiration rate is 28 per minute.*

1. In the SAMPLE interview, what information under "M" did the patient share? \_\_\_\_\_
- Breakfast was at 7 a.m.
  - He became dizzy and tripped.
  - He has no known allergies.
  - He takes warfarin.