EMERGENCY ASSESSMENT INFORMNATION

Target Population: School Nurse Professionals.

Purpose: Update knowledge and skills of nurses attending conference on emergency assessment.

Rationale: School nurses are faced with emergencies in the school setting. The ability to assess and act is a must.

Objectives:
1. Understand the importance of diagnosis & initial assessment in an emergency to enable better intervention.
2. State steps of history collection and patient problems.
3. (Complete) mock assessment of accident victim.
4. Relate age appropriate accidents to one's population: Toddlers, preschool, school age and high school.

Content Outline - Emergency Assessment

I. Primary Survey:
- A. Look for:
  1. General situation
  2. Patient level of consciousness
  3. General appearance
- B. Introduce self - remain calm
- C. Assessment

II. Secondary Survey:
- A. History:
  1. Chief complaint (event)
  2. Medical history
- B. Head-to-toe check

III. Accidents and age:

EMERGENCY ASSESSMENT CHECKLIST*

Through the assessment, look, listen and feel:

Primary Survey:

Evaluate potential life-threatening injuries:

1. While approaching patient, look at:
   a. General situation, especially hazards present.
   b. Patient's level of consciousness.
   c. Patient's general appearance, especially severe hemorrhage, obvious mechanisms of injury and smell

Secondary Survey:

Include head-to-toe exam, looking, listening and feeling the body all the way down.

1. Introduction – Talk with patient. Be reassuring and calming.
2. History:
   a. Chief complaint's location, quality, intensity, chronology, setting

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SYMPTOM RECHECK*

While waiting for the ambulance, recheck these diagnostic signs every five minutes on critical patients:

1. Respiratory rate
2. Pulse
3. Blood pressure
4. Level of consciousness

INFORMATION TO PASS ON*

Present these particulars to the paramedics:

1. Name, ID Number
2. Age, sex and approximate weight
3. Level of consciousness and orientation
4. Chief complaint, symptoms, findings from observation of patient and environment.
5. History of present illness or injury
6. Associated complaints
7. Medical history
8. Allergies
9. Medication that patient is currently taking, the dosage, and when last taken
10. Clinical condition
11. Vital Signs:
    a. Blood pressure
    b. Pulse - rate, quality, regularity
    c. Respirations - rate, pattern, depth
    d. Skin - color, temperature, moisture
12. Other pertinent observations about the environment
13. Any treatment initiated
14. Family physician and receiving hospital

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