Midwifery III

NTQF Level III

Learning guide - 18

Unit of Competence	**Providing Basic First aid and Emergency Care**
Module Title:	**Providing Basic First aid and Emergency Care**
LG Code:	**HLT MDW3 LO4 LG18**
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LO4. Perform patient/client Assessment

Instruction Sheet	Perform patient/client assessment

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics –

History taking

Physical Examination

Principles of physical examination

Vital signs

Documentation of patient/client data

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, **upon completion of this Learning Guide, you will be able to**:

Perform Patient/client history is taking

Describe Principles of Physical Examination

Perform Complete Patient/client physical examination is performed

Measure vital sign

Document complete patient data

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 3 to 6.
3. Read the information written in the information "Sheet 1 in page 3.
4. Accomplish the "Self-check 1 in page 11,
5. If you earned a satisfactory evaluation from the "Self-check" proceed to "Operation Sheet 1, Operation Sheet 2 and Operation Sheet 3" **in page 13.**
6. Do the "LAP test" **in page 14**
7. Your trainer will give you feedback and the evaluation will be either satisfactory or unsatisfactory. If unsatisfactory, your trainer shall advice you on additional work. But if satisfactory you can proceed to Learning Guide #19

Information Sheet 1	Anatomy and physiology of cardiovascular system

1.1 History taking- Is complete history taking may include information gathered from patient/client, family and other care givers

For medical patients the history may be completed prior to the physical examination. History of the casualty can be taken from the casualty himself or herself. If the casualty could not respond or he/she is not conscious, history can be taken from a witness or bystander. Take "SAMPLE" history on: Signs / Symptoms, Allergies, Medications, Pertinent past History, Last Oral Intake, and Event

Initial assessment- After a through observation of the situation and the surroundings, the first aider can proceeds to initial assessment comprising General impression, assessment of responsiveness, and Assessment of **Air way**, **Breathing** and **Circulation** (**A,B** and **C**).

a. General impression – this is performed based on the First Responder's immediate assessment of the environment and the patient's chief complaint

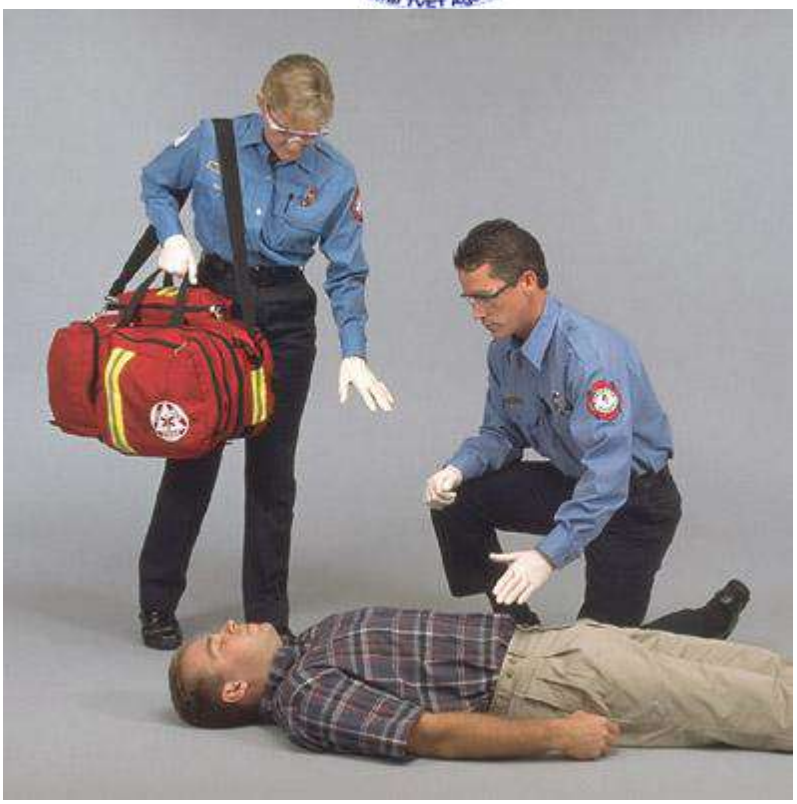

Figure: 1. General assessment

b. Assessment of responsiveness by checking if the casualty is **Alert, responding** to Verbal stimuli, responding to pain stimuli or Unresponsive.

The level of responsiveness / consciousness can be expressed as: Full consciousness – able to speak & answer questions normally **Drowsiness**- Easley aroused (awoken) but lapses in to unconsciousness **Stupor** – Can be aroused with difficulty and is aware of painful stimuli Ex- pin prick **Coma** – Cannot be aroused by any stimuli

Figure 2: first aider assess responsivenes of the casulty

c. Assessment of Air way (open the air way, inspect the air way, clear the air way as needed) , Breathing and Circulation)

Figure 3: Air way assessment: open airway by performing head-tilt/chin-lift maneuver

Figure 4: Open airway;perform jaw thrust.

d. Assessment of Breathing

- Look at the effort of breathing.
- Look, listen, and feel for presence of ventilations
- Ventilate as needed

Figure 5: **Assess breathing; look, listen, feel**

e. Assess the Patient's Circulation

- Assess Pulse , Assess for Bleeding and Assess Skin

Figure 6: checking for radial pulse

Figure 7; ***Check for a carotid pulse.***

Figure 8: Checking Brachial pulse

1.2 Physical examination: Complete physical examination form head to toe Techniques of physical examination (inspection, palpation, percussion and auscultation) Vital signs (temperature, pulse rate, respiration, blood pressure)

The First Responder Physical Examination is designed to locate and begin the initial management of the signs and symptoms of illness or injury. The First Responder should complete a physical exam on all patients following the initial assessment. Inspection and palpation /feeling of body parts/ are the two important methods of physical examination in first aid practice.

Inspect and palpate for DOTS (Deformity, Open wound, tenderness and Swelling). Do the physical examination in the sequence of: **Head ▸ Neck ▸ Chest ▸ Abdomen ▸ Pelvic ▸ Extremities**

Figure 9: Assessment of the head

Figure 10: Assessment of the neck

Figure 11; Assessment of the Chest

Figure 12: Assessment of the abdomen

Figure 13: Assessment of the pelvic

1.3 Vital Sign

Vital sign is an outward signs of what is occurring inside the body. They are the key signs that are used to evaluate the patient's condition. The first set of vital signs that you obtain is called the baseline vital sign. You should take vital sign every 5 minutes for unstable patient and every 15 minutes for stable patient.

1.3.1. Respiration

Breathing is a continuous process in which each breath regularly follows the last with no notable interruption. Breathing normally a spontaneous, automatic process, which occur without conscious thought, visible effort, marked sounds or pain. You will assess breathing by watching the patient chest rise and fall, feeling for air through the mouth and nose during exhalation and

listening to the breath sound with a stets scope over each lung. Chest rise and breath sound should be equal on both sides of the chest. When assessing respirations, you must determine the rate, quality (character) and depth of the patients breathing

Rate Table 1. Normal range respiration for different age group

Age	Range, breath per minute
Adult	12 to 20
Children	15 to 30
Infant	25 to 50

1.3.2 Pulse

The pulse is the pressure wave that occurs as each heart beat causes a surge in the blood circulating through the arteries. The pulse is mostly felt at a pulse point where a major artery lies near the surface and can be pressed gently against a bone or solid organ. To palpate (feel) the pulse, hold together your index and long fingers and place their tip over a pulse point, press gently against the artery until you feel intermittent pulsation

Figure 14 Radial pulse

Figure 16 Carotid pulses

Figure 15 Brachial pulse

Table 2 Normal range for pulse rate

Age	Range beat per minute
Adult	60 to 100
Children	70 to 150
Infant	100 to 160

1.1.4.C Skin condition

The condition of the patient's skin can tell you a lot about the patient's peripheral circulation and perfusion, blood oxygen level and body temperature. When assessing the skin condition, you should evaluate its color, temperature and moisture.

- **Color**
- **Temperature**
- **Moisture**

1.3.3. Capillary refill

Capillary refill is evaluated to assess the ability of the circulatory system to restore blood to the capillary system

Figure 17 Checking capillary refill

Capillary refill should be prompt and the nail bed color should be pink, with adequate perfusion, the color in the nail bed should be restored to its normal pink within 2 second. Or about the time it takes to say “capillary refill” at a normal rate of speech.

1.3.4 Blood Pressure

Blood pressure is the pressure of circulating blood against the wall of arteries A drop in blood pressure may indicate: Loss of blood, Loss of vascular tone and Cardiac pumping problem.

Normal blood pressure

Blood pressure level varies with age and gender. The normal ranges for blood pressure

a) Adults: 90 to 140 mm Hg (systolic)/60 to 90 mm Hg (diastolic)

b) Children (1 to 8 years): 80 to 110 mm Hg (systolic)

c) Infants (newborn to age 1 year): 50 to 95 mm Hg (systolic)

1.2 Level of consciousness (LOC)

Level of consciousness (LOC) should also be assessed as a vital sign. AVPU scale is a rapid method of assessing LOC. (See the previous session for detail)

A = Alert and awake

V = Response to verbal stimulus

P = Responsive to pain

U = Unresponsive

1.3. Pupils

The diameter and reactivity to light of the patient’s pupil reflect the status of the brain’s perfusion, oxygenation and condition.

On injury if the pupil reacts in any of the following ways:

- Become fixed with no reaction to light
- Dilate with light and constrict when light is removed
- React sluggishly
- Become unequal in size

- Become unequal in size when a bright light is introduced into or removed from one eye

Depressed brain function can be produced by the following situation

- Injury to the brain or brain stem
- Trauma or stroke
- Brain tumor
- In adequate oxygen perfusion
- Drugs or toxins (Central nervous system depressant)

Figure 18 Constricted pupil

Figure 19 Dilated pupil

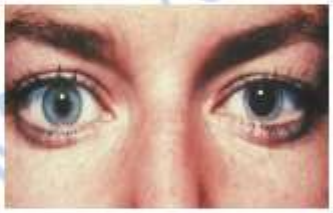

Figure 20 unequal size pupil

The letter PEARRL serves as a useful guide in assessing pupil. They stand for the following:

- P = Pupils
- E = Equal
- A = And
- R = Round
- R = Regular in size
- L = react to Light

1.4 Documentation of patient/client data - Document all the necessary patient information and procedure carried out and outcome of the procedure as well as patient condition before the procedure.

Self-Check 1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. List the most common Initial assessment performed (4 Point)
2. What general principles of first aid she would have to consider while providing care (3 Point)
3. The common site to take pulse for the victim is? (2 Point)
4. Describe AVPU (3 point)
5. Describe the normal ranges of blood pressure of Adult, Children, Infant (3 Point)

Note: **Satisfactory rating - 10 points Unsatisfactory - below 10 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____
Rating: _____
Name: _____ Date: _____

Short Answer Questions

1. _____
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3. _____
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4. _____
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5. _____
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Operation Sheet 1	History Taking

The techniques used for history taking are:

Step 1: Assess responsiveness of the casualty

Step 2: Talk, listen and reassure the conscious casualty

Step 3: Check safety of casualty and of yourself

Step 4: check for breathing, bleeding and level of consciousness

Step 5 : assess any history of illness Eg: Epilepsy, Diabetes mellitus

Step 6 Assess for history of ingested material E.g. Drug, Alcohol, type of food or fluid

Operation Sheet 2	physical examination

The techniques used for conducting physical examination are:

Step 1: Perform initial assessment

Step 2: Assess level of responsiveness

Step 3: Assess:" ABC"

Step 4: Inspect and palpate for DOTS (Deformity, Open wound, tenderness and Swelling)

Operation Sheet 3	vital sign

The techniques used for measuring vital sign are:

Step 1: Hand washing

Step 2: Put on disposable glove

Step 3: Collect the necessary equipment

Step 4 Take vital sign

Step 5: Record patient finding

LAP Test	Practical Demonstration

Name: _____ Date: _____

Time started: _____ Time finished: _____

Instructions: Given necessary templates, tools and materials you are required to perform the following tasks within 2 hours.

Task 1: Perform history taking

Task 2: Conduct physical examination

Task 3: Measure and record vital sign

List of Reference Materials

1. First aid manual, Emergency procedures for everyone, at home, at work, at leisure, 8th edition

2. The Federal democratic republic of Ethiopia Minster of health , First Aid learning module Addis Abeba, Ethiopia 2014

3. First Aid and Accident Prevention Lecture Note for Health Science Students the Carter Center, the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education

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