

| 2010 ALTERED MENTAL & PEDIATRIC INJURIES <i>(including possible CRIME SCENES)</i> | | | | SKILLS CHECKLIST | |
|--|---------------------------------------|--|--|---|-----------------------------------|
| Name | | | | Date | |
| Objective: Demonstrate appropriate assessment and treatment using appropriate equipment and Patient Care Protocols | | | | | |
| SCENE SIZE-UP | | | | | |
| <input type="checkbox"/> BSI | <input type="checkbox"/> Scene Safety | <input type="checkbox"/> Determines MOI / NOI | <input type="checkbox"/> # of Patients | <input type="checkbox"/> Additional Resources | |
| INITIAL ASSESSMENT | | | | | |
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Airway | <input type="checkbox"/> Breathing | <input type="checkbox"/> Circulation | <input type="checkbox"/> Obvious Trauma | <input type="checkbox"/> SICK |
| <input type="checkbox"/> Chief Complaint | <input type="checkbox"/> C-spine | | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Body Position | <input type="checkbox"/> NOT SICK |
| SUBJECTIVE (FOCUSED HISTORY) | | | | | |
| <input type="checkbox"/> Establishes rapport with patient (reassures and calms) and obtains consent to treat (implied / actual) <input type="checkbox"/> Determines patient's chief complaint and follows SAMPLE and OPQRST investigation <input type="checkbox"/> Determines time of onset of signs or symptoms (considers MOI / NOI and acts accordingly) <input type="checkbox"/> Obtains names/dosages of current medications (if possible) | | | | | |
| OBJECTIVE (PHYSICAL EXAM) | | | | | |
| <input type="checkbox"/> Records and documents Baseline vital signs – listens to lung sounds and compares sides <input type="checkbox"/> Performs appropriate trauma/medical exam – exposes/checks for bleeding and/or injuries <input type="checkbox"/> Checks for neurologic deficits using AVPU <input type="checkbox"/> Obtains second set of vital signs and compares to baseline | | | | | |
| ASSESSMENT (IMPRESSION) | | | | | |
| <input type="checkbox"/> Verbalizes impression (SICK / NOT SICK) | | | | | |
| PLAN (TREATMENT) | | | | | |
| GENERAL CARE (check all that apply) | | | | CRITICAL (FAIL) CRITERIA | |
| <input type="checkbox"/> Indicates need for immediate transport <input type="checkbox"/> Considers potential stroke <input type="checkbox"/> Administers oxygen (appropriate rate and delivery device) <input type="checkbox"/> Properly positions patient <input type="checkbox"/> Performs spinal immobilization <input type="checkbox"/> Looks for signs of abuse | | <input type="checkbox"/> Prevents heat loss <input type="checkbox"/> Monitors patient's vital signs <input type="checkbox"/> Considers Index of Suspicion <input type="checkbox"/> Performs ongoing assessment <input type="checkbox"/> Considers potential crime and preserves evidence <input type="checkbox"/> _____ | | ... DID NOT ... <input type="checkbox"/> Take/verbalize BSI <input type="checkbox"/> Appropriately provide/manage airway, breathing, bleeding control, treatment of shock <input type="checkbox"/> Administer appropriate rate and delivery of oxygen <input type="checkbox"/> Indicate need for immediate transport (SICK patient) | |
| COMMUNICATION AND DOCUMENTATION | | | | MEETS STANDARDS | |
| <input type="checkbox"/> Delivers timely and effective short report | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| <hr/> EVALUATOR | | | | 2nd ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO | |