



Chief Complaint

- The major sign and/or symptom reported by the patient
- Symptoms
 - Problems or feelings a patient reports
- Signs
 - Conditions that can be seen, heard, felt, smelled, or measured

Difference Between Signs and Symptoms

| SIGNS | Symptoms |
|---|--|
| <ul style="list-style-type: none"> ■ What you see, hear, feel, and smell ■ Objective data | <ul style="list-style-type: none"> ■ What the patient tells you.....e.g. "I have pain" ■ Subjective data |

Together, signs and symptoms give us a clearer picture of what's going on.

Obtaining a SAMPLE History (1 of 2)

- **S**—Signs and Symptoms
 - What signs and symptoms occurred at onset?
- **A**—Allergies
 - Is the patient allergic to medications, foods, or other?
- **M**—Medications
 - What medications is the patient taking?

Obtaining a SAMPLE History (2 of 2)

- **P**—Pertinent past history
 - Does the patient have any medical history?
- **L**—Last oral intake
 - When did the patient last eat or drink?
- **E**—Events leading to injury or illness
 - What events led to this incident?

Vital Signs

- What are vital signs?

Vital signs are an outward sign of what's going on inside the body.

- Who needs to have their vital signs obtained?

All patients!

Vital Signs

- Why obtain vital signs?
 - Establishes a baseline.
 - Determines trends.
 - Guides patient assessment.

Vital Signs

- How often do we obtain vital signs?
 - Every 5 minutes if critical
 - Every 15 minutes if stable
- When do we take vital signs?
 - For a responsive medical or trauma patient, right after you perform a focused H & P
 - For any unresponsive or patient with significant MOI, right after the rapid physical assessment

Four Components of Vital Signs

- 1) Pulse
- 2) Respirations
- 3) Skin Temperature & Condition
- 4) Blood Pressure

Sometimes LOC with pupil check are included in the VS

1) Pulse

- Check Rate (slow, normal, fast)
- Check Quality (full, weak)
- Check Rhythm (regular, irregular)

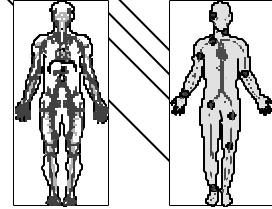


Pulse

Terminology associated with pulses

- Bradycardia
- Tachycardia
- Thready
- Bounding
- Pulseless

Pulse Location



Normal Ranges for Pulse Rate

| | |
|----------|----------------------|
| Adults | 60 to 100 beats/min |
| Children | 80 to 160 beats/min |
| Toddlers | 100 to 120 beats/min |
| Newborns | 120 to 140 beats/min |

2) Respirations

- Check Rate (fast, normal, slow)
- Check Quality (clear, coarse)
- Check Rhythm (regular, irregular)



Respirations

- Rate = the number of breathes per minute

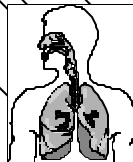
Normal Ranges

| | |
|-------|----------|
| 12-20 | Adults |
| 20-30 | Children |
| 30-40 | Infants |

Respirations

Terminology for Respiratory Quality

- Snoring
- Wheezing
- Gurgling
- Stridor
- Rales



Respirations

- Other terminology

- Dyspnea
- Apnea
- Hypoxia
- Agonal

3) Skin Temperature

- Relative temperature
- Moisture
- Color

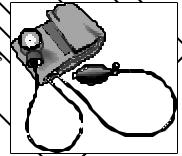


Skin Temperature

- Color
 - Pink, pale, blue, red, or yellow
- Temperature
 - Warm, hot, or cool
- Moisture
 - Dry, moist, or wet

4) Blood Pressure

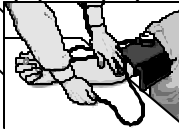
Definition: The pressure in the arteries when the heart beats (systole) and when it rests (diastole)



Blood Pressure

Terminology associated with Blood Pressure

- Sphygmomanometer
- mmHg
- Systolic / Diastolic
- Hypotension
- Hypertension
- Palpation
- Auscultation



Measuring Blood Pressure

- Diastolic
 - Pressure during relaxing phase of the heart's cycle
- Systolic
 - Pressure during contraction
- Measured as millimeters of mercury (mm Hg)
- Recorded as systolic/diastolic
- Auscultation vs. Palpation

Normal Ranges of Blood Pressure

| Age | Range |
|----------------------------|--|
| Adults | 100 to 140 mm Hg (s) 60 to 90 mm Hg (d) |
| Children (1 to 8 years) | 70 to 100 mm Hg (s) |

Blood Pressure

- A drop in blood pressure may indicate:
 - Loss of blood
 - Loss of vascular tone
 - Cardiac pumping problem
- Blood pressure should be measured in all patients older than 3 years.



- The cuff should be 2/3rds the size of the upper arm.
- If the cuff is too big, then you will get a false low.
- If the cuff is too small, then you will get a false high

Rules of thumb for blood pressure:

- If radial pulse is palpable, the SBP is > 80
- If femoral artery pulse is palpable, the SBP > 70
- If carotid artery pulse is palpable, the SBP > 60

Level of Consciousness

- A - Alert
- V - Responsive to Verbal stimulus
- P - Responsive to Pain
- U - Unresponsive

• Check the pupils

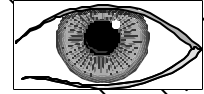
Level of Consciousness

- What causes changes in LOC?

Any condition resulting in a decrease of glucose or oxygen to the brain cells, such as seizures, drug or alcohol ingestion, head injury, diabetes, shock, etc

Pupils

Check pupil size and reactivity to light



Are they Constricted? Dilated? Unequal?
Non-reactive?

Pupil Assessment

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

Reassessment of Vital Signs

- Reassess stable patients every 15 minutes.
- Reassess unstable patients every 5 minutes.

Glasgow Coma Scale

- Eye Opening
 - Spontaneous (4)
 - To Voice (3)
 - To Pain (2)
 - None (1)
- Verbal (cont.)
 - Inappropriate Words (5)
 - Words (2)
 - None (1)
- Motor Response
 - Obeys Commands (6)
 - Localizes Pain (5)
 - Withdraws (4)
 - Flexion (3)
 - Extension (2)
 - None (1)
- Verbal Response
 - Oriented (5)
 - Confused (4)

Capillary Refill

- Evaluates the ability of the circulatory system to restore blood to the capillary system (perfusion)
- Tested by depressing the patient's fingertip and looking for return of blood.



Put it all together

- Your patient has:
 - Decreased level of consciousness
 - Rapid, weak pulse
 - Decreasing BR
 - Cool, clammy, cyanotic skin temperature

Probable Shock!!

