

Chapter 5: Patient Assessment

Lecture

I. Introduction

Time: 20 Minutes

Slides: 1–12

Lecture/Discussion

- A. Patient assessment in the critical care environment
 - 1. Assessment of critical care patients presents unique challenges and requires CCTPs to have a thorough understanding of the clinical scenario and the following skills:
 - a. Sharp clinical assessment skills
 - b. Interpersonal communications and diplomacy
 - c. Balanced approach to assessment and treatment
 - 2. It is important to establish an assessment process that ensures the discovery and appropriate management of the patient's critical care needs in order to:
 - a. Limit morbidity and mortality
 - b. Improve patient outcomes
 - 3. It is also important to be familiar with the assessment process that established the initial care plan because critically ill patients change so quickly.
 - a. Initial nursing or medical plans of care premised on review of pertinent data, including:
 - i. Assessments
 - ii. Laboratory and radiologic studies
 - iii. Other diagnostic tests
 - b. Initial paramedic assessments:
 - i. Use similar assessment skills
 - ii. Include limited field diagnostic tests
 - iii. Often lack time or resources to achieve hemodynamic stability or range of necessary data
 - 4. Differential diagnosis is a useful tool that lists all possible diagnoses, aside from the projected diagnosis, that could be causing a patient's symptoms.
 - a. Allows clinician to use diagnostic testing and treatment to exclude or include each one from list
 - b. CCTPs should have advanced understanding of pathophysiology and full range of potential differential diagnoses for patients
 - i. To assist treatment decisions and assessing their effects
 - 5. Advantages and disadvantages to paramedic assessment model:
 - a. Treats major problems as symptoms found
 - b. Uses standardized assessment approach based on sequencing most immediate threats to life, patient survival
 - 6. Advantages and disadvantages to nursing and medical assessment model:
 - a. Does not always provide treatment during assessment process

- b. Provides wealth of information that can target treatment toward known list of problems
 - i. Beneficial to patients
 - ii. Can be more effective than treating symptoms alone without knowing causes
- 7. Combination of paramedic and medical or nursing models of assessment most ideal in critical care transport environment
- B. Bridging environments and disciplines
 - 1. The systems assessment (presented later) comprises the detailed physical exam; however, if the patient experiences a sudden deterioration in status, the CCTP should revert to the prehospital assessment and intervention strategies for resuscitation.
 - 2. The prehospital mindset may not be the best choice for critical care.
 - a. “Find a life threat—fix a life threat” works well in acute emergency care.
 - b. Critical care nursing and medicine have developed and refined processes, techniques, and interventions unique to critical care patients.
 - i. CCTPs can borrow and refine for their use
 - 3. Critical care patients usually require treatment for problems involving one or more systems, with interrelated, multisystem complications.
 - a. CCTPs use systems assessment approach for:
 - i. Continuing patient evaluation
 - ii. Identifying subjective and objective criteria and performance indicators
 - 4. Critical care has experienced a philosophical shift in the last decade with a return to bedside clinical care.
 - a. Treating the patient, not the machine
 - b. Looking at and listening to patients and families
 - c. Making decisions and solving problems by balancing personal and clinical observations with technology
 - 5. This chapter explores a systems approach using clinical observation and technologic parameters for the continuing assessment of patients in critical condition.
- C. Scene vs interfacility transport
 - 1. Scene transport:
 - a. Involves interactions with other care providers (often)
 - b. Requires acknowledgement and recognition of the care provided before CCTP’s arrival
 - c. Requires expeditiously assessing, treating, packaging, and transporting patient to definitive care
 - d. Means accepting that more comprehensive assessment and sophisticated treatments are best deferred until patient arrives at definitive care facility
 - 2. Interfacility transport:
 - a. Often includes voluminous patient information
 - i. CCTPs should review ahead of time
 - ii. Provides comprehensive picture of patient before transport
 - iii. Permits chance to perform necessary procedures or diagnostic tests ahead of time
 - b. Requires transfer team to have general understanding of patient’s situation
 - i. Hospital staff must understand period of transfer may become the most critical point in continuum of total care
 - ii. CCTP must prompt for needed information, when necessary
 - iii. Maintain professional manner
 - iv. Respect nurse–patient dynamics, recognize separation anxiety and increased stress

- c. Anticipated transport time differentiates “need to know” from “helpful to know” information
- d. Hospital medical record typically includes several sections based on patient’s diagnostic and medical care needs, including:
 - i. Admission orders
 - ii. Advance directives
 - iii. Operative notes
 - iv. Postoperative notes
 - v. Progress notes
 - vi. Consultation notes
 - vii. Preoperative notes
 - viii. Procedure notes
 - ix. Discharge summary
 - x. Lab reports
 - xi. Medication administration records
 - xii. Nurses’ notes and flow sheets

II. Scene Transports

Time: 6 Minutes

Slides: 13–16

Lecture/Discussion

- A. Evaluating available information
 - 1. At the beginning of a scene transport it is important to ascertain mechanism of injury details, including:
 - a. Speed
 - b. Distance of fall
 - c. Type of weapon
 - d. Duration of environmental exposure
 - 2. Current interventions
 - a. Refers to obtaining as much detail as possible about interventions provided before CCTP arrival
 - b. Includes medications administered, procedures performed, other care provided
 - 3. Responses to interventions
 - a. Patient outcomes largely described by response to interventions
 - b. Observing and record each intervention and patient’s response
 - 4. Patient status
 - a. Use general terms that are objective and measurable in nature.
 - i. Subjective terms (stable, unstable, no acute distress, etc.) are too vague
 - b. Glasgow Coma Scale (GCS) score is a useful prehospital scoring system
 - i. Facilitates communication between providers and receiving facilities
- B. Process for patient assessment at the scene
 - 1. Patient assessment by CCTPs for scene transports is no different from patient assessment conducted as a field provider
 - a. CCTPs may use more sophisticated patient monitoring devices and technologies on scene and during transport
- C. Patient packaging for transports
 - 1. Packaging for on-scene transports is dependent on multiple variables, including:

- a. Physical location of patient
 - b. Care in progress on arrival
 - c. Temperature and weather conditions
 - d. Type of CCTP transport vehicle
- 2. More than one CCTP may work together
 - a. One CCTP may obtain patient report
 - b. Second CCTP may:
 - i. Apply monitoring equipment
 - ii. Conduct cursory physical assessment
 - iii. Perform necessary procedures
 - iv. Bundles patient and equipment for transfer to transport unit stretcher
- 3. Local practice protocols and procedures dictate:
 - a. Sequence of packaging and moving patient for transport
 - b. Methods used to secure lines, tubes, and equipment before and during transport
- 4. Expediency is the most important component of patient packaging for scene transports

III. Interfacility Transports

Time: 11 Minutes

Slides: 17–23

Lecture/Discussion

- A. Evaluating available information
 - 1. A seasoned critical care transport nurse or physician can often scan “scene” around hospitalized critically ill patient and gain considerable insight
 - a. Equipment and monitoring devices provide vital information about a patient’s condition
 - 2. Assessment of ventilator settings, medication infusions, and monitoring equipment in use must be detailed and thorough prior to transport.
 - a. Ventilator settings must be replicated using transport ventilator
 - b. Drip fluids may need to be remixed or transferred to different infusion pumps
 - c. Monitoring devices and equipment need to be replaced with critical care transport monitors
 - 3. Current interventions
 - a. Can be extensive
 - b. Maintain focus on current problem necessitating transport
 - i. Subsequent care will be predicated on previous interventions
 - c. Also learn other interventions initiated to address current problem, when attempted, outcomes
 - d. Continually maintain awareness or be able to immediately access total volume of fluids administered, including:
 - i. Blood and blood products
 - ii. Total doses of each medication administered
 - iii. Major procedures performed within previous 24 hours
 - 4. Responses to interventions
 - a. Tends to be more clear-cut than in prehospital setting
 - i. Reason for transport often to access services unavailable at current facility
 - b. Inquire about treatments and interventions tried previously

- i. Not always easily elicited from medical record
 - ii. Benefits patient care during transport
 - iii. Provides helpful information for receiving facility
 - c. Inquire about patient-specific responses to current treatments
 - i. Individuals respond differently to medications and treatments
 - ii. Promotes safer, smoother transition of care
- 5. Patient status
 - a. Interfacility transports encounter patients in two types of conditions:
 - i. Stable
 - ii. Unstable
 - b. Standardized scoring systems and other tools are helpful for charting, billing, and coding but have little value for hands-on patient care
 - i. Example: APACHE
 - c. Determination of patient status must ultimately be done by CCTPs
 - i. Although much of the assessment information used during interfacility transport is obtained from medical record or verbal report from providers
 - d. Critical care providers at the bedside can outline anticipated problems during transport
 - i. CCTPs should ask about known issues with equipment, specific patient behaviors, suggested responses to existing problems
 - e. Determine if advance directives exist prior to transport
 - i. Know the specifics
 - ii. Have copies during transport
- B. Process for patient assessment at the transferring facility
 - 1. CCTPs often split duties:
 - a. One obtains report from transferring facility staff
 - b. One conducts patient assessment and applies transport unit monitors, infusion pumps, ventilators, other equipment
 - 2. Because substantial assessment data are obtained during report, all CCTPs might find it useful to hear bedside report, or receive report while simultaneously conducting assessment and transfer of care
 - a. “Bedside report” a national standard in hospitals to:
 - i. Improve efficiency
 - ii. Decrease errors
 - iii. Decrease overlooked information
 - iv. Include patients in plan of care
 - 3. Assessment
 - a. Begins on entry to sending facility with overview of surroundings
 - i. Ensures routes of travel will accommodate patient, equipment, personnel to transport unit
 - b. CCTPs transfer patient’s monitoring to transport monitoring equipment
 - i. Readings must be reliable and replicate those previously observed on hospital’s monitors
 - c. CCTPs conduct an appropriate assessment by using report received from transferring staff and following outline “General Patient Overview for Interfacility Transfer”
 - i. It is never necessary to perform every assessment outlined
 - ii. Choose assessments pertinent to patient condition, reason for transport
 - d. Begin with general overview that includes items routinely noted in medical record

- i. Facilitates appreciation of balanced, holistic approach to patient and situation
 - ii. Provided by primary critical care nurse or hospital transfer sheet
 - e. Brief synopsis should review applicable elements from following categories:
 - i. Admission data
 - ii. History
 - iii. Allergies
 - iv. Medications
 - v. Radiologic films and findings, and diagnostic reports
 - vi. Laboratory and pathology findings
 - vii. Health perception and maintenance pattern
 - viii. Activity
 - ix. Integumentary system
 - x. Cognitive-perceptual status
 - xi. Cardiopulmonary status
 - xii. Gastrointestinal and genitourinary status
 - xiii. Musculoskeletal status
 - xiv. Personal belongings
 - xv. Advance directives
 - xvi. Patient and family understanding and educational needs
 - f. Elements unique to the patient's needs should be used to develop an individualized critical care plan and documentation designed to meet those needs.
- 4. Be aware of various policies regarding the transfer of narcotics or controlled substances
 - a. Vary by institution, critical care transport program, and state
 - b. Remain flexible based on particular policies
 - i. With regard to remixing, altering, or discontinuing sedation infusions
 - ii. May require involvement of transferring or receiving physician and/or online medical control
- C. Patient packaging for transports
 - 1. Review Skill Drill 5-1: Packaging procedures for an interfacility transport

IV. The Critical Care Systems Assessment

Time: 51 Minutes

Slides: 24–57

Lecture/Discussion

- A. Critical care assessment is typically systems based, using observational skills and clinical parameters of physiologic status.
 - 1. Technologic monitoring is to support observations or provide greater specificity and/or differentiation to the findings.
 - 2. With this in mind, review the following sections:
 - a. General appearance
 - b. Cardiovascular system assessment
 - c. Respiratory system assessment
 - d. Neurologic system assessment
 - e. Gastrointestinal system assessment
 - f. Genitourinary system assessment
 - g. Musculoskeletal system assessment

- h. Psychosocial and emotional system assessment
- 3. The next sections provide a functional framework to discuss the various elements of the critical care systems assessment.
 - a. Depth dictated by patient condition
 - b. Limitations of assessment during transfer would lead CCTP to conduct assessment prior to leaving scene
 - i. Examples: noise, turbulence
- 4. The assessment and the data obtained must be individualized to patients and their conditions.
 - a. Generalization may lead CCTP astray and impact patient care and CCTP credibility
 - b. Critical thinking: ability of CCTPs to obtain, interpret, include/exclude data based on patient's differential diagnoses
- 5. The subjective information obtained from patient and family is as important as objective information obtained during actual exam.
 - a. Subjective history should be recorded as direct quotes and includes:
 - i. Chief complaint
 - ii. Review of systems
 - iii. History of past and present illnesses
 - b. With experience, much of the critical care assessment can be completed with just casual encounters with the patient.
 - i. Merely listening to patients and their families provides myriad of information that assists CCTPs in assessing, treating patients
- B. Assessment of general appearance
 - 1. Includes assessment of patient's apparent health status based on:
 - a. Data from medical records
 - b. Determination of parameters such as:
 - i. Apparent age relative to chronologic age
 - ii. Level of consciousness (LOC)
 - iii. Skin findings
 - 2. CCTPs should also note:
 - a. Presence or absence of gross deformity
 - b. Stature
 - c. Posture
 - d. Gait (if patient is ambulatory)
 - e. Presence and degree of edema
 - f. Skin lesions
 - g. State of fingertips and nail beds
 - h. Position of comfort
 - i. Skin temperature (cool, warm, hot)
 - j. If skin is wet or dry
 - k. Turgor (rapid or sluggish)
- C. Cardiovascular assessment
 - 1. Inspection
 - a. Provides overall sense of patient's baseline health
 - b. Includes patient's skin color (central and peripheral)
 - i. Pallor or cyanosis may indicate hypoxia
 - ii. Cyanosis of nail beds may indicate acute oxygen insufficiency or long-term hypoxia from COPD (when combined with clubbing)
 - c. Includes notation of location and severity of edema, if present
 - i. Assess level of edema (trace, deep pitting)

- ii. Differentiate between dependent and nondependent edema
 - iii. Occurs in lower extremities in ambulatory and seated patients; sacral area in those confined to bed
 - d. Perform bedside assessments with nursing staff prior to leaving bedside as a precaution
 - e. Includes interpretation of ECG rhythm and consideration of questions, including:
 - i. Underlying or baseline rhythm
 - ii. Usual monitoring lead and morphology
 - iii. Arrhythmias experienced by patient, effects, and treatments used
 - iv. Defibrillation or cardioversion
 - v. Pacemaker and/or implanted cardio-defibrillator, plus record of current settings
 - f. Includes observing for jugular venous distention
 - i. Test hepatojugular reflex by applying midabdominal pressure while observing for jugular venous distention
- 2. Assessing pulse
 - a. Assess peripheral pulses for presence, strength, and pattern.
 - i. Bilateral assessment of carotid, radial, brachial, femoral, popliteal, posterior tibial, dorsalis pedis
 - ii. Palpate carotid pulses one side at time, without massaging-type action
 - b. Note trends in assessment findings over time in some cases.
 - i. Example: crush injuries
 - c. Note patterns of pulsations.
 - i. ECG rhythms
 - ii. Sinus or atrial arrhythmias
- 3. Auscultation
 - a. Requires years of practice for proficiency
 - b. Perform at aortic, pulmonic, tricuspid, mitral valve locations with stethoscope diaphragm and bell
 - i. Use good quality stethoscope
 - ii. Stethoscopes with microphones not recommended
 - c. Requires thorough understanding of anatomy and physiology to evaluate each heart sound
 - d. Pay attention to new murmurs
 - i. Systolic murmur following inferior myocardial infarction
 - ii. Diastolic murmurs more worrisome than systolic murmurs
 - e. Perform over carotid, renal, femoral arteries in critically ill patients
 - i. Bruits and/or loud, harsh sounds indicates blood flow through narrowed artery
 - f. Assess blood pressure
 - i. Note that normal blood pressure in critically ill patients defined by the individual patient
 - ii. Note trends in blood pressure over time before transport, especially in response to cardiogenic medications, interventions
 - iii. Compare measurements obtained with trends reported and investigate differences before packaging patient for transport
 - iv. Reassess at intervals based on patient condition or local protocol (every 5 minutes, every 15 minutes)
 - v. Use passive leg raising (PLR) to assess fluid responsiveness in patients with suspected volume depletion.

- g. Remember that not all parameters are assessed on all patients, nor are all parameters checked on the same patient at each assessment.
 - i. Head-to-toe assessment should be completed no less frequently than every 4 hours, or more based on patient acuity.
 - ii. Follow same assessment all the time to prevent inadvertently leaving out a parameter
- D. Respiratory assessment
 - 1. Inspection
 - a. Involves visual examination of patient with emphasis on the chest
 - b. Inspect patient and chest for the following:
 - i. Mental status
 - ii. Skin color and temperature; dry or diaphoretic skin
 - iii. Presence of an artificial airway (endotracheal or tracheostomy tube)
 - iv. Breathing spontaneously versus need for mechanical ventilation
 - v. Equal chest expansion with each breath
 - vi. Use of accessory muscles such as scalene, sternocleidomastoid, and/or intercostals
 - vii. Work of breathing; labored or unlabored
 - viii. Presence of chest tubes, central lines, and dressings
 - ix. Presence of signs of injury (such as bruising, laceration, and penetrating wounds)
 - c. Note that chest wall's shape provides evidence of:
 - i. Trauma
 - ii. Congenital anomalies
 - iii. Chronic obstructive pulmonary disease (barrel chest or increased anterior-posterior diameter)
 - d. Assess work of breathing
 - i. By inspecting use of accessory muscles, intercostal retractions or bulging, nasal flaring.
 - ii. Increased work of breathing can be tolerated only for short period before respiratory decompensation occurs
 - iii. Children with signs and symptoms of increased work of breathing are in grave condition, require immediate aggressive interventions
 - E. Palpation
 - 1. Can also yield information about skin and subcutaneous tissues
 - a. Questions include:
 - i. Warm and dry or cool and clammy?
 - ii. Crackling during palpation (subcutaneous emphysema)?
 - b. Palpate the following:
 - i. Trachea for alignment
 - ii. Chest wall for bilateral chest excursion
 - iii. For subcutaneous emphysema
 - c. Inspect chest excursions
 - i. Should be equal and symmetrical bilaterally
 - ii. Unequal or asymmetrical chest excursion may indicate disease (pneumothorax)
 - d. Consider subcutaneous emphysema as useful indicator of:
 - i. Disease states (ruptured bleb)
 - ii. Air leak in a chest tube
 - iii. Too much tidal volume or positive end-expiratory pressures from mechanical ventilator

- iv. Dislodged chest tube
- 2. Percussion
 - a. Requires CCTPs to have sound knowledge of anatomy, physiology, percussion technique
 - b. Useful when radiography unavailable, but requires less noisy environment
 - c. Performed using one or two hands.
 - d. Attention given to sound made by percussion (normal, dullness, flatness, hyperresonance)
- 3. Auscultation
 - a. Auscultate lungs anteriorly, posteriorly, medially at midaxillary lines
 - b. Assess all lung fields for presence of normal breath sounds (tracheal, bronchial, vesicular, bronchovesicular sounds)
 - c. Assess for adventitious sounds (crackles, rhonchi, stridor, wheezing)
 - d. Note the following:
 - i. Choice of sites affects sound heard
 - ii. Normal breath sounds are only normal when heard over area at which sound is considered normal.
 - e. Note current ventilator settings, parameters, and baseline arterial blood gas measurements when transporting critically ill patient who is mechanically ventilated
 - f. Remember that maintaining an airway and adequate ventilation of highest priority during transport
- F. Neurologic assessment
 - 1. Often most challenging for CCTPs because of complexity of the neurologic system
 - a. Chapter focus is general neurologic assessment
 - i. Neurologic exam tends to be more focused than other assessments to patient's individual needs
 - b. Establish patient's baseline status for comparison with later findings to determine changes in patient's condition
 - i. CCTPs must have thorough knowledge of range of normal responses to determine whether the patient's condition improving or worsening
 - 2. Diagnosis and immediate clinical history guide CCTPs as to required level of detail
 - a. Glasgow coma scale (GCS)
 - i. LOC most important parameter in evaluating patient with CNS injury
 - ii. GCS focal point
 - iii. Assess while patient is both sedated and not sedated
 - iv. Consider trending over time
 - v. Use least noxious stimulus required to illicit response (deep nail bed pressure)
 - vi. Decerebrate and decorticate posturing ominous signs of upper brain stem or deep cerebral injury
 - vii. Note any changes because they may indicate increasing ICP
 - b. Pupil assessment
 - i. Assess bilaterally for size (1 to 6 mm), reactivity to light (direct and consensual), and shape
 - ii. Reactivity to light described as: brisk, sluggish, nonreactive
 - iii. Hippus phenomenon may be seen with compression of cranial nerve III
 - iv. Anisocoria may be normal variant
 - v. Four common pupil shapes: round, oval, keyhole, irregular; round is normal and variations may indicate different conditions

- vi. Report unexplained changes in pupil assessment findings, keeping in mind role of medications and other extraneous influences
 - vii. Assess cranial nerves
- G. Gastrointestinal assessment
 - 1. Inspection
 - a. Perform general overview of oral mucosa and abdominal areas for general information about gastrointestinal system.
 - b. Unusual findings should be reported and may include:
 - i. Dry mucous membranes (dehydration)
 - ii. Large abdomen (ascites, organ swelling)
 - iii. Visible hernias or masses
 - iv. Bruising
 - v. Stools that have a foul odor, dark color, contain blood
 - 2. Auscultation
 - a. Auscultation of abdomen occurs before its palpation or percussion
 - b. Bowel sounds should be present in all four quadrants
 - i. May be hypoactive or hyperactive in various disease states
 - ii. Vary greatly with some clinical conditions (an ileus)
 - 3. Percussion
 - a. Establishes size and location of liver and (sometimes) spleen
 - b. May determine hepatomegaly
 - c. Percuss upward on midclavicular line from level of umbilicus to percuss liver
 - 4. Palpation
 - a. Used to document:
 - i. Tenderness (with simple palpation)
 - ii. Rebound tenderness (pain as pressure of palpation removed)
 - b. Rebound tenderness suggests peritoneal inflammation.
 - c. Follow cautions if pelvic fracture suspected
 - d. Murphy's sign noted with severe right upper quadrant pain on deep palpation, often exacerbated by deep inspiration and associated with cholecystitis
 - i. Performed by applying firm pressure to abdominal wall
 - ii. Nodules of liver may be related to malignancy
 - e. Spleen generally not palpable
 - f. Right kidney may be palpated, but not of much clinical value
 - i. Never palpate if patient has history of polycystic kidney disease
- H. Genitourinary assessment
 - 1. Includes mammary, testicular, and prostate glands
 - a. Limited to patients with specific needs
 - i. Spinal cord injuries, trauma
 - 2. Proper kidney function vital because kidneys excrete majority of toxins from body
 - a. Serum creatinine level best indicator
 - i. Higher creatinine level indicates nephron destruction
 - b. BUN value indicates level of hydration
 - i. BUN-creatinine ratio helps determine whether patient has renal failure
 - 3. Renal insufficiency or renal failure usually secondary diagnosis in critical care
 - a. Signs of metabolic acidosis, congestive heart failure, electrolyte imbalances, anemia
 - b. Monitor:
 - i. Lab values
 - ii. Levels of arterial blood gases
 - iii. Fluid intake

- iv. Urine output
- 4. Patients with burn and crush injuries especially prone to renal failure
 - a. Release of large protein molecules from damaged tissue destroys nephrons
 - i. Patients often require large amounts of fluid to flush molecules through kidney
- 5. Patients in end-stage renal disease may require peritoneal dialysis (PD) or hemodialysis
 - a. PD: catheter placed in peritoneum
 - i. Risk of peritonitis, use aseptic technique
 - b. Hemodialysis: AV shunt in arms attached to machine (mechanical kidney)
 - i. Assess site for a thrill (palpable) and a bruit (audible) which indicate patent and normally functioning shunt
 - ii. AV sites should be used only for hemodialysis
 - iii. Lines typically heparin locked at the completion of treatments; flush prior to aspiration of significant amount of waste
- I. Musculoskeletal assessment
 - 1. CCTP's main concern maintaining stability of joints and assessing for neurovascular compromise of distal extremities
 - a. Often secondary diagnosis for critical care patient
 - i. Multisystem trauma
 - 2. Maintain stability of joint with variety of splints or soft and hard casts
 - a. Anatomic degree of flexion or extension found at rest, or as ordered by physician
 - b. Assess routinely for neurologic changes, vascular compromise related to the immobilizing device:
 - i. Complete bilaterally
 - ii. Include assessment of distal skin color, nail bed color, skin temperature, mobility of distal joints, pulses, pain, sensation
- J. Psychosocial and emotional assessment
 - 1. Complete psychosocial, emotional, cultural needs assessment has likely been completed on patient hospitalized for more than 24 hours
 - a. Transfer information with patient
 - 2. Pertinent aspects relative to CCTPs would be:
 - a. Previously diagnosed psychiatric disorder
 - i. May manifest in unsafe behaviors requiring physical or chemical restraint during transport
 - b. Significant coping needs related to present illness
 - i. May interfere with adequate analgesia and/or require administration of anxiolytics or benzodiazepines
 - c. Level of anxiety
 - i. May interfere with adequate analgesia and/or require administration of anxiolytics or benzodiazepines
 - 3. Remember therapeutic value of compassionate and empathetic interactions with a patient, even in the face of critical illness
 - a. Handle patients gently, explain care, hold hands

V. Communication and Documentation

Time: 3 Minutes

Slides: 58–59

Lecture/Discussion

- A. Documentation of assessment findings
 - 1. Should occur:
 - a. When patient is first encountered
 - b. Routinely as patient condition warrants
 - c. Upon arrival at destination
 - 2. Prudent CCTPs provide for:
 - a. Continuity of care
 - b. Patient safety
 - c. Protection from potential legal issues
- B. Communication should be ongoing with the transferring hospital, which is responsible for care of the patient until arrival at the receiving hospital.
 - 1. CCTPs should:
 - a. Call in changes immediately
 - b. Obtain and implement orders
 - c. Assess and document patient response(s)
 - d. Alert receiving hospital of events occurring en route so they are prepared to receive patient