

Rapid Patient Assessment Exercise

Students are used to having one 30-minute lab station and then moving onto the next. These are often larger groups where some students can sit back and coast. This lab exercise gets everyone into the mix and provides a fast paced and exciting way to highlight assessment skills.

Instead of being in larger groups, students are paired in teams of two (or three in larger classes). They will see a series of patients with time limits (about 5 minutes) where they will perform a history and physical examination. Their assignment will be to do a thorough assessment and come up with a presumptive differential diagnosis and treatment plan on each patient.

Set the patients up in different rooms. Choose “patients” who will be clinically knowledgeable such as adjunct faculty/lab staff, paramedic students, your medical director, or others. Choose patients from the list below based on the number of patients and adjunct faculty members available and the number of students going through the rooms. One person should serve as the timer and assure groups rotate on schedule and in the proper direction.

Each group should have a first-in bag with assessment equipment including vital signs equipment (stethoscope, BP cuff, Pulse Ox, BG monitor, etc.).

The patient presentations (multiple patients in each):

Chest pain – ideally this patient will be of an age that an MI would be possible. The purpose of this station is to expect students to look at multiple causes of chest pain and discomfort. This patient may present with different conditions for different groups so students can’t compare notes.

- **Myocardial infarction (ACS)** – sudden onset, heaviness, onset during activity, patient has risk factors (smoking, diabetes, weight, etc)
- **Pneumonia** – pleuritic pain, cough, malaise
- **Spontaneous pneumothorax** – pleuritic pain, sudden onset, occurred during strenuous activity, diminished lung sound unilaterally in lung apex

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Abdominal Pain - this is a clinical challenge for even an experienced provider so some clear-cut cases may be reasonable here.

- **Appendicitis** – usually a patient in the 2nd or 3rd decades of life. Pain around the umbilicus. No appetite for 2 days. Vomiting earlier.
- **Ectopic pregnancy** – lower unilateral abdominopelvic pain. Missed menstrual cycle.
- **Cholecystitis** – after fatty meal, URQ pain that radiates to the back/shoulder. Significant pain. Trouble sitting still.

Respiratory distress – these are common complaints and things an EMT can differentiate.

- **Asthma attack** – inhaler ran out or lost. Create a situation involving a trigger (exercise, infection). Wheeze present upon auscultation.
- **Pulmonary embolus** – patient has a sudden onset of breathing difficulty with a history of prolonged travel or recent cast on leg (don't volunteer this information).
- **Spontaneous pneumothorax** – patient exercising and develops a sudden onset of unilateral pleuritic chest pain. Proper auscultation will reveal a small area with reduced breath sounds in the lung apex that correlates with the pain.

Altered mental status – The toolbox for the EMT is big with this complaint. Can your students choose the correct treatment? You might not be able to do them all but you have choices!

- **Opioid overdose** – a simulation manikin would be great here. Set the manikin to have slow respiration, low tidal volume, and constricted pupils.
- **Hypoglycemia** – sudden onset and moist skin are big signs here.
- **Sepsis** – altered mental status is one of the first findings in sepsis. Fast respiratory rates and a recent history of respiratory infection or urinary tract infection sets this up well.
- **Stroke** – Choose this scenario if you have a patient of an age group where a stroke is more likely. Signs and symptoms may be vague—and don't forget the possibility of a posterior circulation stroke.
- **Seizure** – EMS often arrives after a seizure has ended. This means having the patient in a post-ictal state gradually coming around is very realistic. The patient may have some blood around their mouth from biting the tongue or lip. You can simulate urinary incontinence by wetting the patient's pants with water.