**Scenario Skills Evaluation-**

The key to a good scenario is knowing you are not seeing everything. As realistic as some simulations and scenarios are, we cannot simulate everything. You must say everything you are thinking and doing. Every step of the way, ask: **“What Do I SEE?”.** Then do the things you would normally do on a call.

The Evaluator will give you the scenario information and rules. When you begin, acknowledge the information they gave you by repeating it (write it down, see the quick form below). Explain you response to the scene. When you arrive on scene, ask **“What Do I SEE?”.** The evaluator will explain the scene. This will be your opportunity to determine any safety issues. If it is not stated, then it is not part of the scenario. You can either mitigate the thread to you and your crew’s safety, or “based on what I see, there are no immediate safety issues, so we will proceed forward”. DO NOT STATE, “BSI, SCENE IS SAFE”.

When you enter the location of the patient, ask, **“What Do I SEE?”.** This may help indicate what the nature of the call or the mechanism of injury is. Introduce yourself. Interact with the patient, family, and / or bystanders. We always operate under providing care to the patient +1. The +1 idea is that there is always someone other than your patient that is involved, whether it be family, friends, other 1st responders, crime perpetrators, etc… Patients are very seldom alone. Give the evaluator your 1st impression of the patient based on how the patient looks. Are they sick (emergent) or not-sick (urgent or non-urgent)? Assess your ABC’s. We use and alphabetical mnemonic to help remember all of the things to do (see the form).

**A**- Airway, **B**-Breathing, **C**- Circulation, **D**- Disability, **E**-Exposure. These you are probably pretty familiar with. **F**- Figure it out… These is our differential diagnosis, or the things we think could be wrong with the patient. We figure it out by assessing the patient and ruling things in or out based on our assessment findings. An example of this might be a patient complaining of Chest Pain, but no injury. My F might include: Heart Attack, Angina, Pulmonary embolism, and Pneumonia.

Here is where we make our **transport decision**. Do you have time to treat on scene, or are they emergent and we need to get going and treat enroute to the hospital? Which hospital are they going to? Do they need specialty treatment? How are we getting them there, ground vs. air?

Now we go to **G**: Get vital signs and diagnostics. In the primary assessment you just wanted to know if they were breathing too fast, or too slow, or normal, or if their pulse was too fast, too slow, bounding, thready, or normal. Now you actually want to put numbers to it. Vital signs should include: Blood pressure, Pulse, Respiratory Rate, Pulse oximeter, and Temperature. Other diagnostics might include a finger stick blood glucose, 12 Lead EKG, end tidal CO2, etc.

**H**: History and Head-to-Toe. Gather your history. What is the story behind your interaction? You can use the SAMPLE mnemonic (Signs and symptoms, Allergies, Medications, Past Medical History, Lasts (intake, void, bowel movement, menses), Events leading up to the 911 call), as well as qualify symptoms with OPQRST (onset, provokes/palliates, quality, radiates, severity 0-10, timing). The head-to-toe is you physical exam of the patient. Do a complete exam and don’t miss anything!

**I:** interventions- Our history guides our physical assessment, meaning based on our complaints, we should have a high index of suspicion of what we will find and where to look during our physical exam. Based on these findings and in the process of ruling out the things it could be (differential diagnosis), we develop our treatment plan and begin treating (if we haven’t already).

With every intervention we do, we need to **reassess** the effectiveness of our treatment. Is the patient getting better, worse, or staying the same? Not only should this include a repeat set of vital signs, but also a quick repeat of the physical exam pertinent (ie: if you gave a breathing treatment, reassess the lungs).

The last step is to make a **disposition**. This is the exchange with another healthcare provider. The hand off is the most dangerous time for a patient. The report needs to be quick, concise, and include the relevant findings and treatments.

Once you exchange care to another provider, you are done.

Disinfect, Document, Resupply.

**“WHAT DO I SEE?”**

**Dispatch Info: Time:**

**Scene Size-up:
CC: 1st imp: SICK v Not Sick**

**Primary (Life Threats): Bleeding? Stop it!**

 ***A***irway: Open, Assess, Suction, Secure

 ***B***reathing: Oxygen, Assist

 ***C***irculatory: Pulses fast, slow

 ***D***isabilities: What is the mentation?

 ***E***xpose: Expose for injuries, protect from exposures heat/cold

***Consider Transport Decision Now***

**Secondary:**

***F*: Figure it out: Differential: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diagnoses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***G***et Vitals & Diagnostics**: BP \_\_\_\_\_\_\_\_P\_\_\_\_\_R\_\_\_\_ SPO2\_\_\_\_ T\_\_\_\_\_**

 **ETCO2\_\_\_\_\_FSG\_\_\_\_\_\_ 12 Lead \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***H:* Hx: Head to Toe**

 **S O HEENT:**

 **A P Chest:**

 **M Q Abd:**

 **P R Back**

 **L S Groin**

 **E T Extremities**

***I*nterventions:**

**Reassess: Dispo:\_\_\_\_\_\_\_**