FINAL PROFICIENCY EXAM RETEST

SCENARIO ONE
You are called to a private residence to evaluate a 65 year old male patient – "sick call".

SCENE SAFETY: Secure
GENERAL IMPRESSION: The pt is sitting upright, looking tired.
LOC: Alert and oriented to P,P,T, and E.
CHIEF COMPLAINT: "I feel so weak, and my chest feels a little heavy."
AIRWAY: Open
BREATHING: Normal rate – a little shallow
CIRCULATION: Radial pulses are present. but are weak and slow. Capillary refill is <2 seconds. Skin is pale, cool and a little moist.
HEAD, FACE, NECK: Neck veins visible but not distended. Pupils at 3 and reactive.
CHEST: Equal rise and fall of the chest with breathing. No accessory muscle use. Heart tones normal – S1 and S2 noted. Breath sounds clear and equal bilaterally.
ABDOMEN: No pulsating masses or other.
PELVIS: Normal.
LEGS: No pedal edema.
UPPER EXTREMITIES: Equal pulses. No edema.
BACK: Breath sounds clear and equal bilaterally.
GCS: 15

VITAL SIGNS: BP: 104/70, P: approximately 45 and weak, R 24 and shallow. O2 sat 92% . ECG **2nd degree Mobitz II.**
SAMPLE: Pt says he has no allergies, takes Lopid, Apresoline 50 mg qid, and Lasix 20 mg once daily. He has a hx of hypertension and high cholesterol. He ate about an hour ago and was teaching class when he was suddenly overcome with weakness.
(Critical interventions include O2 via NRB, IV therapy.)

(En route to hospital, pt will become lethargic.)
LOC/GCS: Responsive to loud verbal with inappropriate sounds and words/11
AIRWAY: Open
BREATHING: Is breathing at slower rate of about 14, regular but shallow
CIRCULATION: No radial pulse present, weak brachial is present – slow. Skin is cool and clammy.
VITAL SIGNS: BP 80/42, P 30, R 14
(Critical interventions – atropine and pacing. Pacing will capture. If variance from algorhythm, pt will deteriorate to asystole.)

REASSESSMENT: On reassessment, pt will be more responsive after capture. BP coming up, P rate to rate on pacer, R up.

GOALS: Immediate application of O2 early in ABC's.
IV line.
Recognition of bradycardia requiring no intervention at first.
Immediate recognition of deterioration requiring intervention with Atropine and pacing.

SCENARIO TWO
You are called to Hwy 69 N near Tyler Pipe on an "auto-pedestrian" call.

SCENE SAFETY: Cars are attempting to bypass the scene on either side.
GENERAL IMPRESSION: The patient appears to be conscious on approach with no major blood loss noted around patient.
LOC: He is awake, alert, and extremely anxious.
CHIEF COMPLAINT: Pain in the right chest and hip.
AIRWAY: Open
BREATHING: Slightly labored and rapid respirations
CIRCULATION: Radial pulses are present but are weak and rapid. Capillary refill is >2 seconds. Skin is pale but dry.
HEAD, FACE, NECK: Some mild road rash but no other obvious trauma. Trachea midline. Neck veins visible but not distended.
CHEST: Bruising and abrasions on the right lateral thorax with multiple areas of point tenderness. The right side is somewhat hyperresonant to percussion. The patient seems to be having difficulty breathing deeply due to pain, so you have trouble hearing breath sounds.
ABDOMEN: Bruising and abrasions with tenderness on the right lateral side of the belly – no distention.
PELVIS: Bruising and abrasions on the right side with severe pain on palpation and instability of that side.
LEGS: Road rash noted mostly on right leg but no obvious bleeding or deformities. +PMS.
UPPER EXTREMITIES: Road rash on right arm with no deformity. +PMS.
BACK: Spine clear of deformity of tenderness. Bruising and tenderness on lateral right wall.
GCS: 15

During loading patient to board and to truck, the patient suddenly shouts, "Gotta pee!" and passes a large amount of grossly bloody urine.

VITAL SIGNS: BP: 90/60, P: 130 and weak, R 36 and shallow but labored. O2 sat 87% . ECG Sinus tach.

SAMPLE: Patient denies allergies or any significant past medical history. He can't remember the last time he ate.
LOC/GCS: Seems to be more confused and is becoming combative.
AIRWAY: Still open
BREATHING: Respiratory distress seems to be worsening**.** O2 sat now 78%.
CIRCULATION: Radial pulses have disappeared, no brachial or femoral, carotid is weak and faster than before. Skin is pale and moist.
HEAD, FACE, NECK: Pupils are dilated to a 7 and sluggishly responsive. Neck veins are becoming distended.
CHEST: The left side of the chest seems to be inflating better than the right. Breath sounds seem to be harder to hear on the right.
(Critical intervention of chest decompression MUST be performed at this point prior to proceeding further.)
REASSESSMENT: Patient's condition will improve if high flow O2, decompression performed, IV's established with appropriate fluid, MAST.
If above is not done, patient's condition to deteriorate requiring intubation, etc.

GOALS: Recognition of unsafe scene and securing scene and or patient to safety.
Immediate application of O2 early in ABC's.
Full spinal restriction procedures.
Recognition of need to transport to Trauma Center and off scene with only necessary interventions.
Recognition of need for needle chest decompression.
Establish 2 large bore IV's and run wide open up to 4 L.