SCENARIO FORM
Trauma #1
Slip and fall/ Simple fracture

Student Name_____ Date_____

Examiner Name_____ Examiner Signature_____

Dispatch/Background Information: You are an EMT on a dual BLS unit working in a system that does not dispatch fire to medical complaints. At 0630 hours you are dispatched Code 3 to an independent living facility for a 68-year old female who fell. As you arrive on scene you are met by a facility staff member who leads you to the patient's room. You find an elderly female sitting on her bathroom floor, holding her knee. She states that she slipped and fell, hitting her knee, as she was using the restroom. She denies hitting her head or losing consciousness.

Yes "x"	***SCENE SIZE UP***	
	Personal Protective Equipment	Safety glasses, gloves
	Environmental Safety/Considerations	Small well-kept studio apartment
	Number of Patients	1
	Mechanism of injury/Nature of Illness	Slipped on rug/ right knee pain
	Additional Resources	No base contact, no cell phone coverage. No fire.
	Need For C-Spine	Denies head/neck pain. Denies hitting head. No LOC. CSM intact x 4
	PRIMARY SURVEY	
	General Impression (CBC)	Patient appears to be in pain, but no obvious life threats at this time
	AVPU	Spontaneously alert and tracking you as you approach
	Alert and oriented x ___	4
	a. Person	Yes, oriented
	b. Place	Yes, oriented
	c. Time	Yes, oriented
	d. Event	Yes, oriented
	Chief Complaint/Life-threats	Slip and fall
	Airway (Assess & Manage)	Open, no obstruction
	Breathing (Assess & Manage)	Regular, non-labored
	a. Lung sounds	Clear and equal bilaterally
	b. Work of breathing	Non-labored. Negative for accessory muscle use, intercostal retractions, tripoding, and pursed lipped breathing
	Circulation (Assess & Manage)	----------
	a. radial pulse -rate & quality	Present and regular bilaterally
	b. skin signs	Pink, warm, dry
	c. capillary refill	<2 seconds
	Neurological exam	CSM intact x4
	Identifies priority patients and makes transport decision	Stable patient, Code 2.
	HISTORY TAKING	
	Signs & Symptoms	
	Allergies	PCN
	Medications	alendronate, metoprolol, buproprion, ASA, ducosate sodium
	Pertinent Past history	Osteoporosis, depression, HTN
	Last Meal	Dinner last night. Soup, Salmon, Night time tea
	Events	Slipped on bathroom mat, hit knee to tile
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	Onset	Slip and fall in bathroom
	Provokes/Palliates	Trying to stand/ not moving
	Quality	Sharp
	Radiation	Down leg

	Severity	10/10
	Time	2 hours PTA
	Targeted History (Pulmonary, Cardiac, Neurological, OB/GYN, GI/GU, Musculoskeletal, Integumentary, Psychological/Social, etc…	Taking any blood thinners? Any previous knee injury/surgery/knee replacement/metal plate? Osteoporosis hx? Did she experience CP/SOB/DZ/N/V/or LOC prior to fall? Was she attempting a bowel movement prior to fall?

	SECONDARY ASSESSMENT	
	Assess affected body part/system or if indicated performs rapid assessment.	Musculoskeletal
	Skin	Pink, warm, dry
	Head	Atraumatic. No deformities, depressions, crepitus.
	ENT	Ears and nose negative for CSF/blood, mucous membranes moist, teeth intact, no oral trauma.
	Neck	Negative for: cervical spine tenderness, step off, and restriction to movement, JVD, tracheal deviation, accessory muscle use.
	Chest	Equal bilateral chest rise. Negative for: intercostal retractions, accessory muscle use, urticarial, scars, pacemaker, and bruising.
	Respiratory	Regular and non-labored.
	Cardiovascular	Good skin sign and cap refill.
	Abdomen/GI/GU	Soft, non-tender, all 4 quadrants. Negative for: distension, rigidity, masses, guarding, scars, breathing, G-tube, insulin pump, and ostomy bag.
	Pelvis	No Foley catheter, stable pelvis, negative urinary/fecal incontinence.
	Posterior	No bedsores, no sacral edema
	Extremities	Right knee pain, tender upon palpitation, and unable to bear weight. Swelling noted. Other extremities unremarkable.
	Psychological	Grimacing in pain. Anxious about losing freedom. Scared of going to hospital.
	VITAL SIGNS/DIAGNOSTICS	
	Pulse	90, regular
	Respirations	20, non-labored
	Blood Pressure	166/92
	Temperature	98.7
	Pupils	PERRL
	SPO2	96% on Room air
	FIELD IMPRESSION & ***DIFFERENTIAL DIAGNOSIS***	
	Field Impression	R/O right knee fx.
	Differentials	Syncope, head trauma, cervical trauma.
	TREATMENT PLAN	
	Intervention	Splint as appropriate. Position patient in position of comfort on gurney, prepare for transport
	Reassessment	Pain: 9/10 LOC: Alert, A+Ox4. Skin signs: Pink, warm, dry. BP: 160/88 RR: 22 HR: 98 SPO2: 99% on room air
	Transport Decision	Code-2, hospital of patient choice.
	REASSESSMENT	
	Repeats Primary Survey	Same as above
	Repeats Vital Signs	Same as last set
	Evaluates Response To Treatment	No change. ABC's reassessed in serial VS.

	Repeats secondary as appropriate	Same as previous findings

POST SCENARIO DEBRIEF:

Provide me with a hospital turn over report.

What is your field impression? Give me your rationale.

Give me three differential diagnoses you considered?

List your interventions. Why do they work in this particular setting?