

Patient Assessment

MFR/EMT/SPECIALIST/PARAMEDIC

Scene Size Up

1. Recognize environmental hazards to rescuers, and secure area for treatment.
2. Recognize hazard for patient, and protect from further injury.
3. Identify number of patients. Initiate a MCI/disaster plan if appropriate.
4. Observe position of patient, mechanism of injury, surroundings.
5. Identify self.
6. Utilize universal precautions in all protocols.
7. Determine if patient has a valid Do-not-resuscitate bracelet/order.

Primary Survey

1. Airway:
 - a. Protect spine from movement in trauma victims. Provide continuous spinal stabilization.
 - b. Observe the mouth and upper airway for air movement.
 - c. Establish and maintain the airway.
 - d. Look for evidence of upper airway problems such as vomitus, bleeding, facial trauma, absent gag reflex.
 - e. Clear upper airway of mechanical obstruction as needed.
2. Breathing: Look, Listen and Feel
 - a. Note respiratory rate, noise, and effort.
 - b. Treat respiratory distress or arrest with oxygenation and ventilation.
 - c. Observe skin color and mentation for signs of hypoxia.
 - d. Expose chest and observe chest wall movement, as appropriate.
 - e. Look for life-threatening respiratory problems and stabilize:
 - i. Open or sucking chest wound: 3-sided seal or similar.
 - ii. Large flail segment: stabilize.

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- iii. Tension pneumothorax: transport promptly and consider pleural decompression.

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3. Circulation
 - a. Check pulse and begin CPR if no central pulse.
 - b. Note pulse quality and rate; compare distal to central pulses as appropriate.
 - c. Control hemorrhage by direct pressure. (If needed, use elevation, pressure points.)
 - d. Check capillary refill time in fingertips.
 - e. If evidence of shock or hypovolemia begin treatment according to shock protocols.
4. Level of consciousness:
 - a. Note mental status (AVPU)
 - i. Alert
 - ii. Verbal stimuli response
 - iii. Painful stimuli response
 - iv. Unresponsive

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b. Measure Glasgow Coma Scale

i. Eye opening

- Spontaneous 4
- To speech 3
- To pain 2
- No response 1

ii. Verbal response

- Oriented and talking 5
- Disoriented and talking 4
- Inappropriate words 3
- Incomprehensible sounds 2
- No response 1

iii. Motor response

- Obeys command 6
- Localizes pain 5
- Withdraws to pain 4
- Flexion to pain 3
- Extension to pain 2
- No response 1

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The secondary survey is performed in a systematic manner.

(Steps listed are not necessarily sequential.)

1. Vital Signs:

- a. Frequent monitoring of blood pressure, pulse, and respirations
- b. Temperature as indicated in protocol.

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- c. Blood glucose measurement as available and appropriate.
- d. Pulse oximetry as available and appropriate

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- e. *EKG monitoring as indicated in protocol.

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2. Head and Face

- a. Observe and palpate for deformities, asymmetry, bleeding, tenderness, or crepitus.
- b. Recheck airway for potential obstruction: upper airway noises, dentures, bleeding, loose or avulsed teeth, vomitus, or absent gag reflex.
- c. Eyes: pupils (equal or unequal, responsiveness to light), foreign bodies, contact lenses, or raccoon eyes
- d. Ears: bleeding, discharge, or bruising behind ears

3. Neck
 - a. Maintain immobilization, if appropriate.
 - b. Check for deformity, tenderness, wounds, jugular vein distention, use of neck muscles for respiration, altered voice, and medical alert tags.
4. Chest
 - a. Observe for wounds, air leak from wounds, symmetry of chest wall movement and use of accessory muscles.
 - b. Palpate for tenderness, wounds, crepitus, or unequal rise of chest.
 - c. Auscultate for bilateral breath sounds.
5. Abdomen
 - a. Observe for wounds, bruising, distention, or pregnancy.
 - b. Palpation.
6. Pelvis
 - a. Palpate pelvis for tenderness and stability
7. Extremities
 - a. Observe for deformity, wounds, open fractures, and symmetry.
 - b. Palpate for tenderness and crepitus.
 - c. Note distal pulses, skin color, and medical alert/DNR tags.
 - d. Check sensation.
 - e. Test for motor strength if no obvious fracture present.
8. Back
 - a. Observe and palpate for tenderness and wounds.

Special Considerations:

1. Trauma patient assessment may require spinal immobilization based on Spinal Injury Protocol.
- *Optional intervention (state approved local medical control protocol)
- a. Acquire 12 lead EKG without delay of patient transport.