~~1.01 PATIENT ASSESSMENT—PRIMARY SURVEY~~

Universal Patient Care

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GLOBAL ASSESSMENT/SCENE SIZE-UP

- Assess scene safety:
  - Evaluate for hazards to EMS personnel, patient, and bystanders
  - Safely remove patient from hazards prior to beginning medical care
  - Determine the number of patients and available/anticipated resources
  - Determine mechanism of injury or potential source of illness
  - Request additional resources if needed and weigh the benefits of waiting for additional resources against rapid transport to definitive care
  - Consider declaration of mass casualty incident if needed
- Use appropriate personal protective equipment (PPE):
  - Consider suspected or confirmed hazards on scene
  - Consider suspected or confirmed highly contagious infectious disease (e.g. contact [bodily fluids], droplet, airborne)
- Wear high-visibility, retro-reflective apparel when deemed appropriate (e.g. operations at night or in darkness, on or near roadways)

PRIMARY SURVEY

Airway, **B**reathing, **C**irculation (**ABC**) is cited below; although there are specific circumstances where Circulation, Airway Breathing (**CAB**) may be indicated for cardiac arrest, or life-threatening hemorrhage control then ABC (**X-ABC**) for trauma patients

AIRWAY (Assess for patency and open airway as indicated)- go to **Airway Management.** If patient is unable to maintain airway patency—open airway:

1. Head tilt/chin lift
2. Jaw thrust
3. Suction
4. Use of the appropriate airway management adjuncts and devices: oral airway, nasal airway, supraglottic airway device or endotracheal tube
5. For patients with laryngectomies or tracheostomies, remove all objects or clothing that may obstruct the opening of these devices, maintain the flow of prescribed oxygen, and reposition the head and/or neck

BREATHING

1. Evaluate rate, breath sounds, accessory muscle use, retractions, patient positioning, oxygen saturation
2. Provide supplemental oxygen as appropriate to achieve the target of 94–98% oxygen saturation (SPO2) based upon clinical presentation and assessment of ventilation (e.g., EtCO2)
3. Apnea (not breathing) – see **Airway Management**

CIRCULATION

1. Control any major external bleeding [See **General Trauma Management Guideline** and/or

Tourniquet]
2. Assess pulse
3. Evaluate perfusion by assessing skin color and temperature
4. Evaluate capillary refill

DISABILITY

1. Evaluate patient responsiveness: **AVPU** (**A**lert, **V**erbal, **P**ainful, **U**nresponsive)
2. Evaluate gross motor and sensory function in all extremities
3. Check blood glucose
4. Expose patient for exam as appropriate to complaint. Be considerate of patient modesty. Keep patient warm
5. Assessment of urgency of transport

SECONDARY SURVEY

The performance of the secondary survey should not delay transport in critical patients. See also secondary survey specific to individual complaints in other protocols. Secondary surveys should be tailored to patient presentation and chief complaint, as applicable. The following are suggested considerations for secondary survey assessment:

1. Head: pupils, ears, naso-oropharynx, skull and scalp
2. Neck: tracheal position, spinal tenderness
3. Chest: Retractions, breath sounds, chest wall tenderness, deformity, crepitus, and excursion, respiratory pattern, symmetry of chest movement with respiration
4. Abdomen/back: tenderness or bruising, abdominal distension, rebound, or guarding, spinal tenderness, crepitus, or step-offs, pelvic stability or tenderness
5. Extremities: pulses, edema, deformity/crepitus
6. Neurologic: mental status/orientation, motor/sensory
7. Evaluate for medical equipment (e.g., pacemaker/defibrillator, left ventricular assist device (LVAD), insulin pump, dialysis fistula)

Obtain **baseline full set of vital signs** and the following:

1. Pulse
2. Blood pressure
3. Respiratory rate
4. Pulse oximetry
5. EtCO2 (as indicated)
6. Blood glucose (as indicated)
7. Cardiac monitoring (as indicated)
8. Neurologic status assessment (see GCS Table below)

ADULT GLASGOW COMA SCALE		PEDIATRIC GLASGOW COMA SCALE	
Eye Opening (4)		**Eye Opening (4)**	
Spontaneous	4	Spontaneous	4
To Speech	3	To Speech	3
To Pain	2	To Pain	2
None	1	None	1
Best Motor Response (6)		**Best Motor Response (6)**	
Obeys Commands	6	Spontaneous Movement	6
Localizes Pain	5	Withdraws to Touch	5
Withdraws from Pain	4	Withdraws from Pain	4
Abnormal Flexion	3	Abnormal Flexion	3
Abnormal Extension	2	Abnormal Extension	2
None	1	None	1
Verbal Response (5)		**Verbal Response (5)**	
Oriented	5	Coos, Babbles	5
Confused	4	Irritable Cry	4
Inappropriate	3	Cries to Pain	3
Incomprehensible	2	Moans to Pain	2
None	1	None	1
Total		**Total**	

Source: *https://www.cdc.gov/masstrauma/resources/gcs.pdf*

HISTORY

- Obtain **OPQRST** history, if appropriate:
  - **O**= Onset (Sudden or gradual)
  - **P**= Provoke (What were you doing when the pain started? Does anything make it better or worse?)
  - **Q**= Quality (What does the pain feel like?)
  - **R**= Region/Radiate (Where is the pain? Does it go anywhere else?)
  - **S**= Severity (On a scale of 1-10, 10 being the worst pain you have ever had, how would you rate that pain now? How would you rate that pain at its worst or during exertion/movement?)
  - **T**= Time (When or what time did this start?)
- Obtain **SAMPLE** history:
  - **S** = Symptoms
  - **A** = Allergies: medication, environmental, and foods
  - **M**= Medications: prescription and over the counter; bring containers to ED if possible.
  - **P**= Past medical history
    - Look for medical alert tags, portable medical records, advance directives
    - Look for medical devices/implants (some common ones may be dialysis shunt, insulin pump, pacemaker, central venous access port, gastric tubes, urinary catheter)

- For females of childbearing age, inquire of potential or recent pregnancy
- **L**= Last oral intake
- **E**= Events leading up to the 9-1-1 call. In patients with syncope, seizure, altered mental status, or acute stroke, consider bringing the witness to the hospital or obtain their contact phone number to provide to ED care team

TREATMENT & INTERVENTIONS

1. EMS personnel shall initiate BLS management and then proceed with ALS management as dictated by the patient assessment and scope of practice
2. See **Airway Management**
3. Place appropriate monitoring equipment as dictated by assessment; these may include:
   - Continuous pulse oximetry
   - Cardiac rhythm monitoring
   - Waveform capnography or digital capnometry
   - Carbon monoxide assessment
4. Establish vascular access if indicated or in patients who are at risk for clinical deterioration.
5. Monitor pain scale if appropriate
6. Monitor agitation-sedation scale if appropriate
7. Reassess patient
8. Stable patients should have at least two sets of pertinent vital signs. Ideally, one set should be taken shortly before arrival at receiving facility
9. Critical patients should have pertinent vital signs frequently monitored

TRANSFER OF CARE

1. The content and quality of information provided during the transfer of patient care to another party is critical for seamless patient care and maintenance of patient safety
2. Ideally, a completed electronic or written medical record should be provided to the next caregiver at the time of transfer of care
3. If provision of the completed medical record is not possible at the time of transfer of care, a verbal report and an abbreviated written run report should be provided to the next caregiver
4. The information provided during the transfer of care should include, but is not limited to
   - Patient's full name
   - Age
   - Chief complaint
   - History of present illness/Mechanism of injury
   - Past medical history
   - Medications
   - Allergies
   - Vital signs with documented times
   - Patient assessment and interventions along with the timing of any medication or intervention and the patient's response to such interventions
5. The verbal or abbreviated written run report provided at the time of transfer of care does not take the place of or negate the requirement for the provision of a complete electronic or written

medical record of the care provided by EMS personnel

PATIENT SAFETY CONSIDERATIONS

1. Routine use of lights and sirens is not warranted
2. Even when lights and sirens are in use, always limit speeds to level that is safe for the emergency vehicle being driven and road conditions on which it is being operated
3. Be aware of legal issues and patient rights as they pertain to and impact patient care (e.g., patients with functional needs or children with special healthcare needs)
4. Be aware of potential need to adjust management based on patient age and comorbidities, including medication dosages
5. The maximum weight-based dose of medication administered to a pediatric patient should not exceed the maximum adult dose except where specifically stated in a patient care guideline
6. Base Hospital should be contacted when mandated or as needed

STANDARD AND SPECIAL CIRCUMSTANCES

STANDARD CIRCUMSTANCES:

1. EMS Personnel shall utilize good clinical judgement and consider additional resources as needed for the scenario
2. Routine Medical Care should be provided to every patient as guided by assessment of the scene and patient condition
3. When situations and/or patient conditions are not specifically addressed by a LEMSA Protocol, EMS Personnel shall utilize other pre-existing standard life support guidelines including PHTLS, ACLS, PALS and good medical judgement
4. EMS Personnel must make Base Hospital Physician contact for direct medical oversight including deviations from EMS Agency treatment protocols and/or policies

SPECIAL CIRCUMSTANCES: EMS personnel may use Special Circumstances protocols only if the indication for treatment is met (e.g. drug shortages) AND the appropriate LEMSA authority has approved its use (e.g. EMS Agency Medical Director or his/her designee)

NOTES

PEDIATRICS:

- Use a weight-based assessment tool (length-based tape or other system) to estimate patient weight and guide medication therapy
- Although the defined age varies by state, the pediatric population is generally defined as without signs of puberty, ≤ 40 kg or ≤ 14 years of age, whichever comes first or unless otherwise specified
- Consider using the pediatric assessment triangle (appearance, work of breathing, circulation) when first approaching a child to help with assessment

GERIATRICS:

- Generally defined as those patients 65+ years
- In these patients, as well as all adult patients, reduced medication dosages may apply to patients with renal disease (i.e., on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e., severe cirrhosis or end-stage liver disease)

- ~~Recognize hazards, ensure safety of scene and secure a safe area for treatment~~
- ~~Apply appropriate universal body/substance isolation precautions~~
- ~~Identify number of patients and whether additional resources are needed~~
- ~~Observe position of patient and determine chief complaint or mechanism of injury~~
- ~~Plan strategy to protect evidence at potential crime scene~~

~~The purpose of the primary survey is to identify and immediately correct life-threatening problems. A primary survey shall be performed on all patients (as defined in Policy 4040) upon contact, following determination of scene safety. Should a provider be unable to perform a Primary Survey, the circumstances shall be documented in a Patient Care Report.~~

~~GENERAL IMPRESSION:~~

- ~~Check for life threatening conditions~~
- ~~AVPU (**A**=alert, **V**=responds to verbal stimuli, **P**=responds to painful stimuli, **U**=unresponsive)~~

~~AIRWAY:~~

- ~~Ensure patent airway~~
- ~~Protect spine from unnecessary movement in patients at risk for spinal injury~~
- ~~Look and listen for evidence of upper airway problems and potential obstructions~~
- ~~Utilize any appropriate adjuncts as indicated to maintain airway~~

~~BREATHING:~~

- ~~Assess for breathing~~
- ~~Intervention for inadequate ventilation and/or oxygenation using approved adjuncts as indicated~~

~~CIRCULATION:~~

~~Check for pulse. If no pulse, begin CPR and/or defibrillate while following appropriate cardiac arrest protocols~~

- ~~Control life-threatening hemorrhage~~

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--SECONDARY SURVEY --

The secondary survey is the systematic assessment and complaint-focused relevant physical examination of the patient.

- The Primary Survey and initial treatment and stabilization of life-threatening airway, breathing and circulation difficulties
- Need for Spinal Motion Restriction
- A rapid trauma assessment (if indicated by related trauma protocol)
- Transport of the potentially unstable or critical patient
- Investigation of the chief complaint and associated complaints, signs or symptoms
- An initial set of vital signs:
  - Pulse
  - Blood pressure
  - Respiration
  - Lung sound
  - Pupils
  - Cardiac rhythm (if indicated by related protocol)
  - Pulse oximetry
  - ETCO2 if indicated
  - Blood Glucose (if indicated by related protocol)
  - Determine Glascow Coma Scale (GCS) Score:

Eye Opening	Verbal Response	Motor Response
4 = Spontaneous	5 = Oriented	6 = Obeys Commands
3 = To verbal stimuli	4 = Confused	5 = Purposeful / Localizes pain
2 = To painful stimuli	3 = Inappropriate words	4 = Withdraws to pain
1 = No Response	2 = Incomprehensible words	3 = Flexion to pain
	1 = No Response	2 = Extension to pain
		1 = No Response

USING THE GCS TO ASSESS INFANTS AND YOUNG CHILDREN:

Eye Opening	Verbal Response	Motor Response
4 = Spontaneous	5 = Smiles, oriented to sounds, follows objects, interacts	6 = Obeys Commands
3 = To verbal stimuli	4 = Cries but is consolable; inappropriate interactions	5 = Purposeful/Localizes pain
2 = To painful stimuli	3 = Inconsistently consolable, moaning	4 = Withdrawal from pain
1 = No response	2 = Inconsolable, agitated	3 = Flexion to pain
	1 = No vocal response	2 = Extension to pain
		1 = No motor response

HISTORY

- Obtain Patient History from available sources.

- ~~Allergies.~~
- ~~Medications. Past medical history relevant to chief complaint~~
- ~~Assessment questions, if appropriate:~~
    - ~~OPQRST (location, factors that increase or decrease the pain severity and a pain scale.)~~
        - ~~O= Onset (Sudden or gradual)~~
        - ~~P= Provoke (What were you doing when the pain started? Does anything make it better or worse?)~~
        - ~~Q= Quality (What does the pain feel like?)~~
        - ~~R= Region/Radiate (Where is the pain? Does it go anywhere else?)~~
        - ~~S= Severity (On a scale of 1-10, 10 being the worst pain you have ever had, how would you rate that pain now? How would you rate that pain at its worst or during exertion/movement?)~~
        - ~~T= Time (When or what time did this start?)~~
    - ~~PASTE (Used for Shortness of Breath Assessment)~~
        - ~~P= Progression (Sudden or gradual?)~~
        - ~~A= Assoc. Chest Pain (If yes, which came first?)~~
        - ~~S= Sputum (Are you coughing anything up? If yes, what color is it?)~~
        - ~~T= Time, Temp, Talkability (When or what time did this start? Have you had or do you have a fever? How many word sentences can the patient speak in?)~~
        - ~~E= Exercise tolerance (What is the patient's tolerance for exertion? Can they get up and walk without getting SOB? What is their baseline tolerance level?)~~
- ~~Mechanism of injury (as indicated by relevant protocol).~~

  ~~For focused history findings relevant to specific patient complaints, see protocols related to each chief complaint.~~

~~EXPOSE, EXAMINE & EVALUATE:~~

- ~~Minimize on scene time for trauma patients~~
- ~~All physical assessments for trauma should determine the presence or absence of **DCAP- BTLS**:~~
    - ~~**D**eformity~~
    - ~~**C**ontusion/Crepitus~~
    - ~~**A**brasion~~
    - ~~**P**uncture~~
    - ~~**B**ruising/Bleeding~~
    - ~~**T**enderness~~
    - ~~**L**aceration~~
    - ~~**S**welling~~
- ~~In situations with suspected life threatening trauma mechanism, a rapid trauma~~

~~assessment should be performed:~~

- ~~Expose head, trunk, and extremities.~~
- ~~Rapid Trauma Assessment looking for and treating life threatening injuries.~~
- ~~See relevant protocols for Head, Neck, Facial, Chest, Abdominal, Pelvis, and Extremity.~~

- ~~Treat any newly discovered life threatening wounds~~