

*Michigan*  
**General Procedures**  
PATIENT ASSESSMENT

Date: May 31, 2012

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***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. Follow the **Mass Casualty Incident Protocol** 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 precautions. Follow the **Spinal Injury Assessment Protocol**.
  - B. Observe the mouth and upper airway for air movement.
  - C. Establish and maintain the airway. Follow the **Emergency Airway Procedure**.
  - 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 level of consciousness for signs of hypoxia.
  - D. Expose chest and observe chest wall movement, as appropriate.
  - E. Look for life-threatening respiratory problems and stabilize:

**PARAMEDIC**

- F. Tension pneumothorax: Follow **Pleural Decompression Procedure**.

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3. Circulation
  - A. Check pulse and begin CPR if no central pulse. Follow **Adult or Pediatric Cardiac Arrest – General Protocols**.
  - 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 or follow the **Tourniquet Application Procedure**.)
  - D. Check capillary refill time in fingertips.
  - E. If evidence of shock or hypovolemia begin treatment according to **Shock Protocol**.
4. Level of consciousness:
  - A. Note mental status (AVPU)
    - a. Alert
    - b. Verbal stimuli response
    - c. Painful stimuli response
    - d. Unresponsive

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**B. Measure Glasgow Coma Scale**

<u>Patient age &gt; 2 years old</u>		<b>Eye opening</b>	<u>Patient age &lt; 2 years old</u>	
● Spontaneous	4		● Spontaneous	
● To speech	3		● To speech	
● To pain	2		● To Pain	
● No response	1		● No Response	
		<b>Verbal response</b>		
● Oriented and talking	5		● Smiles, recognizes sounds, follows objects, interacts	
● Disoriented and talking	4		● Cries, consolable, inappropriate interactions	
● Inappropriate words	3		● Inconsistently inconsolable, moaning	
● Incomprehensible sounds	2		● Agitated, restless, inconsolable	
● No response	1		● No response	
		<b>Motor response</b>		
● Obeys command	6		● Spontaneous movement	
● Localizes pain	5		● Withdraws from touch	
● Withdraws to pain	4		● Withdraws from pain	
● Flexion to pain	3		● Abnormal flexion to pain (decorticate posturing)	
● Extension to pain	2		● Abnormal extension to pain (decerebrate posturing)	
● No response	1		● No response	

Any combined score of less than eight represents a significant risk of mortality.

If the patient is not alert and the cause is not immediately known, consider:

- |                     |                          |                          |
|---------------------|--------------------------|--------------------------|
| <b>A</b> – Alcohol  | <b>T</b> – Trauma        | <b>C</b> – Cardiac       |
| <b>E</b> – Epilepsy | <b>I</b> – Ingestion     | <b>H</b> – Hypoxia       |
| <b>I</b> – Insulin  | <b>P</b> – Psych         | <b>E</b> – Environmental |
| <b>O</b> – Overdose | <b>P</b> – Phenothiazine | <b>S</b> – Stroke        |
| <b>U</b> – Uremia   | <b>S</b> – Salicylates   | <b>S</b> – Sepsis        |

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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.

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- D. Pulse oximetry as available and appropriate.

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- E. ECG monitoring as indicated in protocol.
- F. 12 Lead if available and appropriate, follow **12 Lead ECG Procedure**.

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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 stabilization; follow the **Spinal Injury Assessment Protocol**, if appropriate.
- B. Check for deformity, tenderness, wounds, jugular vein distention, and 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.
- D. Capnography/capnometry if available and appropriate

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.

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- 8. Back
  - A. Observe and palpate for tenderness and wounds.

**Special Considerations:**

- 1. If there is a specific mechanism of injury with only localized injury, a focused exam may be performed in lieu of the full patient survey provided the patient is alert.
- 2. Follow the appropriate assessment protocol:
  - A. General Pre-hospital Care**
  - B. Pediatric Assessment and Treatment**
  - C. Newborn Assessment, Treatment and Resuscitation**
  - D. Cardiac Arrest – General Protocol**
  - E. Pediatric Cardiac Arrest – General Protocol**
  - F. Adult Trauma**
  - G. Spinal Injury Assessment**