

Patient Assessment System

Start

Scene Size Up - Slow down to hurry up!

- Safety – for you and your partners
- MOI; is there an MOI for spine?
- # of patients
- Glove up
- Initial Impression

Initial Assessment - Stop & Fix

1. Obtain Consent
2. **Airway** – if patient is talking you can assume they have an airway
3. **Breathing**
 - If talking you know they are breathing, BUT – is breathing labored? Are they gasping?
 - If not responding – Look, Listen & Feel
 - If no breathing, start rescue breaths
 - If breathing is labored consider other conditions – anaphylaxis, asthma, respiratory stress
4. **Circulation**
 - Check for a pulse at the wrist
 - Major bleeding – blood sweep
5. **Decision** – Should I maintain spinal precautions?
 - Yes if: did not witness entire incident, unconscious, significant MOI, head injury
 - No if: suffered minor accident – stumbled, stung by a bee, etc...
6. **Environment/Expose:** Protect your patient from the environment & expose serious injuries.

Focused Exam & Patient History

Complete all steps, regardless of type of condition, but use the order outlined here.

<p>Trauma? Start Here:</p> <p>Head to Toe Exam</p> <p>Palpate for DOTS Visually look for bruising & deformity Examine Systematically:</p> <ul style="list-style-type: none"> • Head • Neck: trachea, midline • Chest: clavicles, sternum, ribs • Abdomen – 4 quadrants • Pelvis • Lumbar region • Lower extremities (CSM's) • Upper extremities (CSM's) • Back – logroll patient if possible spine issue <p>*CSM's - Circulation, Sensation & Movement Complete? Go to Vitals & SAMPLE</p>	<p>Vital Signs</p> <ul style="list-style-type: none"> • Time • LOC's • Heart Rate (HR) • Respiration Rate (RR) • Pupils • Skin (SCTM) <p><i>You will give urgent treatment during this step.</i></p>	<p>Medical/Illness? Start Here:</p> <p>SAMPLE History</p> <p>S: Signs & Symptoms (OPQRST) O: Onset (<i>gradual, etc</i>) P: Provokes; Palliates Q: Quality (<i>sharp, dull</i>) R: Radiates; Refer S: Severity (<i>1 - 10</i>) T: Time</p> <p>A: Allergies M: Medications (OTC's, Prescription, Herbal) P: Past Pertinent Medical History L: Last Intake/Output E: Events Leading up to Incident</p> <p>Complete? Go to Head to Toe & Vitals</p>
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Focused Spinal Assessment

- Only if >1 hour from definitive care
- A+0x3 or x4
- No distracting injuries
- No alcohol/drugs: recreational, OTC's, prescription
- Normal CSM (unless explainable) in all extremities
- No spinal pain or tenderness
- You must be able to answer "Yes" to all the above in order to release spinal precautions. If the patient answers yes to all questions, you may then make a decision to release or not release spinal precautions.

If you need to continue to hold spinal precautions, you will need to think about the following:

- long term manual stabilization
- evacuation - will need a rigid litter
- prep for a long wait

MOI for spine/Currently Holding spinal precautions

Yes No

Answered "Yes" to All Questions. You **May** Release Precautions

Answered "No" to One or more Questions. Continue spinal precautions

Problem List

Anticipate what problems are going to arise during the time that you are with the patient.

Plan

Plan for: Problems on list; what type of treatment; self-evacuation, staying put, rescue.

Implement Plan

Implement the plan you created. Begin non-urgent treatment. Continue to reassess your patient. Patient vitals: every 15 min. if stable, every 5 min. for unstable. Continue to monitor, reassess and document (SOAP)!