

## 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.

##### Trauma? Start Here:

##### Head to Toe Exam

- Palpate for DOTS  
Visually look for bruising & deformity  
Examine Systematically:
- 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
- \*CSM's - Circulation, Sensation & Movement  
**Complete? Go to Vitals & SAMPLE**

##### Vital Signs

- Time
- LOC's
- Heart Rate (HR)
- Respiration Rate (RR)
- Pupils
- Skin (SCTM)

You will give urgent treatment during this step.

##### Medical/Illness? Start Here:

##### SAMPLE History

- S: Signs & Symptoms (OPQRST)  
O: Onset (*gradual*, etc)  
P: Provokes; Palliates  
Q: Quality (*sharp*, dull)  
R: Radiates; Refer  
S: Severity (1 - 10)  
T: Time  
A: Allergies  
M: Medications (OTC's, Prescription, Herbal)  
P: Past Pertinent Medical History  
L: Last Intake/Output  
E: Events Leading up to Incident  
**Complete? Go to Head to Toe & Vitals**

#### Focused Spinal Assessment

- Only if >1 hour from definitive care
  - A+Ox3 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)!