Patient Assessment

Size up the Scene

- Determine number of patients
- Immediate danger to rescuer?
- Immediate danger to patient?
- Immediate danger to bystanders?
- Determine mechanism of injury (MOI)

Establish Body Substance Isolation (BSI) – Latex Gloves

Initial Assessment: Stop and Fix (immediate threats to life) survey

1. Identify Self & level of training. Get consent.
2. Establish Responsiveness and C-spine control.
3. **A**irway management:
    a. Look in mouth, clear obstructions.
    b. Ask patient to stick out tongue.
4. **B**reathing adequacy: Look, listen, feel.
5. **C**irculation:
    a. Check pulse
    b. Check for bleeding; control major bleeding.
6. **D**isability: Maintain manual stabilization of spine.
7. **E**nvironment/**E**xpose: Assess and treat environmental Hazards.

Patient Exam:

Head: check for skull irregularities, fluids from nose or ears
Neck: check C-spine, trachea, MEDIC alert tag?
Shoulders: compress
Chest: compress at armpits, midchest, abdomen – Breathe deep; press sternum – Breathe deep
Abdomen: press four quadrants around belly button
Pelvis: press from sides and top
Legs: check w/equal pressure down leg
Feet: **C**irculation – check color
Sensitivity – sensation in toes, ID one being squeezed
Motion – press/pull against resistance
Arms: check w/equal pressure along arm
Check **CSM** (as for feet)
Back: Roll and check spine

Vital Signs: (& change with time)

Level of Consciousness: Alert & Oriented (1-4):name, where, time, vent/ Verbal/ Pain/ Unresponsive
Heart: Rate (50-100), Rhythm (regular/irregular), and Quality (weak/strong/bounding)
Breathing: Rate (16-20), Rhythm (reg/irreg), and Quality (shallow/labored/easy)
Skin: Color, Temperature, Moisture

Patient History:

Chief Complaint
Mechanism of Injury (MOI)/History of Present Illness (HPI)
***S**ymptoms:*
Pain: Onset; Palliates/Provokes; Quality; Radiates; Severity; Time
***A**llergies:* food, medication; Reactions
***M**edications:* taking any prescr/OTC/recreational drugs
***P**ast relevant medical history:* happened to you before, to anyone in your family
***L**ast oral intake:* last food and liquids taken; time urinated/bowel movements – problems Alcohol?
***E**vents preceding incident or illness*

***Backcountry* Spinal Clearing Guidelines** (after full patient exam is completed)

1. Patient must be reliable: A+O x 3 or 4; sober; no distracting injuries.
2. Patient must deny spinal pain and tenderness.
3. Patient must have normal **C**irculation (unless otherwise explainable by another injury or illness), **S**ensation (no numbness, tingling or unusual hot or cold sensations), and **M**otion (unless explainable by another injury or illness) in all extremities.

Complete Patient Care & SOAP note; EVAC decision

MONITOR continually