

# WEST MICHIGAN REGIONAL PROTOCOL

## PATIENT ASSESSMENT PROTOCOL

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**Purpose:** To provide for the process of primary and secondary patient assessment.

**MB S P**

### I. Preliminary Considerations

- A. Recognize environmental hazards to rescuers and secure area for treatment.
- B. Recognize hazards for patient and protect from further injury.
- C. Identify the number of patients and initiate the MCI/disaster plan if appropriate.
- D. Observe position of patient, mechanism of injury, surroundings.
- E. Identify self.

### II. Primary Survey

#### A. Airway:

1. Protect spine from movement in trauma victims. Provide continuous spinal stabilization.
2. Observe the mouth and upper airway for air movement.
3. Establish and maintain the airway.
4. Look for evidence of upper airway problems such as vomitus, bleeding, facial trauma, absent gag reflex.
5. Clear upper airway of mechanical obstruction as needed.

#### B. Breathing: Look, Listen and Feel

1. Note respiratory rate, noise, and effort.
2. Treat respiratory distress, or arrest, with oxygenation and ventilation.
3. Observe skin color and mentation for signs of hypoxia.
4. Expose chest and observe chest wall movement, as appropriate.
5. Look for life-threatening respiratory problems and stabilize:
  - a. Open or sucking chest wound: seal
  - b. Large flail segment: stabilize.
  - c. Tension pneumothorax: transport promptly and consider pleural decompression.

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#### C. Circulation:

1. Check pulse and begin CPR if no central pulse.
2. Note pulse quality and rate; compare distal to central pulses as appropriate.
3. Control hemorrhage by direct pressure. (If needed, use elevation, pressure points; tourniquet ONLY in extreme situation.)
4. Check capillary refill time in fingertips.
5. If evidence of shock or hypovolemia, begin treatment according to shock protocols.

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#### D. Responsiveness:

1. Note mental status (AVPU) (alert, responsive to verbal or painful stimuli, or unresponsive).
2. Evaluate Glasgow Coma Scale.

#### E. Determine "Load and Go" criteria for trauma patient:

1. Decreased level of consciousness
2. Difficulty in breathing
3. Absent distal pulses
4. Unstable pelvis
5. Bilateral femur fractures

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### III. The secondary survey is performed in a systematic manner.

(Steps listed are not necessarily sequential.)

#### A. Vital Signs:

1. Frequent monitoring of blood pressure, pulse, and respirations
2. Temperature, if appropriate
3. EKG monitoring as indicated
4. Blood glucose measurement as indicated
5. Pulse oximetry, as available and appropriate

#### B. Head and Face:

1. Observe and palpate for deformities, asymmetry, bleeding, tenderness, or crepitus.

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2. Recheck airway for potential obstruction: upper airway noises, dentures, bleeding, loose or avulsed teeth, vomitus, or absent gag reflex.
3. Eyes: pupils (equal or unequal, responsiveness to light), foreign bodies, contact lenses, or raccoon eyes
4. Ears: bleeding, discharge, or bruising behind ears
5. Breath: note any abnormal odor (ETOH, ketones, bitter almond, etc.)
- C. Neck:
  1. Check for deformity, tenderness, tracheal deviation, wounds, jugular vein distention, use of neck muscles for respiration, altered voice, and medical alert tags.
  2. Maintain immobilization, if appropriate.
- D. Chest:
  1. Observe for wounds, air leak from wounds, symmetry of chest wall movement and use of accessory muscles.
  2. Palpate for tenderness, wounds, fractures, crepitus, or unequal rise of chest.
  3. Auscultate for crackles (wet sounds), wheezes, or decreased breath sounds.
- E. Abdomen:
  1. Observe for wounds, bruising, distention, or pregnancy.
  2. Palpate all four quadrants for tenderness, or rigidity.
- F. Pelvis:
  1. Palpate and compress lateral pelvic rims and symphysis pubis for tenderness or instability.
- G. Extremities:
  1. Observe for deformity, wounds, protruding bone ends, and symmetry.
  2. Palpate for tenderness, crepitus.
  3. Note distal pulses, skin color, and medical alert tags.
  4. Check sensation.
  5. Test for motor strength if no obvious fracture present.
  6. Ask to move extremities to check overall function.
- H. Back:
  1. Observe and palpate for wounds, fractures, tenderness, and bruising while maintaining spinal alignment.

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**IV. Special Considerations:**

- A. Primary survey should take 30 seconds or less in a medical patient or victim of minor trauma. In a multiple trauma patient, assessment and treatment of life-threatening injuries evaluated in the primary survey may require immediate intervention, with treatment and further assessment occurring while enroute to the hospital.
- B. In trauma patients, the spine should be stabilized during patient movement.
- C. Abdominal, pelvic, back and lower extremity exams must be completed prior to PASG application.
- D. Secondary survey should take 1 - 2 minutes to complete.
- E. Be systematic
- F. Interruption of the secondary survey should only occur if the patient experiences airway, breathing or circulatory deterioration.
- G. Obtain and record frequent vital signs and neurologic observations.

Normal Vital Signs	Respirations	Pulse	Systolic BP	Diastolic BP
Adult (> age 8)	12-20	60-100	90- 140	60-90
Older Child (4-8)	12-24	80-120	70-120	
Small Child (1-4)	20-30	80-120	70-120	
Infant (< age 1)	30-50	80-140	60-110	
Neonate (< 1 month)	40-60	100-150	60-100	