Jackson Hole Fire/EMS Operations Manual

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Title: **Treatment Protocol: Patient Assessment**
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PATIENT ASSESSMENT
(Treatment Protocol)

ALL PROVIDERS

- Scene Size-up
  - Identify hazards and ensure scene safety
  - Determine the mechanism of injury (MOI) or nature of illness (NOI)
  - Determine the numbers of patients
  - Identify the need for additional/special resources
- Initial Assessment
  - Form a general impression
    - Observe, then approach
    - Introduce yourself
    - Obtain consent
  - Assess mental status
    - Determine level of responsiveness (AVPU)
      - A – Alert
      - V – Verbal stimuli
      - P – Painful stimuli
      - U – Unresponsive
    - Determine level of orientation (AOX4)
      - Person
      - Place
      - Time
      - Events
  - Check for life-threatening emergencies (ABC's)
    - A – airway
      - Protect c-spine if spinal injury is suspected
      - Consider airway adjuncts to maintain airway
    - B – breathing
      - Assist ventilations as needed
      - Oxygen therapy to maintain oxygen saturation > 90 %
    - C – circulation
      - Stop any bleeding
      - Preserve body heat
- Establish patient priorities
  - Expedite transport in unstable patients

- Focused History and Physical Exam
  - TRAUMA with significant MOI
    - Rapid trauma assessment
    - Baseline vital signs
    - SAMPLE history
  - TRAUMA with no significant MOI
    - Focused trauma assessment
    - Baseline vital signs
    - SAMPLE history
  - MEDICAL – unresponsive patient
    - Rapid medical assessment
    - Baseline vitals
    - SAMPLE history
  - MEDICAL – responsive patient
    - Focused medical assessment (OPQRST)
      - O – Onset
      - P – Provocation
      - Q – Quality
      - R – Radiation, Region, Relief
      - S – Severity
      - T - Time
    - SAMPLE history
    - Baseline vitals signs
- Detailed physical exam
  - Expose, inspect, palpate and auscultate (respect patient privacy)
    - Head and Neck
    - Shoulder girdle
    - Chest
    - Abdomen
    - Pelvis
    - Lower extremities
    - Upper extremities
    - Back
- Ongoing assessment
  - Reassess mental status for changes
  - Repeat any previous exams
  - Repeat vital signs

SAMPLE History.
Patient Profile: age, sex, weight, pregnancy.
The "SAMPLE" History:

S - Signs/Symptoms.
A - Allergies.
M - Medication.
P - Past medical history.
L - Last meal.
E - Events or symptoms leading to condition.

Vital signs:
1. Respirations: rate, depth, quality.
2. Pulse: rate, regularity, quality.
3. Blood pressure.
4. Temperature (when appropriate).
5. Skin signs: color, temperature, moisture