THE RESCUE COMPANY 1
Assessment

The primary survey prioritizes the ABC's and organizes the way trauma patients are evaluated. This is the first chance one has to figure out what happened to the patient and to begin treatments.

A: Airway and Alertness: You are assessing the patients ability to protect their airway and the airways patency, all while maintaining spinal and cervical immobilization.

- Alertness Assessment
  - *Assessed by using **AVPU**:
    - A (alert)
    - V (alert to verbal stimuli)
    - P (alert to pain)
    - U (unresponsive to all stimuli)
- Airway Assessment
  - Can the patient open and protect their airway
  - *Inspect the mouth for at *least* **FOUR** of the following that could be obstructing the airway such as:
    1. The tongue
    2. Teeth
    3. Foreign objects
    4. Blood
    5. Vomitus
    6. Secretions
    7. Edema
    8. Evidence of burns
  - Auscultate for obstructive airway sounds such as stridor
  - Palpate for bony deformity that could be obstructing airway
  - Assess the definitive airway if put in by EMS, make sure it is correctly placed with no obstructions
- Treatment if airway is not patent
  - Suction
  - Remove debris
  - Insert airway adjunct such as oral pharyngeal airway, **STATE** and prepare to insert a definitive airway such as an endotracheal tube
  - Reassess treatment provided

B: Breathing: You are assessing to see if the patient is breathing adequately and regularly.

- Breathing Assessment
  - *Inspect for at *least* **FOUR** of the following:
    1. Spontaneous breathing
    2. Symmetrical rise and fall of chest
    3. Depth
    4. Pattern
    5. Rate of respiration
    6. Signs of respiratory difficulty
    7. Skin color (cyanotic or pale)
    8. Wounds
    9. Contusions
    10. Abrasions
    11. Deformities
  - Auscultate for breath sounds and heart sounds
  - Palpate bony structures of chest looking for any deformities, subcutaneous emphysema, or soft tissue injury (bruises or seat belt marks)
- Treatment if breathing is *present*
  - Administer oxygen non-rebreather at 15 L
  - Check breathing using end tidal CO_2
- Treatment if breathing is *absent*
  - Open the airway, jaw thrust with second person
  - Insert airway adjunct
  - Assist ventilation with bag mask device
  - Prepare to insert a definitive airway such as an endotracheal tube
    - *Once patient is intubated you *must* check tube placement by doing *all* **FIVE** of the following:
      1. Attach $ETCO_2$ detector
      2. Observe chest rise and fall while listening over epigastrium
      3. Auscultate for bilateral breath sounds
      4. After 5-6 breaths observe $ETCO_2$ detector for evidence of CO_2 in exhaled air
      5. Assess for color improvement to patient
    - Assess tube position, secure tube, continue assisting ventilations or begin mechanical ventilation

C: Circulation and Control of Hemorrhage: You are assessing the patients ability to perfuse blood and assessing any uncontrolled bleeding.

- *Circulation Assessment-must do *all* **THREE**
    1. Look for uncontrolled bleeding (see hemorrhage assessment below)
    2. Palpate for presence of central and peripheral pulses, the rate and rhythm
    3. Check the skin color, temperature, and moisture
- Treatment if pulses are *absent*
    - Initiate basic lifesaving CPR
    - Assess for cause
- Hemorrhage Assessment
    - Inspect for uncontrolled external/internal hemorrhage, skin color changes, bruising
- Treatment if there is uncontrolled hemorrhage
    - Use pressure, elevate, quik-clot or tourniquets
    - *Initiate infusion of warmed isotonic crystalloid solution by:
        - Controlled rate
        - Bolus
        - Rapid rate on pressure bag
    - Prepare for possible blood administration and use of the Buddy Lite
    - Reassess as needed

D: *Disability: You are assessing the patients mental status.

- Assessment
    - Inspect pupils: PERRL, Pupils that are equal, round and reactive to light
    - Glasgow Coma Scale

Score	Eye opening	Verbal response	Motor response
1	None	None	No movements
2	Open to painful stimulation	Incomprehensible sounds	Extends to pain
3	Open to voice	Inappropriate words	Abnormal flexion to pain
4	Open spontaneously	Confused, disoriented	Withdraws to pain
5	-	Oriented, converses	Localizes to painful stimulus
6	-	-	Obeys commands

Legend: The GCS is obtained by adding the value for each category: minimal =3, maximum =15.

- Treatment
    - Obtain blood glucose

- Review ABGs (if available)

E: Exposure and Environmental control: You are exposing all of the patient, and warming the environment.

- Assessment
  - *Remove/cut all clothing, cut off (preserve any clothing evidence)
  - Reassess for any uncontrolled bleeding
  - Note any obvious injuries that will need to be addressed
- Treatment
  - *Apply sheet/blanket to the patient

F: *Full set of vitals and Family

- Vitals: obtain baseline (pulse, heart rate, oxygenation, blood pressure, temperature, respirations, weight, and pain), trend for changes
- Family: communicate with family the status of the patient and the plan of care, what hospital you are transporting/transferring the patient to (if family is present and time permits)

G: Get adjuncts: You are obtaining any tests that have not been completed yet and performing interventions that have not been completed yet

- Patients chart including: Laboratory studies, Radiology reports/disk
- Monitoring for cardiac rhythm and rate, telemetry
- Insertion of NGT or OGT, and foley catheter if patient is intubated or if needed due to injury (if time permits)
- Apply supplemental oxygenation, monitor with end tidal CO_2
- *Pain assessment and treatment:
  - Nonpharmacologic comfort measures
  - Analgesic medications

H: History/Head to Toe:

- PMH, events leading to c/c
- Head to toe:
  - Head and Face
  - Neck
  - Chest-Auscultate heart and lungs
  - Abdomen and Flanks-inspect, auscultate, palpate
  - Perineum
  - Downward medial pressure over iliac crests
  - Gentle pressure over symphysis pubis

- Assess needs/contraindications for foley catheter
- All four extremities

I: *Identify All Injuries

J: Reevaluate:

- Primary assessment
- Vital signs
- Pain
- Identified injuries and effectiveness of interventions

* Represent items that MUST be addressed before proceeding to next assessment