ASSESSMENT

I. SCENE SIZE-UP/ASSESSMENT

A. Initiate body substance isolation
B. Recognize hazards to EMS personnel or patient
C. Recognize mechanism of injury or chief complaint
D. Analyze position of patient
E. Identify number of patients
F. Activate additional resources and initiate a triage system, if appropriate
G. Identify self to patient(s)

II. INITIAL ASSESSMENT

A. Airway: open, check for adequacy, note potential problems. Consider neck injury with trauma and initiate manual stabilization
B. Breathing: Is the patient breathing? Monitor: rate, rhythm, depth. Note: respiratory noises and effort. Note: skin color or abnormal behavior
C. Circulation: stop exsanguinating hemorrhage. Evaluate: pulse presence, rate, rhythm, strength.
D. Note level of consciousness (AVPU) in conjunction with airway, breathing, circulation
E. Observe for signs of shock. Watch for cool, clammy, pale skin, thirst, agitation

III. FOCUSED HISTORY AND PHYSICAL EXAM

Emphasis is placed on the patient's complaint and history, allowing for rapid emergency medical care.

A. Medical
1. Assess complaints and signs or symptoms; OPQRST format:
a. Onset
b. Provocation
c. Quality
d. Radiation
e. Severity
f. Time

2. Assess history; "SAMPLE" format
a. Signs/symptoms
b. Allergies
c. Medications
d. Pertinent previous illness
e. Last oral intake
f. Events preceding this illness

B. Trauma
1. Assess mechanism of injury
a. Cause
b. Implements
c. Trajectory
d. Force
e. Speed, condition of windshield and steering wheel, restraints, condition of other passengers n vehicular accidents

2. Inspect and palpate each body region, look and feel for the following
    a. Deformities
    b. Contusions
    c. Abrasions
    d. Punctures/penetrations
    e. Burns
    f. Tenderness
    g. Lacerations
    h. Swelling

IV. DETAILED PHYSICAL ASSESSMENT

A detailed physical assessment should be completed based on the patient's chief complaint.

A. Vital Signs: pulse, blood pressure, respiratory rate and quality, skin condition.
    1. Repeat according to patient condition. Attempt at least one more set.

    2. Observe, record and report any changes in patient condition that deviate from the initial assessment.

B. Perform a detailed physical examination on the patient to gather additional information.
    1. As you inspect and palpate each body region, look and feel for the following
        a. Deformities
        b. Contusions
        c. Abrasions
        d. Punctures/penetrations
        e. Burns
        f. Tenderness
        g. Lacerations
        h. Swelling

2. During assessment of the head also include
    a. Drainage from the ears
    b. Discoloration of eyes
    c. Pupil reactivity
    d. Presence of foreign bodies
    e. Blood in anterior chamber of eyes
    f. Drainage and bleeding from nose

3. During assessment of the neck also include
    a. Jugular vein distention
    b. Presence of crepitus

4. During assessment of the chest also include
    a. Presence of crepitus
    b. Paradoxical motion
    c. Presence, absence, and equality of breath sounds

5. During assessment of abdomen also include
    a. Firmness
    b. Distention

6. During assessment of pelvis also include gentle flexion and compression of the pelvic ring to determine stability if patient does not complain of pain

7. During assessment of all four extremities also include
   a. Distal pulses
   b. Sensation
   c. Motor function

C. Special notes
   1. The detailed physical exam should be systematic, although the exact order may vary depending upon patient presentation.

   2. When reporting findings from detailed physical exam, do not use poorly understood terminology like: lethargic, semi-comatose, semi-conscious, stuporous. Record and report precise responses to specific stimuli.