Scene Size-Up:

1. Recognize personal, environmental, and patient safety hazards. Neutralize or protect from all hazards.
2. Identify all patients and initiate triage if necessary.
3. Identify mechanism of injury, chief complaint, location and position of patients.
4. Call for appropriate backup. May include additional ambulances, helicopter, hazmat team, law enforcement, etc.
5. Use universal precautions any time there is potential for contact with patient blood or secretions.
6. Consider immobilization of c-spine if spinal pain, tenderness, unresponsive from trauma, or significant mechanism of injury.

Initial Assessment:

1. Response and general appearance. Notice how the patient looks and reacts when you approach. Note skin color. Note if awake, arouses to verbal stimuli, arouses to painful stimuli or unresponsive. If awake, note if speaking clearly, moving spontaneously.
2. Determine chief complaint, nature of illness, or potential life threats, as appropriate.
3. Airway: check for patency and note potential problems. Open using head tilt, chin lift or jaw thrust if needed. Initiate oxygen therapy as appropriate.
4. Breathing: is the patient breathing adequately, respiratory effort and noises, skin color and mentation. Start rescue or assisted breathing if needed.
5. Circulation: note presence and quality of pulse, skin color and moisture. If no pulse start chest compressions. Control severe bleeding using direct pressure, pressure points or, lastly, by tourniquet.
6. If no breathing and no pulse, especially without witnesses, look for signs of obvious death and if present, consult medical control for permission to withhold resuscitation efforts.
7. Immediate treatment following assessment: as appropriate for patient and level of responder training.

   a. Control airway using: head position, oral or nasal airway, oral or nasal ET tube, or cricothyrotomy. Use suction as needed to clear secretions.
   b. Ventilate or assist ventilation using pocket mask, or bag-valve with mask or tube and high flow O_2. Administer O_2 by non-rebreather mask or cannula., apply pulse oximeter.
   c. Decompress chest using needle thoracostomy.
   d. Secure cervical/spinal immobilization using appropriate equipment.
   e. Begin transport. All severely injured patients should be transported and given further treatment enroute.
   f. Establish venous access. May use I. O. if no IV access in both adults and children. Give fluid bolus if signs of hypovolemia.
   g. Apply cardiac monitor.
   h. Compress areas of obvious hemorrhage.

Focused History and Physical Exam/Rapid Trauma Assessment – Trauma:

1. Select appropriate assessment (focused or rapid).
2. Obtain vital signs
   a. Obtain quantitative pulse, respirations, blood pressure, pulse oximetry and GCS.
   b. Repeat vital signs according to patient's condition.
3. Obtain S.A.M.P.L.E. history as well as:
   a. Cause.
   b. Weapons: type and caliber of gun, length of knife.
   c. Trajectory if ejected from vehicle or height of fall.
   d. Speed and type of accident.
   e. Use of helmet, seat belt or other safety devices.
   f. Loss of consciousness.
   g. Damage to vehicles and deployment of airbags if present.
   h. Presence of alcohol or drugs.

Detailed Physical Exam:

1. Neurological Function:
   a. Level of consciousness: observe for best eye opening, verbal and motor responses and record Glasgow Coma score.
   b. Eyes: observe for gaze, size, equality, and reactivity of pupils.
   c. Movement: observe and compare extremity movement and strength.
   d. Sensation: if patient is awake and cooperative assess for absent, abnormal or normal sensation, arm and leg, left and right.
   e. Speech: is speech clear, hoarse, slurred or not understandable.
2. Head and face:
   a. Inspect and palpate for deformities, asymmetry, blood, and pain to the skull and face.
   b. Recheck airway for dentures, loose teeth, blood or vomit.
   c. Check pupils for swelling, blood, foreign bodies, contact lenses, lacerations, blurred or diminished vision.
   d. Check ears for bleeding or discharge.
   e. Check for jaw pain or feeling of malalignment when teeth are clenched.
3. Neck:
   a. Inspect for swelling, abrasions, lacerations, contusions, and jugular venous distention.
   b. Palpate for subcutaneous air and laryngeal crepitus and tracheal deviation.
4. Spine:
   a. Evaluate for pain, tenderness and deformity along spine from bottom of skull to top of pelvis.
5. Chest:
   a. Inspect for wounds, use of accessory muscles, altered voice, and unequal chest rise.
   b. Palpate for tenderness, subcutaneous air, rib crepitus, and unequal chest rise.
   c. Listen to lung sounds: equal side to side, crackles, wheezes.

6. Abdomen:
   a. Inspect for wounds, bruising and distention.
   b. Palpate for tenderness, guarding, or rigidity.
7. Pelvis:
   a. Palpate and compress front to back and side to side for pain and instability. Do not rock pelvis.
8. Extremities:
   a. Inspect for wounds, swelling, deformity, shortening and rotation.
   b. Palpate for tenderness.
   c. Check distal circulation, sensation and movement.
   d. Check for equal strength.

Focused History and Physical Exam/Rapid Assessment – Medical

1. Signs and symptoms. The following should be investigated:
   a. Location of symptoms or pain.
   b. Radiation of pain.
   c. Onset of symptoms.
   d. Quality of symptoms.
   e. Quantity of pain or discomfort (0-10 scale).
   f. Duration of symptoms.
   g. Relief or aggravation of symptoms.
   h. Associated symptoms.
   i. Pertinent negatives.
2. Past medical history.
3. Allergies and medications.
4. Survey of surroundings for evidence of drug abuse, mental illness, family problems and other significant information.

Ongoing Assessment:

1. Use a chief complaint directed exam.
2. Skin: rash, ecchymoses, petechiae.

3. HEENT: recent sign of injury or bleeding, facial swelling, scleral color (jaundice, pale), moisture of eyes, lips, mouth., voice quality and ease of swallowing.
4. Neck: range of motion pain, rigidity, swollen glands.\
5. Chest/Breasts: lesions, surgical scars, tenderness, breath sounds.
6. Cardiovascular: quality of heart sounds, peripheral pulses.
7. Abdomen: appearance, hernia, surgical scars, bowel sounds, location of any tenderness, rebound, guarding, rigidity.
8. Back: appearance, surgical scars, tenderness over spine or flanks.
9. Pelvis/Genitalia: distention of bladder or uterus, groin or scrotal tenderness or swelling, vaginal bleeding, penile lesion.
10. Extremities: tenderness from hips to toes and shoulders to fingers, color, temperature, swelling, deformity, loss of function.
11. Neuro: alert, oriented, intact reasoning, facial appearance, speech quality, strength, sensation, coordination, drift, gait.
12. Mood: withdrawn, hallucinations, delusions, suicidal, agitated, impulsive, violent.
13. Repeat initial assessment, monitor vitals, check interventions.