

Assure scene safety:

- Evaluate for hazards to EMS personnel, patient, bystanders.
- Assure patient has extricated self from hazardous environment or has been extricated by trained and equipped rescuers.
- Consider PPE including high-visibility, reflective apparel as appropriate.
- Determine number of patients.
- Determine mechanism of injury.
- Request additional resources as needed. Weigh the benefits of waiting for additional resources against rapid transport to definitive care.

Patient Management

- Critical patients should receive proactive patient management simultaneously with assessment.
- Treatment and interventions should be initiated as soon as possible but not impede extrication or delay transport to definitive care.

ALL LEVELS

1. Consider cervical spine stabilization, spinal motion restriction and/or cervical collar if trauma.
2. Conduct a primary survey (ABC or CAB as indicated).
 - a. Airway – assess for patency
 - i. Consider manual stabilization.
 - ii. Open airway as indicated – head tilt, chin lift, or jaw thrust - as indicated.
 - iii. Perform suction as necessary
 - iv. Consider use of appropriate airway management adjuncts and devices.
 - b. Breathing
 - i. Evaluate rate, breath sounds, accessory muscle use, retractions, patient positioning.]
 - ii. For apnea (not breathing) go to [Airway Management guideline \[RP-1\]](#).
 - c. Circulation
 - i. Control any major external bleeding. See [Extremity Trauma/External Hemorrhage Management guideline \[T-5\]](#).
 - ii. Assess pulse
 1. If none, go to [Cardiac Arrest guideline \[R-1\]](#).
 2. Assess rate and quality of carotid and radial pulses.
 3. Evaluate capillary refill.
 4. Evaluate perfusion by assessing skin color and temperature.
 - d. Disability
 - i. Evaluate patient responsiveness: Glasgow Coma Scale (GCS) or AVPU scale (Alert, Verbal, Pain, Unresponsive).
 - ii. Consider CO (carbon monoxide) assessment.
 - iii. Evaluate gross motor and sensory function in all extremities.
 - iv. If acute stroke suspected, go to [Stroke guideline \[M-15\]](#).
 - e. Expose patient as appropriate to complaint.
 - i. Be considerate of patient modesty.
 - ii. Keep patient warm.
3. Conduct a secondary survey:
 - a. May not be completed if patient has life-threatening conditions.

- b. Do not delay transport of critical patient to conduct secondary survey.
 - c. Tailor secondary survey to patient presentation and chief complaint.
 - d. Considerations for secondary survey assessment:
 - e. Head
 - i. Pupils
 - ii. Naso-oropharynx
 - iii. Skull and scalp
 - f. Neck
 - i. Jugular venous distension (JVD)
 - ii. Tracheal deviation
 - iii. Spinal tenderness
 - g. Chest
 - i. Retractions
 - ii. Breath sounds
 - iii. Chest wall deformity
 - h. Abdomen and Back
 - i. Flank and abdominal tenderness and bruising
 - ii. Abdominal distension
 - iii. Maintain spinal alignment as appropriate
 - iv. Inspect back for soft tissue injuries
 - i. Extremities
 - i. Edema
 - ii. Pulses
 - iii. Deformity
 - j. Neurologic
 - i. Mental status and orientation
 - ii. Motor and sensory
4. Obtain baseline vital signs to document any changes.
- a. Pulse
 - b. Blood Pressure
 - c. Respiratory Rate
 - d. Neurologic Status
 - e. Stable patient should have at least two sets of pertinent vital signs.
 - f. Critical patients should have pertinent vital signs monitored frequently.
5. Obtain OPQRST history.
- a. **O**nset of symptoms
 - b. **P**rovocation – location; any exacerbating or alleviating factors.
 - c. **Q**uality of pain
 - d. **R**adiation of pain
 - e. **S**everity of symptoms – pain scale
 - f. **T**ime of onset and circumstances around onset.
6. Obtain SAMPLE history.
- a. **S**ymptoms
 - b. **A**llergies – medication, environmental, foods
 - c. **M**edications – prescription and over the counter. [Bring containers to ED if possible.]
 - d. **P**ast medical history
 - i. Look for medical alert tags, portable medical records, advanced directives
 - ii. Look for medical devices or implants
 - e. **L**ast oral intake
 - f. **E**vents leading up to the 9-1-1 call.

7. Continually reassess patient.
8. Monitor pain scale if appropriate.
9. Document all patient interventions and responses.

EMR-O; EMT-R

10. Check blood glucose in patients with altered mental status.
11. Patients with cardiac or respiratory complaints.
 - a. Acquire SpO₂.
 - b. Administer oxygen as appropriate for dyspnea or distress with a target of achieving greater than 93% saturation for most acutely ill patients.
 - c. Consider airway adjuncts as appropriate.
 - d. Consider waveform capnography or capnometry for patients who require a non-visualized airway.

EMT-O

- e. 12-lead ECG should be obtained early in patients with cardiac or suspected cardiac complaints.
- f. Conduct continuous ECG cardiac monitoring if available.
- g. Obtain ETCO₂ as available.

AEMT-R

12. Establish vascular access if indicated or in patients who are at risk for clinical deterioration.

INT-R

13. Interpret waveform capnography and 12-lead ECG.

INT-O; PARA R

14. If Intraosseous (IO) access is to be used for a conscious patient, consider lidocaine with slow push through IO needed to mitigate pain from IO medication administration.

VITAL SIGNS (See chart on following page)

Oxygen

- Administer oxygen as appropriate for dyspnea or distress with a target of achieving greater than 93% saturation for most acutely ill patients.

Normal vital signs (see chart)

- Hypotension is a systolic blood pressure less than the lower limit on the chart.
- Tachycardia is a pulse above the upper limit on the chart.
- Bradycardia is a pulse below the lower limit on the chart.
- Tachypnea is a respiratory rate above the upper limit on the chart.
- Bradypnea is a respiratory rate below the lower limit on the chart.

Hypertension (although abnormal, may be an expected finding in many patients)

- Document the hypertension.
- Do not use an intervention unless it is specifically suggested based on the patient's complaint or presentation.
- Look for the occurrence of symptoms (e.g. chest pain, dyspnea, vision change, headache, focal weakness or change in sensation, altered mental status) in patients with hypertension. These should be considered concerning, and care should be provided appropriate with the patient's complaint or presentation.

NORMAL VITAL SIGNS

AGE	PULSE	RESPIRATORY RATE	SYSTOLIC BP
Preterm less than 1 kg	120-160	30-60	36-58
Preterm 1 kg	120-160	30-60	42-66
Preterm 2 kg	120-160	30-60	50-82
Newborn	120-160	30-60	60-70
Up to 1 year	100-140	30-60	70-80
1-3 years	100-140	20-40	76-90
4-6 years	80-120	20-30	80-100
7-9 years	80-120	16-24	84-110
10-12 years	60-100	16-20	90-120
13-14 years	60-90	16-20	90-120
15 years or older	60-90	14-20	90-130

GLASCOW COMA SCORE

ADULT GCS		PEDIATRIC GCS	
Eye Opening (4)		Eye Opening (4)	
Spontaneous	4	Spontaneous	4
To speech	3	To speech	3
To pain	2	To pain	2
None	1	None	1
Best Motor Response (6)		Best Motor Response (6)	
Obeys commands	6	Obeys commands	6
Localizes pain	5	Localizes pain	5
Withdraws from pain	4	Withdraws from pain	4
Abnormal flexion	3	Abnormal flexion	3
Abnormal extension	2	Abnormal extension	2
None	1	None	1
Verbal Response (5)		Verbal Response (5)	
Oriented	5	Oriented	5
Confused	4	Confused	4
Inappropriate	3	Inappropriate	3
Incomprehensible	2	Incomprehensible	2
None	1	None	1
Total		Total	