Dispatched to a patient

Arrive on scene

Ensure scene safety

Apply BSI

Determine MOI/NOI

Number of patients

Consider additional resources (ALS, PD, HazMat)

Enter patient's space (Form General Impression)

Unresponsive (Sternal Rub)

Responsive

PT description (age, sex assigned at birth)

Consider any trauma. Cervical Spinal Stabilization?

Apparent life threats Determine chief complaint

AVPU or A/Ox4

A/Ox4
1. Who
2. What
3. When
4. Where

Does the patient look sick or not sick? Consider LOC, skin parameters, position, etc

Pulse? (Carotid)

No Pulse

CPR

Pulse Present

Patent airway? (head tilt, chin lift) (modified jaw thrust)

Obstructed

Patent

Breathing rate/rhythm? Consider PPV

Primary Assessment (If abnormal, must treat before moving on to secondary)

Assess and control any external exsanguination

Identifies any airway obstruction (can safely assume no obstruction if patient is talking)

Open/Clear airway if obstruction is present

Snoring

no trauma: head tilt/chin lift

trauma: modified jaw-thrust

Gurgling

suction

Stridor

: Stridor is caused by upper airway swelling commonly seen in anaphylaxis, airway burns, and peds with upper respiratory infections

Avoid exacerbating issue and inserting anything into airway

Breathing

Adequate Tidal Volume?

If not, initiate PPV via BVM at 15lpm O2

If yes, move on down

Relative rate (slow, fast, or normal)

Respiratory pattern (regular or irregular)

Any accessory muscle present?

Current spO2?

Auscultate lung sounds

Clear lung sounds

If patient has SOB complaint, but doesn't objectively need it, then apply 2lpm O2 via NC

If patient objectively needs O2, then apply 15lpm O2 via NRB

Rales/Crackles

Consider CPAP (need BP first)

Wheezes

Initiate 2.5mg albuterol and 0.5mg atrovent via neb kit 6lpm O2

Consider inline nebulizer with CPAP (post BP)

Ronchi

Patient should be able to clear on their own. Otherwise, be ready for potential suction

Identify if patient is respiratory distress, failure, or arrest

Remember, the difference between distress and failure is altered mental status

Initiate appropriate oxygen or ventilatory treatment

Circulation

Skin

Color

Normal Color
Pale
Cyanotic
Flush

Temperature

Warm
Hot
Cool
Cold

Moisture

Ashen
Dry
Moist
Diaphoretic

Capillary Refill

<2 secs = good
>2 secs = bad

Pulse

Strength

weak
strong
bounding

Relative Rate

slow
normal
fast

Regularity

regular
irregular

Equality

equal
unequal

Determine if patient is in a state of shock

Initiate shock protocol

Apply O2
Keep warm
Lay supine (if patient tolerates)

Consider environmental emergencies (hypo/hyperthermia)

Make a transport decision
1. Stay and play
2. Load and go

If anything in the ABCs is abnormal, then consider the patient unstable

We're now in the back of the ambulance (Secondary Assessment)

OPQRST

Onset

sudden
gradual

Provocation/ Palliation

Does anything make it better or worse?

Quality

Can you describe what you're experiencing in your own words

Region/Radiation

Can you point to where it is? Does it radiate anywhere else?

Severity

On a scale between 1-10, how bad is it?

Time

How long have you been experiencing this?

SAMPLE

Signs/Symptoms (plug and play

Allergies

Medications

Pertinent Medical Hx

Last Oral Intake

Events Leading up to Chief Complaint

Asks questions that are relevant to the given scenario (plug and play)

Performs proper focused assessment (plug and play)

Vital Signs

Blood Pressure

Heart Rate

Respiratory Rate

Pupils

Diagnostics

Blood Glucose (60-120mg/dl)

SpO2 (>94%)

Provide relevant interventions not already administered

Reassessment
Stable: every 15 minutes
Unstable: every 5 minutes

Form Field Impression

Give radio report