

# Initial Patient Survey Protocol

**\*\*\*\* As in all emergency responses strict adherence to Universal Precautions is essential.**

## 1. INITIAL PATIENT SURVEY (IPS)

1. Review Dispatch Information
  2. Overview the Scene
  3. Introduce Yourself and Partners
  4. Primary Survey
  5. Chief Complaint
  6. Secondary Survey
1. Review Dispatch Information
    - 1) Confirm Location-insure adequate directions to location.
      - 1) Street, house or fire number - determine best route.
    - 2) Request appropriate support units.
  2. Overview The Scene
    - 1) Look for hazards - **ENSURE RESCUERS SAFETY.**
      - 1) Wires, fumes, fire, debris, crowds, traffic, etc.
    - 2) Plan entrance and exit routes.
    - 3) Assess available resources - determine need for further help - obtain assistance from others on the scene.
    - 4) Determine and note mechanism(s) of injury.
    - 5) Mass Casualties - Activate MCI Protocol.
  3. Introduce Yourself and Partners
    - 1) Give your name and agency.
    - 2) Ask the patients name, then use it.
    - 3) Provide reassurance to the patient.
    - 4) Gather information (open and closed-end questions, check for medic alert tag's.)
    - 5) Assess the patients LOC.
  4. Primary Survey - **RAPID ASSESSMENT TO DETERMINE LIFE THREATENING CONDITIONS.**
    - 1) Establish an open airway per protocols and procedures while maintaining C-SPINE.
      - 1) Approach the victim so that they do not turn their head.
      - 2) Use modified Jaw Thrust to open airway.
      - 3) Stabilize C-Spine in neutral position unless resistance is met.
      - 4) Illicit verbal response.
    - 2) Assess BREATHING
      - 1) Look, Listen and Feel for respirations.
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CRITICAL ACTION: SUPPORT RESPIRATIONS PER

  
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rate rhythm and quality.

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PROTOCOLS AND PROCEDURES

Nose to

Naval

- 3) Assess CIRCULATION
  - 1) Check carotid pulse - rate, rhythm, quality.  
\* May be obtained by the person at the head.
  - 2) Check peripheral (radial) pulses for comparison.
  - 3) Assess capillary refill (Peds 1-8 yrs. age)

- 4) BLEEDING
  - 1) Control external bleeding per protocol -  
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CRITICAL ACTION: SHOCK- LOOK FOR IT AND TREAT IT

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CT INTERNAL BLEEDING.

CRITICAL ACTION: INITIATE CPR, CONTROL EXTERNAL BLEEDING AND CIRCULATION AS REQUIRED PER PROTOCOLS AND PROCEDURES

- 5) Complete the Primary Survey
  - 1) Capillary refill-normal, delayed (Peds 1-12)
  - 2) Pupils.
  - 3) Skin-color, temperature and texture (moisture content)
  - 4) Trachea- is it mid-line?
  - 5) Neck Veins-flat or distended.
  - 6) Palpate C-Spine check neck for injury.
  - 7) Examine Chest, Sucking-chest wound flail, contusion, deformity,

CRITICAL ACTION: MUST BE SEALED IMMEDIATELY

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- 8) Palpitate for symmetry, instability, crepitus.
- 9) Lung Sounds-present and equal both sides.
- 10) Oxygen and ventilatory support as indicated.
- 11) Pre-Immobilization/Pre-MAST survey:
  - (1) Palpate abdomen-soft, rigid, distended, guarded, tender,

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- contused, penetrated.
- (2) Pelvic crunch-stable vs. unstable.
- (3) Check areas of the body that will be hidden by MAST - ie. buttocks, legs, etc.  
\*\* Check legs for major wounds, and deformity.
- (4) Brief neurological examination.

CRITICAL ACTION: IF LIFE THREATENING INJURIES ARE PRESENT- LOAD AND GO

5. Chief Complaint

- 1) Ask the patient if and where he/she hurts.

6. Secondary survey - REASSESS ABC'S

- 1) Vital Signs - LOC, BP, Pulse, Respirations, Skin, Pupils, Pulse Oximetry, Glucometer, Cardiac Monitor, or other Diagnostic's as appropriate..
  - 1) Obtain first quantitative set of vitals within 5 minutes if practical.
  - 2) Report according to patient's condition
  - 3) Repeat at least one more set prior to arrival.
- 2) History
  - 1) Obtain from patient, relative or observer. This should include time of incident or onset of symptoms, mechanism of injury in a trauma patient, pertinent medical history and significant findings prior to your arrival.
- 3) Head to Toe Exam - palpate all bones
  - 1) Head and Face
    - (1) Recheck airway for potential compromise, dentures, loose or avulsed teeth.
    - (2) Deformities, asymmetry, blood, pain, contusions.
    - (3) Raccoons eyes, Battle sign.
    - (4) Eyes - pupils, foreign bodies, contact lenses, lacerations, blurred or lost vision.
    - (5) Nose - Deformity, bleeding, CSF discharge.
    - (6) Ears - bleeding, CSF discharge.
  - 2) Neck
    - (1) Deformities, contusions, tenderness, bleeding.
    - (2) Neck veins, deviated trachea, carotid pulse.
    - (3) Use of neck muscles for respirations.
    - (4) Medic Alert Tags.
  - 3) Chest
    - (1) Lung sounds.
    - (2) Symmetry of respirations.
    - (3) Look for paradoxical chest movements.(flail) Bleeding,

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contusions, tenderness, crepitus, sucking chest wounds.

- 4) Abdomen.
  - (1) Bleeding, contusions, tenderness, rigidity, distention
- 5) Pelvis
  - (1) Push down, pull slightly up and squeeze together to determine instability
  - (2) Loss of bowel/bladder control or bleeding
- 6) Genitalia
  - (1) Visible trauma
  - (2) Complaint of pain
  - (3) Priapism
  - (4) Blood from the penis
- 7) Upper Extremities/Shoulders
  - (1) Bleeding, deformities, contusions, tenderness, crepitus
  - (2) Distal pulses, color, temperature, capillary refill (Peds 1-8yrs)
  - (3) Sensation, movement of fingers, finger squeeze (if no obvious fracture)
  - (4) Check for Medic Alert Tags.
  - (5) If exam is normal, range of motion exams can be performed.
- 8) Lower Extremities
  - (1) Bleeding, deformity, contusions, tenderness,
  - (2) Distal pulses, color, temperature, pedal edema, capillary refill (peds, ages 1-8yrs)
  - (3) Sensation, movement of toes, foot push (if no obvious fx)
  - (4) If exam is normal, range of motion exams can be performed
- 9) Back
  - (1) Bleeding, deformities, contusions, tenderness, crepitus.  
Perform in a manner to minimize movement of spine.

**SPECIAL NOTE: SHOULD BE A RAPID, SYSTEMATIC EXAMINATION  
(EXACT ORDER OF SECONDARY SURVEY MAY VARY.) DO NOT INTERRUPT FOR  
TREATMENT UNLESS ABC'S DETERIORATE.**

#### 4) Neuro Exam.(GLASGOW COMA SCALE )

The most important observation in the neuro exam is LEVEL of CONSCIOUSNESS. This can readily be described by observing: ability to open eyes, ability to communicate (best verbal response)and motor function. Further, these observations can be given a numerical score - the Glasgow Coma Score. This then provides a simple, reproducible and accurate means to evaluate and re-evaluate level of conscious. Do not worry about the numerical score - making and recording the observation is the critical part.

The following list summarizes the observation to be made. Do not use vague terms (lethargic, semi- comatose, etc.) but rather describe response to stimuli. Be simple and concise. Do not record a single number for the Coma Scale, but record specific responses. A flow sheet is useful to follow and identify changes rapidly.

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Proper patient management also requires observation of other parameters: vital signs, respiratory status, pupillary responses symmetry of motor functions and sensory deficits.

7. Vital Signs:

- 1) Observe particularly for adequacy of ventilations, depth, frequency and regularity of respirations.

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8.	Glasgow Coma Scale			
1.	Eye Opening			(CHILDREN)
	Never	1	Never	1
	To Pain	2	To pain	2
	To Speech	3	To Speech	3
	Spontaneously	4	Spontaneously	4
2.	Best Verbal Response			
	None	1	None	1
	Garbled	2	Moans to pain	2
	Inappropriate	3	Cries to pain	3
	Confused	4	Irritable cries	4
	Oriented	5	Coos; babbles	5
3.	Best Motor Response			
	None	1	None	1
	Extension	2	Abnormal extension	2
	Abdominal Flexion	3	Abnormal flexion	3
	Withdraws	4	Withdraws to pain	4
	Localized Pain	5	Withdraw to touch	5
	Obeys Commands	6	Normal; spontaneous	6

Totals = 15 possible

9. Communications
- 1) Write findings down - do not forget what you find.
  - 2) Constantly communicate with your patient.
  - 3) Let your partner know what you are finding in your IPS.
    - 1) They can start getting equipment ready.
  - 4) Call Medical Control ASAP !

AUTHENTICATION AND APPROVAL

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Marquette County EMS Medical Director

Date

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