5e-PATIENT ASSESSMENT – Unresponsive – 5th Edition

Scene Size-Up

- ❖ Initial Radio Call: ***“<Patroller name> on scene at <location> with a young female, not moving.”***

  “I WILL ADVISE!”

- Scene Safety
- Standard Precautions - BSI
- Try to determine MOI.
- Form your **general impression** of the patient

PRIMARY Assessment

- **SIMULTANEOUSLY DO THE FOLLOWING ABC”S:**
- IMMEDIATELY CHECK FOR RESPONSE by tapping the shoulder & shouting at the victim

(A) AIRWAY –

- OPEN THE AIRWAY & look at the position of the airway.

(B) BREATHING –

- Look for signs of breathing with good air exchange.
- Look, Listen, & Feel.

(C) CIRCULATION –

- Take a quick carotid pulse (no more than 10 seconds).
- Perform a quick visual sweep for blood.
- Check Patient for Cyanosis.

(D) Disability-

- Try to illicit a “pain” response using caution not to move the patient.
- Assess LOR using AVPU.
- ***ALWAYS SUSPECT POSSIBLE CERVICAL/SPINAL INJURY.***

♥ALL UNRESPONSIVE PATIENTS ARE CONSIDERED CLASS ONE!

♦**Initiate transport decision at this time.**

❖ **RADIO CALL**

“Patroller to Base – I have an unresponsive patient. I need manpower, O_2, trauma kit, BB, toboggan, and start ALS. I have a 101.“

TRY TO Ascertain **CHIEF-COMPLAINT.** Ask bystanders or friends; “What Happened??”

NOTE: **If during the PRIMARY ASSESSMENT you identify an abnormality in the ABCD’s that in your judgement places the patient at IMMINENT life-threatening risk, you should immediately expedite the rest of the assessment process & care. Focus on immediate life threats and rapidly transport to definitive care.**

MANAGE ABCD’s, PROTECT THE CERVICAL SPINE, and INITIATE RAPID TRANSPORT.

Secondary Assessment

Head to Toe Detailed Body Assessment (Rapid Body Survey).

PALPATE the following:

- **Skull**
- **Face** - Inspect & palpate
  - **Eyes** – Examine and look for pupil response. Check for contact lenses.
  - **Ears** – Check for fluid, Discoloration behind the ears
  - **Mouth** – Assess for obstructions & unusual odors (**Especially important if unresponsive!**)
  - **Mandible**- palpate
- **Neck** – palpate and look for tracheal deviation or JVD (Jugular Vein Distention)
- **Clavicle & Sternoclavicular Joint** – palpate and assess evenness, check SC Joint
- **Chest** – Palpate sternum, both sides of rib cage, upper & lower.
- **Abdominal Area** – Palpate all four (4) quadrants pressing gently down with both hands.
- **Hips** - Compress both sides of the Iliac Crest.
- **Pelvis** – Gently compress the Greater Trochanters & apply gentle thumb pressure along the pelvic girdle.
- **Lower Extremities** – Do each leg separately. (CMS not indicated).
- **Back** – Examine and palpate as much of the back as position allows.
- **Upper Extremities –** Do each arm separately. (PMS not indicated).

Remember to look for medical alert tags on the neck, wrist or ankle.

After second arm is completed go directly into:

- **VITALS – Pulse and Respirations.**
- **SAMPLE – Get from bystanders, family, or friends**! **(S)** Signs & Symptoms, **(A)** Allergies, **(M)** Meds, **(P)** Past PERTINENT Medical History, **(L)** Last Meal, **(E)** Events leading up to injury.

❖ **Radio Call**

- **Update:** Give description of injury and **Baseline Vitals.**

  "Patroller to Base – I have a 14 year old female that is still unresponsive, I suspect a possible head injury with no other pertinent injuries found at this time. Vitals are pulse 82 and regular, respirations 16, and regular. I will be transporting in approximately10 minutes to the front side."

- **When ready to transport:**

  "Patroller to Base – I am transporting to Base. ETA is in three minutes. Pt. is still unresponsive!"

REASSESSMENT –

- REASSESS PRIMARY ASSESSMENT.
- Vitals **every 3 - 5 minutes**