ALS Patient Assessment – Primary Survey

AUTHORITY: Division 2.5, Health and Safety Code, Sections 1797.220 & 1798 et al.

PROCEDURE:

The purpose of the primary survey is to identify and immediately correct life-threatening problems.

I. Scene Size Up:

A. Recognize hazards, ensure safety of scene and secure a safe area for treatment.
B. Apply universal body/substance isolation precautions.
C. Recognize hazards to patient and protect patient from further injury.
D. Identify the number of patients and initiate ICS/MCI operations if warranted:
   1. Ensure an ALS ambulance response and order additional resources.
   2. Consider/confirm air ambulance response.
   3. Initiate S.T.A.R.T. triage, if more than one patient.
E. Observe position of patient(s).
F. Determine mechanism of injury.
G. Plan strategy to protect evidence at potential crime scene.

II. General Impressions:

A. Check for life threatening conditions.
B. Introduce self to patient.
C. Determine chief complaint or mechanism of injury.

III. Airway:

A. Ensure open airway
B. Protect spine from unnecessary movement in patients at risk for spinal injury.
C. Ensuring an adequate airway supersedes spinal immobilization.
D. Look and listen for evidence of upper airway problems and potential obstructions:
   1. Vomit.
   2. Bleeding.
   3. Loose or missing teeth.
4. Dentures.
5. Facial Trauma.
E. Utilize any appropriate adjuncts as indicated to maintain airway.

IV. Breathing:

A. Look, listen, and feel in order to assess ventilation and oxygenation.
B. Expose chest, if necessary, and observe for chest wall movement.
C. Determine approximate rate and depth and assess character and quality.
D. Reassess mental status.
E. Intervene for inadequate ventilation with:
   1. Pocket mask or BVM device.
   2. Supplemental oxygen.
F. Assess for other life threatening respiratory problems and treat as needed.

V. Circulation:

A. Check for pulse and begin CPR.
B. Defibrillation as necessary.
C. Control life-threatening hemorrhage with direct pressure.
D. Palpate radial pulse.
   1. Determine absence or presence.
   2. Assess general quality (strong/weak).
   3. Identify rate (slow, normal, or fast).
   4. Assess regularity (regular/irregular).
E. Obtain baseline blood pressure.
F. Assess skin for signs of hypo-perfusion/SHOCK or hypoxia (capillary refill, cyanosis, etc.).
G. Reassess mental status for signs of hypo-perfusion/SHOCK.
H. Treat hypoperfusion if appropriate.
I. Obtain ECG and continually monitor cardiac rhythm as appropriate.

VI. Level of consciousness:

A. Determine need for spinal immobilization, EMS Policy No. 5506, BLS Spinal Immobilization 5115 Cervical Spine Immobilization.
   1. Determine Glasgow Coma Scale (GCS) Score (see page 3 for GCS chart).
   2. Determine glucose level as needed, EMS Policy N. 5751, ALS Altered Level of Consciousness (ALOC).
VII. Expose, Examine & Evaluate:

A. In situations with suspected life-threatening mechanism of injury, complete a Rapid Trauma Assessment.
B. Expose head, trunk and extremities.
C. Head to Toe for DCAP-BTLS
   1. Deformity.
   2. Contusion/Crepitus.
   3. Abrasion.
   4. Puncture.
   5. Bruising/Bleeding.
   6. Tenderness.
   7. Laceration.
   8. Swelling.

**Adult Glasgow Coma Scale:**

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 = Spontaneous</td>
<td>5 = Oriented</td>
<td>6 = Obeys commands</td>
</tr>
<tr>
<td>3 = To verbal stimuli</td>
<td>4 = Confused</td>
<td>5 = Localizes stimuli</td>
</tr>
<tr>
<td>2 = To painful stimuli</td>
<td>3 = Inappropriate words</td>
<td>4 = Withdrawal from pain</td>
</tr>
<tr>
<td>1 = No response</td>
<td>2 = Incomprehensible sounds</td>
<td>3 = Abnormal Flexion</td>
</tr>
<tr>
<td></td>
<td>1 = No response</td>
<td>2 = Abnormal Extension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 = No response</td>
</tr>
</tbody>
</table>

*Note: Always document and report GCS as a breakdown of scores (i.e. GCS = Eye 3, Verbal 3, Motor 4 for a total score of 10).*