REGION 11 CHICAGO EMS SYSTEM PROTOCOL	Title: Adult Initial Assessment - ALS
	Section: General
	Approved: EMS Medical Directors Consortium
	Effective: December 15, 2021

ADULT INITIAL ASSESSMENT – ALS

I. SCENE SIZE-UP

A. Wear appropriate personal protective equipment (PPE).

B. Assess the scene safety:

1. Evaluate hazards to EMS personnel, patients and bystanders;

2. Determine number of patients;

3. Determine the mechanism of injury/nature of illness;

4. Request additional resources as needed, and weigh the benefits of waiting for additional resources against rapid transport to definitive care;

5. Consider declaration of mass casualty incident if needed.

II. INITIAL ASSESSMENT OF ADULT PATIENT

A. Assess **General Impression** of the patient

1. Evaluate patient responsiveness using the AVPU scale.

B. **Primary Survey** - Should be Airway-Breathing-Circulation (A-B-C), unless specific circumstances such as cardiac arrest or major hemorrhage where Circulation-Airway-Breathing (C-A-B) is indicated.

1. **Airway** - Assess for patency

a. Open the airway as needed using either head-tilt, chin-lift or jaw thrust while maintaining spinal motion restriction as appropriate.

b. Suction airway as needed.

c. Consider use of appropriate airway adjuncts including: oral airway (OPA), nasal airway (NPA), supraglottic airway device (SGA), or endotracheal tube (ETT) as per Airway Management Protocol.

d. For airway obstruction, see Airway Obstruction Protocol.

e. For difficult airway situations in which the patient cannot be effectively oxygenated or ventilated, follow the Airway Management Protocol and transport to the closest appropriate hospital for airway stabilization.

2. **Breathing**

   a. Evaluate for rate, breath sounds, accessory muscle use, retractions, and patient positioning.

   b. Administer oxygen as needed to maintain an oxygen saturation of >94% or at 15 L by most appropriate method for any critically ill patient (respiratory distress, shock, smoke inhalation, carbon monoxide poisoning, or cardiac arrest) per Oxygen Delivery Methods Procedure.

   c. If apneic, see Airway Management Procedure.

3. **Circulation**

   a. Control any major external hemorrhage:
      i. Apply direct pressure to wound;
      ii. For life-threatening bleeding that cannot be controlled by direct pressure, follow the Hemorrhage Control Procedure.

   b. Assess pulse:
      i. Assess rate and quality of carotid and radial pulses;
      ii. If pulseless, follow Cardiac Arrest Management: Incident Command for Cardiac Arrest (ICCA) Procedure.

   c. Assess perfusion status via skin color, temperature and capillary refill.

4. **Disability**

   a. Calculate GCS as indicated.

   b. Evaluate gross motor and sensory exam in all extremities.

   c. Check blood glucose in any patient with altered mental status.

   d. If acute stroke suspected, perform Cincinnati Stroke Scale and see Stroke Protocol.

5. **Expose** patient as appropriate to complaint or mechanism.

   a. Be considerate of patient modesty and environmental conditions.

   b. Apply appropriate intervention to maintain normal body temperature.

C. **Secondary Survey** - A full secondary assessment should be completed and documented on every patient unless a critical airway, breathing or circulation problem

requires stabilization. It should not delay transport in critical patients. A secondary survey should include the following components:

1. Head

    a. Pupils
    b. Naso-oropharynx
    c. Skull and scalp

2. Neck

    a. Jugular venous distention
    b. Tracheal position
    c. Spinal tenderness

3. Chest

    a. Chest wall bruising or deformities
    b. Retractions
    c. Breath sounds

4. Abdomen/Flank/Back/Pelvis

    a. Bruising
    b. Distention
    c. Tenderness

5. Extremities

    a. Bruising or deformities
    b. Pulse
    c. Edema

6. Neurologic

    a. Mental Status/Orientation
    b. Motor and sensory exam

D. Obtain Baseline Vital Signs

1. An initial full set of vital signs is required on every patient including: pulse, blood pressure, respiratory rate, pulse oximetry and neurologic status assessment.

2. A repeat set of vital signs is required at least every 15 minutes on stable patients and at least every 5 minutes on unstable patients.

3. For patients with a cardiac or respiratory complaint or in those where acute coronary syndrome is suspected, a 12-lead ECG should be obtained as early as possible and these patients should receive continuous cardiac and pulse oximetry monitoring.

4. Initiate IV/IO access as indicated for medication or fluid administration.

5. Blood sugar should be checked on any patients with altered mental status or with known or suspected diabetes.

6. Continuous waveform capnography must be monitored on any patient with an advanced airway or bag-valve mask ventilation.

7. Pain scale should be documented on any patient with a pain complaint.

E. Obtain OPQRST History:

1. **O**nset of Symptoms

2. **P**rovocation-location, any factors that worsen or relieve symptoms

3. **Q**uality of symptoms or pain

4. **R**adiation of pain

5. **S**everity of symptoms-pain scale

6. **T**ime of onset and circumstances surrounding onset

F. Obtain SAMPLE History:

1. **S**ymptoms

2. **A**llergies

3. **M**edications

4. **P**ast Medical/Surgical History

5. **L**ast oral intake

6. **E**vents leading up to emergency call

G. Reassessment

1. At least every 15 minutes in a stable patient.

2. At least every 5 minutes in an unstable patient or more often if clinically appropriate.