1

Scene Size-up (see Scene Safety Guidelines [Z-06]):

- Scene safety (emergency services, patient(s), and bystanders)
- Environmental hazards assessment
- Need for additional resources (police, rescue, HazMat, rescue, etc.)
- Patient/caregiver interaction , including appropriate PPE.
- Take reasonable steps to protect patient privacy and modesty

ALWAYS DOCUMENT:

- Number of patients/casualties and their disposition/transfer to other medical personnel.
- Additional resources/personnel on the scene or called to the scene.
- Use of personal protective equipment (PPE) used above and beyond standard precautions.
- Possible Crime Scene: document ANY movement of patients or objects in the environment.

- CONTINUED -

2

Initial (Primary) Assessment:

- General impression/appearance of patient,
- Patient's chief complaint, circumstances and/or mechanism of injury, and
- Rapid evaluation of the patient's airway, breathing, and circulation

1st IMPRESSION (Appearance)	• Alertness/interactiveness [APVU scale] • Skin [pallor, mottling, cyanosis, etc.] • Peds: TICLS [tone, interactiveness, consolability, look/gaze, & speech/cry]
AIRWAY	• Face/neck trauma or swelling • Foreign body, secretions, blood, vomitus, etc.
BREATHING	• Work of breathing [use of accessory muscles, body positioning, irregular or gasping respirations] • Breathing/Airway sounds [stridor, wheezing, etc.]
CIRCULATION	• Circulation adequacy [pulses, capillary refill] • Signs of hemorrhage
DISABILITY	• GCS or AVPU responsiveness as appropriate for age/functional level • Assess focal neurologic deficits [motor function, pupillary response, etc.]
EXPOSURE	• Deformity • Obvious injuries

ALWAYS DOCUMENT:

- Chief Complaint/Reason for 911 Activation
- Narrative with
  - History of Present Illness (HPI)
  - Mechanism of Injury, and/or
  - Circumstances Around 911 Activation

PEDS

Color Code using Broslow, PEDIA, or similar tape:

- Any patient requesting a medical evaluation that is too large to be measured with a PEDIA Tape (or ≥ 37 Kg) is considered an adult.
- **ALWAYS DOCUMENT:**
  - Weight or length used to determine color category
  - **AND** Color category used in treatment

3

Critical Interventions per Appropriate Guideline:

- Assess the need for and complete any critical interventions.

- CONTINUED -

4

Secondary Assessment:

- Perform a focused history based on patient's chief complaint:

"AMPLE" History	• Allergies • Medications • Past Medical/Surgical/Social History • Last meal • Events leading up to injury or illness
Pain Assessment ("PQRST")	• Provocative/Palliative (modifying) factors • Quality • Radiation/Region (location) • Severity (0-10) • Time (onset, duration, etc.)

- Complete a secondary exam as directed by patient complaint:

- HEENT
- Cardiovascular
- Respiratory
- Abdominal
- Extremities
- Neurological

- CONTINUED -

5

Vital Signs:

- **Always Document (MINIMUM REQUIRED):**
  - Blood pressure (initial measurement should be taken manually)
  - Pulse rate
    - If regular, check for 15 sec & multiply by 4
    - If irregular, check for full 60 sec
    - Compare with continuous ECG if available
  - Respiratory rate
    - If regular, check for 15 sec & multiply by 4
    - If irregular, check for full 60 sec
  - Mental status
    - AVPU and/or GCS
    - Mental Eval: SI, HI, psychosis sxs, etc.
  - Pain & Severity (pain scale used & score)
- Also Consider:
  - *Temperature* (if hx of fever, or hypo/hyperthermia)
  - *Continuous ECG* (once initiated, cannot be removed until care transferred at destination)
  - *Pulse Oximetry* (if signs or symptoms of respiratory distress)
  - *Capnography* (if signs or symptoms of respiratory distress or unexplained altered level of consciousness)
  - *Orthostatic BP* (lying, sitting, standing)

- **Always document at least 2 measurements (MINIMUM REQUIRED):**
  - Initial vitals - measured at rest (not accurate otherwise)
  - Vitals on or just prior arrival to receiving facility
- Additional repeated vitals:
  - If transport or scene time > 15 minutes
    - Repeat every 5 minutes in unstable patients
    - Repeat every 15 minutes in stable patients
  - If medications or other interventions (i.e. intubation) are performed that would reasonably effect airway, breathing or hemodynamic status, vitals should be documented before and after the treatment.
  - If clinical appearance or vitals change, document vitals if immediate intervention not needed.
- Always document any reasons for not recording vitals (i.e refusal).

6

Treat Chief Complaint per Guidelines:

- See Table of Contents [TOC] for appropriate guideline(s)

7

Reassess & Document:

- Maintain an on-going assessment throughout transport
- Evaluate and document:
  - Response to (or possible complications of) interventions,
  - Need for additional interventions, and
  - Evolving patient complaints/conditions.
- Document all findings and information associated with the assessment, performed procedures, and any administration of medications on the PCR.
- Attach ECG (strips and 12-lead) to the PCR
- Attach Facesheet from destination facility to the PCR

PEDIATRIC POINTS:

- Use infant or child/pediatric BP cuff sizes when appropriate and available
  - 50th percentile BP estimate = (age in years x 2) + 90 mm Hg
  - Hypotension when BP ≤ 70 mmHg + (age in years x 2) + 70 mm Hg
- BP doesn't drop until about 30% of circulating blood volume is lost
- Tachycardia is usually the most common sign of compensated shock in children
- If obtaining a BP is not possible:
  - Evaluate for age appropriate heart rate and
  - Assess perfusion (evaluate for decreased peripheral/central pulses and cool/mottled extremities with decreased capillary refill)

DOCUMENTATION STANDARDS:

- Be truthful, accurate, objective, pertinent, legible, and complete.
  - Use appropriate spelling and grammar.
  - Use only approved medical abbreviations (refer to "Common Medical Abbreviations [**Z-R2**]).
- Summarize all assessments, interventions and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events.
  - Reflect the patient's chief complaint and a complete history or sequence of events that led to their current request or need for care.
  - Contain a detailed assessment of the nature of the patient's complaints and the rationale for that assessment.
  - Reflect the initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment and significant changes important to patient care.
  - Reflect ongoing monitoring of abnormal findings.
- List all treatments and responses to treatments in chronological order.
  - For drug administrations, include the drug name, drug concentration, volume or dosage administered, route, administration time, and response.
  - For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, pacing attempts, etc. should be attached.
- Medical Control: Document clearly any requested orders, whether approved or denied and MD name/location.
- Include an explanation for why an indicated and appropriate assessment, intervention, or action prescribed by the Clinical Guidelines did NOT occur.
- Once the PCR is completed, original document cannot be modified for any reason. Any changes required to correct a documentation error or for clarification shall be recorded in an addendum.