

## INITIAL TREATMENT / UNIVERSAL PATIENT CARE

- Initial Treatment / Universal Patient Care protocol is designed to guide the EMS provider in the initial and ongoing approach to assessment and management of medical and trauma patients.
- The patient examination should focus on rapid assessment and interventions. On-scene management of high priority patients should be limited to stabilization of life-threatening problems. Other procedures should always be performed while en route to the hospital or a landing zone.
- The goal for on-scene time should not exceed ten minutes for high priority trauma and medical patients. Shorter scene times are desirable for high priority patients. Rescue efforts for patients that are entrapped or have access/egress problems should be coordinated to minimize scene time.
- Medical Command should be notified as soon as possible when applicable to prepare the receiving hospital for the patient.
- At any time a provider is uncertain of how to best manage a patient, on-line Medical Command must be contacted for instruction.
- Rarely are emergent transports (red lights and sirens) required once the patient has been evaluated and treated. It is important that the attendant in charge (AIC) carefully evaluate the risks and benefits of an emergency transport to the hospital. The time saved transporting in an emergent mode is frequently very short. Furthermore, the time saved is unlikely to affect patient outcome. Ultimately, the mode of transportation decision is the responsibility of the AIC.

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### A. SCENE SIZE-UP

1. Take appropriate standard precautions. Put on personal protective equipment as appropriate, including gloves, eye protection mask and gown.
2. Assess scene safety.
3. Assess mechanism of injury and/or nature of illness.
  - a. Medical – determine nature of the illness from the patient, family, or bystanders. Why EMS was activated?
  - b. Trauma – determine the mechanism of injury from the patient, family, or bystanders, and inspection of the scene.
4. Determine total number of patients. Initiate a mass casualty plan if necessary and initiate triage.
5. Summon additional resources as necessary to manage the incident. Additional resources include, but are not limited to: fire, rescue, advanced life support, law enforcement, utilities.

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### B. PRIMARY SURVEY

1. Form a general impression of the patient. Consider appearance, work of breathing, and circulation to skin. If a life-threatening condition is found, treat immediately.
2. Pediatric Patients may experience respiratory distress as a result of many different causes. A general impression should be established utilizing the **Pediatric Assessment Triangle (PAT)**. Appearance, work of breathing, and circulation. (Appendix C)
3. Determine the Mechanism of Injury (MOI) or Nature of Illness (NOI)
4. Assess patient's **mental status** (maintain spinal immobilization if required)
  - a. Assess using **GLASGOW COMA SCALE**. (Appendix E)
  - b. If the victim is unresponsive with no breathing or abnormal breathing (ie only gasping), see **Cardiac Arrest Protocol 4205 / 5202 / 6205** as applicable.
  - c. Perform a Blood Glucose Reading on all patients exhibiting altered mental status
5. Assess the patient's **airway** status. Provide manual in-line stabilization of the head and neck for suspected spinal injury.
  - a. For a complete airway obstruction, see **AIRWAY MANAGEMENT protocol 4901 / 5901 / 6901** as applicable.
6. Assess the patient's **breathing**.
  - a. If respirations are inadequate, ventilate with 100% oxygen.
    - i. If optional EtCO<sub>2</sub> is available, maintain CO<sub>2</sub> level at 35 - 45 mm/hg for patients without head trauma.
    - ii. If signs of impending Central Nervous System herniation (increasing BP, bradycardia, decreasing GCS, dilation of one pupil, paralysis, and decerebrate or decorticate posturing) are present, then ventilate 12 - 20 breaths per minute to maintain EtCO<sub>2</sub> at 30 - 35 mm/hg.
  - b. If spontaneous respirations are adequate:
    - i. Severe Distress – Administer Oxygen with a non-rebreather mask at 15 L/minute.
    - ii. Mild to Moderate Distress – Administer Oxygen with a nasal cannula at 2

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to 6 L/minute to maintain SpO<sub>2</sub> at 94 - 99 %.

iii. Do not use nasal cannula in infants and small children. Blow-by oxygen or mask to keep SpO<sub>2</sub> at 94 - 99 %.

7. Assess the patient's **circulation**.
  - a. Assess pulses at appropriate pulse points.
  - b. Control major bleeding.
  - c. Check perfusion by evaluating skin color, temperature, and moisture.
  - d. Acquire 12 lead ECG and transmit if applicable.
  - e. ALS providers – Establish IV/IO access per individual protocol and apply cardiac monitor if applicable.
8. **Expose** patient.
9. Identify the priority of the patient based on assessment findings.
10. Expedite transport for high priority patients

### C. SECONDARY SURVEY

1. Obtain vital signs, including:
  - a. Respirations
  - b. Pulse
  - c. Blood pressure
  - d. Skin color, temperature, and condition
2. Obtain chief complaint.
3. Obtain history of present illness and past medical history
4. Conduct a physical examination (head-to-toe assessment) or focused exam

D. Perform Ongoing Exam and assess interventions.

E. Consider Patient Comfort Protocol **5902 / 4902** as applicable for ALS providers.

**NOTE:** Assessment Mnemonics can be found in Appendix D.