Santa Barbara County General Patient Guidelines

I. Purpose: To establish a consistent approach to patient care.

A. Initial Response

1. Review dispatch information with crew members and dispatch center as needed
2. Consider other potential issues (location, time of day, weather, etc.)

B. Scene Arrival and Size-up

1. Address Body Substance Isolation/Personal Protection Equipment (BSI/PPE)
2. Evaluate scene safety
3. Determine the mechanism of injury (if applicable) or nature of illness
4. Determine the number of patients
5. Request additional help if necessary
6. Consider spinal precautions (refer to Policy 540 – Spinal Motion Restriction)

C. Primary Survey – Assessment of A-B-C's will be modified to C-A-B during instances of cardiac arrest or major arterial bleeding)

1. Airway
   a. Open airway as needed, maintaining inline cervical stabilization if trauma is suspected
   b. Insert appropriate airway adjunct (if indicated)
   c. Suction airway (if indicated)
   d. If a partial or complete Foreign Body Airway Obstruction (FBAO) is present, utilize appropriate interventions
2. Breathing
   a. Assess rate, depth, and quality of respirations
   b. Assess lung sounds
   c. If respiratory effort is inadequate, assist ventilations with BVM
   d. Initiate airway management and oxygen therapy as indicated
3. Circulation
   a. Assess skin color, temperature, and condition
   b. Check distal/central pulses, including capillary refill time
   c. Control major bleeding
   d. Initiate shock management as indicated
4. Disability
   a. Evaluate patient responsiveness: AVPU Scale (Alert, Verbal, Pain, Unresponsive)
   b. Evaluate Circulation, Sensory, Motor (CSM) function in all extremities
   c. Assess pupillary response
   d. Check blood glucose in patients with altered mental status
5. Exposure

a. Expose the patient as appropriate to their complaint
   i. Be considerate of patient modesty
b. Keep patient warm

D. Determine Chief Complaint. Initiate treatment per SBCEMSA policies/protocols

II. Secondary Survey – Should not delay transport in critical patients. Assessment should be tailored to patient presentation and chief complaint.

A. Head
   1. Pupils
   2. Nasopharynx
   3. Skull and Scalp

B. Neck
   1. Jugular Vein Distension (JVD)
   2. Tracheal position
   3. Spinal tenderness

C. Chest
   1. Retractions
   2. Breath sounds
   3. Chest wall deformity

D. Abdomen/Back
   1. Flank/abdominal tenderness or bruising
   2. Abdominal distention

E. Extremities
   1. Edema
   2. Pulses
   3. Deformity

F. Neurologic
   1. Mental Status/Orientation
   2. Motor/Sensory

III. Obtain Baseline Vital Signs

A. Full Set of Vital Signs
   1. Blood Pressure and/or Capillary Refill
   2. Heart Rate
   3. Respiratory Rate
   4. Pain Scale (Use Numeric, FACES or FLACC scale as age-appropriate)

B. ALS assessments, in addition to the primary/secondary surveys and vital signs listed above, may include the following:
   1. Continuous Cardiac Monitoring
   2. 12-Lead ECG as indicated per Policy 539: 12-Lead ECG Process

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3. Pulse Oximetry
4. Capnography (when utilizing Dual Nasal Cannula (if available), CPAP, or BVM)
5. Abnormal vital sign(s) should be reassessed and documented often. Any medications or procedures performed should be documented as contemporaneously as possible.

IV. History of Present Illness (HPI) – include pertinent negatives and additional signs/symptoms

A. Obtain OPQRST History:

1. **O**nset of symptoms
2. **P**rovocation – location; any exacerbating or alleviating factors
3. **Q**uality of pain
4. **R**adiation of pain
5. **S**everity of symptoms – pain scale
6. **T**ime of onset and circumstances around the onset

B. Obtain SAMPLE History:

1. **S**ymptoms
2. **A**llergies – medication, environmental, and foods
3. **M**edications – prescription and over-the-counter; bring containers to ED if possible
4. **P**ast medical history
5. **L**ast oral intake
6. **E**vents leading up to the 911 call

C. Do not leave these areas blank in documentation; if the information is unknown or unavailable, utilize an appropriate null data entry choice.

V. Base Hospital contact shall be made for all required patients in accordance with Policy 303: Mandatory Base Hospital Communications

VI. Transport to the appropriate facility per the appropriate policy

A. Policy 510: Trauma Triage Criteria & Patient Destination
B. Policy 511: EMS Transport Zones
C. Policy 550: Stroke System Triage & Destination
D. Policy 620: Hospital Diversion
E. Policy 622: Base Hospital Service Areas and Ground Ambulance Transport Zones

VII. Continuously monitor vital signs and document all findings as contemporaneously as possible.

A. Continue appropriate treatments during transport and reassess for changes in patient status.

VIII. Documentation

A. Completion of patient care report per Policy 700: Documentation of Prehospital Patient Care
B. Submit cardiac monitor data, including any 12-lead ECG(s), for all ALS patients.
   1. *For 911 patients*: If 12-Lead ECG is obtained prior to EMS arrival, obtain hardcopy and transport 12-Lead ECG with patient to the receiving facility.
C. Maintain patient confidentiality at all times.