ELSEVIER Clinical Skills

Emergency Primary Assessment – CE

CHECKLIST

S = Satisfactory U = Unsatisfactory NP = Not Performed

Step	S	U	NP	Comment
If the primary assessment was to take place at the scene of the incident, assessed the scene for environmental hazards and alerted the proper authorities as needed to secure the scene.				
Performed hand hygiene and donned gloves. Donned mask, eye protection, and fluid-resistant gown as indicated.				
Performed an across-the-room assessment upon the patient's arrival to quickly identify any life-threatening conditions such as uncontrolled hemorrhage. If a massive hemorrhage was present, applied direct pressure or a tourniquet as needed.				
Performed the primary assessment systematically, using the mnemonic A-B-C-D-E.				
A = Airway and Alertness with Simultaneous C-spine Motion Restriction				
Assessed the patient's level of alertness using the AVPU scale.				
Maintained c-spine protection if indicated either manually or with an appropriate-size cervical collar.				
If the patient was alert or responsive to verbal stimuli, had the patient open his or her mouth to assess the airway.				
If the patient was not able to open his or her mouth and responded only to pain or was unresponsive, manually opened the airway with either the jaw thrust (trauma) or the head tilt–chin lift (no trauma).				
Inspected for potential airway obstructions. If a definitive airway was in place, assessed for proper placement of the airway.				
If the airway was partially or completely obstructed, intervened as needed.				
If the patient was at risk for a c-spine injury, had an assistant manually stabilize the patient's head until the primary and secondary assessments were complete and c-spine injury had been ruled out by radiograph or clinical examination, or until more definitive stabilization could be instituted. In the absence of an assistant, placed towel rolls or foam blocks alongside the patient's head to help maintain				

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alignment, and reminded a conscious patient to avoid moving.				
B = Breathing and Ventilation				
Observed for spontaneous breathing, respiratory rate and depth, the rise and fall of the chest for symmetry, the use of accessory muscles, and any open chest wounds, such as an open pneumothorax. Noted any signs of respiratory distress.				
Briefly auscultated breath sounds bilaterally.				
If spontaneous respirations were present, and the patient was alert, intervened as needed.				
If respirations were absent or abnormal, intervened as needed.				
C = Circulation and Control of Hemorrhage				
Evaluated a central pulse for rate and strength.				
Observed and palpated the skin for warmth, color, and moisture.				
Checked for exsanguinating external hemorrhage, and, if present, applied direct pressure to the site. If bleeding of the extremities was not controlled by direct pressure and if necessary, applied a tourniquet.				
If circulation was absent or altered, intervened as needed.				
D = Disability (Neurologic Status)				
Evaluated neurologic status using the GCS, or, if the patient was intubated, the FOUR score.				
Assessed pupil size, equality, and reaction to light.				
E = Exposure and Environmental Control				
Removed the patient's clothing to allow for quick identification of all obvious injuries, other signs of illness, and any uncontrolled bleeding.				
Kept the patient warm by covering with a warm blanket, using warming lights, keeping the room temperature warm, or using other commercial warming devices.				
Completing the Procedure				
After completing the primary assessment and addressing any life-threatening conditions, evaluated whether the patient should be transferred				

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elsewhere. Then proceeded to the secondary assessment.				
Monitored the patient for changes in airway patency; breathing effectiveness; changes in pulse, skin temperature, and color; and changes in neurologic status.				

Learner: _____ Signature: _____

Evaluator: _____ Signature: _____

Date: _____