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1 INITIAL. - Score Primary and Secondary Survey Ardhiles WK 2 3 4 5 6 TOSIBHA 21 7 8 9 10 And maybe one day you will be assigned to one of these places? 11 Emergency and disaster point. You should be prepared for emergency rescue and disaster relief 12 How do we assess emergencies? 13 PRIMARY SURVEY Life Safing Time Safing (maximum 10 minutes) SECONDARY SURVEY Life Safing 14 Initial actions before assisting/managed victim: if the victim is zgt.L, call for help from another ambulance. 1 ambulance per victim is optimal. Carrying the minimum basic equipment required, namely: 1. Long spine lock/scoop stretcher and immobilization of the head 2. Kolar braces/ neck collar 3. Oxygen and breathing equipment, as well as airways 4. Injury Box (TTV tools, bandages, drugs and fluids) 5. Self-defense for rescuers Safe conditions for rescuers and victims (vehicles, electricity, fire, floods, etc.) 15 PRIMARY SURVEYS : STEPS Used as a rapid detection and immediate correction of vital organs, which are threatened with a maximum of 2 minutes, aimed at detecting anomalies ABC Primary survey should not stop until completion, unless the blockage of the respiratory tract and heart stop STEP - STEP 16 2. (A) Respiratory tract : Airway review if there is snoring, rinsing, hoarseness (stidor). Is the airway adekuat, do open airways (tilt of the head, chin lift, in trauma patients performed jaw thrust). If there is an inordable object remove / smear finger, if many secrets do suction 17 3. (B) Breathing : Breathing : BreathDo 3M (see breast movement, hear the sound of breathing, feel the breath) / Look, Listen, Feel - Lee shortness of breath, looks extra breathing muscles - Breathing strong : Regular rhythm or not, If shortness of breath / not strong to give oxygen : nasal sinking, RM, NRM, Venturi Mask If the breath is stopped / (C) Circulation/Circulation: Whether the patient experiences cardiac arrest, using a sleepy heart rate check, if the pulse does not significantly perform CPR is there any external/internal bleeding. Stop immediately with : Bebat click on the wound Height Turnstile if necessary There are any signs of shock: Cold perfusion, fast and weak pulse fast and weak CRT zlt; 2 seconds 19 Initial review Results If in the initial survey there is a problem on abc, immediately given important actions such as: Installation of neck collar, oxygen administration, administration bebat press if there is bleeding. Continued neck-to-knee examination (finding the root cause of ABC problems). Inspection includes : 1. Inspection : to see DECAP BLS BLS Contusio, Abrasia, Penetration, Burn, Laseration, Swelling) 2. Palpasi : to search for TIC (Tenders, Instability, Crepitation) 3. Auskulation : to hear abnormal sounds in the breath, heart and abdomen. 4. Shock: distinguish the organ contains fluid or air 20 Necks: Inspection (DECAP BLS)Palpasi (TIC, lack of jugular venous consumption / JVD and trachea deviation as a sign of pneumothorax tension. Heart Sound From Heart Tamponade Sign) Drums: Hypersonor sign of pneumothorax tension, dim hematofrac mark 21 Abdomen : Inspection (DECAP BLS) Suspected pelvic intretion bleeding: Inspection (DECAP BLS) Palpation (tic, suspected pelvic fractures and pelvic bleeding). Pelvic bleeding has the largest volume of femur: Inspection (DECAP BLS) Palpation (TIC, Suspected femoral and femur bleeding) : Reducing abnormal respiratory disorders awareness circulation (shock) fractures of the femur, pelvis, iliac of the breast Lift to the ambulance immediately, go directly to the hospital 23 Secondary examination : ...? 24 Goal: Finding physical changes that can develop into an emergency. Conducted after the initial examination Secondary examination can be done while in the ambulance in critical patients Equipment: Stetoscope, tensimeter, clock, lamp examination, thermometer, glucometer, ECG, monitor 25 Stage secondary Survey Prove intervention on the victim according to the findings in the survey, such as: install infusion, install bidal. Check TTY Ask patients : S A M P L E - S : Symptoms : Symptoms : Complaints received - A : Allergy : Food / Medicine / - M : Medications : Last medicine consumed - P : Illness suffered - L : Last food: Eat What time - E : Event : What is 26 Secondary review : Head ToeKepala Examination : - Inspection : - rhinorea, erya, battle sign - See the reflex of the pupil: isokor/no, size. - Palpation: TIC, starting from the occipital bone, parietal, temporal, frontal, orbit, zygomatics, nasal, maxilaris, candidibularis. 27 Neck : Inspection : DECAP BLS Palpasi : TIC, jugular venous stretched (JVD), trachea deviation, strong sleepy pulse. Breast : Inspection : DECAP BLS Palpasi (TIC, Paradoxical movement, like a bottle of breast sign) Auscultation (breathing Pneumotrak sign of tension, cardiac noise from the heart sign) Shock : hypersonor pneumothorax tension sign, hematothorax mark 28 Abdomen : Inspection (DECAP BLS) Palpation 4 Regions (TIC). Suspected intra-dose bleeding Inspeksi (DECAP BLS) Palpasi (TIC.. Curiga fractur pelvis and perdarahan pelvis). Femur: Inspeksi (DECAP BLS) Palpasi (tic.. Kuriga fractur femur and perdarahan femur. 29 Celeasi Secondary Lacukane dokumentasi. haki: Inspeksi: DECAP BLS Palpasi : TIC, PMS (Pulse, Motoric, Sendik) Tangan: Inspeksi : DECAP BLS SelSesai Secondary Lacukane dokumentasi. Observasi berkala : ABC, TTV, irama EKG, kelancaran infus. Aliran oksigen 30 ? 31 See you next time MULTIPLE TRAUMA 1 / WHAT IS MULTIPLE TRAUMA? Significant lesions to more than one important system of bodies or bodies of the body. 2/ IS THE SEVERITY OF THE INJURY SWORN TO BE DETERMINED AT THE SCENE? Inaccurate because many young patients have large reserves and are not present with lesions that can be severe until they are compensated. A number of scales and scoring equipment have been developed to determine the extent of the injury. However, these tools are not perfect, and in order to maintain an acceptable level of safety, the emergency system must obelie patients with multiple injuries. Transportation to the trauma center should be based on the trauma mechanism, underlying illness, psychosis, such as changes in signs of death and neurological condition, as well as the presence of visible damage to several body systems. The mechanism of the injury shows whether the events and conditions that lead to injuries are known. Critical injury mechanisms are associated with a high probability of multiple injuries. Less pronounced mechanisms are of concern to older patients who have had the disease before. A patient with ankylosing spondyl is less able to withstand spinal and pelvic injuries than a healthy young man. 4/ GIVE EXAMPLES OF THE MECHANISMS OF CRITICAL INJURIES. 5/ HOW SHOULD A PATIENT WITH MULTIPLE INJURIES BE ASSESSED? All trauma patients should be evaluated using standard advanced injury life support protocols, including ABCDE assessments of your head, airway, breathing, circulation, disability, and exposure. Initial assessment surveys are followed by secondary examinations to identify non-life-threatening injuries. 6/ TELL ABOUT THE IMPORTANT COMPONENTS OF THE INITIAL ASSESSMENT OF PATIENTS WITH INJURIES? Primary examination, resuscitation, secondary examination, reassessment and final care. 7 / WHAT IS THE PURPOSE OF THE INITIAL ASSESSMENT? Identify life-threatening injuries in order of time and first. 8/ LIST THE FIRST STEPS IN MULTI-THOUSANDTHERAPY IN THE EMERGENCY ROOM. - Call the trauma intensive care unit. - Indicate the captain's injury and the claim is negative 0, if stated. - Transfer of patients from the ambulance to the emergency room. - Immediate medical history, including trauma mechanisms, treatment was carried out at the scene, and the response to this treatment. - Take vital signs while the patient undresses. - Evaluate the ABC and intervene if necessary. - Take blood to determine type, cross-reaction and basic tests. 9 / HOW SHOULD PATIENTS BE UNDRESSED? Since the non-21, it is necessary to X-ray the spine, all movements should be avoided. To be able to see completely quickly, protecting the spine, just cut off the patient's clothes. Keep in mind that one of the purposes of taking away clothing is to remove items from the patient that may cause further injury to the patient or cause harm to medical personnel, such as mirror fragments, metal fragments or weapons. 10/ ABC (AND D) INJURIES? 1. AIRWAY: The communication of the airways is assessed by hearing the pronunciation, asking the patient's name, and searching the patient's mouth for signs of obstruction (blood, vomiting, or foreign objects). The head traum captain must determine if the patient needs active airway management and check for the availability of additional oxygen continuously where all patients do not require immediate catheter implantation. Mandatory airway control rules Injury - Massive facial injuries. - Head injury with GCS (Glasgow Coma Scale) under the age of 8. Penetrating trauma to the skull vault. - The rocket penetrates the neck. - Neck injury with widespread hematoma or voice change. - Multi-system trauma with prolonged stun. Relatively indicated for respiratory treatment for injuries: - Obstruction of the upper respiratory tract for any reason. - Any patient with injuries that impair breathing. - Flank plaque with increased breathing rate or decreased oxygen protection level. - Any patient with one or more rib fractures will need a ventilator or general anesthetic. Patients with pleural embolism on both sides. - Gunshot wounds to the chest. - Patients with continued pleural hemorrhage, recurrent or unrea respond to the circulation of the chest (tubular thoracostay). - Patients with severe loss of volume stun. 2. BREATHING Ventilation is evaluated by observing symmetrical up and down breasts and listening to breathing on the sides, on the front chest and armpits. The breast should be pressed slightly to find the gas under the skin and as the bones creak. Oxygen protection must be monitored continuously. The injury manager determines whether a tubular thoracost or hardware support is needed immediately. 3. CIRCULATION of circulatory function is assessed, carrying away the mental state of the patient, the color and properties of the skin (cold and warm for warm and dry). Signs of survival and the presence or absence of radial, femoral and sleepy chains. It is recommended to start continuous cardiac monitoring. Pre-hospital vascular access and the type and volume of infusions. The injury captain decides whether to create an additional vascular line or add the volume of crystaloids that is needed, or whether it should be provided. 4. DISABILITY (or neurological condition). The patient's neurological condition should be assessed (level Mobility). The initial GCS should be evaluated and this score should be compared to the GCS pre-hospital. In any sensory transformation, performing rectal examination is useful for determining the sicular strength of the anus. 11 / HOW IS THE AIR TRAJECTORY ASSESSED? Ask the patient a question. Normal voice reaction indicates that the air trajectory is not in immediate danger. A hoarse, weak or pro-game voice can imply a path of harm. Excited response or swinging area indicates tissue hypoxia until there is evidence to the contrary. A final response to the airways is required (the cuff tube is in the airways). 12/ THE MOST COMMON CAUSES OF RESPIRATORY OBSTRUCTION IN THE PATIENT'S INJURY. The tongue, followed by blood, teeth or sets of removable teeth, vomiting and mild swelling. 13/ WHAT INITIAL TECHNIQUES ARE USED TO CREATE AN OPEN-AIR PATH? The procedure of lifting the chin and jaw, mechanically, push the lower jaw and tongue forward to open the airway, and use your hands to remove debris and suck the diaphragm to optimize air trade. Respiratory oropharyngeal and nasopharyngeal are useful sub-devices for maintaining the way out in the open air where patients are in a coma. All of these procedures must be performed with a firm retention of the cervical spine. 14 / FINAL AIRWAY RULES? Apnea, unable to maintain or protect the airways (modified mental state), is unable to maintain oxygenation, hemodynamic instability, need expansion or muscle sedation, and need increased ventilation. 15/ WHAT IS THE FINAL AIRWAY PLAN AVAILABLE? - Oral orto chi no chi. Endo-nasal airways. - Surgical airways: open ring cartilage (cryothyroidotomy) or tracheotomy. 16 / WHEN THE WORK OF THE RIGHT (MODIFIED FREE)? In any case, which patient needs final airway, but endo-air passages or nasal or nasal ortongit cannot be performed safely, patients with extensive facial injury or anterior neck injury are at high risk. Open cartilage (cryothyroidotomy) should not be performed where patients with direct seral trauma, patients with ruptured aesthete, or patients under the age of 12. Tracheostomy and transtracheal ventilation are the preferred options in these cases. 17/ WHAT TYPE OF INTRAVENOUS ROUTE SHOULD BE SET, WHERE IS THE PATIENT WITH CRITICAL INJURY? Two large intravenous catheters should be placed. Forearm veins are the preferred place to create an original intravenous line. Although internal jugular catheters allow you to control the pressure of the central vein, they rarely provide sugar for intravenous infusions with large volumes. If the introduction of Cordis does not fit in place. These intravenous lines should only be used when there are no other lines, and the catheter should be placed on the same side of the chest injury if vascular damage under impact is suspected. Hip intravenous and intravenous routes are indicated where patients with low blood pressure will need to quickly transmit large volumes. 18 / WHERE TO OPEN THE VEINS? Ankle disease. A safenous vein can be found between the front tendon of the shin and the fish. An ultrasound of the bedside bed can increase the likelihood of successful central intravenous placement. 19/ WHAT PARAMETERS SHOULD BE CONTROLLED WHERE THE VICTIMS ARE MULTI-STRETCHED? Signs of vitality, neurological condition, pulse, oxygen protection and, if possible, pressure of central veins and flow of urine. Hypothermia has the opposite effect on the first day, and the central temperature can drop quickly when the patient undresses and receives a large amount of intravenous cold infusion. Tahpnea is a sensitive sign of hypoxia and acidosis and should be measured more accurately than just estimates. The neurological condition, color and properties of the skin, and the flow of urine should be monitored. 20 / WHAT ARE THE MAIN FACTORS FOR ASSESSING HEMODYNAMIC STABILITY? Mental state (alert, verbal, pain and non-notice), skin circulation (pink/warm vs. blue and hemodynamic parameters (blood pressure, heart rate, respiratory rate). Keep in mind the assessment of the palpable impulses of systolic blood pressure. The captured rotation pattern corresponds to sitotic blood pressure of 80 mmHg. Art. femur (ingical), sisicological blood pressure zgt:70 mm Hg. Art. Sleepy vessels (zgt), sislergic blood pressre is 6 mmHg. The speed of the flow of urine helps to predict the circulation of the final organ. 21/ WHEN TO DONATE BLOOD? 0-negative blood (donor) should be available to patients with cardiac arrest due to hypovolemic shock. If the crystaloid 40 ml/kg is transmitted quickly and there is no significant improvement in circulation patients of the same type of blood who do not perform cross-reflex (type-specific blood non-crossmatization) should be given, if any. Otherwise, start using Type 0. 22 / ARE TESTS USEFUL? No, although all victims with critical injuries should be classified as blood and crosshairs. These basic blood values and amylase (or better than lipase) can be helpful in detecting occult trauma and pre-existing anemia. Urine analysis must be performed to detect hematoma. Many trauma centers have an extensive trauma panel, which can be useful if the patient needs surgery or has a underlying disease. However, no tests have identified the injury, and the trauma panel is less helpful in determining the initial treatment, discharge or needing surgery. 23/ WHAT IS A SECONDARY EXAMINATION? The medical examination is carried out completely after the evaluation and stabilization of the ADC. This assessment includes the assessment of the thoracic, abdominal, pelvic, dorsal and other branches. The purpose of the rectal examination is to determine whether there is blood in the rectum, whether there is an appropriate muscle syth ring and sensation, and whether the prostate is in a normal position. 24/ WHAT X-RAYS SHOULD BE TAKEN IMMEDIATELY? After stabilizing the patient, portable X-rays of the lateral cervical spine, chest and pelvis should be finished. In the case of gunshot wounds, the keys to the shooting A bed on both sides may be necessary to determine the position of the bullet. If the mechanism of the injury is an outlier, a drop, cross-table lumbar spine should be added to the original series. 25 / HOW DO PEOPLE CLEAN THE FIXED SPINE (CLEAR THE C-SPINE)? Spinal lesions should be ruled out before the patient's head and neck are damaged. Patients who are awake without other significant lesions can be moved without X-rays if they have no symptoms and no sensitivity to neck pain when pressed directly. Patients with symptoms or other important lesions (in person) need a series of 3-positional spinal imaging (ana back, lateral, lateral and odontoid) to assess the cervical spine. Observation of the C7-T1 level is mandatory because 10% of unstable cervical spine fractures occur at this level. If this series of 3 positions does not fit, you can perform the kind of swimmer (the patient's hand extends over his head using X-rays aimed through the armpit). In cases where patients are at high risk with symptoms and suspicious imaging or patients in intensive care are sedated/endotelic, CT in the neck may be needed to remove unstable bone damage. Persistent symptoms, wearing a head without bone damage, the likelihood of ligament damage may need to be assessed with neck sprain. CT scan or IRM scan. 26 / HOW TO PRIORITIZE DIAGNOSTIC TESTS? Priority is given to potentially life-threatening circumstances. After conducting an external hemorrhage, the diagnosis of hemorrhage in the sinuses of conjunctivitis takes precedence. If the lacartomy is not immediately shown, the patient should receive a diagnostic abdominal cavity, abdominal CT or abdominal ultrasound to assess the abdominal sinus. After these procedures, attention should be focused on eliminating curable intracranial hemorrhage, such as lower hematoma or anolytic. Other specialized probes should be conducted on the basis of the mechanism of injury and initial progression to assess the dynamics of the host and peri-peritiva. patients who may have bleeding diathesis (e.g. haemophilia) or are treated with antifreeze medication, immediately a mild head injury should perform CT. Links: Emergency Medicine Secrets of Abernathy Surgical Secrets Orthopedic Secrets BS NGUYEN VAN THINH (17/7/2010) (17/7/2010) primary survey dan secondary survey adalah

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