

Activity 3.2.1

Survey and Assess

DATE	PORTAL DAY	LESSON	TURN IN
Friday 2026-11-30	Triage ethics debate	Lesson 3.2 Emergency Response	Exit ticket

Where this sits. Day 1 of 2. Scene survey and primary assessment today; secondary assessment Tuesday.

01 Why today matters

A new case starts today: you are on a flight medical team, there is one badly hurt person somewhere in a canyon, and a storm is coming in.

Before you touch the patient you have to decide whether it is safe to reach her, and that decision, made under time pressure, is the ethical problem of the day.

02 What you already know

- Lesson 3.1 is closed. You found a source, identified an organism, and wrote to the hospital.
- From Unit 2 you can take and read vitals: pulse, respiration rate, blood pressure.
- You know from Unit 1 that rushing a scene destroys evidence. Here it can destroy a rescuer.

WHAT THIS SHEET WILL NOT TELL YOU

- This sheet does not tell you what is wrong with the patient. You assemble that from what you observe, over two days.
- It does not tell you whether the scene is safe. You have to survey it and decide.
- There is more than one thing wrong with this patient, and the loudest injury is not automatically the most dangerous one.

03 Vocabulary

TERM	WHAT IT MEANS, PLAINLY
cross-trained	Trained in more than one skill, so one person can cover several jobs. Standard on small field teams.
paramedic	The highest field-certified level of emergency medical technician. Can give many medications and perform advanced airway procedures.
emergency medical technician	Written EMT. Certified to provide emergency care and transport, at several levels of training.
triage nurse	The nurse who decides the order in which arriving patients are seen.
scene size-up	The fast, ordered look at a scene you do before going in: control the situation, look for hazards, gather information, protect and prioritise.
risk assessment	Naming each hazard and judging how likely it is to hurt someone and how badly.

bystander	Someone at the scene who is present but not injured.
primary assessment	The rapid check for anything that could kill the patient in the next few minutes. Trained responders do it in under 15 seconds.
mechanism of injury	Written MOI. What physically happened to the body. A fall from height and a fall from standing produce different injuries even when they look the same.
responsiveness	How much the patient reacts. Alert and talking, responds only to voice, responds only to pain, or unresponsive.
spinal immobilization	Holding the head, neck, and back in line so a damaged spine is not moved further.
spinal board	The rigid board a patient is strapped to so the spine cannot move during a lift or transport.
cervical fracture	A break in one of the bones of the neck.
ABCs	Airway, Breathing, Circulation. The order you check them in, because a blocked airway kills faster than bleeding.
airway	The path from mouth and nose to lungs. If it is blocked, nothing else you do matters.
stridor	A high-pitched noisy sound on breathing in, caused by a narrowed airway. It is a sound you can hear without a stethoscope, and it is always taken seriously.
head-tilt chin-lift	The manoeuvre that opens an airway by tilting the forehead back and lifting the jaw. It is not used if a spinal, neck, or head injury is suspected.
bag-valve-mask	A mask with a hand-squeezed bag that pushes air into a patient who is not breathing well enough on their own.
bloodborne pathogen	A disease-causing agent carried in blood. The reason gloves are not optional at a scene.
laceration	A jagged tear in the skin, as opposed to a clean cut.
medical alert bracelet	A bracelet a person wears that lists conditions or allergies a responder needs to know when the person cannot speak.

Every term on this list is flagged for the illustrated glossary, scoped to this activity only. Terms are not shared forward or backward between activities, because a definition from a later activity can hand you an answer you were supposed to derive.

04 How to do the work

- 1 Each person on your team picks a different emergency response career from the list: paramedic, EMT, disaster response technician, emergency medicine physician, emergency medicine nurse practitioner, emergency services coordinator, triage nurse, emergency communications specialist. No duplicates in a team.
- 2 Research yours with reliable sources. In your notebook record: the education, licence, or certification required, the daily responsibilities, the personal and professional qualities the job demands, and a few honest sentences on what does or does not appeal to you about it.
- 3 As a team, describe how your chosen roles would work together, both in the field and back at the hospital. Invent a scenario and say who does what, in what order.
- 4 Listen to the Medflight Request dispatch audio. Write down every fact the dispatcher gives you, before you form any opinion about it.
- 5 You land. It is hot, a storm is moving in, and the patient is somewhere among rocky bluffs and trees. Work the scene size-up in order: control the situation, look for hazards, assess the situation with all your senses, protect and prioritise.

- 6 Open the Survey the Scene interactive graphic and click every hotspot. Every one. The hazard you skip is the one that gets somebody hurt.
- 7 Write your risk assessment: every scene hazard you found, a short description of the location, the extent of the emergency, the environmental dangers, the number of people injured or ill, and the behaviour of the patient and any bystanders.
- 8 Decide, in writing, whether it is safe to go in, and describe the specific route you would walk and the precautions you would take on the way. Note which hazards you are accepting and which you are avoiding.
- 9 Start the primary assessment. Read the patient description carefully and record it as observations, not conclusions. Where she is lying, where blood has come through her clothes, whether she responds to your voice, what she is wearing, what marks are on her.
- 10 From that description, write your general impression, the most likely mechanism of injury, and the patient's responsiveness. Three separate answers.
- 11 Step 4 of the primary assessment: given the mechanism of injury, is this patient at risk of a spinal or neck injury? Say yes or no and say what in the mechanism drives your answer. Review the Cervical Fracture model.
- 12 Step 5, the ABCs. Listen to the Patient Breathing Sounds audio. Describe the sound in your own words and calculate her respiratory rate in breaths per minute. Show the arithmetic, including the length of the clip you counted over.
- 13 Read the circulation description. Then research and answer three things: for an unconscious person at rest, is that heart rate low or high? What does a weak pulse suggest? What do pale, cool, moist skin suggest about the circulatory system?
- 14 Write your most pressing concerns for this patient at the end of the primary assessment, ranked, with a reason for the ranking.

05 Safety

READ EVERY LINE BEFORE YOU START

- This is a paper and screen day. No simulated blood, no equipment, no hands on anyone.
- The scene-safety rule that carries out of the classroom: if a scene is not safe, you do not enter it. You move to a safe distance, call for help with the training and equipment the scene needs, and you wait. A second casualty helps nobody. This is the single most-broken rule in real emergency response and it is the reason people who wanted to help end up hurt.
- Content warning, given now so you can plan. The bleeding-control station uses simulated blood and a wound model that includes a broken bone pushing through skin, and the medication station links to a video of a needle going into a real person's arm. If any of that is a problem for you, for any reason, tell Mr. Mendoza before the day starts. Come to the desk, send a message, or write it on a slip. You do not have to explain, and there is a different job waiting that earns the same credit.

06 Where students get stuck

- Running to the patient. Every instinct you have says go, and the scene size-up exists precisely because that instinct gets responders killed. Survey first, every time, even when it feels cold.
- Skipping hotspots on the scene graphic because you think you know what matters. One of the things in that scene is going to matter later in a way that is not obvious now.
- Treating responsiveness as awake or not awake. There is a scale between them, and where a patient sits on it changes what you do next.

- Writing conclusions in the observation section. 'She is in shock' is a conclusion. 'Skin pale, cool, moist; pulse weak; heart rate 106' is what you observed. Keep them in different columns so you can change your mind without losing your data.
- Assuming the most visible injury is the most dangerous one. Airway comes before breathing, breathing before circulation, and circulation before the thing that looks the worst. That order is not a suggestion.
- Ignoring the bracelet because it is not an injury. It is a message from the patient, written for exactly this moment, when she cannot tell you herself.

07 What you turn in

EXIT TICKET

Exit ticket. Two parts. Part one: your safe-or-not-safe call on the scene, in one sentence, with the two hazards that most drove it. Part two, the ethical question: a scene is unsafe and a patient is visible and in trouble. What do you do, and what do you say to a teammate who wants to go in anyway? Two or three sentences. Your career research, risk assessment, and primary assessment notes stay in your notebook and are checked Tuesday.

08 Check yourself

- ☐ What are the four steps of a scene size-up, in order? (Vocabulary and step 5)
- ☐ Why is airway checked before circulation, even when there is visible bleeding? (Where students get stuck)
- ☐ Give one example of a scene hazard that threatens the rescue team rather than the patient. (Step 6 and your risk assessment)