1.02 PATIENT ASSESSMENT –SECONDARY SURVEY

The secondary survey is the systematic assessment and complaint-focused relevant physical examination of the patient.

- The Primary Survey and initial treatment and stabilization of life-threatening airway, breathing and circulation difficulties.
- Need for Spinal Motion Restriction.
- A rapid trauma assessment (if indicated by related trauma protocol).
- Transport of the potentially unstable or critical patient.
- Investigation of the chief complaint and associated complaints, signs or symptoms.
- An initial set of vital signs:
  - Pulse.
  - Blood pressure.
  - Respiration.
  - Lung sounds.
  - Pupils.
  - Cardiac rhythm (if indicated by related protocol).
  - Pulse oximetry.
  - Blood Glucose (if indicated by related protocol).
  - Determine Glascow Coma Scale (GCS) Score:

Eye Opening	Verbal Response	Motor Response
4 = Spontaneous	5 = Oriented	6 = Obeys Commands
3 = To verbal stimuli	4 = Confused	5 = Purposeful / Localizes pain
2 = To painful stimuli	3 = Inappropriate words	4 = Withdraws to pain
1 = No Response	2 = Incomprehensible words	3 = Flexion to pain
	1 = No Response	2 = Extension to pain
		1 = No Response

USING THE GCS TO ASSESS INFANTS AND YOUNG CHILDREN:

Eye Opening	Verbal Response	Motor Response
4 = Spontaneous	5 = Smiles, oriented to sounds, follows objects, interacts	6 = Obeys Commands
3 = To verbal stimuli	4 = Cries but is consolable; inappropriate interactions	5 = Purposeful/Localizes pain
2 = To painful stimuli	3 = Inconsistently consolable, moaning	4 = Withdrawal from pain
1 = No response	2 = Inconsolable, agitated	3 = Flexion to pain
	1 = No vocal response	2 = Extension to pain
		1 = No motor response

HISTORY

- Obtain Patient History from available sources.
- Allergies.
- Medications. Past medical history relevant to chief complaint
- Assessment questions, if appropriate:
  - OPQRST (location, factors that increase or decrease the pain severity and a pain

scale.)
    - O= Onset (Sudden or gradual)
    - P= Provoke (What were you doing when the pain started? Does anything make it better or worse?)
    - Q= Quality (What does the pain feel like?)
    - R= Region/Radiate (Where is the pain? Does it go anywhere else?)
    - S= Severity (On a scale of 1-10, 10 being the worst pain you have ever had, how would you rate that pain now? How would you rate that pain at its worst or during exertion/movement?)
    - T= Time (When or what time did this start?)
  - PASTE (Used for Shortness of Breath Assessment)
    - P= Progression (Sudden or gradual?)
    - A= Assoc. Chest Pain (If yes, which came first?)
    - S= Sputum (Are you coughing anything up? If yes, what color is it?)
    - T= Time, Temp, Talkability (When or what time did this start? Have you had or do you have a fever? How many word sentences can the patient speak in?)
    - E= Exercise tolerance (What is the patient's tolerance for exertion? Can they get up and walk without getting SOB? What is their baseline tolerance level?)
- Mechanism of injury (as indicated by relevant protocol).

  For focused history findings relevant to specific patient complaints, see protocols related to each chief complaint.

EXPOSE, EXAMINE & EVALUATE:

- Minimize on scene time for trauma patients

- All physical assessments for trauma should determine the presence or absence of **DCAP-BTLS**:
  - **D**eformity
  - **C**ontusion/Crepitus
  - **A**brasion
  - **P**uncture
  - **B**ruising/Bleeding
  - **T**enderness
  - **L**aceration
  - **S**welling
- In situations with suspected life threatening trauma mechanism, a rapid trauma assessment should be performed:
  - Expose head, trunk, and extremities.
  - Rapid Trauma Assessment looking for and treating life threatening injuries.
  - See relevant protocols for Head, Neck, Facial, Chest, Abdominal, Pelvis, and Extremity.
- Treat any newly discovered life-threatening wounds.