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Emergency First Responder

Secondary Survey

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Objectives

By the end of this session you should be able to:

- Outline and demonstrate elements of a secondary survey for the medical and trauma patient while considering findings and initiating care management

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Initial Assessment

- Form a general impression of the Patient
- WHY ?
- Assess responsiveness
- Determine Chief Complaint

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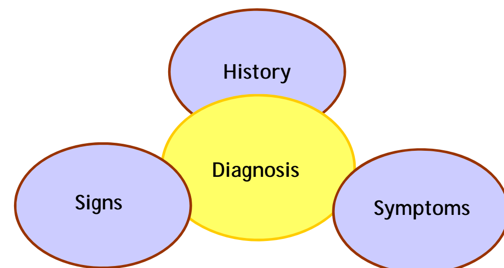
Making A Diagnosis



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SAMPLE History

S Signs & Symptoms
A Allergies
M Medications
P Pertinent medical history
L Last oral intake
E Events leading up to or causing the illness / injury

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Signs

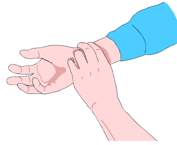
Something you can see, feel, smell or hear or touch.

Examples:

Blood, Swelling, Gurgling

Important Signs

- Respirations
- Pulse
- Capillary refill
- Pupil size and reactivity
- Skin condition
- Level of consciousness



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Symptoms

A condition the patient complains of or tells you about

Examples:

Pain, Dizzy, Thirsty

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Symptoms

O-P-Q-R-S-T

- Onset?
- Provokes?
- Quality?
- Region / Referral / Recurrence / Relief?
- Severity?
- Time?

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Detailed Physical Exam

Head to Toe

Take appropriate precautions

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Examine from Head to Toe

- Look and feel for signs of injury:
  - D - Deformity
  - C - Contusions
  - A - Abrasions
  - P - Punctures & Penetrations
  - B - Burns
  - T - Tenderness
  - L - Lacerations
  - S - Swelling
- Search all areas of body in a clear, concise and consistent format

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Examine the Head and Eyes

- Examine head:
  - Use both hands
  - Do not move casualty's head
  - Remove eyeglasses if necessary
  - DCAP-BTLS

- Examine eyes:
  - Cover one eye for 5 seconds
  - Watch for pupil contraction

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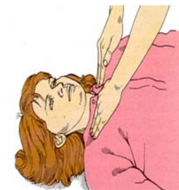
Examine the Neck

- Examine neck:
  - Examine each side
  - Check for pain
  - Check neck veins
  - Check the trachea is central
  - Examine for stoma
- Check for a medical identification tag – Why?

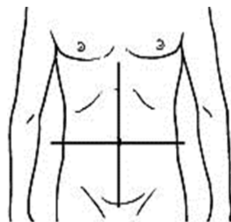
Examine the Chest

- Examine chest:
  - Check for pain on inhalation/exhalation
  - Look for signs of difficult breathing
  - Note injuries, bleeding, or abnormal, unequal or painful movement
  - Check for collarbone or rib fractures



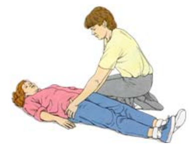
Examine the Abdomen

- Look for signs of external bleeding,
  - Penetrating injuries or protruding parts
- Check for abdominal rigidity or swelling
- Check for soiled clothing



Examine the Pelvis and Back

- Examine pelvis:
  - Check for obvious bruising, bleeding or swelling
  - Check for tenderness if no pain has been reported



- Examine back:
  - Stabilize head and neck
  - Check one side of the back at a time

Examine the Extremities

- Observe the extremity
- Examine for tenderness
- Check for movement
- Check for sensation
- Assess the circulatory status

On-going Assessment

- Monitor casualty's vital signs
  - Every 5 minutes if unstable
  - Every 15 minutes if stable
- Maintain an open airway
- Monitor breathing and pulse
- Monitor skin colour and temperature

On-going Assessment

- Check Interventions
- Watch closely for changes in the casualty's condition
- Would you know if the patient was in pain? How?
- What can you do to provide pain relief?

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Vital Signs

- Breathing: Rate, Character
- Pulse: Rate, Strength, Rhythm
- Skin: Colour, Temperature, Condition
- Pupils: Size, Reactivity, Equality

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Assessing Respiration

- Record
  - Rate
  - Character
    - Depth
    - Difficulty / Ease
    - Noise
- Consider O_2 therapy

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How do we obtain a rate?

- Patient
  - Comfortable
  - Unaware of the process
- Equipment – watch
- Observe / feel chest movement for thirty seconds X2 to get rate

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Normal Respiratory Rates

Age	Rate
New-born	40-60
1 year	30-40
3 years	25-30
5 years	20-25
7 years	20-25
10 years	15-20
15 years	15-20
Adult	12-20

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Abnormal Respiratory Rates

- Adequate breathing rates
  - Adults 12 to 20 Rpm
  - Children 20 to 40 Rpm
- Inadequate breathing rates
  - Adults <10 or > 20 Rpm
  - Children <20 or > 40 Rpm

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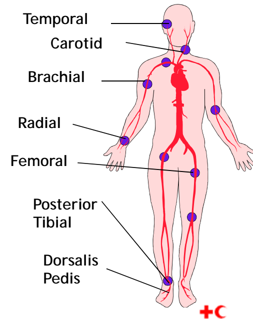
Assessing the Pulse

- Main areas palpated:
  - Carotid
  - Radial
  - Femoral
  - Brachial on an Infant
- Record
  - Rate
  - Strength
  - Rhythm



Taking a pulse

- Patient
  - Comfortable
  - Cannot control pulse rate
- Equipment
  - Watch
  - Pulse oximeter
- Record the rate over a thirty second period and double
- Use two fingers to check for a pulse
- Apply light pressure when taking the pulse
- Do not use your thumb as it has it's own pulse!

Pulse rates

Age	Rate
Newborn	120 - 160
1 year	100- 160
3 years	90 - 150
5 years	80 - 140
7 years	70 - 120
10 years	70 - 120
Adolescent	60 - 100
Adult	60 - 80

Assessing the Skin

- Use the back your the hand
- Record
  - Colour
  - Temperature
  - Condition
- Coloured people
  - Check mucous membranes

Assessing Pupils

- First evaluate in ambient light for constriction or dilation
- Next pass a light across each pupil and note the response
- Each pupil should constrict equally
- Pupils, Equal And Reactive to Light
  - PEARL

Capillary refill Rate

The rate at which blood refills the capillaries after being forced out

- Normal Rate ?
- Abnormal rate ?

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Examination Appropriateness

- Care must be exercised when conducting a detailed physical exam on scene
- Patient dignity must be maintained

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Summary

- Components of secondary survey
- Head to toe survey
- Respiration
  - Rates
  - How to obtain a rate
- Pulse
  - Rates
  - How to obtain a rate

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Summary

- Skin
  - Colour
  - Temperature
  - Condition
- Capillary Refill
- SAMPLE History
- O-P-Q-R-S-T