EL DORADO COUNTY EMS AGENCY

PREHOSPITAL PROTOCOLS

Effective: January 1, 2017

EMS Agency Medical Director

BLS Patient Assessment – Secondary Survey

PROCEDURE:

I. The secondary survey is the systematic assessment and complaint focused relevant physical examination of the patient. The secondary survey may be done concurrently with the patient history and should be performed after the Primary Survey and the initiation of Routine Medical Care. The purpose of the secondary survey is to identify problems which, though not immediately life or limb threatening, could increase patient morbidity and mortality. Exposure of the patient for examination may be reduced or modified as indicated due to environmental factors (cutting off or removing clothing in extreme cold temperatures).

II. History:
   a. The patient's history should be optimally obtained from the patient directly. If language, culture, age, disability barriers or patient condition interferes with obtaining the history, consult with family members, significant others or scene bystanders. Check for advanced directives such as POLST form or DNR order. Be aware of the patient's environment and issues such as domestic violence, child or elder abuse or neglect and report concerns. The following information should be obtained during the history:
      i. Allergies;
      ii. Current medications;
      iii. Past medical history relevant to the chief complaint.
      iv. Have patient prioritize his or her chief complaint if complaining of multiple problems;
      v. Mechanism of injury or onset of current symptoms;
      vi. In addition obtain history relevant to specific patient complaints.

III. Head and Face:
   a. Observe and palpate skull (anterior and posterior) and face for DCAP-BTLS;
   b. Check eyes for equality, responsiveness of pupils, movement and size of pupils, foreign bodies, discoloration, contact lenses or prosthetics eyes;
   c. Check nose and ears for foreign bodies, fluid or blood;

d. Recheck mouth for potential airway obstruction (swelling, dentures, bleeding, loose or avulsed teeth, vomit, absent or present gag reflex) and odors, altered voice or speech patterns and evidence of dehydration.

IV. Neck:
   a. Observe and palpate for DCAP-BTLS, jugular vein distension, use of neck muscles for breathing, tracheal deviation, stoma and medical information medallions.

V. Chest:
   a. Observe and palpate for DCAP-BTLS, scars, implanted devices such as pacemakers and indwelling IV/arterial catheters, medication patches, chest wall movement, asymmetry and accessory muscle use while breathing.
   b. Have patient take a deep breath if possible and observe and palpate for signs of discomfort, asymmetry and air leak from any wound.

VI. Abdomen:
   a. Observe and palpate for DCAP-BTLS, scars and distension;
   b. Palpation should occur in all four quadrants taking special note for tenderness, masses and rigidity.

VII. Pelvis/Genital-Urinary:
   a. Generally, a patient's genital area should not be exposed and examined unless it is necessary for patient care. If possible have an EMT of the same gender do the exam.
   b. Observe and palpate for DCAP-BTLS, asymmetry, sacral edema and as indicated for other abnormalities.
   c. Palpate and gently compress lateral pelvic rims and symphysis pubis for tenderness, crepitus or instability.
   d. Palpate for bilateral femoral masses or deformities, if warranted.

VIII. Shoulder and upper Extremities:
   a. Observe and palpate for DCAP-BTLS, asymmetry, skin color, capillary refill, edema, medical information bracelet, and equality of distal pulses;
   b. Assess sensory and motor function as indicated.

IX. Lower Extremities:
   a. Observe and palpate for DCAP-BTLS, asymmetry, skin color, capillary refill, edema and equality of distal pulses;
   b. Assess sensory and motor function as indicated.

X. Back:
   a. Observe and palpate for DCAP-BTLS, asymmetry and sacral edema.

XI. Complete set of vital signs and metrics include the following:
   a. Blood pressure.
   b. Pulse rate.

c. Respiratory rate.
d. Pupil size and reaction.
e. Level of consciousness.
f. Body temperature.

XII. Precautions and comments:

a. Observation and palpation can be done while gathering a patient's history.
b. A systematic approach will allow the rescuer to be rapid and thorough and not miss subtle findings that may become life-threatening.
c. Minimize scene times, especially with trauma patients and pediatrics, by preparing the patient for immediate transport.
d. Complete the examination before treating other identified non-life-threatening problems.
e. Reassessment of vital signs and other observations are necessary, particularly in critical or rapidly changing patients. Vital signs (BP, pulse, respirations) should be taken and recorded approximately every 5 minutes. Changes and trends observed in the field are essential data to be documented and communicated to the transport personnel and /or receiving facility.
f. As stated in the primary survey DCAP-BTLS is a mnemonic that stand for:
    i. Deformity
    ii. Contusion/crepitus
    iii. Abrasion
    iv. Puncture/Penetration
    v. Bruising/Bleeding
    vi. Tenderness
    vii. Laceration
    viii. swelling