ALS Patient Assessment - Secondary Survey

AUTHORITY: Division 2.5, Health and Safety Code, Sections 1797.220 & 1798 et al.

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.

II. History:
A. A patient's history should optimally be 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 a DNR order, Medic-Alert bracelet and prescription bottles as appropriate. 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:
   1. Allergies;
   2. Medications;
   3. Past medical history relevant to the chief complaint.
   4. Have patient prioritize his or her chief complaint if complaining of multiple problems;
   5. Ascertain recent medical history such as hospital admissions, surgeries, etc;
   6. Mechanism of injury if appropriate;
   7. 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 prosthetic eyes;
C. Check nose and ears for foreign bodies, fluid or blood;

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D. Recheck mouth for potential airway obstructions (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 tugging, tracheal shift, 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 in 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.
C. Assess lung sounds and heart tones as appropriate.

VI. Abdomen:
A. Observe and palpate for DCAP-BTLS, scars and distention;
B. Palpation should occur in all four quadrants taking special note of tenderness, masses and rigidity.

VII. Pelvis/Genital-Urinary:
A. Generally, a patient’s genital area should not be exposed and examined unless the assessment of this body region is required due to the patient’s condition, such as trauma to the region, active labor or suspected/known bleeding. When possible have an EMT or paramedic of the same gender as the patient perform evaluations of the pelvis/genital area.
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, 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. **Precautions and Comments:**
   A. Observation and palpation can be done while gathering a patient’s history.
   B. A systematic approach will enable the resucer 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 packaging/preparing the patient for immediate transport upon ambulance or air ambulance arrival (spinal immobilization, miller board, pediatric immobilization device, ensuring rapid ingress/egress for BLS personnel and equipment.)
   D. The Secondary Survey should ONLY be interrupted if the patient experiences airway, breathing or circulation deterioration requiring immediate intervention. Complete the examination before treating the 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 should be taken approximately every 5 minutes. Changes and trends observed in the field are essential data to be documented and communicated to the transport personnel or receiving facility.
   F. As stated in the Primary Survey DCAP-BTLS is a mnemonic that stand for:
      1. Deformity;
      2. Contusion/Crepitus;
      3. Abrasion;
      4. Puncture;
      5. Bruising/Bleeding;
      6. Tenderness;
      7. Laceration;
      8. Swelling.