



Secondary assessment

The **purpose** of a secondary assessment (composed of **a head-to-toe**, history and vitals) is to continually monitor the victims condition and **find any non-life threatening conditions** requiring treatment.

The head-to-toe should be completed **after the primary survey** (patent airway, breathing satisfactorily and with a circulation)



Head-to-toe:

It is used on victims who meet the following criteria:

1. Victim of trauma injuries (except minor injuries affecting peripheral areas)



2. Unconscious or very reduced level of consciousness victims .

What is being looked for?

you should look for abnormality.

For example: asymmetry; deformity; bruising; point tenderness, minor bleeding...



The six areas

Head and neck:

- a. **Head:** Feel for indentations, look for blood or fluid and watch the victim for signs of discomfort. If it is a trauma injury, check both ears for signs of blood or fluid.

- b. **Neck:** if there tenderness or deformity, then you should stop the survey and immediately **immobilize the neck**, placing one hand each side of the head, with the thumb around the ear.



2. Shoulders, chest and back

(a) **Shoulders** – You should try and expose the shoulders if possible, looking for obvious deformity, You should then place a hand on each shoulder, pressing along it watching for deformity or pain.



(b) Chest – The chest is ideally done exposed (*be aware of the sensitivity of females*)


You should be looking for sections of the chest which are **out of line** with the rest of it, or which are **moving differently** to the rest of the chest whilst breathing. You should also look for **obvious wounds**.



(c) Back – you can feel down their spine.

3. Arms and hands:

run both your hands down one arm at a time, looking for deformity or pain.

4. Abdomen: The abdomen contains the remainder of the body's critical organs, so **should be watched for potential damage**. The abdomen is mostly done  by gentle pushing, using the flat of your hands. Again, use symmetry, and push both sides simultaneously. Watch for the abdomen being hard or for pain caused by the palpation.

5. Pelvis – The pelvis (hips) is a large bone, with potential for a fair amount of damage. gently rock the hips from side to side.



6. Legs and feet – As with arms, use both hands at the same time, running them down the inside and outside of each leg simultaneously. You should also look for any shortening or rotation of one leg compared to foot, check that it has normal motility (can be moved normally) and has no obvious injuries the other. Finally, you take each foot, check that it has normal motility (can be moved normally) and has no obvious injuries



History

CHAMPION.

C: Chief complaint

H: History of chief complaint

A: Allergies

M: Medical history and medications

P: Pain assessment

I: Important Information

O: Onset

N: Next of Kin



Chief Complaint: What is the problem?

History of Chief Complaint: How did this happen? Has it ever happened before?

Allergies: Are you allergic to anything?

Medical History & Medications:  Do you have any medical conditions (angina, high BP, diabetes)? Do you take any medications? What is the name of your normal doctor?

Pain Assessment:

Pain Assessment Model

S	Site	Where exactly is the pain?
O	Onset	What were they doing when the pain started?
C	Character	What does the pain feel like?
R	Radiates	Does the pain go anywhere else?
A	Associated symptoms	e.g. nausea/vomiting
T	Time/duration	How long have they had the pain?
E	Exacerbating/ relieving factors	Does anything make the pain better or worse?
S	Severity	Obtain an initial pain score

Important Information: Name, date of birth, age, sex, address

Onset: When did the symptoms start?
What were you doing?

Next of Kin: Is there anyone you would like contacted?

Vitals

Purpose: it is important to keep a check on a victim's vital signs, and keep a record of any changes.

Assessments: The vital signs you are looking to record relate to the body's essential functions.



The four main vital signs routinely monitored by medical professionals and health care providers include the following: **Body temperature. Pulse rate (heart rate). Respiration rate (rate of breathing) Blood pressure (Blood pressure.)**

Breathing: In addition to rate, you should note if the breathing is heavy or shallow, and importantly if it is regular or irregular .



Circulation: The two main checks are:

1. Capillary Refill – You check capillary refill by squeezing reasonably hard for about a second on the nail bed. This

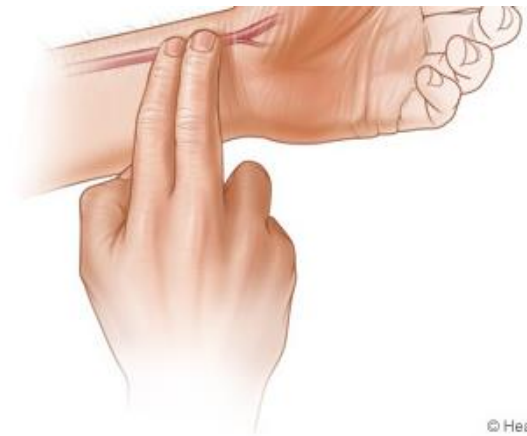
should move the blood out, and the nail bed will appear white. If the pink colour returns quickly then this is normal.

If it takes longer than  **two seconds** for colour to return, then this could indicate **a problem**

2. Pulse check: When measuring a pulse you should measure the pulse rate, regular or irregular

There are three main places you might wish to check for a pulse:

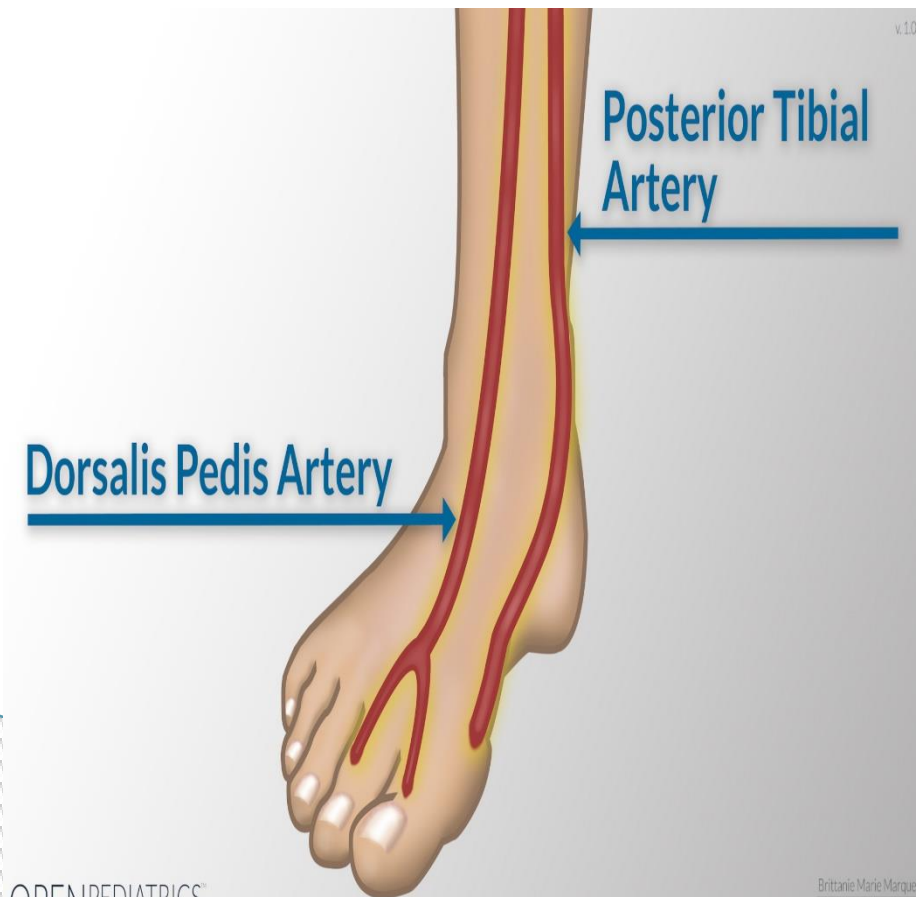
(a) Radial pulse: It is located on the wrist (over the radial bone). To find it, place the victim's hand palm up and take the first two fingers of your hand (NEVER use your thumb, as it contains a pulse of its own)



(b) Carotid Pulse – This is in the main artery which supplies the head and brain, and is located in the neck. This is best used on unconscious victims, or those victim where you are unable to find a radial pulse. To locate it, place your two fingers in to the indentation to the side of the windpipe, in line with the Adam's Apple .



(c) Pedal Pulse – The pedal pulse can be found in several locations on the foot



Skin Colour and Temperature: Related to circulation, is the colour of the skin. Changes in circulation will cause the skin to be different colours, and you should note if the victim is pale, or blue tinged.

It should also be noted if the victim's skin is sweaty or very dry.



Pupils: Valuable information can be gained from looking a victim's pupils. For this purpose, first aid kits should have a penlight or small torch in them.

Ideally, the pupils of the eye should be equal and reactive to light, usually written down as **PEARL**.

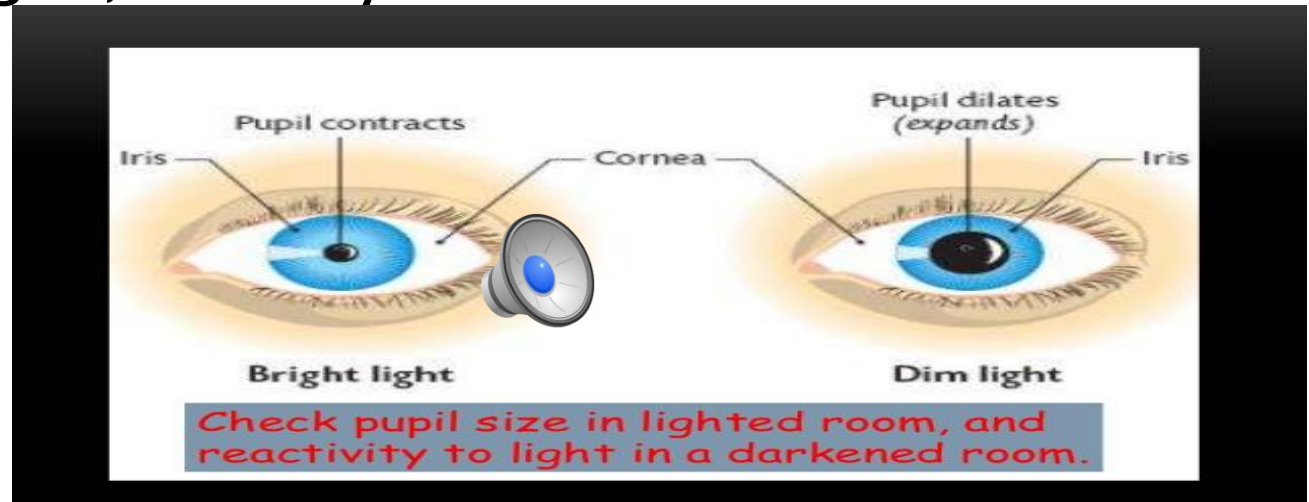
P: Pupils

E: Equal

A: And

R: Reactive to

L: Light



A normal reaction would be the pupil getting smaller quickly as the light is shown in to it. Repeat on the other eye.



Thank you!