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.