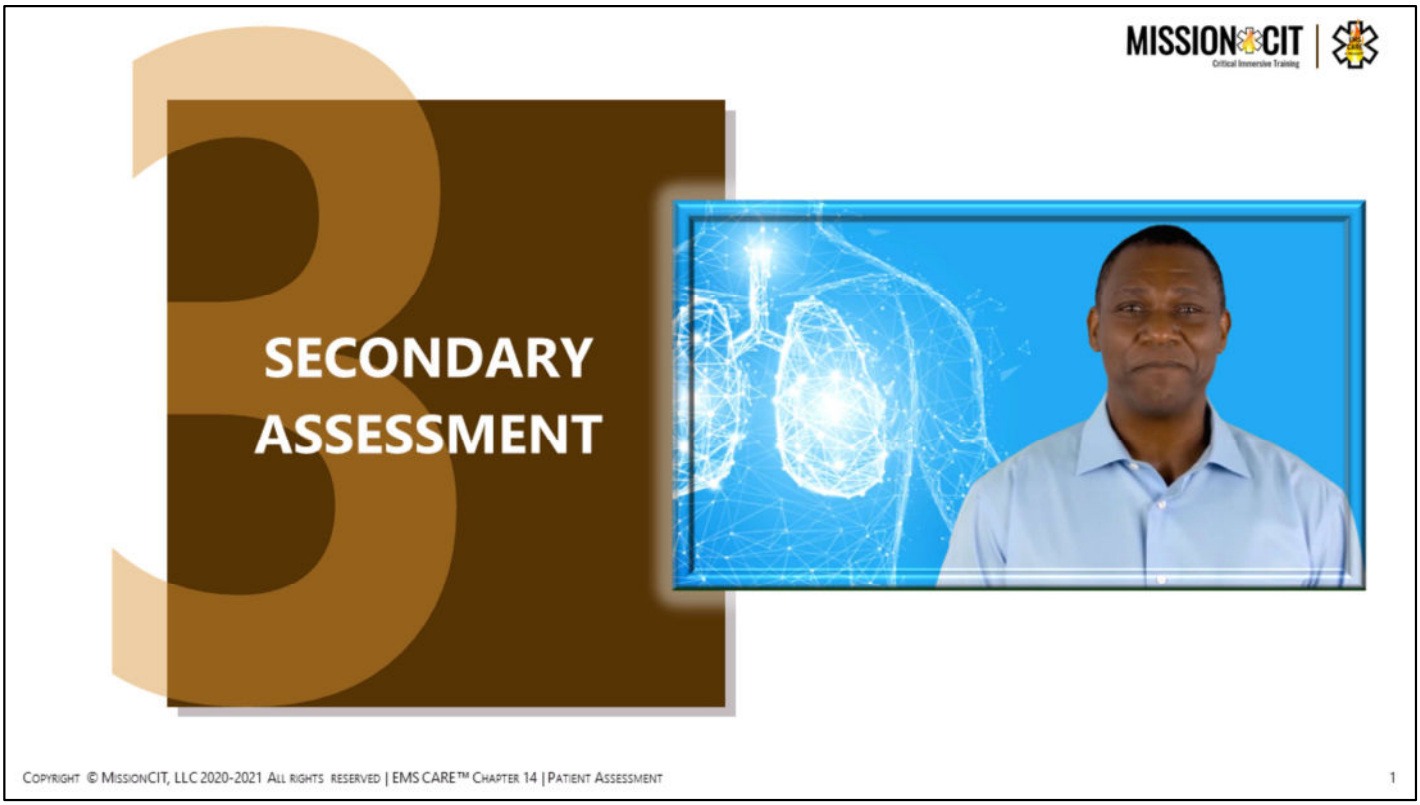
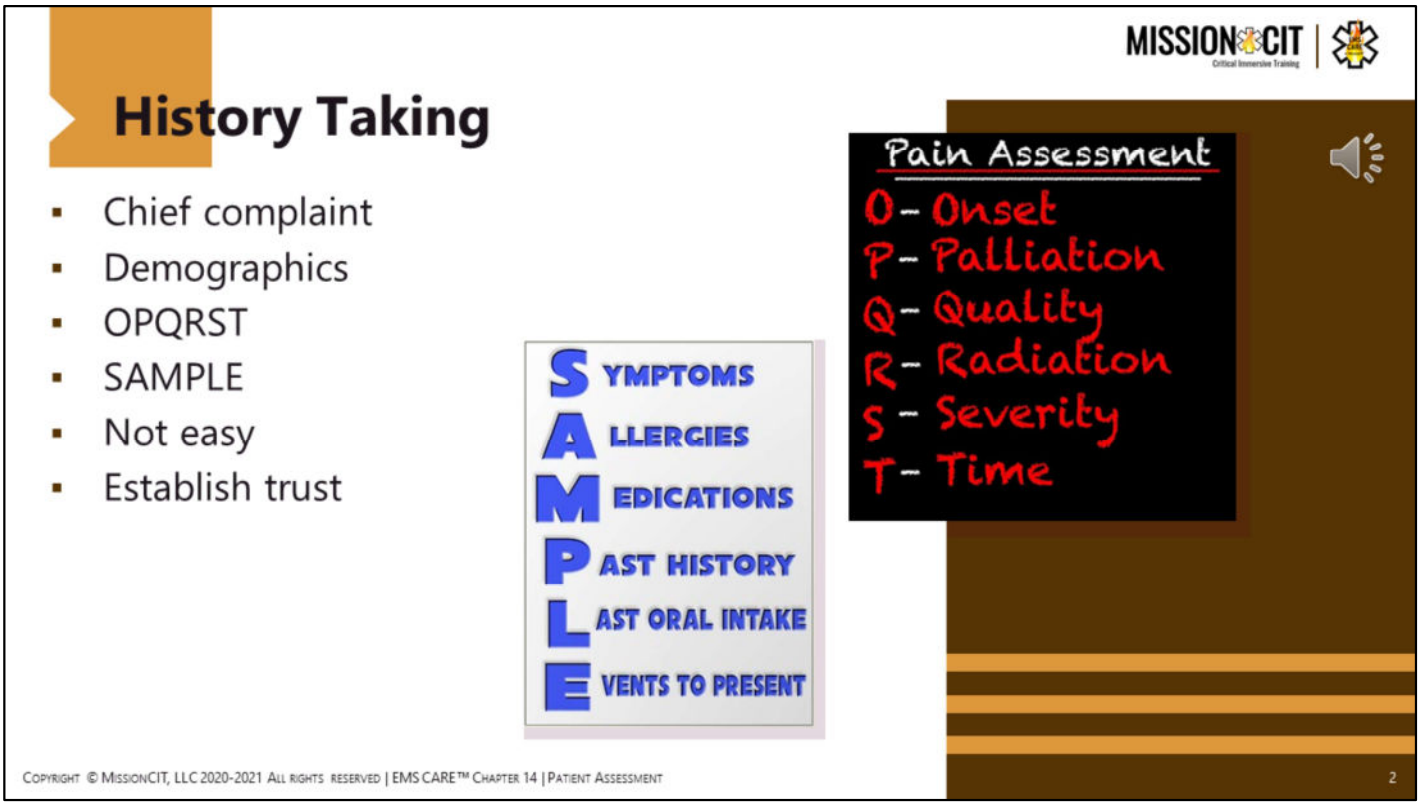


Thank you Missah!

In this lesson, let's look at the secondary assessment, which is a more detailed assessment of the patient and is often done in non-emergency situations.

So, let's get started!



While one person is handling the patient, the other can take down the history of the patient from other family members or bystanders, as the case may be. You can talk to the patient if he or she is responsive and get answers.

Also, make a note of the chief complaint and the visible signs and symptoms along with demographic information such as,

- Date and time of the incident
- Patient's age, gender, and race
- Medical history and current health status

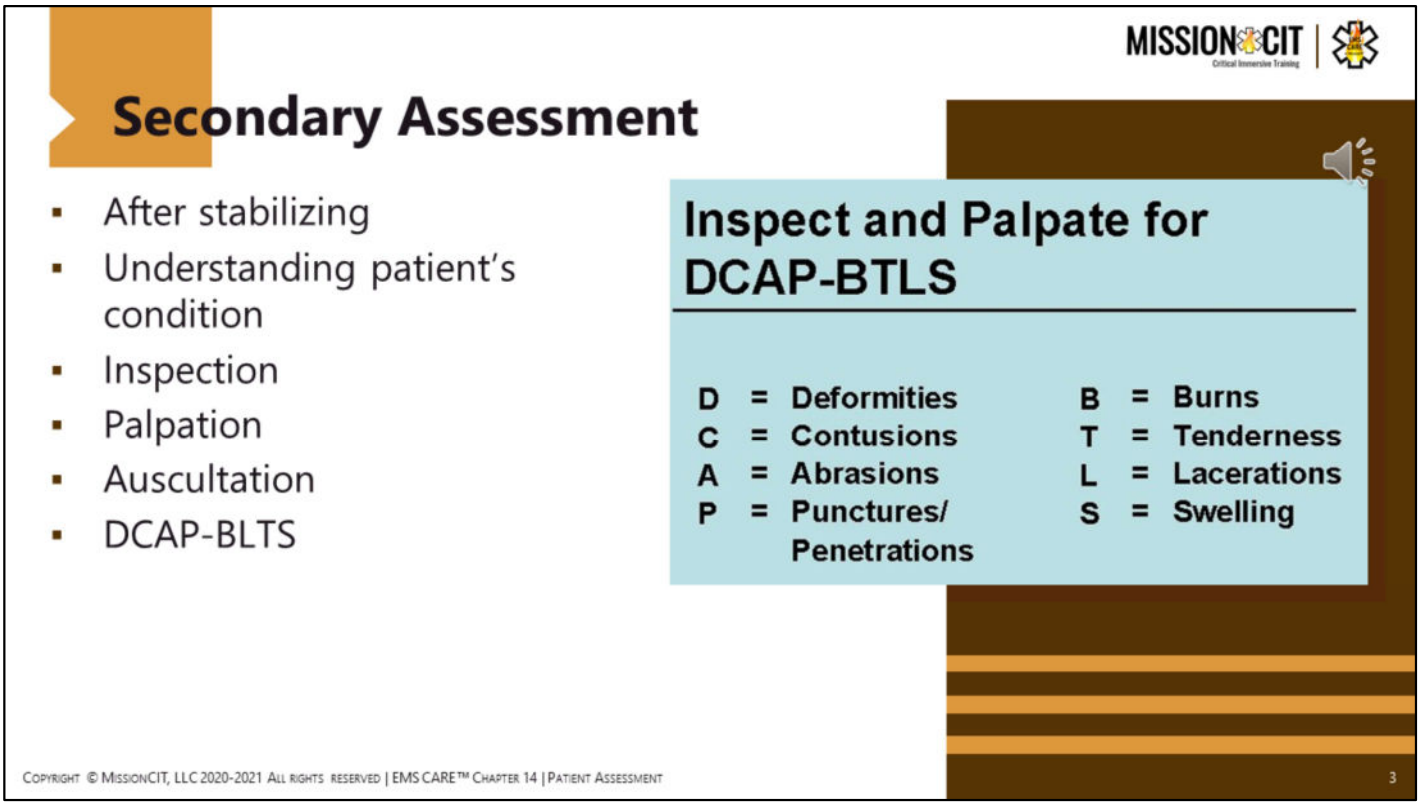
You can use the OPQRST that stands for,

- Onset
- Provocation or palliation
- Quality
- Region or radiation
- Severity
- Timing

Alongside, identify the pertinent negatives. You can also use SAMPLE to gather information and this mnemonic stands for,

- Signs and symptoms
- Allergies
- Medications
- Pertinent medical history
- Last oral intake
- Events leading up to the injury or illness

This history taking may not be easy if the patient is silent, unwilling to disclose, crying, intoxicated, angry, anxious, excited, or has multiple symptoms. Sometimes, depression, cognitive inabilities, language or cultural barriers, hearing problems, and visual impairments can also impede it. Do your best to talk to the patient and to establish a level of trust, so the patient can open up.



The secondary assessment can be performed at the scene, in the back of an ambulance, or you can choose not to do this assessment at all. The purpose here is to go beyond the 60 to 90 second primary assessment and to get a better understanding of the patient's condition. It involves a systematic head-to-toe assessment or sometimes, it can be focused on just a certain part of the body.

So, how and what to assess?

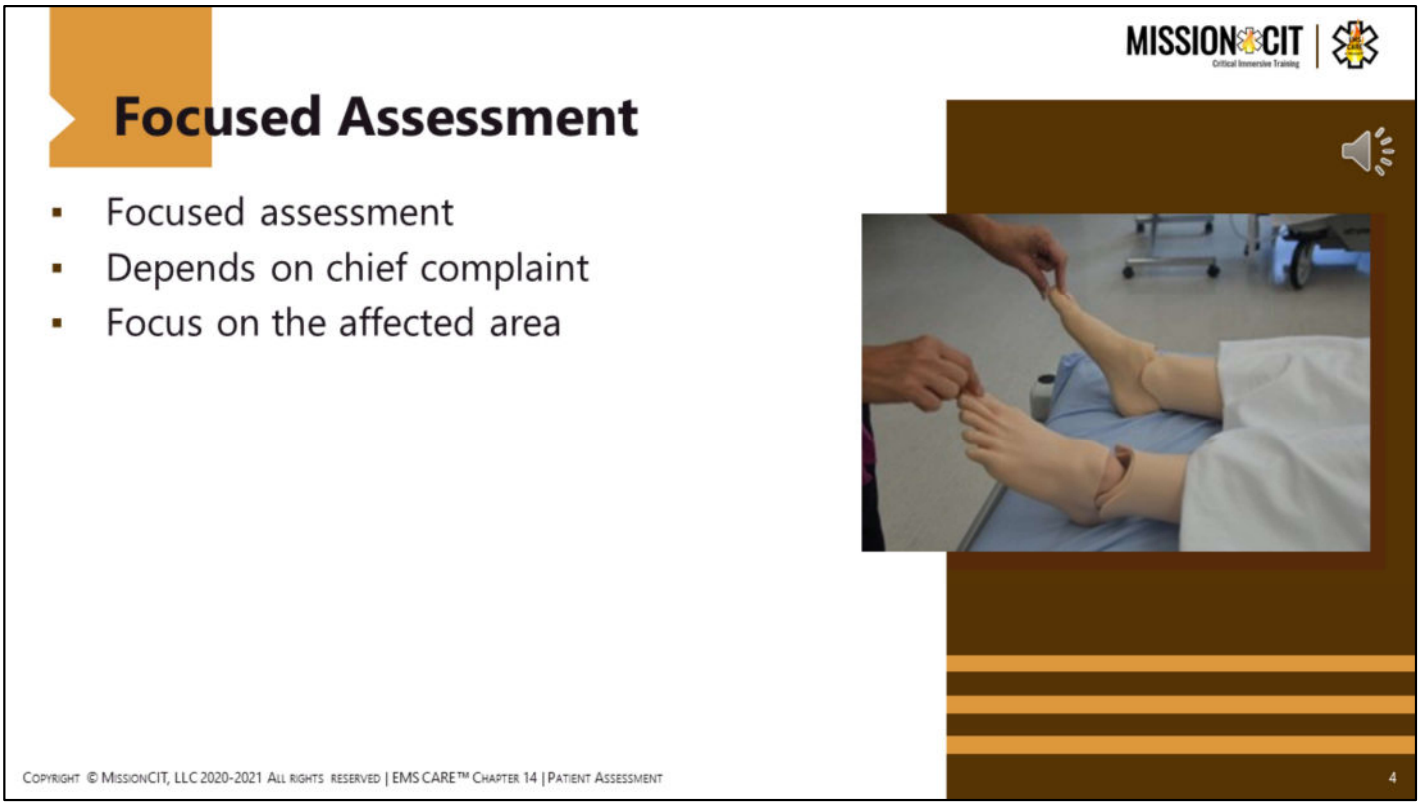
- Inspection, where you look at the patient for any abnormalities
- Palpation, where you touch or feel the patient for abnormalities
- Auscultation, where you listen to the sounds of the body

Use the mnemonic DCAP-BTLS to remember what you must do. It stands for,

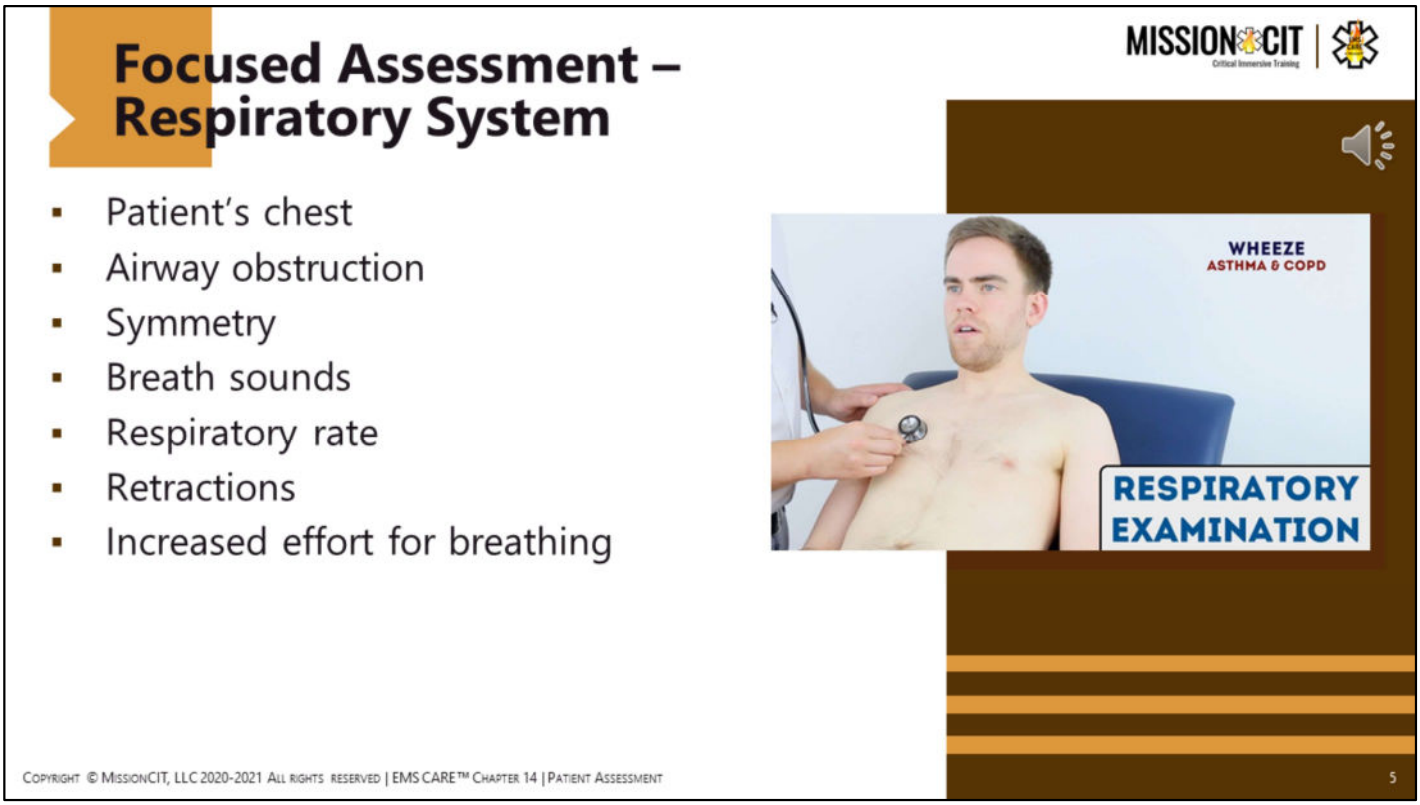
- Deformities
- Contusions
- Abrasions
- Punctures or penetrations
- Burns

- Tenderness
- Lacerations, and
- Swelling

Finally, compare the findings on one side of the body with the other when possible.

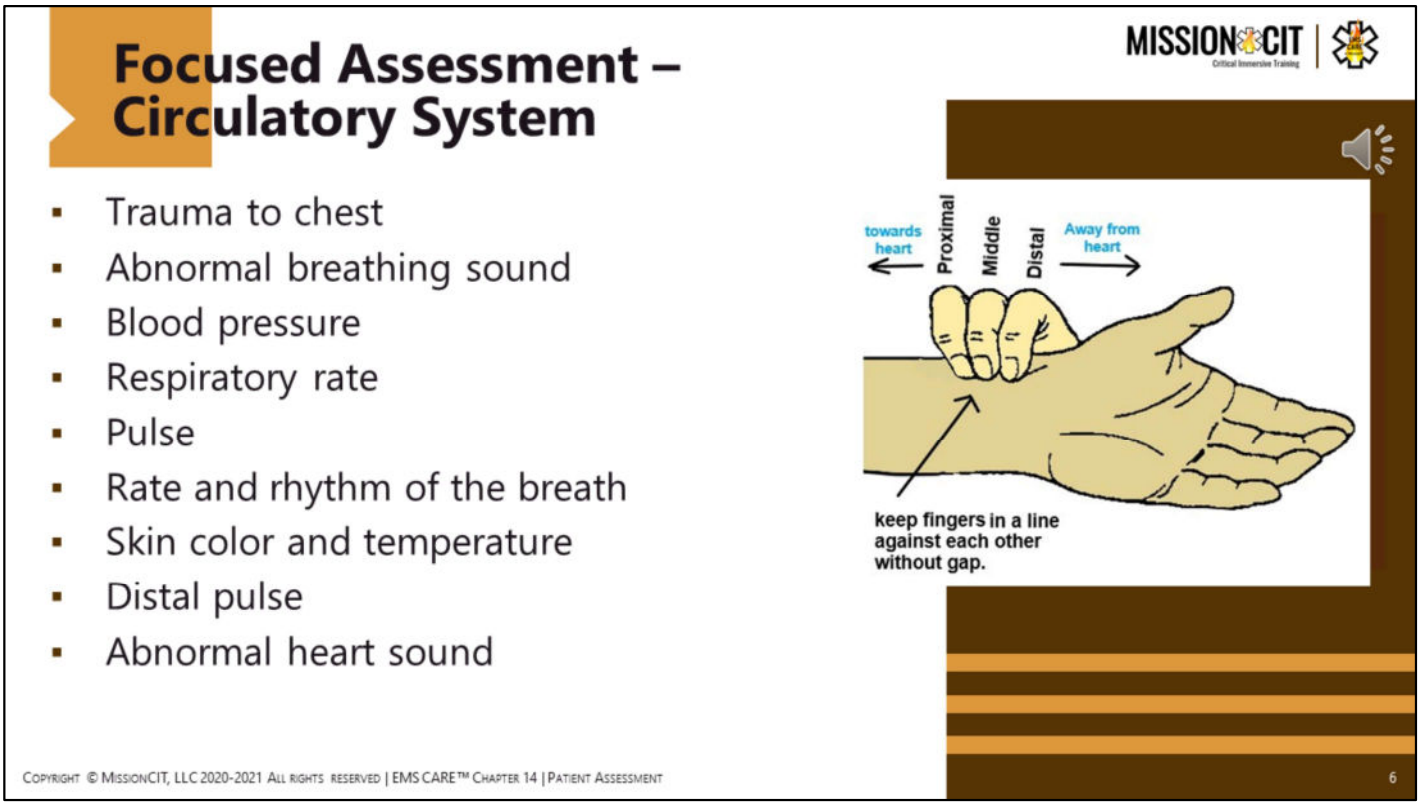


Do a focused assessment on patients who have sustained non-significant mechanisms of injury or are unresponsive to get more details on the cause of the problem. The question of whether you should do a focused assessment or not depends on the chief complaint, as the goal here is to pay attention to the body part or system that's affected by the complaint.



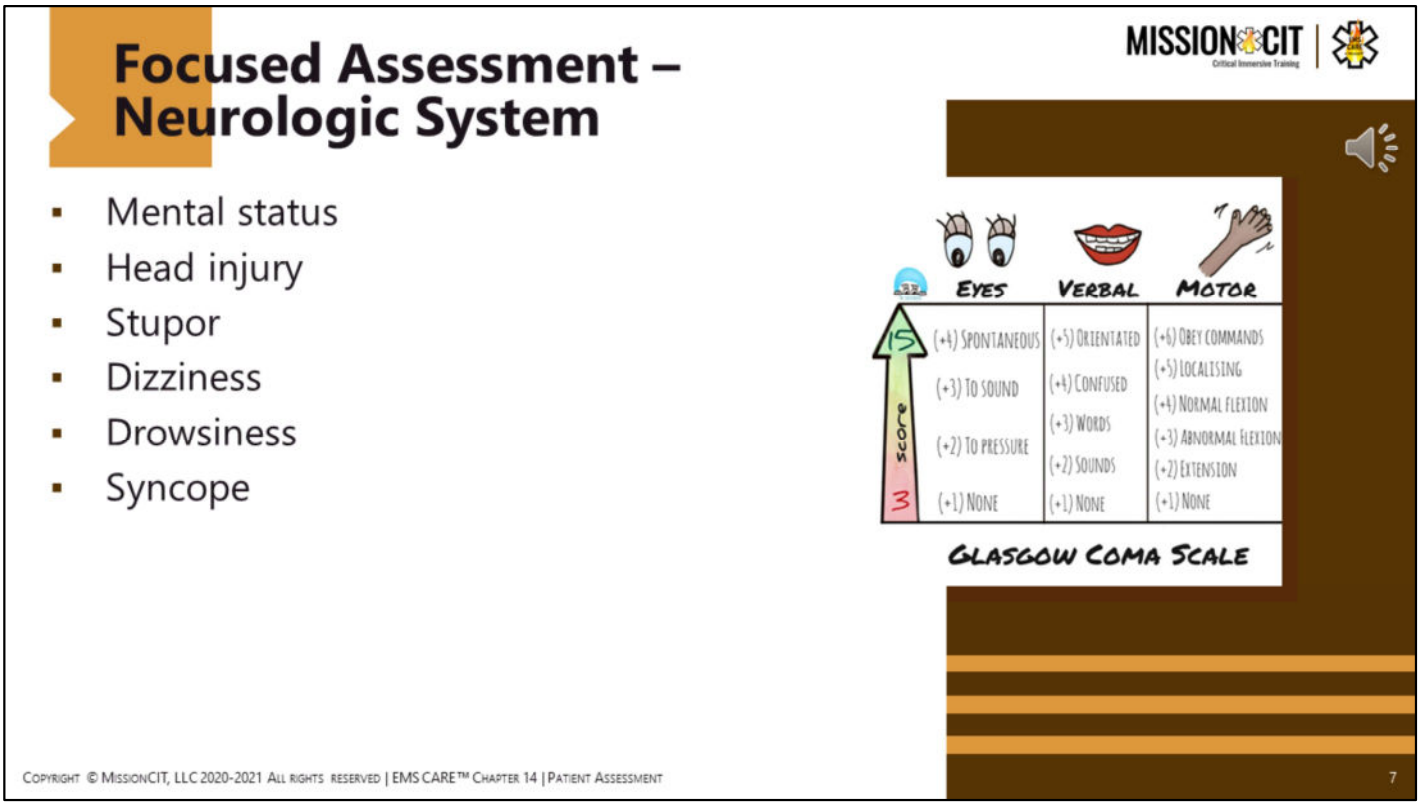
While doing a focused assessment on the respiratory system,

- Expose the patient's chest
- Look for signs of airway obstruction
- Inspect for symmetry
- Listen to breath sounds
- Measure the respiratory rate. The normal respiratory rate for an adult at rest is between 12 and 20 breaths per minute
- Look for retractions and increased work for breathing



Moving on to the circulatory system,

- Look for trauma to the chest
- Listen for abnormal breathing sounds
- Consider the blood pressure, respiratory rate, and pulse. The common pulse locations are radial, brachial, and carotid.
- Pay attention to the rate, quality, and rhythm of breaths
- Check the skin for abnormal temperature, color, or moisture
- Check and compare the distal pulses
- Consider auscultation for abnormal heart sounds

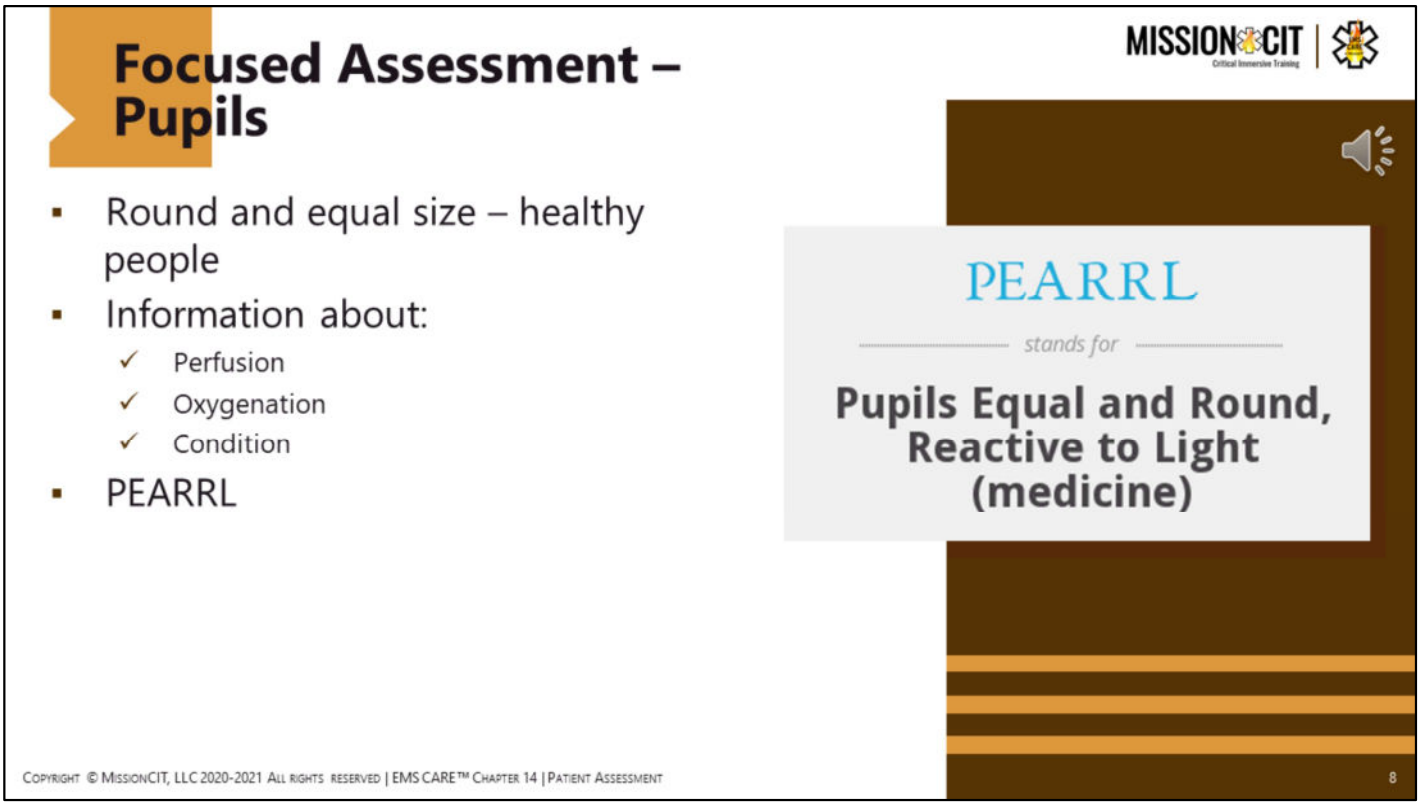


Finally, let's see how you can do a focused assessment on the neurologic system.

It should be performed only on patients who have,

- Changes in mental status
- Possible head injury
- Stupor
- Dizziness or drowsiness
- Syncope

Your assessment must include an evaluation of the level of consciousness and orientation. Use the AVPU scale when needed or the Glasgow Coma Scale can also provide additional information.

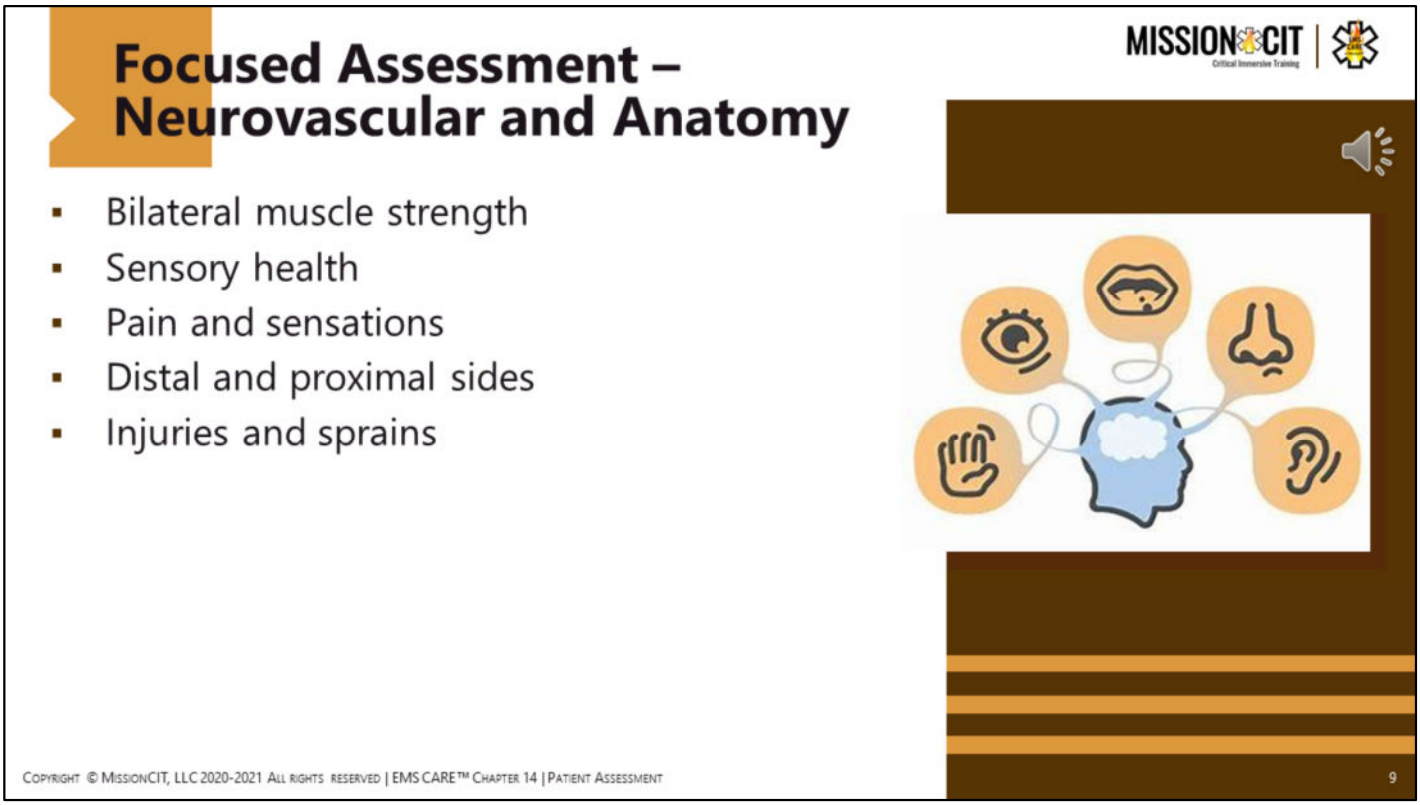


Your patient's pupils can tell a lot about the health condition.

In healthy people, pupils are round and of approximately equal size. The diameter and reactivity to light can reflect the status of the brain's perfusion, oxygenation, and condition and in the absence of any light, the pupils will become fully relaxed and dilated.

An abnormal pupillary response can indicate altered brain function. A useful mnemonic for evaluating pupils is PEARRL., which stands for,

- Pupils
- Equal
- And
- Round
- Regular in size
- React to light

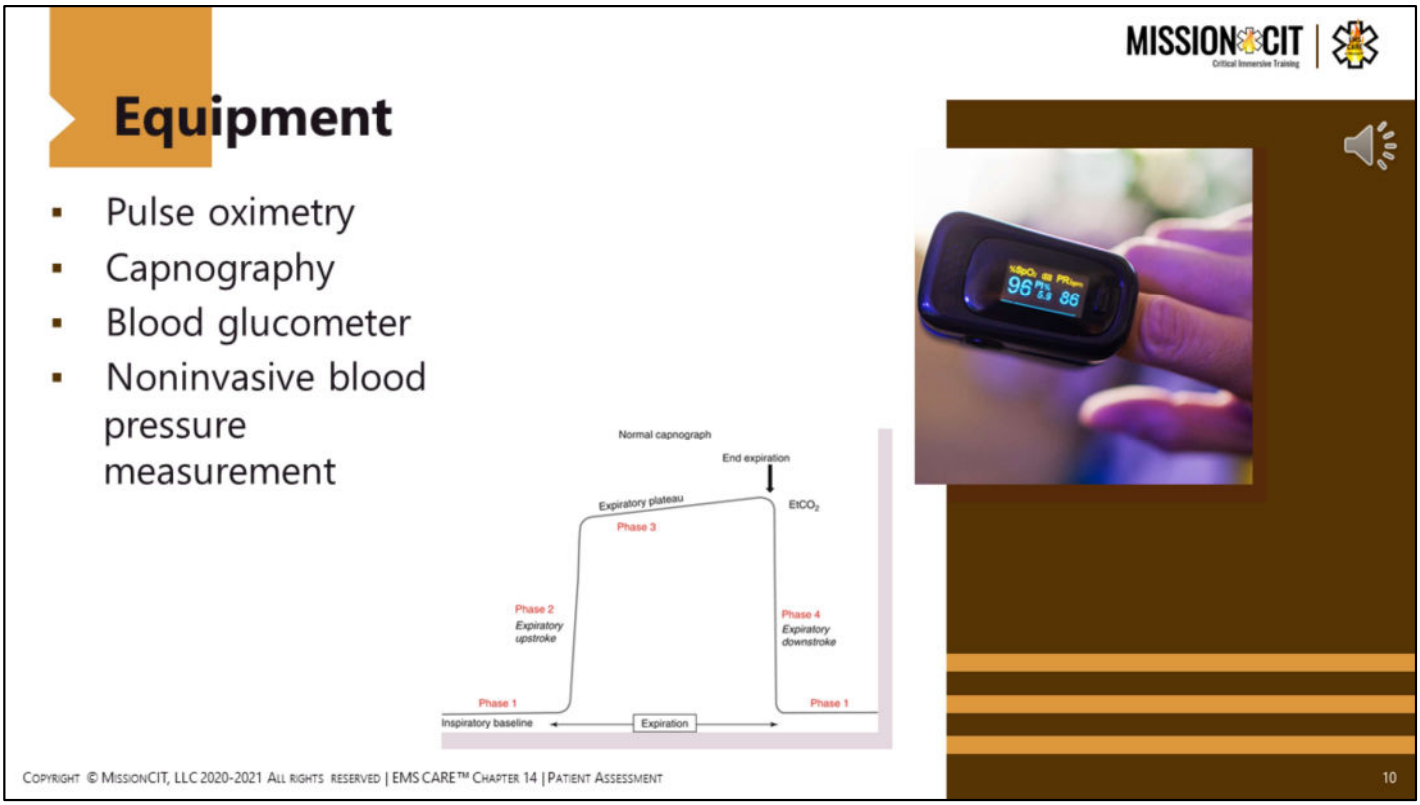


Check the neurovascular system and look for,

- Bilateral muscle strength and weakness
- Sensory health and their working
- Pain, sensations, and position

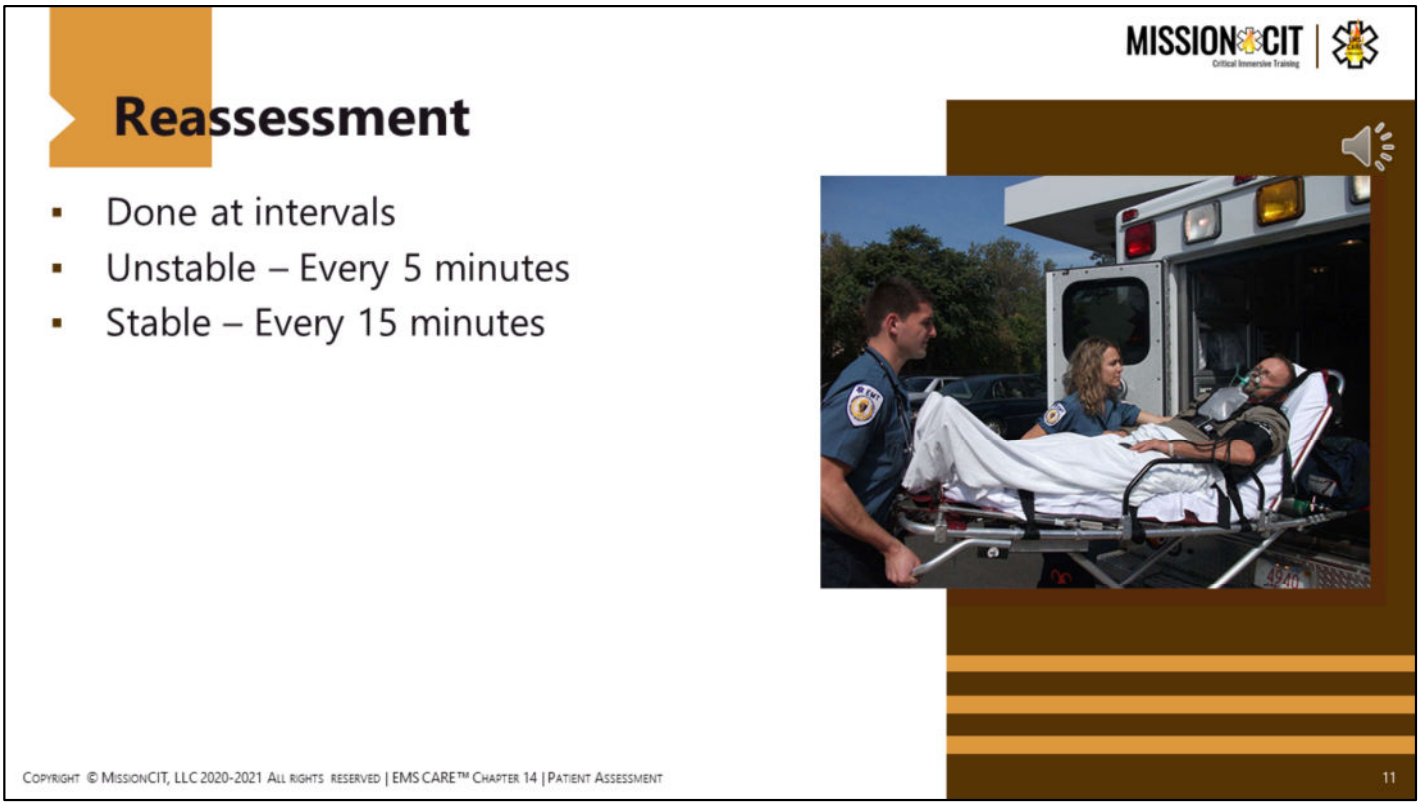
Compare the distal and proximal sensory and motor responses of one side with the other.

As for the anatomical assessment, check for injuries and sprains on the head, neck, cervical spine, chest, abdomen, pelvis, extremities, and posterior body.



Some of the equipment you can focus on for assessment are:

- Pulse oximetry. Here are some readings to help you interpret the pulse oximeter readings. Normal - 96 to 100 percent, Mild hypoxia - 91 to 95 percent, Significant or moderate hypoxia - 86 to 90 percent, and Severe hypoxia - 85 percent or less.
- Capnography indirectly indicates how well tissues are using oxygen and performing other physiological functions. It measures the amount of carbon dioxide exhaled. The normal level 35 to 45 mm Hg. In patients breathing spontaneously, a special nasal cannula is applied. In a ventilated patient, a plastic “collar” fits between the bag–valve and the mask (or advanced airway).
- Blood glucometer. The normal blood glucose level is usually at least 70 to 100 milligram/deciL.
- Noninvasive blood pressure measurement.



Reassessment is the assessment you do at regular intervals throughout the care. It is often repeated after the primary assessment and involves checking the vital signs and comparing them with previous readings to know the patient's status, and accordingly, understand the trends.

This process helps to reassess the chief complaint and identify and treat any changes in the patient's condition.

How often should this be done?

Once every five minutes when the patient is unstable, and once every 15 minutes when the patient is stable.

This brings us to the end of this lesson, and in the next one, Missah will take you through the chapter review.