MODULE 02
THE SECONDARY ASSESSMENT

2.1 D.O.T.S.

Once the primary survey has been completed (DRs ABC) – with breathing confirmed and any major external bleeds have been controlled (the obvious "taps have been turned off") we can then try to identify and further signs of injury (again this depends on the situation, common sense prevailing), e.g.:

- Someone who you have been with for a period of time and who just feels faint and the goes unconscious whilst sitting on the floor, will probably not warrant a full examination, whereas;
- Someone who has fallen down some stairs / hit by a car probably would

As a First Aider, what is it that you will be checking for. You are not a Doctor, Nurse or Paramedic and you do not posses X-Ray eyes – you are just examining for what is obviously not right. However, why do a secondary assessment.

We have already stated that you should never leave an unconscious patient lying on their back if you need to go to get help – and you must put the patient into the Recovery Position before leaving them alone.

However, let us say that the patient had a closed fracture of the lower leg - which was not obvious at first glance – and you then lifted that leg up to roll them into the Recovery Position. There is a high chance you could convert that into an open fracture and cause massive external bleeding.

However, if you had conducted a brief examination, that might have revealed a deformity there, which may have led you to have lifted the other leg up (leaving the injured leg on the floor) – thereby rolling the patient over more safely.

So what are you checking for? Simply *"Any lumpy, bumpy bits and boggy patches".* However, telling the Emergency Services that you found a "*lumpy, bumpy bit"* on their lower leg, may elicit some scepticism as to your knowledge. A good, simple mnemonic as to what you are examining for is the acronym D.O.T.S.

D – DEFORMITY

O – OPEN WOUNDS

T – TENDERNESS

S - SWELLING

2.2 SECONDARY SURVEY

Once the primary survey has been completed (DRs ABC) – with breathing confirmed and any major external bleeds have been controlled (the obvious "taps have been turned off") we can then try to identify and further signs of injury (again this depends on the situation, common sense prevailing), e.g.:

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There are 4 areas of the body where enough blood could be lost internally to become critical, they are the

1. Chest
2. Abdomen
3. Pelvis
4. Long bones (legs and arms)

These 4 areas would be incorporated in our Head to Toe exam (or Secondary Survey) and is included in the expression "*Blood on the Floor, and 4 more":*

SECONDARY SURVEY RESULTS **At all times check for D.O.T.S.** **(Deformity: Open wounds: Tenderness: Swelling)**	
Head	Check for bleeding and / or deformity
Ears / nose and eyes	Check for discharge (blood and / or yellow straw coloured fluid (often tinged with blood) and / or bruising
Neck	Check for deformity / bruising / instability of spine / open wounds
Chest (1)	Check collar bone / equal chest expansion / wounds / stability of chest
Abdomen (2)	Check for wounds / abdominal guarding or rigidity
Lower back	Check for deformity / instability
Pelvis (3)	Check for stability (if no trauma) / check if in line / check incontinence
Lower limbs (4)	Check for wounds / swelling / deformity
Upper limbs (4)	Check for wounds / swelling / deformity

Recovery Position

Following a careful, but quick, examination of the casualty and providing their condition warrants it (no spinal injury etc.) unconscious casualties should be placed in the recovery position. However, even with an unconscious spinal injury, **if you have to leave them alone, they must be placed in the recovery position as carefully as possible.**

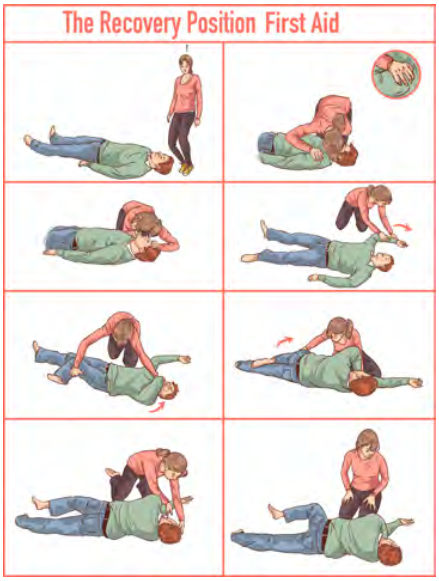
As previously explained, there is a severe risk of unconscious casualties lying on their back either inhaling their own vomit or, more commonly, asphyxiating when their tongue falls to the back of their throat.

There are many methods of putting people in variations of the recovery position. They are all correct, although the method presently favoured by the Resuscitation Council (UK) is felt by many to be easier as it uses the natural levers of the body.

Providing the recovery position, and method of putting them into it, fulfils the following criteria then they are all equally correct:

- Airway is kept open;
- Postural draining (of vomit etc.) and;
- Stable "3-point" position.

The method presently recommended by the UK Resuscitation Council is as follows:



1. With the casualty on their back open their airway *(head tilt / chin lift method), Confirm* Normal Breathing;
2. Remove any spectacles to safety, together with any keys / bulky objects in pockets (in case they dig into the leg);
3. Kneel beside the patient and make sure both legs are straight;
4. Place the arm nearest to you at right angles to their body, elbow bent with the hand palm uppermost **(however do not force the arm);**
5. Grasp the far leg just above the knee and pull it up (with 2 hands if necessary), keeping the foot on the ground. Keep the leg up with your hand nearest their leg;
6. Bring the far arm across their chest and hold the back of the hand against the patient's cheek nearest to you;
7. Keeping their hand pressed against their cheek, pull on the far leg to roll the patient towards you onto their side;
8. Adjust the upper leg so that both hip and knee are bent at right angles;

9. Tilt the head back gently to ensure the airway remains open and adjust the hand under the cheek (if necessary) to keep the head tilted;
10. Call for an ambulance and monitor their vital signs regularly.

If the patient is kept in the recovery position for more than 30 minutes, provided there are no serious injuries present (e.g. fractures) then turn them onto the opposite side to relieve pressure on the lower arm.

NEVER LEAVE AN UNCONSCIOUS, BREATHING CASUALTY ALONE FLAT ON THEIR BACK, EVEN TO CALL 999 / 112. ALWAYS PUT THEM INTO THE RECOVERY POSITION FIRST.

- DO NOT TRY TO GIVE AN UNCONSCIOUS CASUALTY ANYTHING TO EAT OR DRINK.
- DO NOT MOVE THE CASUALTY **UNNECESSARILY**, DUE TO THE RISK OF SPINAL INJURY AND
- NEVER ATTEMPT TO MAKE A SEEMINGLY UNRESPONSIVE CASUALTY SIT OR STAND UP;
- IF THE PATIENT IS ON THEIR SIDE FOR MORE THAN 30 MINUTES, CONSIDER ROLLING THEM ON THE OTHER SIDE – **PROVIDED THEIR INJURIES & CIRCUMSTANCES ALLOW.**

Adaptations - Heavily Pregnant mother

If the patient is a heavily pregnant female the general consensus (although this is hotly debated between many healthcare professionals) is to roll the patient onto their left side (injuries allowing). The theory behind this is that the main vein that feeds into the heart (the inferior vena cava) travels up the right-rear part of the body, and if rolled onto her right side, the foetus could actually rest on this, impeding venous return to the heart. This is unlikely to kill mum, however it is not going to aid her recovery.

If however you need to roll her onto her right side (for example, she may have a suspected fracture of the right leg) – this can still be done, but then placement of a cushion or rolled up clothing as a wedge to move the baby out of the way should obviate any issues with the venous return.

Adaptations - Modified Recovery Position maintaining in-line stabilisation for suspected spinal injuries

With suspected spinal injuries (i.e. the casualty has sustained a fall, been struck on the head/neck, or sustained a shallow diving accident) particular care must be taken during handling to maintain in-line alignment of the head, neck and chest.

When opening an airway, head tilt may be used but the tilt should be **the minimum that allows unobstructed breathing.** Ideally, one person should support their head and maintain an open airway without any further movement of the patient – using the jaw-thrust method if possible.

However, if the patient starts to vomit, thereby compromising their airway, the modified recovery position maintaining in-line stabilisation should be used to minimise movement and keep the casualty's head and torso in line at all times.

Ideally this should be done with at least 2 trained people but remember, even if you are alone, the airway takes priority over all other injuries and the patient, if they are left alone or they start to vomit, must be placed into the Recovery Position. Ideally however, either the log roll or the modified recovery position should be used.

Review Questions – Primary & Secondary Survey and the Recovery position

1. When examining a patient, we use the acronym DOTS to remind us what we are examining for. What does the acronym DOTS stand for?
2. What are the 3 criteria for a recovery position?
3. What is the variation of the recovery position if the patient has a suspected spinal injury?
4. Why is it best practice to undertake a Secondary Survey?