
History Taking and Secondary Assessment

Lesson 10: History Taking and Secondary Assessment

You Are the Emergency Medical Responder

You arrive at the scene of a motor-vehicle collision, a fender bender, in which a woman who was driving her husband to the hospital because he was complaining of chest pain, rammed into the car in front of her. A police unit is on the scene assisting the husband, who collapsed and apparently is unconscious. Your partner proceeds to help the police officer with the unconscious patient. You notice that the woman is clutching one of her arms.

As a responding firefighter how would you respond to and assess the injured woman?

Primary Assessment VS History Taking/Secondary Assessment

- Primary Assessment – Determines if patient has any life-threatening conditions.
- History Taking/Secondary Assessment – Provides more information about the patient through interviewing, monitoring vital signs and conducting a physical exam.

Obtaining the Focused/Medical History

- Finding out as much information is crucial
- Obtain consent from a responsive patient first
- Unconscious/Disoriented/Uncooperative
 - Interview family, friends, bystanders
- Other sources of information
 - Medical alert bracelets/necklaces
 - Pill containers
 - Vial of Life label on outside of refrigerator
- Document

Components of a Patient History

- Chief complaint
 - Why EMS was called
- Mechanism of Injury (MOI)
 - How the injury occurred/forces that caused injury
- Nature of Illness (NOI)
 - History taken first with responsive patient
- Pain
- Other relevant medical information

Activity

You arrive at the home of a patient who is lying on the ground. A 6-foot ladder is nearby and hedge trimmers are on the ground next to the patient. The patient's leg is twisted and he is moaning in pain. The patient is alert and responsive. He tells you that he was on the ladder trimming the hedges and his foot slipped. "I fell to the ground and I think I may have broken my leg. It hurts really badly and I can't move it." His wife confirms the events.

Identify the patient's chief complaint and MOI.

SAMPLE History*

- **S**igns and symptoms
- **A**llergies
- **M**edications
- **P**ertinent past medical history
- **L**ast oral intake
- **E**vents leading up to the incident

History Taking DVD and Skill

Secondary Assessment

- Purpose: To locate and further assess the signs and symptoms of an injury or illness*
- Head-to-toe exam
 - Rapid assessment
 - Detailed physical exam
- If life-threatening conditions are found in the primary assessment, make sure to provide care first, before performing the secondary assessment

Physical Exam w/ MOI DOTS*

- **D**eformities
- **O**pen injuries
- **T**enderness
- **S**welling

Medical Conditions (NOI)*

- **O**nset – abrupt or gradual / how did this start?
- **P**rovocation – what makes it worse/better
- **Q**uality – describe the pain (in their own words)
- **R**egion/radiate – where is the pain/does it radiate?
- **S**everity – on a scale of 1 – 10
- **T**ime – getting better or worse over time?

Rapid Trauma Assessment

- **D**eformities
- **C**ontusions
- **A**brasions
- **P**unctures/penetrations
- **B**urns
- **T**enderness
- **L**acerations
- **S**welling

Secondary Assessment DVD

Detailed Physical Exam

Gathers additional information about injuries or conditions that may need care.

- Head
- Neck
- Back
- Chest
- Abdomen
- Pelvis
- Extremities

Vital Signs*

Taken after managing life-threatening problems and after the secondary assessment.

- Respiratory rate – normal is...
 - 12 – 20 breaths per minute
- Pulse – normal is...
 - 60 – 100 beats per minute
- Blood pressure – normal is...
 - 120/80
 - Auscultation – listening
 - Palpation – feeling radial pulse

Signs of Abnormal Breathing

- Gaspings
- Noisy breathing
- Excessively fast or slow breathing
- Painful breathing

Abnormal Breath Sounds

- Crackles (rales) – small popping, bubbly sounds
- Rhonchi – low-pitched, snoring
- Stridor – high-pitched noises
- Wheezing – high-pitched whistling

Pulse Problems

- Irregular pulse
- Weak or hard-to-find pulse
- Excessively fast or slow pulse
- May need to check longer than 30 seconds

Obtain Baseline Vital Signs*

1. Check respirations for rate, rhythm and quality of breathing. (Without the patients knowledge)
 - Look, Listen and Feel
 - Count number of times patient breathes in 30 seconds and multiply by 2.
2. Check for pulse.
 - Two fingers on top of major artery (carotid, radial, brachial)
 - Count number of beats in 30 seconds and multiply by 2.
3. Check skin characteristics.

Blood Pressure Measurement

- Equipment
 - Sphygmomanometer
 - Stethoscope
- Measured in millimeters of mercury
 - Systolic: force exerted against arteries when heart is contracting
 - Diastolic: force exerted against arteries when heart is between contractions
- No odd numbers!



Ongoing Assessment

- Every 5 minutes if patient unstable; every 15 minutes if patient is stable
- Reassessment of—
 - Primary assessment
 - Vital signs
 - Chief complaint
 - Interventions or care provided

You Are the Emergency Medical Responder

The injured woman accompanies you to a separate area so you can assess her for injuries. She is still clutching her arm. After assessing this patient, you find no life-threatening conditions.

What steps would you take to identify any injuries or conditions that may need medical care?

Enrichment

Pulse Oximetry

- Measurement of oxygen saturation percentage; usually obtained with vital signs
- Normally 96 to 100 percent SpO₂
- Reading below 94 possibly indicates hypoxia