SECONDARY AND CENTRAL NERVOUS SYSTEM (CNS) SURVEY

Objective

A systematic head-to-toe survey used to detect problems that are not always obvious and do not necessarily pose an immediate threat to life but could become serious; uses precise responses to specific stimuli to assess presence and extent of damage to the central nervous system.

Head

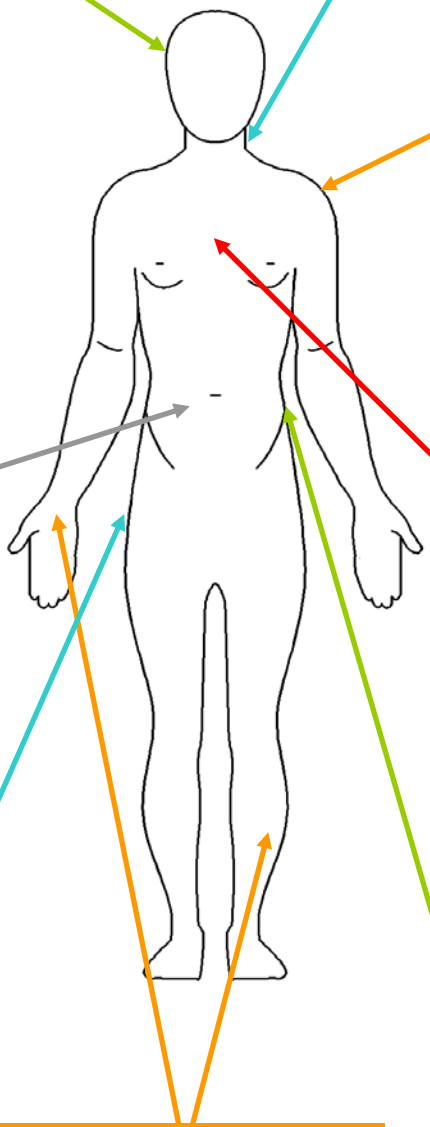
Scalp: Run fingers over scalp without applying excessive pressure, assess for any deformities/abnormalities, bleeding.
Facial Structure: Assess for deformity, asymmetry, swelling or bleeding and tenderness, check sensation to different areas of the face and record any irregularities.
Eyes/nose/ears: Assess for CSF or bleeding, check pupil size and ocular motor function. Check pupil reaction to light with a pupil torch. Enquire about any hearing disturbances or abnormalities.

Neck

Assess cervical spine for mid-line tenderness, pain or obvious deformity. Prevent movement when assessing the neck of the patient.
Assess if swallowing action is present visually, by instructing patient to swallow.

Shoulders

- Palpate the shoulders bony parts and assess for deformity, crepitus, bruising and swelling/pain.
- Apply gentle restraining force to the patient's shoulders, and instruct him/her to shrug shoulders, assessing strength and equality of muscle action.



Abdomen

- Assess for injury, bruising, distension, rigidity, and deformity. Palpate abdomen while assessing for any indication of discomfort.
- Assess sensory function to touch, and get patient to verbally identify area being touched.

Chest

Get the patient to inhale deeply:
- Assess for deformity, tenderness, bruising and paradoxical movement, look for open/sucking chest wounds, palpate the chest wall.
- Auscultate all sites
- Check for injuries/bruising
- Check sensory reaction to touch, comparing left to right side, ask patient to verbally identify area being touched without visualising the action.

Pelvis

- Check pelvis for stability, by applying gentle downward pressure.
- Check for bleeding, tenderness, deformity, and abnormal positioning of legs and hips.
- Check sensory function on opposite sides.

Back

- Palpate the back of the patient, with minimal movement, assess for injury, tenderness, bleeding, deformity
- Assess sensory function

Limbs

- Palpate limbs, assess for deformities, crepitus, swelling, bruising and needle marks.
- Test strength and motor functions by applying gentle restraining force while instructing the patient to push and/or pull against your hands.
- Assess range of movement.