

A Guide to Patient Assessment - 2016

Assessment is THE most important skill for a ski patroller. Do a good assessment and you will recognize a patient's problems, provide appropriate care, avoid further injury, and transport the patient to the next level of care quickly and safely. This guide lets you do great assessments right away. Use it and you'll know what to DO.

To do great assessments:

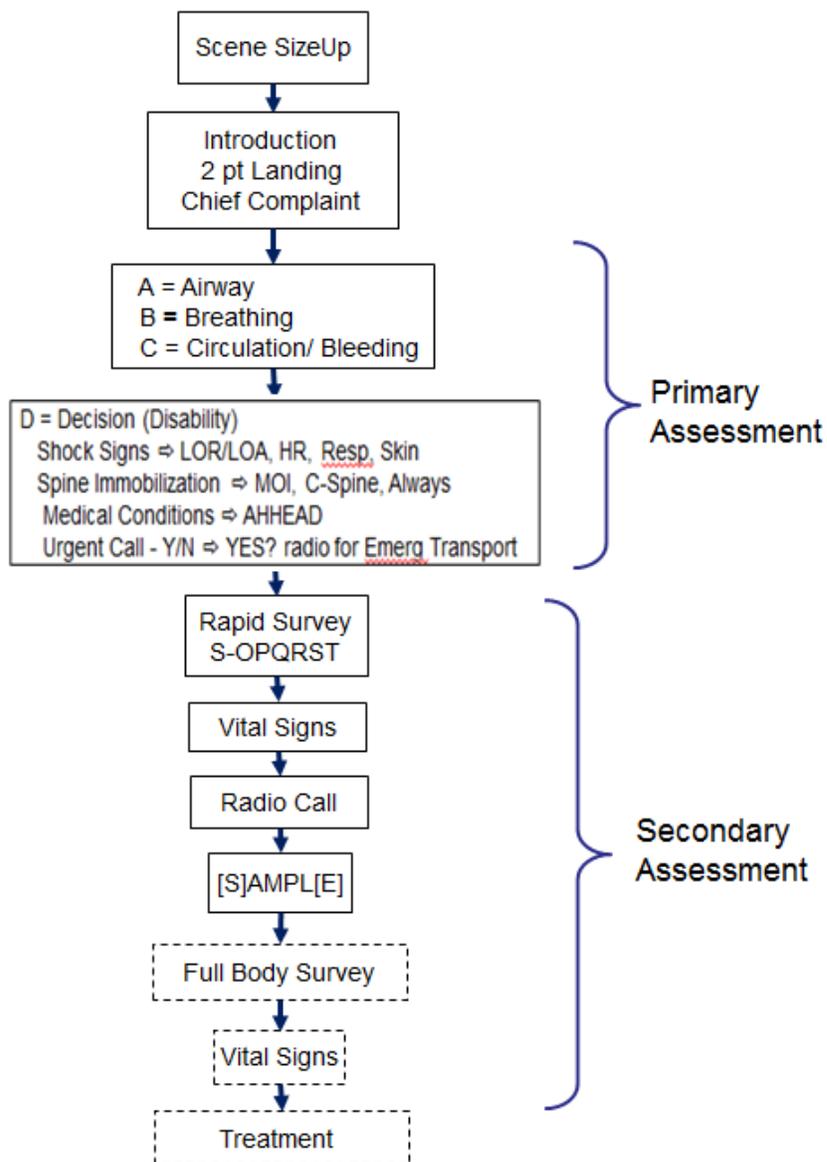
1. Learn this assessment as a mechanical procedure.

You must know the procedures in this guide like you know your own name. Don't worry about "why," just learn the steps

2. Improve your technique by thoroughly reading the chapters in the OEC textbook.

Once the assessment is second nature, the textbook will give you the "why" knowledge.

The diagram below gives the COMPLETE assessment flow that is to be committed to memory.



The steps of this flow are ALWAYS done, regardless of whether the injury is simple or severe. Memorize the steps in the Flow – create a mnemonic that will work for you. Practice saying the steps in sequence to yourself in the car. Do whatever you need to in order to be able to spout the sequence at a moment’s notice.

Truly effective assessment requires integrating everything you will learn in this OEC course with your “on the hill” experiences. As a new patroller, without that experience, the danger is Complacency. Assume your patient may have serious injuries that aren't evident. Err on the side of CAUTION.

Let’s briefly define these steps, and then we will explain them in more detail.

Scene Size-Up – look over the scene, assure the scene is safe for you and your patient, protect the scene (crossed skis, use bystanders, etc), put on glove protection. Assess the mechanism of injury – how did this scene come to be? How many patients are there?

Introduction/Chief Complaint – Introduce yourself, and ask your patient for permission to help. Get a quick pulse check and ask them not to move their head.

Ask them “Tell me what happened. Tell me what hurts.” Solicit a response.

ABC - Does your patient have a patent airway, are they breathing, do they have a pulse, and is there no sign of any bleeding? These are all potentially life threatening signs if the answer is “no” to any

D - Four critical decisions to be made.

Are there any signs or symptoms of shock (Head, Heart, Lungs, Skin), and if so, to what degree?

And why? We treat these as two steps Level of Response/Level of Alertness & shock signs.

By MOI or otherwise (Always questions), might there be head or spinal injury, and is head immobilization required?

Are there any medical conditions we should be aware of that might make the situation worse?

Based on the primary assessment, is this an urgent situation requiring immediate evacuation. If so, make a radio call for Emergency Transport (Location, MOI, CC),

Rapid Survey – quickly and systematically assess head to toe, lumps and bumps (<1 min)

Vital Signs – measure the patient’s baseline pulse rate and respiration rate

Radio Call – where you are, what you have (MOI, CC, Assessment), and what you need

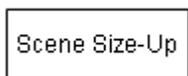
SAMPLE - obtain a patient medical history

Full Survey – Time and conditions allowing, perform a thorough physical exam

Vital Signs – take a second set of vitals

Commit this flow to memory. It is absolutely essential. Stress and distractions can throw the best patrollers off track. Depend on your mechanical knowledge of the assessment flow. ALWAYS follow this flow, no matter how simple or how complex the problem appears. Learn each step and its checklist, in sequence. Commit them to memory. Some areas suggest you verbalize all steps. Appendix A gives a detailed flow summary.

SCENE SIZE-UP



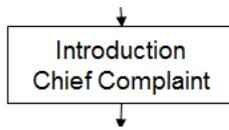
CHECKLIST

- 1. Check Scene Safety; Make scene safe
- 2. Check for other patients & witnesses
- 3. Consider Mechanism of Injury (MOI)
- 4. Apply Body Substance Isolation (BSI)

As you near your patient, first make sure that the scene is safe, for you, and for the patient. If not, you must make it safe before you can approach. Put a pair of crossed skis uphill in the snow, to make the scene obvious. Look for other patients, and make sure witnesses stay around.

Look to see how the accident may have occurred and how bad it might be (MOI). Be wary of “BIG” – big fall, big height, big impact, big “yardsale”. Put on gloves as a minimum, and consider other precautions if called for.

INTRODUCTION/CHIEF COMPLAINT



CHECKLIST

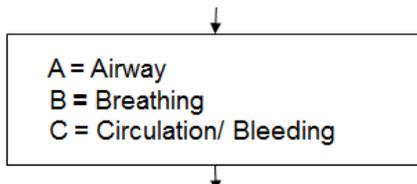
1. Introduce yourself
2. Ask permission to assist
3. 2-pt landing
4. What is the Chief Complaint

Approach the patient from the front, introduce yourself, and ask if you might help them. “Hi, I am Sue. I am a ski patroller. May I help you?”. This is a necessary step. A fully responsible & alert adult can refuse your help.

With your help agreed to, place one hand on their head and ask them not to move their head, and get a quick pulse check with the other. Take in their body language, skin condition (color, temperature, moisture). Skin condition is felt by feeling their forehead with the inside of your forearm, but may require putting a hand inside their clothing.

Solicit the chief complaint (if you can) by asking the patient “tell me what happened, tell me what hurts”. Not only will the information be extremely useful in the next several steps, but the fact that they answered tells you a lot. And be aware of both “what” they answered as well as “how” they answered. Is the response labored, halting, unsure.

ABCs



CHECKLIST

1. Check for “Yes/No” on airway, breathing, pulse and bleeding. Address any issues immediately

Is there is any immediate threat to the patient’s life. If there is, you must address it at this point, and move no further along the Flow.

These are NOT simple Y/N questions. If there is an issue, you must find the answer. Is it medical or trauma related? You might pull some items from further down in the flow to help you puzzle it out.

Under A, you are going to check that the patient “has an airway” and can maintain it on their own. If there is no airway, you will open it with jaw thrust or head tilt- chin lift. Under B, you are going to “Look, Listen and Feel” for 10 seconds for respiration, principally chest rise. Under C (if not done already), you will check for a pulse for about five beats. If either respirations or pulse is absent or inadequate, move directly into either full CPR or assisted breathing, whatever the situation calls for.

C also means bleeding. If the patient is conscious and responsive, “GO TO SKIN” on the chief complaint. Is there any blood? If so, control the bleeding. If the patient is either not conscious or not responsive, do a pat down of clothing and a quick inspection. Are there any signs of bleeding or pooling of blood?

If there are any ABC issues, you must address them immediately. Go no further until this has happened. You might go no further than maintaining the patient’s airway. You will have to radio for help now.

If the ABCs check out, verbalize “I have my ABCs”.

Appendix B gives a detailed ABC flow. All students should try to understand every step of this diagram. One key element of this chart is when Positive Pressure Ventilation is required, even though a person may be breathing. But just not adequately.

DECISION (DISABILITY)

D = Decision (Disability)
 Shock Signs ⇒ LOR/LOA, HR, Resp, Skin
 Spine Immobilization ⇒ MOI, C-Spine, Always
 Medical Conditions ⇒ AHHEAD
 Urgent Call - Y/N ⇒ YES? radio for Emerg Transport

CHECKLIST

- D1 - Level of Responsive / Level of Alertness
- D2 - Shock Signs
- D3 - By MOI/CC need head immobilization? Check C1-C7. Ask Always questions
- D4 - Any medical conditions (HHEAAD)
- D5 - Is this situation urgent (Y/N)

While there may no immediate threat to life, you must determine if the situation is dire none-the-less. There are two key elements to assess – the appearance of shock signs (including signs of neurological disorders) and the need for spinal immobilization. .

SHOCK -

Signs of shock will show up in the quality of a person’s neurological response, heart rate, respiration, and skin signs (“head, heart, lungs, and skin”). Shock (aka hypoperfusion - lack of perfusion) means that the organs and tissues of the body are not getting adequate nutrients and/or oxygen.

Head: First determine the patient’s level of responsiveness (LOR) using AVPU, with A - alert, V - responsive to verbal commands, P - responsive to painful stimuli, and U - unresponsive. If there has been a response to your introduction, you can assume the patient is alert. If no response, first yell, “Open your eyes”. If they do, the status is V - responsive to verbal commands. If no response, rub their sternum or pinch the trapezius. If there is a response, their status is P - responsive to pain. If no response, their status is U- unresponsive.

If the person is alert, determine “How Alert” (Level of Alertness). Ask the LOA questions. What is your name? Where are you? What time is it? What happened just prior to your accident? (Person /Place /Time/ Event). The latter question is different than “Tell me what happened...”. You are asking how much the person remembers just prior to the incident. This is a key to determining the level of concussion if there was a head injury.

Determine if you can effectively communicate, and decide if you can trust the answers. Altered mental status, extreme pain, fear, or lack of a common language can all block accurate communication. Level of Response is reported as “A&O by X (1,2,3,or 4), not oriented to Person/Place/Time/Event”.

One of the most effective and early signs of hypoxia (lack of oxygen to the brain) is anxiety or restlessness or feeling of doom. Don’t overlook or dismiss them.

If the person is altered in any way (↓LOR, confusion, anxiety), you must dig to find out why. Use AEIOUTIPS to help go through the possibilities. Some may require bringing forward questions that would be asked later in the Assessment flow – eg Any medical conditions we should be aware of (eg Diabetes). Some may require performing some test – eg Cincinnati Stroke Scale test. Some may require asking when they arrived at the resort (Altitude Sickness), any recent illness (Uremia – metabolic upset). You need to determine if there is something you can do to restore stasis, or something urgent is happening.

Heart: This is NOT a counted pulse. It is a qualitative assessment. Is the pulse rate strong or steady? Or is it rapid, thready, irregular. You have already assessed this in one of the two steps before this.

Lungs: This is NOT a counted respiration. . It is a qualitative assessment Is breathing normal or is it labored, raspy, shallow, or otherwise compromised? Is the person making noises as they breath?

Skin: Normal skin is warm, pink, and dry. Is the person sweating, hot, cold, flushed, bluish? If uncertain, look at the inside of their lip or fingernail beds for color.

It helps initially to verbalize your findings of head, heart, lungs, & skin (eg “patient is A&Ox4, pulse is strong and regular, breathing is rhythmic, and skin is warm, pink,and dry”)

SPINAL IMMOBILIZATION

Now turn your attention to indications or suspicion of head or spinal injury.

There are three elements to this determination. The first is MOI and Chief Complaint. Was this a significant event or something simple? Second is a spinal check. You might not be able to get all the way down their entire spine, but you can always do a palpation of C1-C7 regardless of patient position by wrapping your hands around the patient's neck and feeling behind.

And finally, ask the patient the "Always" Questions. They help to uncover any symptoms of injury to the patients' head, neck, or back.

1. "Did you hit your head?" If yes, ask if person has had a previous concussion.
2. "Did you hit your back?"
3. "Does your neck hurt?"
4. "Does your back hurt?"
5. "Did you ever lose consciousness?"

There is always a question about #5 as a momentary loss of consciousness is not necessarily a sign of a concussion or brain injury. If MOI checks out and there is no pain on head or back (at least C-spine), one needs to make sure that the patient now has full normal mental status, and can answer your questions correctly. If all these are okay, you might consider not immobilizing the patient. **USE YOUR JUDGEMENT.**

If there is any POSITIVE indication on any of these 3 factors (MOI/CC, C1-C7, Always), OEC V recommends doing a more thorough motor response evaluation from the Glasgow Coma Scale (6 levels – patient follows commands, localizes pain, withdraws from pain, flexor posturing, extensor posturing, and no response). AND it is always best to check CMS on all extremities to see if there is any neurological deficiency.

Any patient suffering a concussion with associated headache, visual disturbances, nausea, etc should be examined by a physician. A concussion is a brain injury caused by a shaking of the brain inside the skull, which temporarily prevents the brain from working normally. It is not always easy to know if someone has had a concussion. Not everyone who has had a concussion passes out. Check their helmet for sign on impact.

If you get past this D3 step, it is okay for the patient to move their head and back. You might check the rest of their spine if only C-spine was done just to confirm your findings.

MEDICAL

You need to find out if there is some underlying medical condition, which may or may not be related to the situation at hand, that could make the situation worse. The acronym is AHHEAD – Asthma, Hemophilia, Heart Disease, Epilepsy, Allergies, Diabetes. Always check for a medic alert tag or bracelet, especially on unconscious patients.

URGENT/EVACUATION

When you have finished this step, you should have a good indication of the urgency of the situation, the need for spinal immobilization, and the requirement for emergency transport. Remember, your job is not to diagnose but to assess the seriousness of what you face, and act appropriately. So, while there are many causes of shock, for example, you only care that the signs are there, and how serious they might be. A person going into shock or in shock will not be a patient for long.

What are the kind of situations that require urgent assessment, treatment, and evacuation? Among them are – (1) affects airway and cannot be immediately corrected, (2) affects O2 exchange in lungs, (3) compromises heart ability to pump, (4) not responsive, (5) uncontrolled bleeding, or (6) in or might go into shock. There are others as well. You should check with your patrol on their protocols for this.

Remember, sometimes a response of "I just don't feel well at all" may be your only indication of something serious. So the signs of perfusion will tell you if the condition is serious (or heading in that direction) or not. At other times, there may be no sign at all of anything seriously wrong, other than an altered level of responsive.

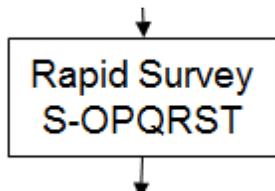
Watch carefully for changes in responsiveness during your assessment and treatment. **Decreasing responsiveness is an ominous sign requiring emergency transport.**

One of the items that neophyte patrollers have with an assessment flow is “When do I make a radio call? This is URGENT, shouldn’t I radio right now?” Well, If the situation is URGENT, the answer is Yes. But think through what you are going to do – to not make a complete hash of everything. And remember, there may still be things to discover. Try thinking about this – “Paint a Picture” for your supervisor. For example

“I have a 17 year old male, chief complaint is chest pain, MOI is hitting a rail on the barrel feature, Patient is A&Ox2, having difficulty breathing and showing signs of shock. Counted vitals, equipment, and complete exam to follow in a moment. Arrange for emergency transport. We are in the Gold Coast Terrain Park”

Note there has been no call for equipment. Remember personnel are a critical resource!

RAPID BODY SURVEY



RAPID BODY CHECKLIST

1. Head - Feel shape, check ears for fluid (look at gloves)
2. Anterior neck – Is trachea out of place or jugular veins abnormal.
3. Cervical Spine – check at least C1-C7, more if possible
4. Shoulders - Squeeze one then the other, move along clavicles
5. Chest – Resist expansion; High & Low; Sternum
6. Abdominal quadrants – check all 4
7. Pelvis - Palpate in. Do NOT press downward.
8. Each Leg - Palpate from hip to the feet
9. Each Arm - Palpate from shoulder to hands
10. Peripheral CMS (circulation, motion, sensation) on all extremities

OPQRST CHECKLIST

- S – Symptom
- O – Onset
- P - Provoke
- Q - Quality
- R - Radiate
- S - Severity
- T - Time

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For the Chief Complaint, and any other injury found, ask the patient to point with a finger to where it hurts, then Expose and Isolate the injury site for any sign of deformity, bleeding, tenderness, swelling, or the like. If you find a problem that is serious, attend to it then, otherwise continue on with the survey. The purpose of the survey is to make sure nothing is missed ie that the chief complaint is not masking something else that might be serious. And for every injury on an extremity, DO CMS!! (**Remember: Expose, Isolate, CMS**)

As you progress through the survey, watch and listen to the patient for discomfort to your touch, or pain in their eyes, Maintain eye contact with the patient because you will first see discomfort in the eyes. Be sure to distinguish between fear and pain in the patient’s appearance. Leave the injured extremity for last.

Use all your senses during the exam: sight, sound, touch and smell. Your touch during the exam must be firm and continuous, surrounding the area you are examining. Don’t “bounce” around or “flutter” and miss something..

The Rapid Body Survey is a head-to-toe, 60 second, “lumps and bumps” examination. Head – quick palpation for tenderness, swelling, or bruising.

Neck – check for trachea mis-alignment and jugular swelling

Spine – DO NOT roll a patient with a potential neck or back injury; put hands around neck to feel C spine; assess as much as of the spine as possible. If no spinal immobilization is required, check their entire spine and posterior ribs by rolling the patient if necessary, or “digging in the snow”.

Clavicles – walk each clavicle from sternum to shoulder.

Shoulders – grab the shoulders and squeeze

Chest – resist high, resist low, edge of hand on sternum

Abdomen – four quadrants, fingers pointed up for upper quadrants, down for lower; rock hand along middle for signs of guarding and AAA pulsations.

Pelvis – hands on iliac crests; press in; DO NOT press down

Hips – just as with the shoulders, grab each hip joint and squeeze.

Legs – one leg at a time, palpate from groin to feet, firmly.

Arms - one arm at a time, palpate from shoulder to hands, firmly

REMEMBER - **Expose, Isolate, CMS** for each injury site

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S-OPQRST ----

OPQRST is a tool for assessing pain which has a non-traumatic cause – ie. It has some sort of “medical” origin. A key thing to remember is that the answers to OPQRST might very well change over time, so in urgent cases, it is important to be tracking the changes – especially if the pain is getting better or worse.

In cases where the pain is caused or associated with trauma, the answers are usually obvious or do not lend any new information. But asking some or all is a judgement call.

S - Symptoms

“Where does it hurt?” or “How does it feel?” are questions about pain symptoms. A response of “It hurts!” doesn’t give you much to go on. Follow up with a set of questions to judge the type and level of pain, and to determine if some medical or drug condition might be causing or complicating the current complaint.

O - Onset

“How and when did the pain start to happen?” What initially caused it? Is the pain from today, or how long as it been there?

P - Provokes

“Does anything make it worse?” “Does anything make it better?” For example, exertion may make chest pain worst and sitting down may relieve the pain. Moving the wrist or arm a certain way may provoke the pain.

Q – Quality

How does the pain feel? Sharp, dull, shooting and crushing are typical responses. Ailments have unique qualities. Don’t give examples, as the patient is likely to agree with whatever you use.

R –Radiates/Refers

“Does the pain radiate, shoot or move to anywhere else?” Identify abdominal and cardiac pain that often radiates to the jaw, shoulder or arm. In some cases, due to crossed wiring inside the body, an injury to an organ will cause pain at some distant location. For example, a spleen injury will often result in pain in the left shoulder.

S - Severity

“If ten is the worst pain you have ever felt, what is this pain right now?” Ask, “What was that worst pain?” to calibrate. Any prior trauma may alter their scale versus yours.

T - Time questions

“Have these symptoms occurred before?”. “Is the pain getting worse, moderating or staying the same?” “Does it come and go, or is constant

The answers will help you decide if you dealing with something new, or old, and the urgency with which it should be handled.

It is very possible that you might have both a trauma and a medical issue, especially when the latter may have contributed to the former. In this case, go after the more serious issue first, using the appropriate flow element, and then go after the less serious one. Prioritize.

VITAL SIGNS



CHECKLIST

1. Pulse (strength, rate, quality)
2. Respirations (strength, depth, rate, and quality)

You must measure these vital signs repeatedly (along with level of consciousness) during an assessment. Do not try to memorize the results. Write them down! **Deterioration of vital signs requires immediate transfer to definitive care.**

Pulse:

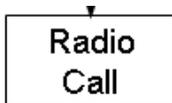
Feel for the strength, rate, and quality of pulse. An abnormal pulse reflects both cardiac impairment and the quality of perfusion. **Increasing pulse rate is an indication of shock. You ignore it to your patient's peril.**

Do all pulse checks using multiple fingers. Count pulse for fifteen seconds after locating it and multiply by 4.

Respirations

Feel for the strength, depth, rate, and quality of respirations. The patient cannot breathe naturally while aware of their breathing, so measure respirations without the patient's awareness (eg as continuation of pulse). The measure of breathing adequacy is Rate (bpm) x Tidal Volume (air per breath) = air per minute. A person is NOT getting enough air if they are breathing rapidly with shallow breaths. In such a case, you must assist with positive pressure ventilations. Memorize the appropriate rates when such an issue might arise.

RADIO CALL –



CHECKLIST

- S = sex
- A = age
- I – injury
- L = location (where are you?)
- E = equipment needed
- R = Request for additional help and/or ambulance, IF NEEDED.

How the radio call is done will vary greatly from ski hill to ski hill, so we have adopted a protocol with a “Paint a Picture” label. Remember all patrols stress that short and concise is the RULE for all communications, so write down everything on your leg tape as you are doing the assessment, and then “read” from that. If you have made a previous call on D5 for emergency transport, some of this would NOT be repeated.

- Identify yourself: Your name & Location
- Patient Info: Age & Sex
- Initial Info: MOI and Chief Complaint (CC)
- Assessment; Other findings, LOR/Vitals (if Urgent)
- Equipment; What is needed
- Transport Plan To Base? To Emergency Transport? ETA?

So, an example of a non-emergency call radio call would sound like this:

“Dispatch, this is David NSP at Big Dipper. I have a male, 25 years old. Chief Complaint is shoulder injury after a simple fall. No other injuries. I need sled and sled bag.

And would sound like this for an emergency call:

Dispatch, this is David NSP at Big Dipper. I have a male, 25 years old. Chief Complaint is mid back pain with compromised CMS after impacting a tree. Assessment found no other injuries. Patient is A&Ox4, Pulse is 100, respirations are 20. I need sled, Backboard, and O2. Requesting emergency transport. ETA to LZ is 20 minutes."

Recall that the request for CC, MOI and request for Emergency Transport may have been included in an earlier call and need not be repeated again. But if the earlier call was not made, these need to be included now.

SAMPLE



- CHECKLIST**
[S – signs & symptoms]
A – allergies
M – medicines
P – Prior medical conditions
L – last oral intake
[E – events leading to current complaint]

As part of the Rapid or Focused Survey the S question was asked – what are the signs and symptoms of the pain. This S is the first letter of the acronym SAMPLE - questions for determining medical history.

- S – signs & symptoms.
- A – allergies
- M – medicines
- P – Prior medical conditions
- L – last oral intake
- E – events leading to current complaint

[S]- Signs & Symptoms

Already completed as part of the Focused or Rapid Surveys. It is how we get the patient to guide our discovery. Repeat it again only if you think the patient’s condition might be changing

A - Allergies

Ask about severe allergies (medicine, foods), find out if they are having a reaction, and do they carry any medication. If conscious and alert, you may assist their self administration.

M – Medicines

You want to find out about four kinds of “medicines”

- Prescription
- Over-the-counter
- Recreational drugs
- Alcohol

If positive to prescription and over-the-counter drugs, ask:

- “What are the medicines?”
- “What are you taking that for?”
- “Did you take it as prescribed? If “No”, then follow up “Was it a contributing cause?”
- “Do you have it with you?”

These questions may identify chronic medical conditions. The current complaint may require taking medication. If conscious and alert, you may assist their self administration.

The evaluation may identify immediate threats to life from alcohol poisoning and drug overdoses.

P - Prior Medical Conditions (asked earlier)

This question was also asked earlier. Now ask it another way, eg “Are you under a doctor’s care for any reason?” Remember HEAD. If there is some problem, ask if carrying any medications – nitroglycerin, inhaler, antihypertensives, antihistamines.

Ask or look for a medic-alert bracelet or necklace, especially if you have an unresponsive patient, but hopefully this was done earlier.

Warning: Children with chronic medical conditions are often taught that they are not sick, just kids that need to take this pill or shot every day.

P also stands for pregnancy. Any woman, post puberty, with abdominal pain must be assumed pregnant until proven otherwise. There are some standard “female” questions to ask that we will review in class. Privacy is especially important when asking these questions, and may be best to get a female patroller.

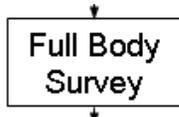
L – Last Oral Intake

Asking about recent meals can point to medical problems. Food patterns may also complicate diabetes, blood sugar regulation problems, or extremely thin people. This question also looks for complications from dehydration which will aggravate altitude sickness.

[E] – Events Leading to Being Here

You obtained this information perhaps twice earlier. Repeat it again only if you think the patient’s condition might be changing

FULL BODY SURVEY



CHECKLIST

1. Head – shape, eyes, ears, nose, mouth
2. Anterior neck – Is trachea out of place or jugular veins abnormal.
3. Spine - DO NOT roll a patient with a potential neck or back injury; at least put hands around neck to feel C spine
4. Shoulders - squeeze one, then the other; move along clavicles
5. Chest - Resist expansion; High & Low; Sternum
6. Abdominal quadrants – check all 4
7. Pelvis - Palpate in. Do NOT press downward.
8. Legs – palpate one, then the other, pedal test
9. Arms - palpate one, then the other, grip test

If you did an urgent survey earlier in the Assessment flow, this “repetition” is to fill-in elements that you did not include (eg pedal and grip test), perhaps check CSM again, or just to be complete. In some resorts, the full body survey is not done on the hill, but in a medical clinic or first aid shack.

If you are unable to do what you had left out, you should alert the patrollers that show up to assist you complete it. A key instance would be a full spine check on a patient who you have determined required spinal immobilization. If they are presenting supine, the first instance that you would have to palpate the entire spine and check the posterior ribs would be when they are log-rolled onto the backboard.

2nd Vital Signs



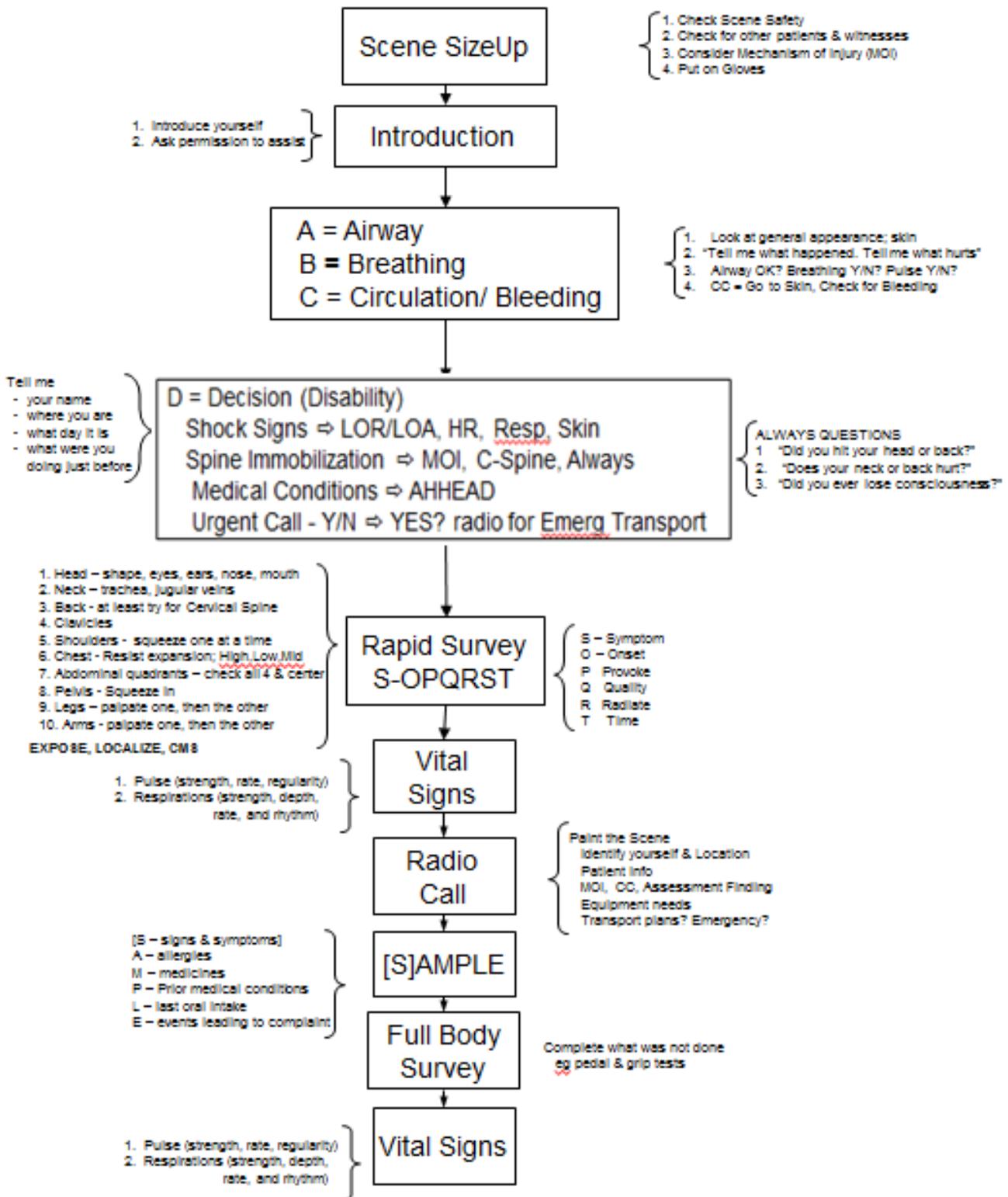
CHECKLIST

1. Pulse (strength, rate, quality)
2. Respirations (strength, depth, rate, and quality)

Take a counted pulse and (while continuing to hold the patient’s wrist) counted respirations and record them. Notice the patient’s skin signs and review their level of responsiveness. Re-check any identified injury sites,

checking for any change in appearance or patient discomfort and checking the effectiveness of any splints or bandages you have applied. You are now at the point of beginning to treat your patient's injuries.

APPENDIX A: DETAILED ASSESSMENT FLOW



APPENDIX B: Details of ABC

TV = tidal volume
 NPA = nasopharyngeal airway
 OPA = oropharyngeal airway

PPV = positive pressure ventilation
 NRB = non rebreather mask
 BVM = bag-valve-mask
 PM = pocket mask

