

FREC 4 **AIDE MEMOIRE**

01603 339 159
www.nrmedical.training
info@nrmedical.training

Capacity & Consent

- Consent **MUST** be voluntary & can be verbal, written or implied
- **ALWAYS** assume capacity unless you can demonstrate a lack of
- An unwise decision is **NOT** evidence of lack of capacity
- You **MUST** always give as much information and support possible to assist an individual to make an informed decision
- Decisions **MUST** be in the patient's best interests
- You **MUST** consider the least restrictive option

2 Part Capacity Assessment

1

Is there an impairment of, or disturbance in the person's mind or brain? (permanent or temporary) (This covers a range of problems, including but not limited to psychiatric illness, emotional distress, learning disability, dementia, brain damage, neurological conditions, the effects of hypoxia, pain or acute behavioural disturbance).

YES – Move To Part 2

NO – Patient Has Capacity

2

An individual is unable to make a decision for themselves if they are unable to meet **any one** of the following criteria:

- **Understand** the information relevant to the decision.
(Adjustments should be used as appropriate to assist in understanding)
- **Retain** that information
- Use or **weigh** that information as part of the decision-making process
- **Communicate** their decision (through any communicative means).

Remember to document and evidence any assessment of capacity

GCS SCORE

EYES

4

Patients eyes open spontaneously

3

Eyes open to verbal commands and speech

2

Eyes open to painful stimuli

1

Eyes do not open

Score

VOICE

5

Orientated

4

Confused

3

Inappropriate words

2

Incomprehensible sounds

1

No verbal response

MOTOR

6

Obeys commands

5

Localises pain

4

Withdraws from pain

3

Flexion to pain

2

Extension to pain

1

No motor response

OBS/TIME	:	:	:	:	:	:
AVPU						
RESPIRATORY RATE						
SPO2						
PULSE RATE						
BLOOD PRESSURE						
TEMPERATURE						

ATMIST HANDOVER



AGE

INCIDENT DATE / TIME

MECHANISM OF INJURY/ILLNESS

INJURIES FOUND / SUSPECTED

SIGNS & SYMPTOMS

TREATMENT GIVEN

Primary Survey

D

SAFE APPROACH | CONSIDER EARLY CALL FOR HELP

R

ALERT | NEW CONFUSION | VOICE | PAIN | UNRESPONSIVE

C

INDIRECT/DIRECT PRESSURE | TOURNIQUETS | WOUND PACKING

A

HEAD TILT | JAW THRUST | SUCTION | DRAINAGE | OPA/NPA |
iGEL (SUPRAGLOTIC AIRWAY)

B

2 BREATHS/10s - CONSIDER OXYGEN - TRAUMA OR <NORMAL RANGE
<2 BREATHS/10s - ASSISTED VENTILATIONS - 1 EVERY 6 SECONDS
0 BREATHS - COMMENCE RESUS

C

PULSE PRESENT?
RATE/RHYTHM/STRENGTH
CAP REFILL >2 = ABNORMAL

RESUS

ADULT - 30:2
INFANT/CHILD - 15:2

CONSIDER C SPINE

WHEN THINGS CHANGE - REASSESS

COMA

FOR USE IN TRAUMA WHEN RESOURCES ALLOW

C

CLOTHES OFF

O

OXYGEN ON

M

MONITORING ON

A

ACCESS 360

Secondary Survey

DO NOT START UNTIL PRIMARY COMPLETE



D

NEW NEUROLOGICAL PROBLEMS

PEARLA | GCS | ACVPU | BLOOD
GLUCOSE | SPO2 | TEMP | BE FAST |
NEWS2

E

EXPOSE | EXAMINE | ENVIRONMENT

FIND INJURIES | TOP-TOE | THERMAL
PROTECTION IS LIFE SAVING

WHEN THINGS CHANGE – REASSESS

Post ROSC

1. Reassess:

Reassess DRCABCDE systematically

Ensure scene safety and crew roles clear

2. Airway & Breathing:

Maintain airway and ventilation (If Required)

Oxygen: titrate to maintain SpO₂ within normal range (avoid hyperoxia)

3. Circulation:

Record time of ROSC

Attach 12-lead ECG (look for STEMI, arrhythmias)

Check blood glucose

Consider causes: 4 H's / 4 T's

4. Disability:

Assess GCS and pupils

Manage seizures if present

5. Exposure / Environment:

Thermal protection: prevent hypothermia

Reduce unnecessary movement – consider spinal injury if MOI is suggestive

6. Ongoing Management:

Monitor closely (SpO₂, ECG, BP, EtCO₂ if available)

Prepare for deterioration (re-arrest is common)

Plan for extrication and transport (liaise with ambulance / critical care team)

Continue documentation and communication

MANAGEMENT OF CHEST INJURIES

Positioning

Reassurance

Occlusive / non occlusive dressings

Prepare for rapid deterioration

F

FEEL

L

LOOK

A

AUSCULTATE

P

PERCUSS

S

SEARCH

T

Tracheal Deviation

W

Wounds & Bleeding

E

Emphysema (Surgical)

L

Laryngeal Crepitus

V

Veinous Engorgement

E

Evaluate



SIGNS & SYMPTOMS OF FRACTURES

**Loss of Power or
Unnatural Movement**

Deformity or Irregularity

Pain & Tenderness

Swelling & Or Bruising

DISLOCATIONS

Dislocations require hospital treatment

**DO NOT ATTEMPT TO PUT
JOINT BACK INTO PLACE**

**CHECK PULSES ON
AFFECTED LIMBS**

REASSURANCE



Head Injury

Concussion VS Compression

CONCUSSION

- **Unconsciousness for a short period, followed by an increase in levels of response and recovery.**
- **Short term memory loss (particularly of the incident) irritability and confusion.**
- **Mild general headache.**
- **Pale clammy skin.**
- **Shallow / normal breathing.**
- **Rapid weak pulse (blood is diverted away from extremities).**
- **Normal pupils, reacting to light.**
- **Possible nausea / vomiting on recovery.**

COMPRESSION

- **Could have a history of recent head injury with apparent recovery, but then deteriorates.**
- **Levels of response become worse as condition deteriorates.**
- **Intense headache.**
- **Flushed dry skin.**
- **Deep noisy slow breathing (pressure build up on respiratory centre in the brain).**
- **Slow strong pulse (caused by rise in blood pressure).**
- **One or both pupils dilate as pressure builds on the brain.**
- **Condition becomes worse, fits may occur, no recovery.**



TEMPERATURE EXTREMES

Heat Exhaustion vs Heat Stroke

HEAT EXHAUSTION

Pale, sweaty skin

Nausea, loss of appetite, vomiting

Fast, weak pulse and breathing

Cramps in arms, legs, abdomen

"I feel cold", but hot to touch

HEAT STROKE

High body temperature ($>40^{\circ}\text{C}$)

Confusion, agitation, disorientation

Throbbing headache

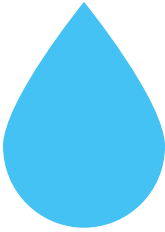
Possibility of seizures

Lowered levels of
response/unconsciousness

Nausea, vomiting

Flushed, hot, dry skin (no sweating)

BURN TREATMENT



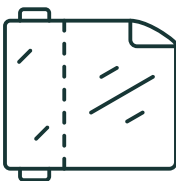
HYDRATE FOR A MINIMUM OF 20 MINS

**GENTLE APPLICATION USING TEPID
WATER. WATER TO BE AS CLEAN AS
POSSIBLE.**



MAINTAIN BODY TEMPERATURE

**TAKE ALL STEPS POSSIBLE TO MAINTAIN
BODY TEMPERATURE.**



DRESS USING CLING FILM OR BURNS DRESSING

**NEVER WRAP. APPLY IN SHEETS TO
ALLOW FOR SWELLING**

Tone
Interactiveness
Gaze
Cry
Consolability

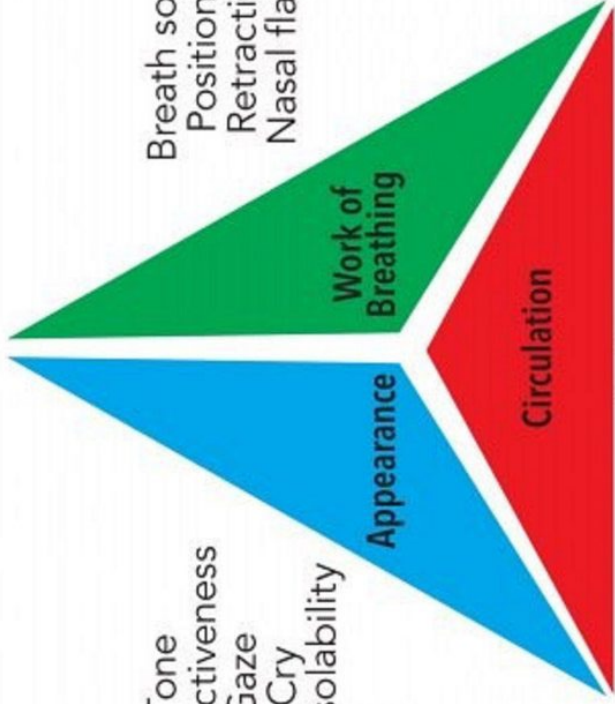
Appearance

Breath sounds
Positioning
Retractions
Nasal flaring

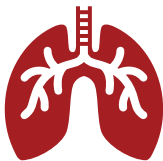
Work of Breathing

Circulation

Pallor
Mottling
Cyanosis



Paediatric RR By Age



$<1\text{yr} = 30 - 40$

$1 - 2\text{yr} = 26 - 34$

$2 - 5\text{yr} = 24 - 30$

$5 - 12\text{yr} = 20 - 24$

$> 12\text{yr} = 12 - 20$

Paediatric HR By Age



$<1\text{yr} = 110 - 160$

$1 - 2\text{yr} = 100 - 150$

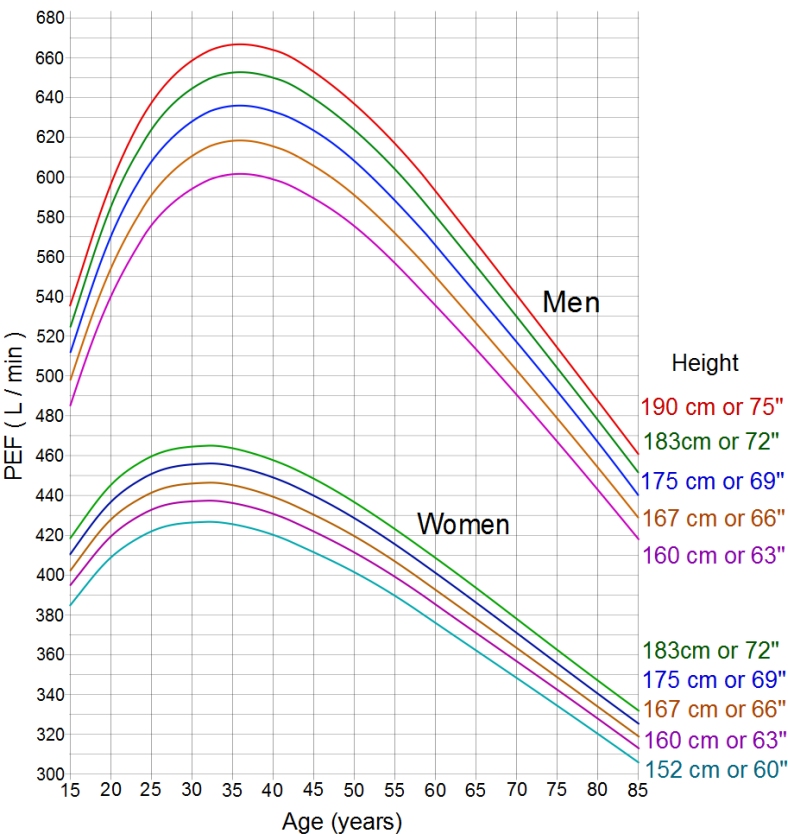
$2 - 5\text{yr} = 95 - 140$

$5 - 12\text{yr} = 80 - 120$

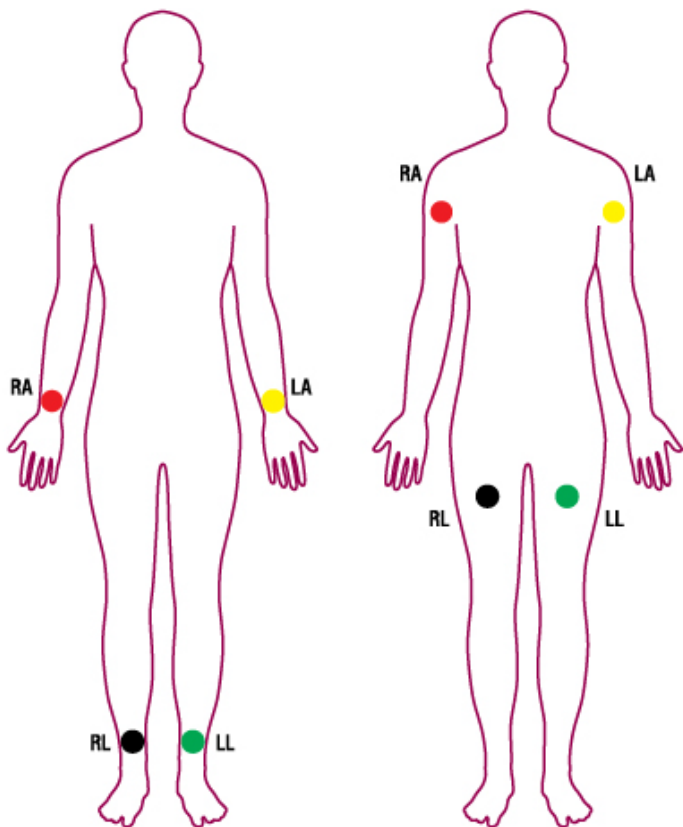
$> 12\text{yr} = 60 - 100$

Normal values for peak expiratory flow (PEF)

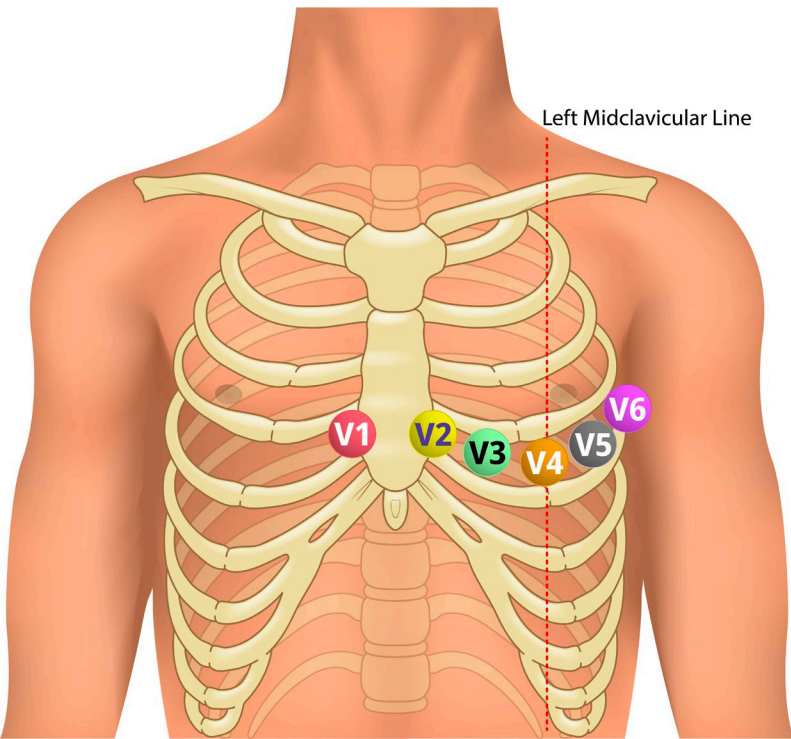
EN 13826 or EU scale

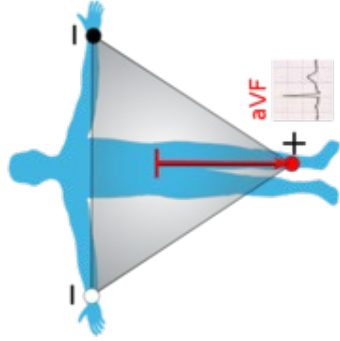
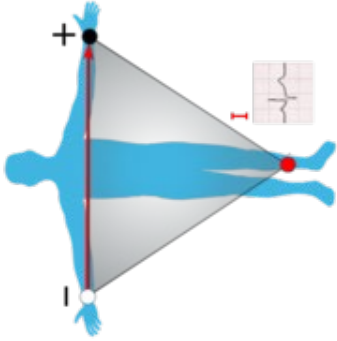
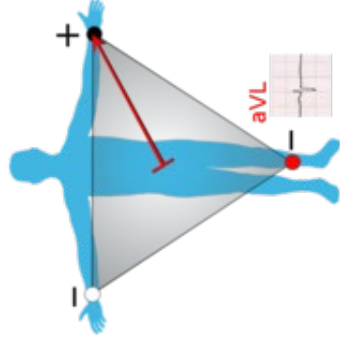
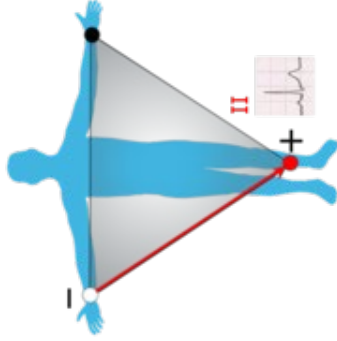
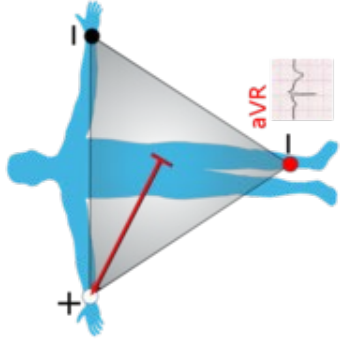
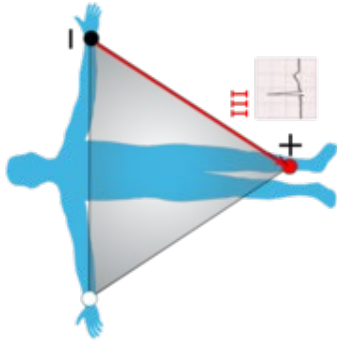


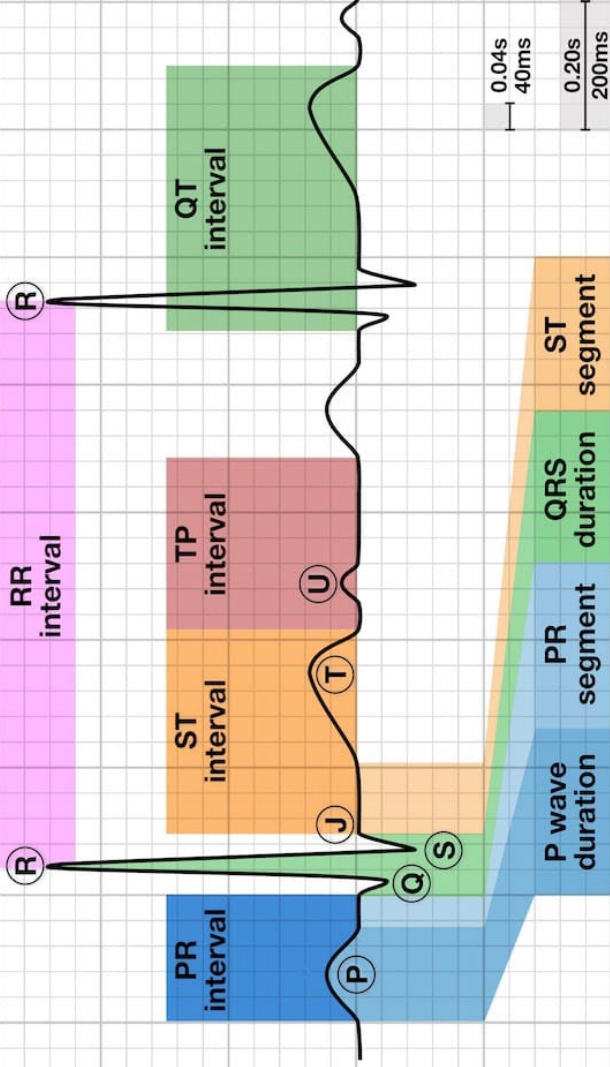
Limb Lead Placement



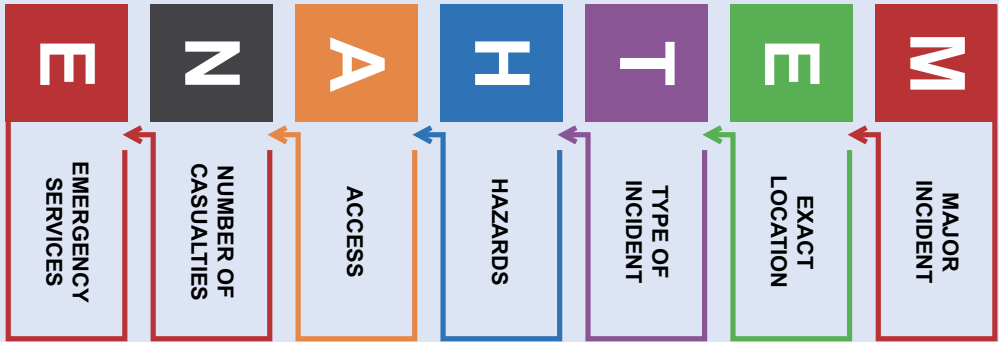
Chest Lead Placement







Ten Second Triage (TST)



Ten Second Triage (TST) Tally Chart

P1																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

P2																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

P3																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Not Breathing																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Ten Second Triage (TST)

