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1 CANADIAN DIVISION SURGEON

Aeromedical Programs SAR Tech 2020



# MEDICAL NCO HANDBOOK



Canada 



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## 1.0 ADMINISTRATIVE



## 1.1 Medical General Memoranda (MGM's)

### 2020

2001	Jan 20	<b>New Policy</b> implemented for AMP Medicinal Inspections authorized by the Div Surg; if a Medical Inspection has the same corrections as the last AMP medical inspection, that inspection will constitute as a failure of the AMP Medical Inspection.
2002	Jan 30	Delete 6510-01-606-7097 Dressing, Chest Wound Seal, Valved (UOM = EA) from the following medical kits (ROLE 1, AE, PHCI, Ambs, DART, Dive Team, Navy, MO/PA/Med Techs, SAR and Combat-Trauma kits) and replaced by adding 6510-01-658-7745 Chest Seal with Valve 2.0 no Pad or Cap.
2003	Feb 7	Delete NS 6515-01-235-2649 SUPPORT CERVICAL SHORT 'STIFNECK' LARGE OPENING IN FRONT FOR AIRWAY ACCESS from the following SAR Medical Kit and replace by adding NS 6515-01-305-2457 SUPPORT, CERVICAL, using a 1:1 replacement. Additionally, Remove 6515-21-903-0732 STETHOSCOPE (COMBINATION TYPE) BLACK "LITTMANN CLASSIC II" from the following medical kits and Replace by adding NS 6515-01-673-7560 STETHOSCOPE CLASSIC III 27IN BLACK TUBE LITTMANN.
2004	Apr 23	Note the CF/NSN Change for the Mask, Infant 6515-CF-002-7985 / 6515-22-606-5378 – Currently in the SAR Kits. The item remains the same, just a CF# changed to a true NSN.
2005	May14	Medical Equipment packing list has been updated. Equipment Feb/April/ May 2020 in red Ink. Updated/uploaded on Div Surg Website.

### 2019

1901	Feb 22	A safer decompression needle NS 6515-01-541-0635 ARS NEEDLE, HYPODERMIC FOR DECOMPRESSION, 14G, and 3.25IN. Remove NS6515-CF-002-0794 from kits.
1902	July 11	Deployed Air Rescue Treatment System (DARTS) is ready to release to service. NS numbers will be amended.
1903	Sep 12	STL's authorized to purchase Geratherm's with their budgets to replace or purchase new ones; Authorised through DAR.
1904	Sep 19	Medical Equipment packing list has been updated; see 3.0 EQUIPMENT Sept 19 2019 in red ink.
1905	Sep 30	AMP Medical Inspection sheet modified and new response letter developed. Response letter shall be signed by the CO and forwarded to the AMP SAR Tech with 90 days of inspection.
1906	Oct 5	Remove NS 7210-21-865-2581 Blanket Emergency/Rescue (-60 Deg F) weatherproof Bright Color 56"WX84"L from the following medical kits, and replace by adding NS 7210-21-870-6172 Blanket Emergency / Rescue (-60 Degrees F) weatherproof bright color 56"WX84"L Air-spotting folds to Pocket Size, using a 1:1 replacement ratio.

		Additionally, Remove NS 6515-CF-002-7605 Tube Catheter Extension (Coloplast Product) for Urinary Collection from the following SAR medical Kits. The replacement product RUS4539-32 PSCN 6515-20-AOU-0391 comes complete with the 18" extension tube.
1907	Oct 19	IO Power Driver, hand held (Red) drill replaces all black drills. Black drills are for training purposes only. NS number changed.
1908	Nov 6	CTOMS is now authorized to sell the Ready-Heat Products once again in the Canadian jurisdiction, shortage situation should end.
1909	Dec 2	IV catheters standardized; IV Catheter, BD Isyte Autoguard BC 16, 18 and 20 Gauge implemented.
1910	Dec 2	i-gel Supraglottic Advanced Airway implemented; King Air Supraglottic Advanced Airway's removed from all operational kits and returned to the Pharmacy.
1911	Dec 11	New Annex H released. The rules in small red triangles were published on subsequent Note page. SARSET supported the change at the 2019 SSWG in November.

## 2018

1801	Jun 1	Medical Equipment packing list has been updated. Medium and XL gloves added to accommodate various hand sizes. Geratherm now has OAC and NSN's have been added.
1802	Jun 6	PCR submission procedure amended.
1803	Oct 5	Medical Equipment packing list has been updated. Replace all CONTAINER, SHARPS, TRANSPORTABLE NS 6515-CF-002-8742 currently in circulation & in any medical kit with NS 6530-20-011-4406 DISPOSAL CONTAINER, HYPODERMIC NEEDLE AND SYRINGE, 0.15L. Additionally the Accu-Check Aviva and its control solutions is replaced by the respective Contour Next items in SAR medical kits NS 6630-CF-002-9326.
1804	Dec 18	Remove IV (WO Knubley's Ripper) Pole from all medical kits.

## 2017

1701	Mar 22	Remove for disposal (or return) all TALON EZ IO (NSN 6515-CF-002-8898) from SAR penetration kits. Replace with: IO Power Driver (NSN 6515-01-571-3152). Ensure each SAR Tech Pen kit is equipped with a Power Driver, needle sets, and stabilizer patch IAW amended ST kit lists published on the Div Surg Website. * Inform all unit SAR Techs and advise AMP SAR Tech when changes implemented.
1702	Mar 22	IN route of administering drugs is discontinued from ST medical Protocols and Procedures. All Intra-nasal injection syringes to be removed from ST Penetration kits (Drug kit). Affected protocols; 4.3 Narcotic OD and 4.4, Seizure and Drug monograph. Narcan (4.3) and Midazolam (4.4) to be administered by alternate indicated routes, IM or IV. IN route administration has been found to be prone to dosing



		inaccuracy and is not required when IM or IV route is preferred method. * Inform all unit SAR Techs, advise AMP SAR Tech when completed.
1703	Mar 22	SAR Techs to receive familiarization from Med Section on replacement Blood Glucose monitor, Contour Next, by Assention. Device to be implemented in kits w/o undue delay. Advise AMP ST when complete.
1704	Dec 1	There were significant changes to protocols 1.1 and 2.1 (requiring stickers) as well as a shift to TL responsibility of several others. SAR Tech Med NCO's, CCNCM's were all briefed and provided Protocol amendment stickers and instructions. Units to ensure all protocol books have been amended and inform AMP SAR Tech upon completion.

## 2016

1601		New Annex H for 2016. All users to implement new version immediately. Yellow color fields must be filled as a minimum for annual currency. Amplifying information provided as a comment in the upper right corner. Note that Wing Surg Review is no longer required.
1602		Feb Piggyback IV giving sets added to Pen kit to make IV meds admin easier. See kit list for NSN.
1603		Emergco charcoal patient warming system Unit Medical NCO's are required to have these units put on the section SCA. This will make them visible in DREMIS so you can order replacement units and heat bricks. See your supply tech to action.
1604		Nex Splint is to be removed from SAR Kits. SAR will revert to a single choice hard cervical collar. June 2016
1605		<b>Alert!</b> <u>SAM Chest Seal</u> It has been observed that some SAR TECHs are not aware they need to remove the cap from the SAM seal to ensure it is kept open (when used with a needle-decompression) Local familiarization / refresher training is to be conducted by the ST Section Medical NCO.
1606		<b>Fentanyl Safety Alert!</b> –The use of Fentanyl and street drugs that may contain Fentanyl, has brought to light the necessity for first responders to take precautions when in the presence of these dangerous drugs. The JIBC has created a website to provide information for first responders on dealing with this potent risk. The link is located on the Div Surg website and can be accessed through the DWAN or sent to your home account. All SAR Techs should be made aware of this resource for information.

## 2015

1501	<p><b>Alert!</b> BD Vacutainer (BD 367342) has been distributed to some units as a replacement for pediatric IV starts. This product is unsuitable due to the push button retraction device that is commonly used for short term blood draw/lab work. This item is required for your Sup kit(childbirth)</p> <p>Instead use kit identified by: 6515-21-870-8687 (BD 367283)</p>
1502	<p>Triage Tags. Use only SMART brand Tags (MIST Version) Also note that black "deceased" cards need to be ordered separately, NSN 6515-CF-002-9039</p>
1503	<p>Disposable skin stapler</p> <p>The wrong stapler has been discovered in some of our pen kits. It is much larger than the one intended for use by ST's.</p> <p>Use only 6515-CF-001-8103 Ref: photo comparison in SAR Tech Alerts</p>
1504	<p>New Procedure! D50 W syringe will replace D10 W in the 250ml bags for Diabetic Protocol. New procedure will involve the addition of 50mls of D50 into 250ml of NS. See SAR Medical Directive #2 for further information.</p>

## 1.2 Blank RSV Inspection (Annex to 6750-7 (AMP FS))

DATE 2020

### MEDICAL SECTION AMP INSPECTION

Date:

Unit:

Point of Contact:

Telephone:

1. The CF Aerospace HSS Sqn staff, NAME, carried out an inspection of the Medical Section.
2. The inspection was carried out covering the following aspects of administration and training:
  - a. General maintenance of medical equipment;
  - b. the standard of training;
  - c. maintenance of records and publications;
  - d. correct storage of medical equipment; and
  - e. the condition of the medical section in general.
3. Observations and recommendations concerning the above mentioned items are included in this report.
4. Appropriate Equipment Checklists (ECL) were identified, and equipment issues are noted in this inspection report as required.



5. RECORDS:

ITEM	YES	NO	COMMENTS
a. Annex H up to date and correctly maintained.			
b. ASM booklet's properly filled out and filed			
c. SAR Protocols (B-GA-005-000/FP-D01) held in sufficient quantity and up to date			
d. All other medical references up to date			
e. PCR forms (DND 1530) correct, local copy kept and distributed.			
f. Medical Note books on hand (DND 1531)			
g. Medical General Memoranda (website)			
h. Medical Equipment Record (website)			

6. EQUIPMENT:

ITEM	YES	NO	COMMENTS
a. Medical kits: quantity, condition and packed properly to the standard			
b. AED / PROPAQ inspection in date			
c. Training aids available in SAR section			
d. Pharmacy support, expiry dates tracked			
e. Medical supply available for repacking of medical kits			
f. Infectious PPE kits available			

7. TRAINING:

ITEM	YES	NO	COMMENTS
a. Weekly medical training planned			
b. ASM training planned and on the schedule			
c. Med Re-cert preparation/ current			
d. Practice SIM book available			
e. Outside resources utilized			

8. ORGANISATION:

ITEM	YES	NO	COMMENTS
a. Individual responsibilities & TOA's defined			
b. SAR Team complete			xx SAR Tech members inspected.

9. MEDICAL SECTION:

ITEM	YES	NO	
a. Physical medical security			
b. Narcotics safe combination is changed			
c. Size is adequate			
d. Storage is adequate			

10. OBSERVATIONS AND RECOMMENDATIONS:

Corrected action(s) with regards to noted observations are to be actioned within 90 days of receipt of this report; and subsequently, reported to the AMP SAR Tech when they are completed using the official form found on Page 13 of this Medical NCO Handbook.

Para	Corrected Actions and Comments

NO NOTICE MED CHECKRIDE CONDUCTED:  
SATISFACTORY/NOT SATISFACTORY/NOT ASSESSED

OVERALL ASSESSMENT: SATISFACTORY/NOT SATISFACTORY

Inspected by: AMP SAR Tech

Date: xx/xx/2020

Signature: \_\_\_\_\_



Unit:

Address:

3386-1 (STL XXX Sqn)

Date in electronic signature

Air Division Surgeon  
PO Box 17000 Stn Forces  
Winnipeg, MB R3J 3Y5

RESPONSE TO YEAR MEDICAL  
INSPECTION AT XXX SQN CITY

Reference: Date AMP Medical Inspection XXX Sqn, Full Date.

1. XXX Squadron SAR Tech section has completed actions in response to the observations made at reference. Details of the actions taken are enclosed in the Annex A.
2. Further information can be obtained through STL's Name, XXX Sqn SAR Tech Leader, at Contact Number and Email Address.

X

LCol Name and Initials  
CO XXX Sqn

Annex:

Annex A: 3386-1 AMP Observations



Annex A 3386-1 (STL XXX Sqn)

Observation Para at Reference	Observations	XXX Sqn Action Taken / Recertification Completed
Para's 5, 6, 7, 8 or 9 as required.	Actions Highlighted by the AMP SAR Tech to Correct During the AMP Medical Inspection.	Actions Taken to Correct the Highlighted Issue(s).

\*Please note, if any highlighted corrected items are found on the subsequent inspection those items will constitute a failure of that inspection.

\*STL/DSTL's to ensure Medical NCO's are notified, briefed and properly prepared for the Unit AMP SAR Tech Inspection.

1.3 Annex H (Medical Training Module Record)

SAR TECHNICIAN																	ANNEX H	
MEDICAL TRAINING MODULE RECORD																	CFACM 60-0531	
SN	Rank	Name					INT	Qual Level	Unit	Year								
										2020								
Quarterly Medical Currencies																		
Jan	Feb	Mar	1st	Apr	May	Jun	2nd	Jul	Aug	Sep	3rd	Oct	Nov	Dec	4th	Total		
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Comments													Date Completed					
Hospital Practice	Modules		Dates Completed															
Equipment	AED																	
	PRO PAQ																	
	Glucose Monitor																	
	REEL Splint																	
	KED																	
	KTD																	
	Geratherm																	
Procedures	7.1 Patient Assessment																	
	7.2 Advanced Airway Insert																	
	7.3 Spinal Assessment																	
	7.4 Urinary Catheterization																	
	7.5-7.7 IV / IO Therapy																	
	7.8 Tourniquet Removal																	
	7.9 Chest Decompression																	
	7.10 OG Tube Insertion																	
	Patient Immobilization																	
	Pre-Hospital Mth																	
Protocol Review	1 Cardiac																	
	2 Respiratory																	
	3 Trauma																	
	4 Medical																	
	5 Environmental																	
Medical Simulation	Type Of Scenario		Date	TL	TM	C	A	Type Of Scenario		Date	TL	TM	C	A				
Drug Review	Drug		Date	Drug		Date												
	1st			3rd														
	2nd			4th														
SAR Tech:							Medical NCO:											
Med Prof Check Due Da							STL:											
CPR Completion Date:																		
Last Med Recert Date:																		
									Msjor R. Grainger									
									1CAD AMP Flt Surg									
DISTRIBUTION LIST: Original - Unit Training File // Copy - 1 CAD AMP Flight Surgeon																		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1		Notes/ Rules are highlighted in small red insert comment triangles inbedded in the Annex H.																
2																		
3	Note 1	Tomb Stone Data is required for each member.																
4	Note 2	RTM or RTL or TL.																
5	Note 3	Quarterly Currencies Include: Medical Modules; Equipment; Procedures; and Protocol Reviews. Medical Simulations. Drug Review.																
6	Note 4	"Maintenance" of medical competency training (A minimum of 4 training days in hospital or on car). Include type of Practicum and the Dates it was completed.																
7	Note 5	Each Module is to be completed a minimum of once per year (including RTMs). Each module is to be a supervised skills station, NOT to be combined with																
8		Medical Simulations or SAR Missions If below Standard, it should be recorded and the weakness identified as per Annex D of CFACM 60-0531.																
9	Note 6	Module dates are to be filled in the columns from left to right throughout (subsequent).																
10		Once a date is entered the yellow caution will clear.																
11	Note 7	To include CPR. CPR is an annual currency.																
12	Note 8	To include all Airway Management Skills.																
13	Note 9	To include all types of infusion preparation: Pressure Infusion, Saline Lock, and Buddy-Lite, and Drug specific requirements such as D50/ antibiotic reconstitution.																
14	Note 10	To include: Spinal Immobilization, C-Collar, Spinal Rolls, Splinting, and Patient Packaging.																
15	Note 11	To include: Drug Dosage Calculations, Burn Formula, IV Flow Rates and Pediatric Calculations before sign-off.																
16	Note 12	All Protocols from each Chapter must be reviewed/ completed before the sign-off of that Chapter.																
17	Note 13	A minimum of one scenario conducted at members qualification level (TL/TM) in addition to their Annual Medical Proficiency Check.																
18		(Minimum of 2 scenarios annually). Include date and type of simulation.																
19	Note 14	A minimum of one drug is to be reviewed quarterly to include: Indications; Contraindications; Mechanism of Action; Precautions; Adverse Effects; and Dosage.																
20	Note 15	Medical Recertification Course replaces requirement for a Medical Proficiency Check if completed before annual medical proficiency check due date.																
21		Units to complete TR10B.																
22	Note 16	Date CPR training completed. CPR is an annual currency.																
23	Note 17	If the member has not yet completed a Med Recert, than record date of last medical course, either RTM or RTL1.																
24	Note 18	The IC Medical NCO is to verify all data and ensure it is compliant to all the rules and policies prior to providing their signature.																
25																		

1	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP																																																																														
2	2020	CONTINUATION TRAINING																					QUARTERLY				SEMI-ANNUAL				ANNUAL				LO CB OO BK A BB RE V IA TI ONS																																																																																					
3	442 SQN	ROTARY WING TRAINING											FIXED WING TRAINING										QUARTERLY				SEMI-ANNUAL				ANNUAL																																																																																									
4	Sheet1	LIVE HOISTS				EQUIPMENT HOISTS				WATER			SUPPLY DROPS			IVE PARA		QUARTERLY				SEMI-ANNUAL				ANNUAL																																																																																														
5	JANUARY	LAND TRG	FIELD EXERCISE			LAND HOIST SINGLE			LAND HOIST DOUBLE			BOAT HOIST SINGLE			BOAT HOIST DOUBLE			WATER HOIST SINGLE			WATER HOIST DOUBLE			ROPE LOWERING SYSTEM			LAND STOKES			BOAT STOKES			LAND RESCUE BASKET			BOAT RESCUE BASKET			WATER RESCUE BASKET			CABA ENTRY			FREE ENTRY			HOVER TRIM CONTROLLER			ACTUAL PUMP			ACTUAL SRK			RADIO / MESSAGE DROP			PARA SUPPLY			STATIC LINE CONFINED AREA			FREEFALL CONFINED AREA			LIVE PARA STATIC LINE X 2			SAR-PELS PARA X 2			LIVE PARA FREE FALL X 1			MEDICAL TRAINING MODULE			CONFINED AREA PARA WEARING BUSH SUIT, SAR-PELS AND ELMO X 1			PARAMERGENCIES			CLEARANCE CALLING X 1 DAY			CLEARANCE CALLING X 1 NIGHT UNMANNED			CABA / AGA X 6			DIVE CYCLES X 6			OPEN BOOK EXAM			CATEGORIZATION EXAM			OPEN WATER OPERATIONS LIVE PARA W/SARPELS, LPY, NIGHT PARA X 1			PARA SATURATION X 1			DYNAMIC ROLLOUT BRIEFING WITH HOIST TRANSFER			ASM SHIFTS X 4			MOUNTAIN EX X 1			
6	FEBRUARY																																																																																																																							
7	MARCH																																																																																																																							
8	1 <sup>st</sup> QTR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																	
9	APRIL																																																																																																																							
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12	2 <sup>nd</sup> QTR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																
13	SEMI-ANNUAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																	
14	JULY																																																																																																																							
15	AUGUST																																																																																																																							
16	SEPTEMBER																																																																																																																							
17	3 <sup>rd</sup> QTR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																		
18	OCTOBER																																																																																																																							
19	NOVEMBER																																																																																																																							
20	DECEMBER																																																																																																																							
21	4 <sup>th</sup> QTR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																	
22	SEMI-ANNUAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																
23	ANNUAL TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0																																																																	

X

SAR TECH LEADER



## 1.4 SAR Medical NCO Admin Process

Current: May 2020.

### Patient Care Reports (PCR) DND 1530:

1. Maintain blank copies in the standby kits, ensure there are plenty of copies for Operations.
2. The Med NCO will encrypt and send all (signed TL and STL) copies to the 1 CAD AMP SAR Tech **within 7 calendar days** of the mission for standards review and feed-back.
3. All hardcopies are reviewed by the AMP SAR Tech and reviewed and signed by 1 CAD AMP FS.
4. There is no requirement to CC 1 CAD Surgeon, SARSET, CFSSAR or SSO SAR.
5. 1 CAD Div Surg maintains hard copy and an electronic copy on a Protected "B" flash stick.

### Annex "H" Report:

1. Create and establish a new annual document prior to January of each year, ensuring all tomb stone data is entered on each sheet.
2. Instruct SAR Tech's on proper use of Annex H for recording Medical Training etc.
3. Monitor the SAR Section progress quarterly.
4. Complete year end- review and sign all Annex H's before submitting to the STL for signatures. Send all STL signed Docs to 1 CAD AMP SAR Tech electronically before Feb 1<sup>st</sup> the following year.
5. File hard copies locally and have them available for the AMP Medical Inspection.

### Annual Skills Maintenance (ASM) Skills Practice Doc

1. Ensure SPECO or provincial requirements are completed and in date for all members prior to their ASM shifts.
2. Print the required ASM booklets for your SAR Tech's prior to their ASM shifts.
3. Recover all ASM booklets/records from the SAR Tech's after all their shifts are complete.
4. SAR Tech's that are posted should try to complete their ASM's prior to the APS.
5. Med NCO's shall scan and forward the ASM booklets/records to the new unit Med NCO.
6. Scan and send electronically to JIBC at year end.
7. Secure and maintain hard copy record's locally for 5 years.

### 5<sup>th</sup> Edition SAR Tech Protocols

1. Maintain spares to replace manuals lost during Operations.
2. Actively engage incoming SAR Tech's to update local AOR info.
3. Ensure all amendments are complete and up to date.

### Section Training Plan (Medical)

1. Complete prior to January and socialize with STL and Medical cell members;
2. Plan and delegate leaders for each evolution.
3. Supervise Annex H completion for all SAR Tech members including newly qualified RTMs.
4. Provide the STL on or before Nov 1 a list of all the SAR Techs that will require a waiver complete with justification.

### SAR Kit Change Index

1. Use Kit Change Index to track history of our Medical Kit contents
2. Report any discrepancies or concerns to the 1 CAD AMP SAR Tech.

## 1.5 Wing Mailing Addresses

<p>(Canada post)</p> <p>424 (T &amp; R) Squadron          Attention: SAR Tech Medical NCO          8 Wing Trenton          Box 1000 Stn F          Astra, On          K0K 3W0</p>	<p>By Courier: FedEx etc.</p> <p>424 (T&amp;R Squadron)          Attn: SAR Tech Medical NCO          8 Wing Trenton          84 North Star Drive          Trenton, On Canada          K0K 3W0</p>
<p>442 (T &amp; R) Squadron          Attention: SAR Tech Medical NCO          19 Wing          PO Box Stn          Main Lazo B.C.          V0R 2K0</p>	<p>413 (T&amp;R) Squadron          Attention: SAR Tech Medical NCO          14 Wing, PO Box 5000 Stn          Main Greenwood NS          B0P 1R0</p>
<p>435 (T &amp; R) Squadron          Attention: SAR Tech Medical NCO          17 Wing, PO Box 17000 Stn Forces          Winnipeg Manitoba          R3J-3Y5</p>	<p>103 SAR SQN          Hanger 1          Attention: SAR Tech Medical NCO          CL Dobbin          Drive 9 Wing          Gander,          Gander NL          A1V-1X1</p>
<p>1 Canadian Air Division Surgeon CF          Aerospace HSS Sqn, Bldg 25 Department          of National Defense PO Box 17000 Stn          Forces Winnipeg, MB          R3J-3Y5</p>	



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## 2.0 TRAINING





**JIBC**

School of  
Health Sciences

Centre for Professional  
Health Education

# **SAR Tech QL5A Hospital Clinical Session Annual Skills Maintenance (ASM)**

**Student:** \_\_\_\_\_

**Squadron:** \_\_\_\_\_

**Course:** QL5A - ASM

**Date:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_

**Clinician(s):** \_\_\_\_\_

## **Introduction**

The students in this clinical session are enrolled in the SAR Tech QL5A Program.

The goal of the SAR Tech QL5A Recruit program is to prepare students to assess and manage common injuries and conditions using SAR Tech QL5A treatments and protocols.

The students have been trained in the following procedures relating to medical and trauma patients:

- Use of universal precautions
- Primary Care Paramedic patient assessment model
- Chest auscultation
- Core skills: airway management, breathing management, CPR, hemorrhage control, oxygen therapy
- Spinal management, fracture management, wound management, burn management
- Administration and maintenance of peripheral IV's
- Administration of drugs by SL, nebulizer, SC, IV and IM routes
- Primary Care Paramedic and SAR Tech QL5A Protocols
- Management of common medical conditions
- Management of common injuries

## **Objectives**

Upon completion of this on car session, the student will:

- Observe and discuss the presentation, signs and symptoms, and management of patients with common injuries and conditions
- Demonstrate the use of core patient assessment and management skills while performing ambulance calls
- Be able to demonstrate the use of core ambulance skills while performing ambulance calls
- Integrate and adapt the use of patient assessment and management skills into the environments encountered while in an ambulance setting

**Focus**

The focus of this clinical session is the assessment and management of patients with classic injuries and conditions. We would like the students to observe a variety of patients and to compare the presentation of these patients to what they have learned in the classroom. We would like the students to be able to practice the assessment of medical and trauma patients. With conscious patients, have the students focus on history taking. With unconscious patients, have the students focus on physical assessment. Finally, we would like the students to have the opportunity to practice their core patient assessment and management skills as the opportunity arises.

**Notes to the Clinician**

Please focus your evaluation and feedback on the following areas:

**Patient Assessment and Management Skills**

Provide feedback on the student’s techniques and decision-making. In particular, provide feedback on applying skills and techniques that are appropriate for the patient at hand. For example, ensure that history taking is organized, and that the questions are appropriate for the patient. Discuss key features of the patient’s presentation, and how the patient is similar/different to the “textbook” description of various conditions.

**Communication Skills**

Critique the student’s on the appropriateness of their interactions with patients, hospital staff and other members of the health care team.

**IV Skills**

IV training is part of the student’s curriculum, and they are encouraged to start IV’s in a clinical setting when appropriate. However, this is not the main focus of this session. Focus your discussion and evaluation on use of appropriate technique. Also, please discuss the complications of IV therapy, and “when” and “why” to initiate an IV.

**Do’s and Don’ts (Building the Health Care team)**

Please share your experience with our students. The students need to know how their actions with the patient, and their interaction with you, affect others. What are the things that the student can do to help you and the patient? What things have ambulance crews done in the past that makes your job easier or more difficult?

**Evaluation**

**Critical Patient Follow-up**

Ambulance attendants rarely get to follow-up on the outcome of critical patients. If the opportunity arises, it would be helpful for the student to “follow” a critical patient throughout the shift. We would like them to have an appreciation that the end of the call for the ambulance crew is only the start of the call from the patient’s point of view.

Help the students to identify where their assessment and treatment has facilitated the ongoing care and treatment of the patient.

**Tricks of the Trade**

Our students learn a lot from watching RN’s and other health care members perform their regular duties. We appreciate seeing any of the helpful tips and tricks of the trade that cannot be learned in the classroom.

Evaluate the students using the following checklists and summary pages. To successfully complete the clinical session, the students must:

Acceptably perform all checklist items in the following categories:

- Safety
- Patient Assessment Skills
- IV and Drug Administration Skills
- Communication Skills
- Complete all procedures safely, with acceptable technique, and using universal precautions
- Be able to provide rationale and discuss theory relevant to the procedures performed

Evaluate those Patient Management Skills that the student has the opportunity to perform during the session. We realize that experiences and opportunities to perform these skills will vary from session to session. Optional items are listed in shaded boxes in the checklist. Skills or actions that are unacceptably performed must be identified for review with the Program Coordinator.



The Program Coordinator will review the results of the clinical session in conjunction with the clinician and student. The Program Coordinator and student will develop a plan to remediate any weaknesses or unacceptable performance noted during the clinical session. This may include additional time in a classroom or hospital setting.

Use the following categories to evaluate the student's performance.

- Acceptable**      Student completes objectives with occasional prompting.
- Unacceptable**      Unacceptable. Student is unable to complete objective, despite prompting.

## Patient Assessment & Management Log

**Note to Assessor:** Use the following categories to evaluate the student's performance.

**A** - Acceptable      Student completes objectives with occasional prompting.  
**U** - Unacceptable      Unacceptable. Student is unable to complete objective, despite prompting.

On the following pages, please provide feedback on the student's techniques and decision-making. In particular, provide feedback on applying skills and techniques that are appropriate for the patient at hand. For example, ensure that history taking is organized, and that the questions are appropriate for the patient. Discuss key features of the patient's presentation, and how the patient is similar/different to the "textbook" description of various conditions.

<b>Evaluate student's skills for each patient seen.</b>					<b>A (Acceptable), U (Unacceptable)</b>										
	<b>Assessor (Print name)</b>	<b>Assessor (Signature)</b>	<b>Hospital</b>	<b>Date</b>	<b>Primary Survey</b>	<b>History</b>	<b>Vital Signs</b>	<b>Head to Toe</b>	<b>Safety</b>	<b>Communication</b>	<b>IV - Successful Start</b>	<b>IV - Number of Attempts</b>	<b>IV - Drug</b>	<b>IV - Type</b>	<b>IV - Route</b>
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**QL5A Annual Skills Maintenance Clinical Checklist**

<b>Evaluate student's skills for each patient seen.</b>					<b>A (Acceptable), U (Unacceptable)</b>										
	<b>Assessor (Print name)</b>	<b>Assessor (Signature)</b>	<b>Hospital</b>	<b>Date</b>	<b>Primary Survey</b>	<b>History</b>	<b>Vital Signs</b>	<b>Head to Toe</b>	<b>Safety</b>	<b>Communication</b>	<b>IV – Successful Start</b>	<b>IV – Number of Attempts</b>	<b>IV – Drug</b>	<b>IV – Type</b>	<b>IV – Route</b>
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**QL5A Annual Skills Maintenance Clinical Checklist**

<b>Evaluate student's skills for each patient seen.</b>					<b>A (Acceptable), U (Unacceptable)</b>										
	<b>Assessor (Print name)</b>	<b>Assessor (Signature)</b>	<b>Hospital</b>	<b>Date</b>	<b>Primary Survey</b>	<b>History</b>	<b>Vital Signs</b>	<b>Head to Toe</b>	<b>Safety</b>	<b>Communication</b>	<b>IV – Successful Start</b>	<b>IV – Number of Attempts</b>	<b>IV – Drug</b>	<b>IV – Type</b>	<b>IV – Route</b>
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**QL5A Annual Skills Maintenance Clinical Checklist**

<b>Safety</b>	
<ul style="list-style-type: none"> <li>• use of universal precautions (e.g. gloves, eye protection, etc.)</li> <li>• disposal of sharps</li> <li>• use of sterile technique</li> <li>• does not perform unsafe acts or procedures</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>
<b>Patient Assessment Skills</b>	
<b>Primary Survey</b> <ul style="list-style-type: none"> <li>• sequencing</li> <li>• organized, thorough</li> <li>• appropriate interventions</li> <li>• decision-making</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>
<b>History</b> <ul style="list-style-type: none"> <li>• appropriate to patient</li> <li>• organized, thorough</li> <li>• completeness (obtains all relevant information)</li> <li>• relates to overall patient presentation</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>
<b>Vital Signs</b> <ul style="list-style-type: none"> <li>• organized, thorough</li> <li>• accuracy</li> <li>• completeness</li> <li>• relates to overall patient presentation</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>
<b>Head to Toe</b> <ul style="list-style-type: none"> <li>• organized, thorough</li> <li>• relevant to patient</li> <li>• auscultates chest</li> <li>• can identify normal and abnormal breath sounds</li> <li>• relates findings to overall patient presentation</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>
<b>Communication Skills</b>	
<ul style="list-style-type: none"> <li>• explains all procedures to patient</li> <li>• ensures patient privacy</li> <li>• gives concise, well organized, specific, and accurate reports</li> <li>• employs active listening skills</li> <li>• communicates clearly and concisely with other health team members</li> </ul>	<b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b>

**QL5A Annual Skills Maintenance Clinical Checklist**

**Patient Management Skills**

Evaluate those Patient Management Skills that the student has the opportunity to perform during the session. We realize that experiences and opportunities to perform these skills will vary from session to session. Optional items are listed in shaded boxes in the checklist. Skills or actions that are unacceptably performed must be identified for review with the Program Coordinator.

<p><b>IV Skills:</b></p>	<p>IV training is part of the student’s curriculum, and they are encouraged to start IV’s in a clinical setting when appropriate. However, this is not the main focus of this session.</p> <p>Focus your discussion and evaluation on use of appropriate technique. Also, please discuss the complications of IV therapy, and “when” and “why” to initiate an IV.</p>
<p><b>Peripheral IV’s</b></p> <ul style="list-style-type: none"> <li>• prepares equipment</li> <li>• appropriate size catheter</li> <li>• uses sterile technique</li> <li>• selects an appropriate vein</li> <li>• initiates IV</li> <li>• calculates and maintains appropriate flow rate</li> <li>• secures site and tubing</li> <li>• states common complications and their management</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>IV Maintenance</b></p> <ul style="list-style-type: none"> <li>• change solution bags</li> <li>• calculate, set, and monitor flow rates</li> <li>• draw medication from a vial or ampoule</li> <li>• recognize complications of IV therapy</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Blood Glucose Reading</b></p> <ul style="list-style-type: none"> <li>• obtains blood glucose reading using chemstrip or glucometer</li> <li>• relates reading to patient presentation</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Core Skills</b></p> <ul style="list-style-type: none"> <li>• airway maneuvers</li> <li>• oropharyngeal airway</li> <li>• suction</li> <li>• bag-valve-mask</li> <li>• CPR</li> <li>• hemorrhage control</li> <li>• oxygen administration</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>

**QL5A Annual Skills Maintenance Clinical Checklist**

<p><b>Drug Administration</b></p> <ul style="list-style-type: none"> <li>• states appropriate dose for patient</li> <li>• draws medication from vial or ampoule</li> <li>• administers SL medications</li> <li>• administers Ventolin by nebulizer</li> <li>• administers SC medications</li> <li>• administers IV medications</li> <li>• administers IM medications</li> <li>• discusses pharmacology of drugs used, including indications, action, and use</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Trauma Management</b></p> <ul style="list-style-type: none"> <li>• recognizes S/S of classic case injuries</li> <li>• discusses underlying pathophysiology of classic case injuries seen</li> <li>• discusses management of classic case injuries</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Injuries Seen (list)</b></p>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Medical Conditions</b></p> <ul style="list-style-type: none"> <li>• recognizes S/S of classic medical cases</li> <li>• discusses underlying pathophysiology of classic medical cases seen</li> <li>• discusses management of classic medical cases</li> </ul>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>
<p><b>Conditions Seen (list)</b></p>	<p><b>Comments:</b> <input type="checkbox"/> <b>Acceptable</b> <input type="checkbox"/> <b>Unacceptable</b></p>



**QL5A Annual Skills Maintenance Clinical Checklist**

<b>Other Procedures Performed/Seen (list)</b>	<b>Comments:</b> <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable
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<b>PERFORMANCE DEFICIENCIES</b>	
	<b>NOTES:</b>
D Excessive time needed to complete procedures.	
D Broke universal precautions.	
D Significant inaccuracy noted.	
D Technique or actions may be harmful to patient.	
D Incorrect procedure or sequences used.	
D Incorrect equipment assembly or usage.	
D Unable to correctly answer questions about rationale and/or theory related to procedures.	

<b>RECOMMENDED ACTION PLAN</b>	
D No action necessary	
D Additional practice of noted procedures is needed with occasional supervision.	
D Additional practice of noted procedures is needed under DIRECT supervision. Repeat evaluation is required.	
D Tutorial and remedial work is needed prior to re-evaluation.	



**QL5A Annual Skills Maintenance Clinical Checklist**

As a SAR Tech student I would like to see:
As a clinician I would like to see:

**On completion of shift(s), please review comments with student and sign.**

--	--

**Clinician** (print name and sign)

(Date)

--	--

**Student** (print name and sign)

(Date)

\*Preceptor and SAR Tech signatures are required.



## QL5A Annual Skills Maintenance Preparation Notes

QL5A Skills	Note to SAR Techs	Note to Clinicians
Focus on Assessment and Management of patients with Classic Injuries and Conditions	<p>Y Observe a variety of patients and compare the presentation of these patients to what you have learned in the classroom.</p> <p>Y Practice assessment of medical and trauma patients.</p> <p>Y On conscious patients - focus on history taking.</p> <p>Y On unconscious patients - focus on physical assessments.</p> <p>Y Practice core patient assessment and management skills</p>	<p>Focus your evaluation and feedback on:</p> <p>Y Patient Assessment and Management Skills</p> <p>Y Communication Skills</p> <p>Y IV Skills</p> <p>Y Do's and Don'ts</p> <p>Y Critical Patient Follow-up</p> <p>Y Tricks of the Trade</p>
Patient Assessment & Management Log	Track each patient you see on the "Patient Assessment & Management Log"	Record, sign and evaluate skills performed by the SAR Tech for each patient seen.
Safety, Patient Assessment, Communication, and Patient Management Skills checklists	Review and perform skills requirements as listed under each category.	Review, comment, and assess student's competency for each skill section.
Evaluation	<p>Review and discuss with clinician at the end of ASM session. Sign evaluation with clinician.</p> <p>Forward complete tracking documents to JIBC School of Health Sciences for validation and recording.</p>	<p>Y Review with student at the end of the ASM Session.</p> <p>Y Complete each section, comment and sign.</p> <p>Y SAR-Tech is responsible for forwarding documentation to JIBC School of Health Sciences.</p>



**SAR Tech QL6A  
SAR Tech Clinical CME  
(On-Car – ER – OR)  
ASM**

**SAR Tech:** \_\_\_\_\_

**Squadron:** \_\_\_\_\_

**Course:** QL6A \_\_\_\_\_

**Date:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_

**Clinician(s):** \_\_\_\_\_

# OR / ER Checklist

## Contents

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- **Airway Management Log:**
  - OPA, NPA, BVM, NG Tube
- **OR Evaluation Comments**
- **Case Type Statistic Log**
- **ER Checklist:**
  - **Physical Assessment**
    - History Taking
    - IV
  - **Naso/Orogastric Tube Insertion**
- **Medical Administration Log**
- **Clinician Evaluations**

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*QL6A Clinical Checklist*

## Airway Management Log (OPA, NPA, BVM)

**GOAL: SAR Tech demonstrates airway management skills using  
OPA's, NPA's, BVM's**

Objectives: (1) Following airway assessment, recognizes appropriate adjunct for clinical presentation,  
and  
(2) Identifies indications, limitations and possible associated complications.

	Preceptor / Assessor <i>(Please print)</i>	Preceptor / Assessor <i>(Signature)</i>	Hospital	Date	IV	Drug	OPA NPA KING LT	BVM	NG TUBE
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**QL6A Clinical Checklist**

**Clinical Assessment Assessor 1**

EVALUATION (please comment):		COMMENTS / RECOMMENDATIONS
Note specific areas of strength for this SAR Tech		
<ul style="list-style-type: none"><li>• OPA</li><li>• NPA</li><li>• BVM</li></ul>	<ul style="list-style-type: none"><li>• NG Tube</li></ul>	
Have you observed a trend of improvement during the time you have spent with this SAR Tech? Please explain.		

**Clinical Assessment Assessor 2**

EVALUATION (please comment):		COMMENTS / RECOMMENDATIONS
Note specific areas of strength for this SAR Tech		
<ul style="list-style-type: none"><li>• OPA</li><li>• NPA</li><li>• BVM</li></ul>	<ul style="list-style-type: none"><li>• NG Tube</li></ul>	
Have you observed a trend of improvement during the time you have spent with this SAR Tech? Please explain.		

**Clinical Assessment Assessor 3**

EVALUATION (please comment):		COMMENTS / RECOMMENDATIONS
Note specific areas of strength for this SAR Tech		
<ul style="list-style-type: none"><li>• OPA</li><li>• NPA</li><li>• BVM</li></ul>	<ul style="list-style-type: none"><li>• NG Tube</li></ul>	
Have you observed a trend of improvement during the time you have spent with this SAR Tech? Please explain.		

## CASE TYPE STATISTICS LOG (ER/On-car)

**To be filled out by the SAR Tech per block or shifts precepted.**

Clinical Setting Types of calls Key	Number of Calls	Clinical Setting Types of calls Key	Number of Calls
<b>1) Cardiac – Chest Pain</b>		<b>5) Medical</b>	
a) Chest Pain – Acute Coronary Syndrome		a) Diabetes	
b) Chest Pain – AMI		b) Seizures	
c) Chest Pain – Non Cardiac		c) Overdoses	
<b>2) Cardiac – Arrhythmia</b>		d) Poisoning	
a) Symptomatic Bradycardia		e) Neurologic Emergency	
b) NCT		f) Anaphylaxis	
c) WCT		g) Obstetrical Emergency	
d) Other		h) Other	
<b>3) Collapse</b>		<b>6) Trauma</b>	
a) Cardiac Arrest		a) Multi-system	
b) Syncope		b) Single-system	
c) Other		c) Head Injury	
<b>4) Respiratory</b>		d) Spinal Cord Injury	
a) Asthma		e) Burns	
b) COPD		f) Environmental	
c) Pneumonia		g) Other	
d) Congestive Heart Failure – Pulmonary Edema		<b>7) Populations</b>	
e) Other		a) Neonates (<28 days)	
		b) Pediatrics (1 mo – 9 yr)	
		c) Adult (>10 – 65 yr)	
		d) Geriatric (>65 yr)	

**Considerations:** If there are two (2) major presenting problems, and you have performed an assessment on both problems, then record the patient exposure number for both situations.



**Note to Assessor:** Use the following categories to evaluate the SAR Tech's performance.

- A** - Acceptable      SAR Tech completes objectives with occasional prompting.
- U** - Unacceptable      Unacceptable. SAR Tech is unable to complete objective, despite prompting.

On the following pages, please provide feedback on the SAR Tech's techniques and decision-making. In particular, provide feedback on applying skills and techniques that are appropriate for the patient at hand. For example, ensure that history taking is organized, and that the questions are appropriate for the patient. Discuss key features of the patient's presentation, and how the patient is similar/different to the "textbook" description of various conditions.

<b>Evaluate SAR Tech's skills for each patient see</b>	<b>A</b> (Acceptable), <b>U</b> (Unacceptable)
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	Clinical Assessment <i>(Print Name)</i>	Clinical Assessment <i>(Signature)</i>	Hospital / Ambulance Station	Date	Primary Survey	History	Vital Signs	Head to Toe	Safety	Drugs / Route	IV Starts	Comments
1.												
2.												
3.												
4.												
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**QL6A Clinical Checklist**

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**The SAR Tech adhered to the following checklist (if not, please explain in Comments section on following pages):**

<ol style="list-style-type: none"> <li>1. Verifies physician's order             <ul style="list-style-type: none"> <li>• Ensures correct medication/solution/rate</li> </ul> </li> <li>2. Correctly calculates drug dosage             <ul style="list-style-type: none"> <li>• Uses formula to correctly determine volume of drug to administrator</li> </ul> </li> <li>3. Selects the right medication             <ul style="list-style-type: none"> <li>• Uses 5 "R's" (ensures correct medication, checks expiration date)</li> </ul> </li> <li>4. Prepares equipment             <ul style="list-style-type: none"> <li>• Selects appropriate equipment</li> </ul> </li> <li>5. Correctly withdraws medication dose             <ul style="list-style-type: none"> <li>• From ampoules, multi-dose vials</li> </ul> </li> <li>6. Identifies patient             <ul style="list-style-type: none"> <li>• Uses 5 "R's" (ensures correct patient, confirm allergies)</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>7. Uses aseptic technique             <ul style="list-style-type: none"> <li>• Maintains sterility throughout process</li> </ul> </li> <li>8. Cleans site             <ul style="list-style-type: none"> <li>• As per hospital policy</li> </ul> </li> <li>9. Administers correct medication dosage             <ul style="list-style-type: none"> <li>• Uses 5 "R's"</li> </ul> </li> <li>10. Confirms medication administration             <ul style="list-style-type: none"> <li>• Medication, route, dosage, patient response</li> </ul> </li> <li>11. Correctly disposes of all sharps             <ul style="list-style-type: none"> <li>• Does not recap needles/uses sharps containers</li> </ul> </li> <li>12. Documents medication order             <ul style="list-style-type: none"> <li>• Medication, dose, time, route, initial</li> <li>• Signature and status</li> </ul> </li> </ol>
--	---

**Medications within SAR Scope of Practice**

- |                          |               |
|--------------------------|---------------|
| Acetaminophen            | Glucose Gel   |
| Acetazolamide            | Haloperidol   |
| Acetylsalicylic Acid     | Ibuprofen     |
| Bacitracin & Polymyxin B | Morphine      |
| Cefazolin                | Naloxone      |
| Clindamycin              | Nifedipine    |
| Dexamethasone            | Nitroglycerin |
| Dextrose                 | Normal Saline |
| Diazepam                 | Oxygen        |
| Dimenhydrinate           | Salbutamol    |
| Diphenhydramine          | Polysporin    |
| Epinephrine              | Thiamine      |

# PRECEPTOR / CLINICIAN 1

EVALUATION (please comment):	COMMENTS / RECOMMENDATIONS
Note specific areas of strength for this SAR Tech. <ul style="list-style-type: none"><li>• Physical Assessments</li><li>• History Taking</li><li>• IVs</li><li>• Medication Administration</li><li>• Naso/Orogastric Tube Insertion</li><li>• BVM Ventilation</li></ul>	
Have you observed a trend of improvement during the time you have spent with this SAR Tech? Were there any errors/mistakes to report? Please explain.	

On completion of shift(s), please review comments with SAR Tech and sign:

--	--

Preceptor / Clinician (print name and sign)

(Date)

--	--

SAR Tech (print name and sign)

(Date)

**\*Preceptor and SAR Tech signatures are required.**

## PRECEPTOR / CLINICIAN 2

EVALUATION (please comment):	COMMENTS / RECOMMENDATIONS
<p>Note specific areas of strength for this SAR Tech.</p> <ul style="list-style-type: none"> <li>• Physical Assessments</li> <li>• History Taking</li> <li>• IVs</li> <li>• Medication Administration</li> <li>• Naso/Orogastric Tube Insertion</li> <li>• BVM Ventilation</li> <li>• ET Tube Care / Suctioning</li> </ul>	
<p>Have you observed a trend of improvement during the time you have spent with this SAR Tech? Were there any errors/mistakes to report? Please explain.</p>	

On completion of shift(s), please review comments with SAR Tech and sign:

--	--

Preceptor / Clinician (print name and sign)

(Date)

--	--

SAR Tech (print name and sign)

(Date)

**\*Preceptor and SAR Tech signatures are required.**

### PRECEPTOR / CLINICIAN 3

EVALUATION (please comment):	COMMENTS / RECOMMENDATIONS
<p>Note specific areas of strength for this SAR Tech.</p> <ul style="list-style-type: none"> <li>• Physical Assessments</li> <li>• History Taking</li> <li>• IVs</li> <li>• Medication Administration</li> <li>• Naso/Orogastric Tube Insertion</li> <li>• BVM Ventilation</li> <li>• ET Tube Care / Suctioning</li> </ul>	
<p>Have you observed a trend of improvement during the time you have spent with this SAR Tech? Were there any errors/mistakes to report? Please explain.</p>	

On completion of shift(s), please review comments with SAR Tech and sign:

--	--

Preceptor / Clinician (print name and sign)

(Date)

--	--

SAR Tech (print name and sign)

(Date)

**\*Preceptor and SAR Tech signatures are required.**

## PRECEPTOR / CLINICIAN 4

EVALUATION (please comment):	COMMENTS / RECOMMENDATIONS
<p>Note specific areas of strength for this SAR Tech.</p> <ul style="list-style-type: none"> <li>• Physical Assessments</li> <li>• History Taking</li> <li>• IVs</li> <li>• Medication Administration</li> <li>• Naso/Orogastric Tube Insertion</li> <li>• BVM Ventilation</li> <li>• ET Tube Care / Suctioning</li> </ul>	
<p>Have you observed a trend of improvement during the time you have spent with this SAR Tech? Were there any errors/mistakes to report? Please explain.</p>	

On completion of shift(s), please review comments with SAR Tech and sign:

--	--

Preceptor / Clinician (print name and sign)

(Date)

--	--

SAR Tech (print name and sign)

(Date)

**\*Preceptor and SAR Tech signatures are required.**

## 2.3 New Simulation Protocols

<b>Scenario:</b> 1.1 B Cardiac Chest Pain		
<b>Problem:</b> 58 YOF with Chest Pain while Hiking		
<b>Patient:</b>	58 year old female	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>1.1 Cardiac Chest pain</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Recognize the chest pain as cardiac in nature similar to patient's Angina</li> <li>Recognize patient's nausea</li> <li>Manage with Nitro and gravol.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Give ASA immediately</li> <li>Give Nitro for pain</li> <li>Recognize drop in BP but can continue with 2<sup>nd</sup> and 3<sup>rd</sup> Nitro</li> <li>Recognizes that Morphine is not required due to pain relief.</li> <li>Can integrate transport of patient with Nitro treatment.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y    N    N/A</b>	
• Did the SAR Tech recognize indications for Chest pain protocol?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech recognize drop in BP from the first Nitro?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech integrate transport between medication administrations so there was not undue delay in the transport of the patient?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech monitor BP and determine he was able to and continue with Nitro treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech recognize he did not need to treat with morphine and Graval?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Land on beach trail
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Patient conscious</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>None</li> <li>Airway is clear</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing adequately</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Fast radial pulse</li> </ul>
<b>H</b>	Assess for Hypo/hyperthermia	<ul style="list-style-type: none"> <li>Norm thermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cool and clammy skin. No cyanosis and no physical evidence of cardiac disease. Numbness in her left arm. She has a thin build.</li> </ul>
<b>DECISION</b> – Patient has enough history she <b>may</b> meet the Chest pain protocol and therefore, it is prudent to stay at scene to collect critical history enough to initiate treatment and make the patient more comfortable.		
<b>Primary</b>	Chest pains, radiating to jaw, some SOB.	<ul style="list-style-type: none"> <li>Oxygen, blanket, rest</li> </ul>
<b>Vital Signs</b>	Baseline vitals while obtaining a critical history	<ul style="list-style-type: none"> <li>Within parameters for using the Chest Pain protocol.</li> </ul>
<b>Critical History</b>	Developed chest ache/pain while hiking up the incline section	<ul style="list-style-type: none"> <li>Is on Nitroglycerin for chest pain</li> </ul>



<b>DECISION</b> – Patient does meet the indications for the Chest pain protocol. Patient’s pain is cardiac in nature similar to her angina.		
<b>Protocol</b>	Initiate Chest Pain protocol, ASA PO, Nitro x3 to relieve pain.	Pain is like her angina pain, but is more persistent.
<b>Procedures</b>	IV RL 100 ml/hr or IV lock	
<b>Secondary</b>	Full history to determine that this pain is heart pain and seems to come on more easily now, different than her angina pain because it lasts longer.	Pale, cool and clammy skin resolves itself as the pain disappears. No cyanosis, and no physical evidence of cardiac disease.

**PATIENT INFORMATION SHEET**

<b>Scenario: 1.1 B Cardiac Chest Pain</b>							
<b>Problem: 58 YOF with Chest Pain While Hiking</b>							
<b>Mission:</b> 442 Cormorant tasked to the West Coast Trail Provincial Park. Patient is a 58 YOF complaining of chest pain radiating to her jaw. The weather is warm and sunny with a 5km breeze from the west. You are able to do a beach landing close to the patient. It is a short distance on the beach to get to the patient; the tide is turning.							
<b>On approach:</b> You find the patient sitting on the sand, lying against a beach log with a small fire going. She is with 3 other female hikers who were out hiking the West Coast Trail. She has a slight build, is sweaty and in respiratory distress.							
<b>Patient (Information given only if asked):</b> She knows a lot about her chest pain and gives information out freely, sometimes giving out too much information and requiring the SAR Tech to slow her down so he can treat.							
<b>HISTORY</b>							
<b>C/C</b>		Pain in her chest.					
<b>Hx C/C</b>		While hiking up the incline section of the trail developed chest pain that did not seem to ease up when they reached the beach again.					
<b>L</b>		<i>dull ache in chest.</i>					
<b>O</b>		<i>1 hours ago</i>					
<b>T</b>		<i>The pain eased off when she stopped hiking, but is still there.</i>					
<b>A</b>		<i>Sitting and resting will ease the pain, was 7/10. She tried her spray 3 times and the pain went down to 2/10, then she ran out of spray. Now the pain is back to 7.</i>					
<b>A</b>		<i>Some dizziness and feels sick to her stomach</i>					
<b>R</b>		<i>Radiates to her jaw</i>					
<b>P</b>		<i>Walking with her heavy pack brings on the pain</i>					
<b>Pertinent Functional Enquiry</b>		<ul style="list-style-type: none"> <li>This morning shortly after breakfast they started out and she felt fine. During an incline section the pain came on and did not ease up when they got to the beach. Her pain is usually a substernal chest ache but does not radiate to her jaw. Also, it tends to come on with stress and when she is anxious, not when out on a day like today.</li> <li>Does not feel short of breath,</li> <li>Rest or a nitro spray relieves normal angina pain.</li> </ul>					
<b>Non-Pertinent FE</b>		<ul style="list-style-type: none"> <li>Family has a history of heart disease, Mother has asthma. This is their 4<sup>th</sup> day on the trail. The weather has been fine for the whole trip. They had another 2 days to go before meeting their ride.</li> <li>Usually eats very well. They have been carrying all their food.</li> </ul>					
<b>Medical History</b>		<b>Medications</b>			<b>Allergies</b>		
Angina 4 years		• Nitro Spray			• NKA		
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	4,5,6 (15)	88 reg, strong	24 reg, shallow	150/60	Pale, clammy, warm	92% Pain 7/10	
1 <sup>st</sup> nitro	4,5,6 (15)	80 reg, strong	24 reg, shallow	120/60	Pale, clammy, warm	98% pain 5/10	
2 <sup>nd</sup> Nitro	4,5,6 (15)	88 reg, strong	24 reg, shallow	105/60	Pale, clammy, warm	98% pain 3/10 nausea	
Gravol 25mg	4,5,6 (15)	88 reg, strong	24 reg, shallow	105/60	Pale, clammy, warm	98% pain 3/10 nausea	
3 <sup>rd</sup> Nitro	4,5,6 (15)	72 reg, strong	24 reg, shallow	100/60	Pale, clammy, warm	98% pain 0/10	
<b>#</b>	<b>Head/</b>	<b>Neck</b>	<b>Chest</b>	<b>ABD / Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	
Initial	Warm, clammy no cyanosis	No JVD	A/E = clear to bases, bypass surgery scar	Soft, no masses, no surgery scars	Surgery scars on right thigh	NAD	<b>Back</b>
	No change	No change	No change	No change	No change	No change	NAD
<b>SPECIAL INFORMATION</b>							
This patient's chest pain lasts longer than her normal angina pain and is associated with nausea this time. The pain responds to the 3rd Nitro. Her nausea is relieved with gravol. SAR Tech should be able to initiate transport between the administration of medications. Extrication should keep patient at rest.							
If SAR Tech suspects unstable angina due to history he may go to Morphine early. Adjust vitals to reflect this. The BP will not drop like it would with nitro and pt may be a little more calm.							

<b>Scenario:</b> 1.1 C Cardiac Chest Pain Unstable		
<b>Problem:</b> 58 YOM boat captain develops Chest Pain		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>58 Year old male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>1.1 Cardiac Chest pain</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Recognize the chest pain as cardiac in nature like similar to patient's Angina</li> <li>Treat with ASA, Nitro, Graval and MS</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Give ASA immediately</li> <li>Give Nitro for pain</li> <li>Recognizes pain is not like Angina pain but is cardiac in nature</li> <li>Recognizes that patient requires full chest pain protocol treatment</li> <li>Can integrate rapid transport of patient with Nitro treatment.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize indications for Chest pain protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech integrate transport between medication administrations so there was not undue delay in the transport of the patient?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize patient had monitor BP and determine he was able to and continue with Nitro treatment?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize he had to treat with morphine and Graval?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Hoist to boat
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Patient conscious</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>None</li> <li>Airway is clear</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing adequately</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Fast radial pulse</li> </ul>
<b>H</b>	Assess for Hypo/Hyperthermia	<ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cool and clammy skin. No cyanosis, and no physical evidence of cardiac disease. Numbness in his left arm. He has a heavy build.</li> </ul>
<b>DECISION</b> – Patient has enough history he <b>may</b> meet the Chest pain protocol and therefore it is prudent to stay at scene to collect critical history enough to initiate treatment and make the patient more comfortable.		
<b>Primary</b>	Chest pains, numbness in arm, some SOB.	<ul style="list-style-type: none"> <li>Oxygen, blanket, rest</li> </ul>
<b>Vital Signs</b>	Baseline vitals while obtaining a critical history	<ul style="list-style-type: none"> <li>Within parameters for using the Chest pain protocol.</li> </ul>
<b>Critical History</b>	Developed pain suddenly without exertion	<ul style="list-style-type: none"> <li>Is on Nitroglycerin for chest pain</li> </ul>
<b>DECISION</b> – Patient does meet the indications for the Chest pain protocol. Patient's pain is cardiac in nature similar to his angina and will require morphine and graval to manage it. Tells pilot he will be at least half hour while they help the patient.		
<b>Protocol</b>	Initiate Chest Pain protocol, ASA PO, Nitro x3, MS and Graval to relieve pain.	Pain is like an MI very different than his angina.
<b>Procedures</b>	IV RL 100ml/hr or IV lock	
<b>Secondary</b>	Full history to determine that this pain is heart pain and different than his angina pain.	Pale, cool and clammy skin resolves itself as the pain disappears. No cyanosis, and no physical evidence of cardiac disease.

**PATIENT INFORMATION SHEET**

<b>Scenario: 1.1 C Cardiac Chest Pain Unstable</b>							
<b>Problem: 58 YOM boat captain develops Chest Pain</b>							
<b>Mission:</b> 103 Cormorant tasked 160 NM off St Johns' to a 78' fishing vessel. Sea State is 3 and boat is a clean hoist. The ship's captain is a 58 YOM complaining of chest pain and SOB. The weather is warm and sunny with a 15km breeze from the west. You are able to hoist to the vessel. The pilot says you have 45 minutes on scene time if required.							
<b>On approach:</b> You find the patient sitting in the galley of the boat. Crewmembers are there. The patient looks very pale and diaphoretic. He is breathing heavily and clutching his chest.							
<b>Patient (Information given only if asked):</b> Appears very anxious about his chest pain. He can handle some mild angina pain with his nitro but this is not at all like it and his nitro did not work. Being apprehensive, he only answers question when asked. Does not offer much information freely.							
<b>HISTORY</b>							
<b>C/C</b>	Pain in his chest.						
<b>Hx C/C</b>	He was piloting the boat and felt a sudden onset of severe chest pain.						
	<b>L</b> <i>Crushing substernal pain in his chest.</i>						
	<b>O</b> <i>1 hour ago</i>						
	<b>T</b> <i>The pain has been constant since it started.</i>						
	<b>A</b> <i>Nothing makes it better or worse. It is a 10/10 for an hour now.</i>						
	<b>A</b> <i>Feels acutely SOB with this pain – pain came on first.</i>						
	<b>R</b> <i>Does not radiate anywhere, stays in his chest.</i>						
	<b>P</b> <i>Can't even walk because of the pain – crewmembers helped him here.</i>						
<b>Pertinent Functional Enquiry</b>	<ul style="list-style-type: none"> <li>• While piloting the ship, 2 hours into his watch, he suddenly developed chest pain. It did not come on like his angina after working too hard. This just suddenly appeared. It is a lot worse. His angina is normally a dull ache that relieves with one Nitro Spray. He tried his Nitro but it didn't even touch it.</li> <li>• Feels acutely short of breath.</li> <li>• Normal angina pain is a dull ache that is relieved by rest or a nitro spray.</li> </ul>						
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>• Family has a history of heart disease, Mother has asthma, and his two younger sons have asthma.</li> <li>• Usually eats very well, lots of coffee.</li> </ul>						
<b>Medical History</b>			<b>Medications</b>			<b>Allergies</b>	
<ul style="list-style-type: none"> <li>• Angina 1 year</li> <li>• Asthma</li> <li>• Hypertension</li> </ul>			<ul style="list-style-type: none"> <li>• Nitro Spray</li> <li>• Captopril</li> </ul>			<ul style="list-style-type: none"> <li>• NKA</li> </ul>	
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	4,5,6 (15)	95 reg, strong	36 reg, shallow	170/80	Pale, clammy, warm	90%	
After Nitros	4,5,6 (15)	95 reg, strong	36 reg, shallow	160/80	Pale, clammy, warm	94% pain 8/10	
Morphine 2.5 mg							
Morphine 2.5 mg	4,5,6 (15)	88 reg, strong	26 reg, shallow	160/80	Pale, clammy, warm	96% pain 6/10	
After Gravalol	4,5,6 (15)	78 Reg Strong	26 reg, shallow	150/80	Pale dry	96% pain 1/10	
	4,5,6 (15)	78 Reg Strong	26 reg, shallow	150/80	Pale Dry	96% pain 0/10	
<b>#</b>	<b>Head/</b>	<b>Neck</b>	<b>Chest</b>	<b>ABD / Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Clammy no cyanosis	No JVD	A/E = clear to bases, bypass surgery scar	Soft, no masses, no surgery scars	NAD	NAD	NAD
	Same	Same	Same	Same	Same	Same	Same
<b>SPECIAL INFORMATION</b>							
This patient's chest pain is severe due to an MI. He remains anxious until pain has been treated where he will settle down. Patient requires rapid transport to a Coronary Care Unit. Alternating Nitro and MS treatment to manage pain would be appropriate.							

<b>Scenario:</b> 1.1 D Cardiac Chest Pain Unstable		
<b>Problem:</b> 55 YOM boat captain develops Chest Pain		
<b>Patient:</b>	55 Year old male	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>1.1 Cardiac Chest pain</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Recognize the chest pain as cardiac in nature unlike patient's regular Angina.</li> <li>Treat with ASA, Graval and MS</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Give ASA immediately</li> <li>Nitro contraindicated due to taking Viagra less than 24 hrs prior.</li> <li>Recognizes pain is not like Angina pain but is cardiac in nature</li> <li>Recognizes that patient requires full chest pain protocol treatment</li> <li>Can integrate rapid transport of patient with administration of Pain meds.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize indications for Chest pain protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech integrate transport between medication administrations so there was not undue delay in the transport of the patient?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize patient could not receive Nitro?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize he had to treat with morphine and Graval?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Hoist to boat
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Patient conscious</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>None</li> <li>Airway is clear</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing adequately</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Fast radial pulse</li> </ul>
<b>H</b>	Assess for Hypo/Hyperthermia	<ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cool and clammy skin. No cyanosis, and no physical evidence of cardiac disease. Numbness in his left arm. He has a heavy build.</li> </ul>
<b>DECISION</b> – Patient has enough history he <b>may</b> meet the Chest pain protocol and therefore it is prudent to stay at scene to collect critical history enough to initiate treatment and make the patient more comfortable.		
<b>Primary</b>	Chest pains, numbness in arm, some SOB.	<ul style="list-style-type: none"> <li>Oxygen, blanket, rest</li> </ul>
<b>Vital Signs</b>	Baseline vitals while obtaining a critical history	<ul style="list-style-type: none"> <li>Within parameters for using the Chest pain protocol.</li> </ul>
<b>Critical History</b>	Developed pain suddenly without exertion	<ul style="list-style-type: none"> <li>Is on Nitroglycerin for chest pain</li> </ul>
<b>DECISION</b> – Patient does meet the indications for the Chest pain protocol. Patient's pain is cardiac in nature and unlike his regular angina and will require morphine and gravol to manage it. Tells pilot he will be at least half hour while they help the patient.		
<b>Protocol</b>	Initiate Chest Pain protocol, ASA PO, MS and Graval to relieve pain.	Pain is like an MI very different than his angina.
<b>Procedures</b>	IV RL 100ml/hr or IV lock	
<b>Secondary</b>	Full history to determine that this pain is Cardiac pain and different than his angina pain.	Pale, cool and clammy skin resolves itself as the pain disappears.

**PATIENT INFORMATION SHEET**

**Scenario: 1.1 D Cardiac Chest Pain Unstable**

**Problem: 58 YOM boat captain develops Chest Pain**

**Mission:**  
103 Cormorant tasked 160 NM off St Johns' to a 78' fishing vessel. Sea State is 3 and boat is a clean hoist. The ship's captain is a 58 YOM complaining of chest pain and SOB. The weather is warm and sunny with a 15km breeze from the west. You are able to hoist to the vessel. The pilot says you have 45 minutes on scene time if required.

**On approach:**  
You find the patient sitting in the galley of the boat. Crewmembers are there. The patient looks very pale and diaphoretic. He is breathing heavily and clutching his chest.

**Patient (Information given only if asked):**  
Appears very anxious about his chest pain. He can handle some mild angina pain with his nitro but this is not at all like it and his nitro did not work. Being apprehensive, he only answers question when asked. Does not offer much information freely.

**HISTORY**

**C/C** Pain in his chest.  
**Hx C/C** He was piloting the boat and felt a sudden onset of severe chest pain.  
**L** *Crushing substernal pain in his chest.*  
**O** *1 hour ago*  
**T** *The pain has been constant since it started.*  
**A** *Nothing makes it better or worse. It is a 10/10 for an hour now.*  
**A** *Feels acutely SOB with this pain – pain came on first.*  
**R** *Does not radiate anywhere, stays in his chest.*  
**P** *Can't even walk because of the pain – crewmembers helped him here.*

**Pertinent Functional Enquiry**

- While piloting the ship, 2 hours into his watch, he suddenly developed chest pain. It did not come on like his angina after working too hard. This just suddenly appeared. It is a lot worse. His angina is normally a dull ache that relieves with one Nitro Spray. He tried his Nitro but it didn't even touch it.
- Feels acutely short of breath.
- Normal angina pain is a dull ache that is relieved by rest or a nitro spray.
- Took a Viagra last night.

**Non-Pertinent FE**

- Family has a history of heart disease, Mother has asthma, and his two younger sons have asthma.
- Usually eats very well, lots of coffee.

Medical History	Medications	Allergies
<ul style="list-style-type: none"> <li>• Angina 1 year</li> <li>• Asthma</li> <li>• Hypertension</li> <li>• Triple bypass 1 yr ago</li> </ul>	<ul style="list-style-type: none"> <li>• Nitro Spray</li> <li>• Captopril</li> </ul>	<ul style="list-style-type: none"> <li>• NKA</li> </ul>

**PHYSICAL FINDINGS**

#	LOC	Pulse	Resp	BP	Skin	Pulse Ox
Initial	4,5,6 (15)	95 reg, strong	28 reg, shallow	96/50	Pale, clammy, diaphoretic	90% Pain 10/10
Morphine 2.5 mg	4,5,6	N/C	N/C	94/50	N/C	92% Pain 8/10
Morphine 2.5 mg	4,5,6 (15)	88 reg, strong	26 reg, shallow	100/54	Pale, clammy	96% pain 6/10
After Gravol	4,5,6 (15)	78 Reg Strong	26 reg, shallow	94/55	Pale dry	96% pain 1/10
All others	4,5,6 (15)	78 Reg Strong	26 reg, shallow	92/55	Pale Dry	96% pain 0/10

#	Head/	Neck	Chest	ABD / Pelvis	Lower Ext	Upper Ext	Back
Initial	Clammy no cyanosis	No JVD	A/E = clear to bases, bypass surgery scar	Soft, no masses, no surgery scars	NAD	NAD	NAD
	Same	Same	Same	Same	Same	Same	Same

**SPECIAL INFORMATION**

Nitro contraindicated due to Viagra. This patient's chest pain is severe due to an MI. He remains anxious until pain has been treated where he will settle down. Patient requires rapid transport to a Coronary Care Unit. Rule out treatable causes such as pneumothorax.

<b>Scenario:</b> Cardiac Arrest 1.2 A / Discontinue Resuscitation 1.4		
<b>Problem:</b> Cardiac Arrest - unsuccessful		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>70 year old male found unresponsive at home.</li> </ul>	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>Cardiac Chest Pain AED 1.2</li> <li>Discontinue Resuscitation 1.4</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to manage the airway compromise prior to beginning AED protocol.</li> <li>SAR Tech must decide whether to initiate the AED protocol or whether the patient meets requirements of traumatic arrest due to possible hypovolemia.</li> <li>The SAR Tech must decide whether to defibrillate the cardiac arrest patient prior to advanced airway insertion.</li> <li>SAR Tech must decide whether to discontinue resuscitation following three "No Shock Advised" or whether there is sufficient evidence of reversible cause of cardiac arrest to continue resuscitation.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Airway must be managed prior to continuing through the primary survey.</li> <li>Defibrillation prior to intubation, do not be delayed for other interventions.</li> <li>Sufficient history must be obtained prior to physician contact to justify DC orders</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform appropriate critical interventions during the primary survey?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech decide to initiate the AED protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Were defibrillations performed prior to advanced airway insertion?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Were defibrillations delayed at any time for advanced airway insertion?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech ensure everyone was clear prior to defibrillating?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech use good time and resource management to obtain sufficient information prior to contacting EP?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Was the SAR Tech able to recognize possible causes of cardiac arrest? Hypoxia (aspiration), Seizures (EtOH or IDDM), Hypovolemia, Cardiac, Chest wall trauma?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech adequately discuss the history and physical findings with the physician prior to discontinuing resuscitation?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of the scene in accordance with SAR rescue procedures.	<ul style="list-style-type: none"> <li>House is in disrepair. Empty alcohol bottles around.</li> <li>Recognizes transport time delay.</li> </ul>
<b>LOC</b>	Unresponsive.	<ul style="list-style-type: none"> <li>Recognizes decreased LOC, intervenes and monitors appropriately.</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	No indication of C spine issues Vomitus and fluids collected in airway. OPA undersized. Inadequate ventilations on	<ul style="list-style-type: none"> <li>Patient found lying unresponsive on living room carpet.</li> <li>Airway must be suctioned, maintained</li> <li>Suctions and clears dark vomitus from airway</li> </ul>
<b>R</b>	Absent respirations. Poor ventilations on assessment.	<ul style="list-style-type: none"> <li>Ventilations with 100% oxygen at 12 – 20/min</li> </ul>
<b>H</b>	Assess	<ul style="list-style-type: none"> <li>Pt is cool</li> </ul>
<b>C</b>	No pulse	<ul style="list-style-type: none"> <li>Compression 30:2 rate of 100/min</li> <li>Weak pulses with CPR</li> </ul>
<b>RBS</b>	Left side lower chest wall bruise. A/E = bilaterally, coarse crackles throughout with decreased air entry to bases	<ul style="list-style-type: none"> <li>Palpates to determine no chest wall instability</li> <li>Recognizes possible aspiration</li> </ul>
<b>DECISION –</b>		
<b>Vital Signs</b>	No vital signs	<ul style="list-style-type: none"> <li>Pulses with CPR only</li> </ul>
<b>Critical Hx</b>	Obtains history of fall, IDDM, alcohol use.	<ul style="list-style-type: none"> <li>Obtains history regarding time of arrest</li> </ul>
<b>DECISION:</b>		
<ul style="list-style-type: none"> <li>Recognizes possible causes of cardiac arrest - Hypoxia (aspiration), Seizures (ETOH or IDDM), Hypovolemia, Cardiac, Chest wall trauma. Completes primary survey interventions and initiates AED Protocol.</li> <li>Manages airway compromise prior to initiating AED protocol.</li> <li>Initiates AED protocol prior to advanced airway. Does not delay defibrillation for advanced airway.</li> </ul>		
<b>Protocol 1.2</b>	<ul style="list-style-type: none"> <li>"Shock Advised"</li> <li>"No Shock Advised"</li> <li>"No Shock Advised"</li> <li>"No Shock Advised"</li> </ul>	<ul style="list-style-type: none"> <li>Proceed with 2 min CPR (gets airway ready)</li> <li>Advanced airway inserted during this time. Successful insertion and tube suctioning required.</li> <li>Tries fluid bolus IV/IO RL x 1 Liter minimum bolus</li> <li>Starts obtaining further history for DC orders</li> <li>Rules out treatable causes.</li> </ul>
<b>DECISION -</b>		
<ul style="list-style-type: none"> <li>Recognizes prolonged transport time. Makes decision to discontinue resuscitation following completion of discontinue resuscitation criteria.</li> <li>Recognizes possible causes of cardiac arrest - Hypoxia (aspiration), Seizures (EtOH or IDDM), Hypovolemia, Cardiac, Chest wall trauma?</li> <li>Discusses the history and physical findings with the physician prior to discontinuing resuscitation.</li> </ul>		
<b>Protocol 1.4</b>	<ul style="list-style-type: none"> <li>Absent Vital Signs</li> <li>Identifies criteria for DC Protocol</li> <li>500 cc RL fluid bolus</li> <li>Reliable Criteria for the determination of death is recognized</li> <li>History and physical exam completed sufficient to satisfy receiving discontinue orders.</li> </ul>	<ul style="list-style-type: none"> <li>Maintains BLS until criteria met.</li> <li>Weak pulses with CPR</li> <li>Improved pulses with CPR</li> <li>Assesses ABC's for one minute</li> <li>No response to painful stimulus, no pulse, no respirations, and pupils fixed and dilated.</li> <li>Contacts EP for DC orders</li> <li>Discontinues resuscitation.</li> </ul>

PATIENT INFORMATION SHEET

Scenario: Cardiac Arrest - 1.2 A - / Discontinue Resuscitation 1.4

Problem: Cardiac Arrest – unsuccessful and discontinue resuscitation

**Mission:**

442 Cormorant is tasked to Squirrel Cove near Campbell River. Time to scene is 45 minutes.  
 • Patient is unresponsive 70-year-old male in cardiac arrest. CCG has been on scene for 25 minutes.  
 • Extraction time is 65 minutes to receiving facility.

**On approach:**

- CCG is performing BLS with BVM and CPR prior to your arrival.
- They state the patient was found unresponsive on the floor of the house. On initial assessment he was in cardiac arrest.
- They tell you the patient placed the original call complaining of nausea and dizziness.
- There is a neighbor on scene. The neighbor told them the patient was talking up until shortly before their arrival. The neighbor left the house to guide the rescuers in and when he got back with them the patient wasn't moving.

**Patient (Information given only if asked):**

- Remains unresponsive.
- Information received from neighbor on scene if asked. (See History)
- He contacted his neighbor after calling for medical assistance. When CCG arrived the patient was in cardiac arrest with dark coffee ground vomit in the airway.
- Patient had fall four days ago that resulted in a chest wall injury. He was complaining of pain and taking lots of ASA to control it.
- His fall resulted from his uncontrolled diabetes – blood sugars have been very high and he has not seen his physician as he has been drinking for days.

**HISTORY**

<b>C/C</b>	<i>Cardiac Arrest</i>
<b>Hx C/C</b>	Prior to collapsing the patient complained of the following <b>L</b> (L) lower chest wall pain <b>O</b> 4 days ago <b>T</b> dull pain – sharp on inspiration and movement <b>A</b> large bruise - SOB <b>A</b> Movement – cough – breathing <b>R</b> Minimal with ASA <b>P</b> Fall onto woodpile
<b>Pertinent Functional Enquiry</b>	<b>General:</b> <i>The patient had a fall four days ago that resulted in a chest wall injury. He has been complaining of pain and taking lots of ASA. His fall resulted from his uncontrolled diabetes. His blood sugars have been very high and he has not seen his physician as he has been drinking for days.</i>  <b>CNS:</b> ETOH abuse, Alcoholic Seizures <b>CVS:</b> MI (old), Angina <b>Endocrine:</b> Uncontrolled IDDM – high sugars <b>Musculo-Skeletal:</b> Recent fall – Chest wall injury
<b>Non-Pertinent FE</b>	<b>Resp:</b> <i>Chronic cough</i>

Medical History		Medications	Allergies
<ul style="list-style-type: none"> <li>• IDDM – 25 years</li> <li>• Smoker</li> <li>• Drinker</li> <li>• Duodenal ulcer 1995</li> </ul>	<ul style="list-style-type: none"> <li>• MI – 1997</li> <li>• Chronic Bronchitis</li> <li>• Angina</li> </ul>	<ul style="list-style-type: none"> <li>• ASA 325 mg. PRN</li> <li>• Losec 20 mg. OD</li> <li>• Buckley’s Cough Syrup</li> <li>• Ventolin Inhaler</li> <li>• Cardizem 100 mg. tid</li> </ul>	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Sulfa</li> </ul>

**PHYSICAL FINDINGS**

#	LOC	Pulse	Resp	BP	Skin	Pulse Ox
Initial	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	None BS 6.8mmol
After 3 no shocks	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	Not obtainable
After fluid bolus	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	94%
All Others	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	94%

#	Head/Neck	Chest	ABD/ Pelvis	Lower Ext	Upper Ext	Back
Initial	Pupils equal, unreactive, 8mm Alcohol type odor. Dark vomitus in mouth and nose. Jugulars veins flat	Coarse crackles throughout with decreased air entry to bases (L) lower chest wall bruise	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin
After suctioning Airway	Pupils equal, unreactive, 8mm Alcohol type odor. Dark vomitus in nose. Jugulars veins flat	Still coarse crackles improved air entry to bases	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin
Prior to DC	Pupils equal, unreactive, 8mm Alcohol type odor. Dark vomitus in nose. Jugulars veins flat	same	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin

**SPECIAL INFORMATION**



<b>Scenario:</b> Cardiac Arrest - AED 1.2 B / Discontinue Resuscitation 1.4		
<b>Problem:</b> Cardiac Arrest		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>75 year old male found unresponsive at cabin</li> </ul>	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>Cardiac Arrest - AED 1.2 Discontinue Resuscitation 1.4</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to manage the airway compromise prior to beginning AED protocol.</li> <li>The SAR Tech must decide whether to defibrillate the cardiac arrest patient prior to advanced airway insertion.</li> <li>SAR Tech must decide whether to discontinue resuscitation following three “No Shock Advised” or whether there is sufficient evidence of reversible cause of cardiac arrest to continue resuscitation.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Airway must be managed prior to continuing through the primary survey.</li> <li>Should suction and inset OPA and assess bagging.</li> <li>Unable to maintain proper bagging. Insert advanced airway due to continued vomit in airway.</li> <li>Sufficient history must be obtained prior to physician contact to justify DC orders</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform appropriate critical interventions during the primary survey?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech decide to initiate the AED protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Was advanced airway performed due to continued airway compromise vomiting?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech ensure everyone was clear prior to defibrillating?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech use good time and resource management to obtain sufficient information prior to contacting EP?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Was the SAR Tech able to recognize possible causes of cardiac arrest? Hypoxia (aspiration), Cardiac?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech adequately discuss the history and physical findings with the physician prior to discontinuing resuscitation?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures.	<ul style="list-style-type: none"> <li>Weekend cabin retreat</li> <li>Recognizes transport time delay.</li> </ul>
<b>LOC</b>	Unresponsive.	<ul style="list-style-type: none"> <li>Recognizes decreased LOC, intervenes and monitors appropriately.</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	No history or physical findings supportive of c-spine injury. Vomitus and fluids collected in airway. No OPA Inadequate ventilations on assessment.	<ul style="list-style-type: none"> <li>Patient found lying unresponsive on living room carpet.</li> <li>Airway must be suctioned, maintained. Patient continues to vomit and have airway problems until he is intubated.</li> </ul>
<b>R</b>	Absent respirations. Poor ventilations on assessment.	<ul style="list-style-type: none"> <li>Unable to ventilate properly until advanced airway</li> <li>- Ventilations with 100% oxygen at 12 – 20/min</li> </ul>
<b>C</b>	No pulse	<ul style="list-style-type: none"> <li>Compression 30:2 rate of 100/min</li> <li>Weak pulses with CPR</li> </ul>
<b>H</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>RBS</b>	A/E = bilaterally, coarse crackles in right lung	<ul style="list-style-type: none"> <li>Recognizes possible aspiration</li> </ul>
<b>DECISION –</b>		
<b>Vital Signs</b>	No vital signs	<ul style="list-style-type: none"> <li>Pulses with CPR only</li> </ul>
<b>Critical Hx</b>	Obtains history of fall, IDDM, alcohol use.	<ul style="list-style-type: none"> <li>Obtains history regarding time of arrest</li> </ul>
<b>DECISION:</b>		
<ul style="list-style-type: none"> <li>Recognizes possible causes of cardiac arrest - Hypoxia (aspiration), Cardiac. Completes primary survey interventions and initiates AED Protocol.</li> <li>Manages airway compromise prior to initiating AED protocol.</li> <li>In this case due to the persistent vomiting compromising the airway, patient should have advanced airway by now. Proceeds to initiate the AED protocol.</li> </ul>		
<b>Protocol 1.2</b>	<ul style="list-style-type: none"> <li>"Shock Advised"</li> <li>"No Shock Advised"</li> <li>"No Shock Advised"</li> <li>"No Shock Advised"</li> </ul>	<ul style="list-style-type: none"> <li>proceed with 2 min CPR</li> <li>Check advanced airway placement</li> <li>Starts obtaining further history for DC orders IV/IO RL x 1L minimum bolus.</li> <li>Rules out treatable causes.</li> </ul>
<b>DECISION -</b>		
<ul style="list-style-type: none"> <li>Recognizes prolonged transport time. Makes decision to discontinue resuscitation following completion of discontinue resuscitation criteria.</li> <li>Recognizes possible causes of cardiac arrest - Hypoxia (aspiration), Cardiac?</li> <li>Discusses the history and physical findings with the physician prior to discontinuing resuscitation.</li> </ul>		
<b>Protocol 1.4</b>	<ul style="list-style-type: none"> <li>Absent Vital Signs</li> <li>Identifies criteria for DC Protocol</li> <li>500 cc RL fluid bolus</li> <li>Reliable Criteria for the determination of death is recognized</li> <li>History and physical exam completed sufficient to satisfy receiving discontinue orders.</li> </ul>	<ul style="list-style-type: none"> <li>Maintains BLS until criteria met.</li> <li>Weak pulses with CPR</li> <li>Pulses with CPR</li> <li>Assesses ABC's for one minute</li> <li>No response to painful stimulus, no pulse, no respirations, pupils fixed and dilated.</li> <li>Contacts EP for DC orders</li> <li>Discontinues resuscitation.</li> </ul>

PATIENT INFORMATION SHEET

<b>Scenario: Cardiac Arrest - AED 1.2 B / Discontinue Resuscitation 1.4</b>							
<b>Problem: Cardiac Arrest</b>							
<b>Mission:</b> 442 Cormorant is tasked to Redonda Island in Desolation Sound. Landing on the beach you have a 20 minute walk to the cabin. Time to scene is 45 minutes.							
<ul style="list-style-type: none"> <li>• Patient is 75-year-old male with chest pain. Family member (nephew) is on scene with him.</li> <li>• Extraction time is 65 minutes to receiving facility.</li> </ul>							
<b>On approach:</b>							
<ul style="list-style-type: none"> <li>• As you approach you see the nephew giving CPR to his Uncle.</li> <li>• Patient's nephew has been performing CPR since he collapsed 15 minutes ago.</li> <li>• The nephew tells you the patient complained of nausea and dizziness earlier in the day so he called for medical assistance.</li> <li>• His Uncle collapsed and on initial assessment the patient was in cardiac arrest.</li> </ul>							
<b>Patient (Information given only if asked):</b>							
<ul style="list-style-type: none"> <li>• Remains unresponsive.</li> <li>• Information received from the nephew on scene if asked. (See History)</li> <li>• The patient complained of nausea and dizziness and called for medical assistance. When the nephew returned he found the patient unconscious on the floor. When you arrived the patient was in cardiac arrest with vomit in the airway.</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b>	<i>Cardiac Arrest</i>						
<b>Hx C/C</b>	Prior to collapsing the patient complained of the following						
	<b>L</b> <i>chest pain prior to your arrival</i>						
	<b>O</b> <i>collapsed 15 minutes ago</i>						
	<b>T</b> <i>CPR being done by nephew.</i>						
	<b>A</b> <i>CPR being ongoing for 15 minutes while you hiked in</i>						
	<b>A</b>						
	<b>R</b>						
	<b>P</b> <i>Complained of dizziness and some chest pain</i>						
<b>Pertinent Functional Enquiry</b>	<b>General:</b>	The patient had chest pain four days ago and some chest pain prior to your arrival. It is like his last heart attack, where he had 4 days of pain prior to going to hospital. He wanted to finish off his holidays before going in to see the doctor.					
	<b>CVS:</b>	MI (old), Angina					
	<b>Endocrine:</b>						
<b>Non-Pertinent FE</b>	<b>Resp:</b>	<i>Chronic cough</i>					
<b>Medical History</b>		<b>Medications</b>		<b>Allergies</b>			
<ul style="list-style-type: none"> <li>• Smoker</li> <li>• Drinker</li> <li>• Duodenal ulcer 2005</li> <li>• hypertension</li> </ul>	<ul style="list-style-type: none"> <li>• MI – 1999</li> <li>• Chronic Bronchitis</li> <li>• Angina</li> </ul>	<ul style="list-style-type: none"> <li>• ASA 325 mg. PRN</li> <li>• Losec 20 mg. OD</li> <li>• Buckley's Cough Syrup</li> <li>• Ventolin Inhaler</li> <li>• Cardizem 100 mg. tid</li> </ul>	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Sulfa</li> </ul>				
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	None BS 6.8mmol	
After 3 no shocks	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	Not obtainable	
After fluid bolus	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	94%	
All Others	1,1,1	Absent	Absent	Absent	Pale, cool, cyanosed	94%	
<b>#</b>	<b>Head/Neck</b>		<b>Chest</b>	<b>ABD/ Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils equal, unreactive, 8mm		Coarse crackles throughout with decreased air entry to bases (L) lower chest wall bruise	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin
After suctioning airway	Pupils equal, unreactive, 8mm Jugulars veins flat		Still coarse crackles. Improved air entry to bases	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin
Prior to DC	Pupils equal, unreactive, 8mm		same	Soft x 4, no BS	Foot rash	Elbow Rash	Mottled skin
<b>SPECIAL INFORMATION</b>							
Should attempt to suction airway and insert OPA prior to inserting King LT							

<b>Scenario: Cardiac Arrest - AED 1.2A - / Post Arrest Stabilization 1.3</b>		
<b>Problem: Witnessed Cardiac Arrest with post arrest stabilization.</b>		
<b>Patient:</b>	47 Year old male	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>AED 1.2</li> <li>Post-Stabilization Protocol 1.3</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Patient management including critical interventions, post-arrest stabilization and ongoing assessment must be maintained while organizing rapid patient extraction.</li> <li>Stay on boat and carry out AED protocol as long as shock advised and time permits.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Defibrillation should occur prior to advanced airway insertion and should not be delayed for other interventions.</li> <li>Following successful resuscitation, post arrest stabilization should be maintained while organizing rapid extraction.</li> <li>Chest auscultation should occur prior to fluid bolus or transport in aircraft.</li> <li>Ventilations should be managed according to patient's SaO<sub>2</sub>.</li> <li>Transport should not be delayed for fluid bolus.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
		<b>Y N N/A</b>
• Did the SAR Tech perform appropriate critical interventions during the primary survey?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Were defibrillations performed prior to advanced airway insertion?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Were defibrillations delayed at any time for advanced airway insertion?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Was extraction initiated as soon as resuscitation was effected?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech use good time and resource management to ensure treatment and transport were balanced during extraction?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech recognize abdominal distension and place the OG tube in a timely manner?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech recognize increasing SaO <sub>2</sub> and ventilate accordingly?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
<b>COMPONENT</b>	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures.	<ul style="list-style-type: none"> <li>Establishes that tpt time is crucial and elects to perform rapid extraction post-resuscitation.</li> </ul>
<b>LOC</b>	1,1,1 = 3	<ul style="list-style-type: none"> <li>Patient remains unconscious</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>A+D</b>	No D spine concerns Opens with jaw maneuver	<ul style="list-style-type: none"> <li>Airway clear - Accepts airway easily</li> </ul>
<b>R</b>	Absent	<ul style="list-style-type: none"> <li>Ventilates at 12-20/min</li> </ul>
<b>C</b>	Absent radial and carotid pulses	<ul style="list-style-type: none"> <li>Chest compressions</li> </ul>
<b>H</b>	Assess	<ul style="list-style-type: none"> <li>Pt was normothermic when he collapsed</li> </ul>
<b>RBS</b>	NAD, no medical alerts	<ul style="list-style-type: none"> <li>Cyanotic</li> </ul>
<b>DECISION</b>		
<b>Primary Survey</b>	Initiates AED protocol prior to advanced airway insertion. Does not delay defibrillation for advanced airway insertion. Chest auscultation needs to be performed prior to patient extraction.	<ul style="list-style-type: none"> <li>Successful placement of AED Patches</li> </ul>
<b>Vital Signs</b>	Obtains VSM and pulse oximetry post-arrest. Patient is hypotensive. Extraction will not be delayed for fluid bolus.	
<b>History</b>	Obtains critical history and pertinent information to cardiac arrest management. Gathers other relevant history post resuscitation.	<ul style="list-style-type: none"> <li>No contraindications to protocol found.</li> </ul>
<b>Secondary</b>	Complete history and physical assessment performed en-route.	<ul style="list-style-type: none"> <li>History sufficient to identify patient with cardiac risk factors and history.</li> <li>No abnormalities found</li> </ul>
<b>Protocol</b>	Cardiac Arrest Protocol: <ul style="list-style-type: none"> <li>Defibrillation x 3 then 2</li> <li>Advanced airway insertion following first set of defibrillations.</li> </ul> Post-Arrest Stabilization: <ul style="list-style-type: none"> <li>Advanced airway insertion if not already performed.</li> <li>IV RL 250 ml fluid bolus</li> <li>Maintains IV at 100 cc/hr.</li> <li>Orogastric tube placed after identifying abdominal distension.</li> </ul>	<ul style="list-style-type: none"> <li>Pulse returns following five defibrillations.</li> <li>Defibrillations cannot be delayed for advanced airway insertion.</li> <li>Delayed intubation results in lowered SaO<sub>2</sub>.</li> <li>B/P increases to &gt;90 mmHg</li> <li>B/P is maintained &gt; 90 mmHg</li> <li>If orogastric tube not placed then lowered SaO<sub>2</sub> with increasing distension.</li> </ul>
<b>Procedures</b>	Performs continuous airway management and monitoring. Appropriate notification to receiving facility of all findings and interventions.	<ul style="list-style-type: none"> <li>SaO<sub>2</sub> increases until &gt;92%. Ventilations should be managed appropriately.</li> </ul>

PATIENT INFORMATION SHEET

<b>Scenario: Cardiac Arrest –AED 1.3A / Post Arrest Stabilization 1.3</b>							
<b>Problem: Witnessed Cardiac Arrest with post arrest stabilization.</b>							
<b>Mission (Read to Student)</b> 103 Cormorant is tasked to meet a 55-foot fishing vessel 120 nautical miles off St Johns' for a 47-year-old male with chest pain. Transport time 60 minutes. Pilot states you have 40 minutes on scene time if required. Hoist insertion finds a patient standing on the deck bundled up in heavy clothing. As you arrive on deck the patient collapses into other fisherman's arms and is lowered to the deck.							
<b>Patient (Information given only if asked)</b>							
<ul style="list-style-type: none"> <li>• Information obtained from captain of his vessel if asked. (see History)</li> <li>• Crew can give information Hx c/c &amp; C/C</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b> <i>Cardiac Arrest</i>							
<b>Hx C/C</b> Patient working on deck and felt crushing/heaviness in chest, radiating to left arm. Had chest pain and collapsed as you arrive.							
<b>L</b> <i>pain in Chest</i>							
<b>O</b> <i>as you arrive.</i>							
<b>T</b> <i>pulseless</i>							
<b>A</b> <i>You started CPR as soon as the collapse occurred</i>							
<b>A</b> <i>NAD</i>							
<b>R</b> <i>NAD</i>							
<b>P</b> <i>pain in chest</i>							
<b>Pertinent Functional Enquiry</b>							
<b>General:</b> Initial Chest Pain started 3 hours prior to your arrival							
<b>CNS:</b> Crushing with heavy ache to arm. nausea, vomited x1, dizziness and very							
<b>CVS:</b> Pounding in chest							
<b>Resp.</b> Substernal radiating across chest to (L) arm							
<b>Musculo-Skeletal:</b> Ache in left arm							
<b>Skin:</b> diaphoretic							
<b>Non-Pertinent FE</b>							
<b>General:</b> Recent fatigue							
<b>CNS:</b> Headaches Periodic weakness							
<b>CVS:</b> Has had chest heaviness for three months, when working hard							
<b>Resp:</b> Smoker's cough							
<b>GI/GU:</b> Heart burn							
<b>Endocrine:</b> GP told him he should watch his diet.							
<b>Musculo Skeletal:</b> General fatigue after exertion							
<b>Medical History</b>			<b>Medications</b>		<b>Allergies</b>		
<ul style="list-style-type: none"> <li>• chest trauma in 2008 from MVA</li> <li>• diaphragm repair</li> <li>• Occasional headaches</li> <li>• Drinker</li> </ul>			<ul style="list-style-type: none"> <li>• ASA 325 mg. PRN</li> <li>• Zantac 75 mg. PRN</li> </ul>		<ul style="list-style-type: none"> <li>• None</li> </ul>		
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	1,1,1	Absent	Absent	Absent	Pale, cool, diaph, cyanosed	None BS 6.8mmol	
After 5 <sup>th</sup> defibrillation	1,1,1	44	Absent	70/30	Pale, dry, cool	74%	
Post arrest initiated	1,1,1	52	Absent	85/45	Pale, dry, cool	82%	
After Fluid Bolus	1,1,1	58	Absent	95/55	Pale, cool, dry	88%	
All Others	1,1,1	64	Absent	95/55	Pale, warm, dry	94%	
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/ Pelvis</b>		<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils equal, unreactive, 8mm No JVD	= A/E clear to bases bilaterally	Soft, non-tender, no B/S		NAD	NAD	NAD
After fluid bolus	Pupils equal, sluggish, 6 mm	= A/E clear to bases bilaterally	Abdominal Distension developing. Increases with delays in advanced airway insertion. Interferes with ventilations		NAD	NAD	NAD
All others	Pupils equal, sluggish 4mm	= A/E clear to bases bilaterally	If advanced airway placed with OG tube, abd distension diminishes.				
<b>SPECIAL INFORMATION</b>							
This patient gets pulses back very early in the call. He requires delicate post arrest stabilization to increase his SaO <sub>2</sub> and Increase his blood pressure. A 250 ml fluid bolus and close monitoring of his SaO <sub>2</sub> is required.							

<b>Scenario: Post-Arrest Stabilization 1.3</b>		
<b>Problem: Post arrest stabilization – arrive after CCG AED resuscitation</b>		
<b>Patient:</b>	47 Year old male	
<b>Protocols &amp; Procedures</b>	<ul style="list-style-type: none"> <li>Post-Arrest Stabilization Protocol 1.3</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to defibrillate the cardiac arrest patient prior to intubation. Patient management including critical interventions, post-arrest stabilization and ongoing assessment must be maintained while organizing rapid patient extraction.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Following successful resuscitation, post arrest stabilization should be maintained while organizing rapid extraction.</li> <li>Chest auscultation should occur prior to fluid bolus or transport in aircraft.</li> <li>Ventilations should be managed according to patient's SaO<sub>2</sub>.</li> <li>Transport should not be delayed for fluid bolus.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y</b>	<b>N</b> <b>N/A</b>
• Did the SAR Tech perform appropriate critical interventions during the primary survey?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Were defibrillations performed prior to advanced airway insertion?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Were defibrillations delayed at any time for advanced airway insertion?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Was extraction initiated as soon as resuscitation was effected?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech use good time and resource management to ensure treatment and transport were balanced during extraction?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech recognize abdominal distension and place the OG tube in a timely manner?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR Tech recognize increasing SaO <sub>2</sub> and ventilate accordingly?	•	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
<b>COMPONENT</b>	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures.	Establishes that transport time and scene conditions are detrimental to patient outcome and elects to perform rapid extraction post-resuscitation.
<b>LOC</b>	1,1,1	• Compares with coast guard assessment
<b>M</b>	N/A	•
<b>D+A</b>	No concerns Opens with jaw maneuver	• Obtained from coast guard • Airway in place from coast guard
<b>R</b>	Absent	• CCG continues AR
<b>C</b>	72 – weak regular	• Came back after defibrillations
<b>H</b>	Assess	• Pt is cool
<b>RBS</b>	NAD, no medical alerts	• Cyanotic, belly distended
<b>DECISION</b>		
<b>Primary Survey</b>	Checks over patient to determine changes since CCG started CPR	• CPR by CCG correct, correct airway and good ventilations. Patient's belly is distended and ventilations are more difficult than when first started.
<b>Vital Signs</b>	Vitals on monitor and respirations absent. Patient blood pressure is normal. Patient does not regain consciousness. He remains in respiratory arrest.	• Patient remains in respiratory arrest, requiring advanced airway insertion.
<b>History</b>	Obtains critical history and pertinent information to cardiac arrest management. Gathers other relevant history post resuscitation.	• No contraindications to protocol found.
<b>Secondary</b>	Complete history and physical assessment performed enroute.	• History sufficient to identify patient with cardiac risk factors and history. • No abnormalities detected on physical exam.
<b>Protocol</b>	Cardiac Arrest Protocol: <ul style="list-style-type: none"> <li>performed by CCG</li> </ul> Post-Arrest Stabilization: <ul style="list-style-type: none"> <li>Insert advanced airway if not already performed.</li> <li>Maintains IV RL at 100 cc/hr.</li> <li>Orogastric tube placed after identifying abdominal distension.</li> </ul>	<ul style="list-style-type: none"> <li>Advanced airway insertion</li> <li>B/P is maintained &gt; 90 mmHg</li> <li>If orogastric tube not placed then lowered SaO<sub>2</sub> with increasing distension.</li> </ul>
<b>Procedures</b>	Performs continuous airway management and monitoring. Appropriate notification to receiving facility of all findings and interventions.	• SaO <sub>2</sub> increases until >92%. Ventilations should be managed appropriately.

<b>Scenario Post-Arrest Stabilization 1.3</b>							
<b>Problem: Post arrest stabilization – arrive after CCG AED resuscitation</b>							
<b>Mission (Read to Student)</b> 442 Cormorant is tasked to Quatsino Sound area for a 35 YOM suspected of drowning. The patient was found unconscious in the water and brought to shore by crew of an assisting vessel. Coast guard and boat crewmembers are on the scene. You are able to land on the beach close to the patient. You are 40 minutes from hospital.							
<b>On approach:</b> The coast guard are performing CPR and running the AED protocol. When you come up, they have finished their 3 sequences of shocks and are getting a pulse back again. They have an OPA in the patient and are ventilating at a rate of 16/min							
<b>Patient (Information given only if asked)</b> <ul style="list-style-type: none"> <li>Remains unconscious throughout mission.</li> <li>Information obtained from captain of assisting vessel and coast guard. (see History)</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b>	<i>Respiratory Arrest</i>						
<b>Hx C/C</b>	Patient was found in the water by the crew of a passing vessel. He initially looked like he was waving his hand, but when they arrived he looked unconscious. They brought him to the shore and initially he had a pulse. They called the coast guard. The water was warm – about 20 degrees. Unknown how long patient was in the water. He had a survival suit on. They removed his wet clothing and had him wrapped in a blanket. He lost pulses before the coast guard arrived and they started CPR.						
<b>Pertinent Functional Enquiry</b>	<b>General:</b>	The Coast Guard ran the AED protocol and got pulses back. The patient would lose pulses again after 10-15 minutes. Each time 3 defibrillations would bring back his pulses except for the second last time which took 2 sets of 3 shocks. This last time before you arrived it took 3 sets of 3 shocks to get pulses back.					
	<b>Skin:</b>	Is dry, cyanotic. His body core temperature is 35.5 degrees.					
<b>Non-Pertinent FE</b>	<b>General:</b>	Patient has been on the rocky beach for a while. The crew of the assisting boat had been out fishing when they saw him					
<b>Medical History</b>		<b>Medications</b>			<b>Allergies</b>		
• Unknown		• Unknown			• None		
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	1,1,1	88	Absent	80/30	Pale, cool, diaph, cyanosed	72%	
Post arrest initiated	1,1,1	88	Absent	90/30	Pale, dry, cool	74%	
After advanced airway insertion	1,1,1	88	Absent	95/45	Pale, dry, cool	82% Temp 35°C	
After Orogastric tube	1,1,1	78	Absent	100/55	Pale, warm, dry	94%	
All Others	1,1,1	72	Absent	105/55	Pale, warm, dry	94%	
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/ Pelvis</b>		<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils equal, unreactive, 8mm No JVD	= A/E clear to bases bilaterally	Soft, non-tender, no B/S – Abdomen distended		NAD	NAD	NAD
After advanced airway and orogastric tube	Pupils equal, sluggish, 6 mm	= A/E clear to bases bilaterally	Abdomen deflated, patient easier to ventilate.		NAD	NAD	NAD
	Pupils equal, sluggish 4mm	= A/E clear to bases bilaterally					
<b>SPECIAL INFORMATION</b>							
This patient gets pulses back as you arrive. He requires delicate post arrest stabilization to prevent re-arrest. Advanced airway insertion, orogastric tube to deflate his stomach will increase his SaO <sub>2</sub> and prevent him from re-arresting. Although his initial blood pressure is low, it comes up right away after intubation and does not require a fluid bolus. After being in arrest for so long, it takes a minute or so for the heart to recover and bring up his pressure.							

<b>Scenario:</b> <b>Stroke 1.6</b>		
<b>Problem:</b> <b>Cerebrovascular Accident</b>		
<b>Patient:</b>	46 Year old Female	
<b>Protocols &amp; Procedures:</b>	1.6 Stroke <ul style="list-style-type: none"> <li>8.4 Rapid Neurological Exam</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide between transporting pt to closer secondary hospital or further Hospital with a Stroke center. Patient must reach definitive Tmt within 3 hrs of onset.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must recognize criteria for Stroke and not delay transport.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y    N    N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the signs and symptoms of Stroke?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Was sufficient history and patient assessment performed to rule out diabetic emergency?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech avoid delay and elect to proceed to Stroke center and notify receiving hospital to activate Stroke team?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech accurately determine timeline to ensure definitive Tmt can be given within 3 hours of onset?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
<b>COMPONENT</b>	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures.	<ul style="list-style-type: none"> <li>Safe to carry out primary survey</li> </ul>
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Alert but confused</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li>N/A</li> </ul>
<b>D+A</b>	Determine if C-Spine is a concern Check airway	<ul style="list-style-type: none"> <li>No suspicion of C-spine injury</li> <li>Airway patent</li> </ul>
<b>R</b>	Assess breathing	<ul style="list-style-type: none"> <li>Short of breath but it is adequate</li> </ul>
<b>C</b>	Check circulation	<ul style="list-style-type: none"> <li>Bounding and slow</li> </ul>
<b>H</b>	Assess for Hyper/hypothermia	
<b>RBS</b>	Quick check for other injuries.	If pupils are checked right is 7mm and left is 4mm
<b>DECISION</b> – Recognizes signs of stroke. Employs FAST assessment to aid in quick diagnosis. Recognizes need to transport early.		
<b>Vital Signs</b>	Obtain initial set	Vital Signs suggestive of CVA
<b>Critical History</b>	Obtains critical history and pertinent information relevant to CVA. Gathers sufficient accurate history prior to physician contact.	<ul style="list-style-type: none"> <li>3/3 new symptoms found with FAST assessment; Facial droop, Arm drift, and slurred speech.</li> <li>R/O Diabetic emergency, Blood Glucose 4.4</li> </ul>
<b>Protocol</b>	Stroke 1.6 Neurological exam 8.4 (Must not delay tpt)	
<b>Procedures</b>	FAST approach, O2 to SaO2 ≥ 92%. Obtain BG, Rapid Tpt. Document initial GCS and neurological exam.	
<b>Secondary</b>	History and physical exam completed to rule out other treatable causes and to determine extent of injury on affected side.	<ul style="list-style-type: none"> <li>Mild paralysis left arm and leg. Ensure they are protected.</li> </ul>

**PATIENT INFORMATION SHEET**

<b>Scenario:</b> <b>Stroke 1.6 A</b>						
<b>Problem:</b> <b>Cerebrovascular Accident</b>						
<b>Mission (Read to Student)</b> 103 standby Cormorant tasked airborne while on a training flight to a campground in Square pond. Patient is a 46 YOF with altered LOC. You are able to land in a clearing and get picked up by truck and brought to patient who is at campsite. The AC tells you he has two hours of fuel available.						
Patient (Information given only if asked) Patient’s husband states his wife suddenly became confused about 20 minutes ago. They were sitting around the fire relaxing after having gone for a hike. Husband thinks it may be her diabetes acting up. Her diabetes is controlled with diet. Last meal was 3 hours ago.						
<b>HISTORY</b>						
<b>C/C</b>	<b>Decreased LOC secondary to Cardiovascular Accident</b>					
<b>Hx C/C</b>	Sitting around campfire with husband and suddenly became confused. <b>L</b> Headache and right side of body <b>O</b> 20 minutes before your arrival Started suddenly <b>T</b> No pain <b>A</b> Mild paralysis on right side, dizziness, confusion. <b>R</b> Nothing relieves it <b>P</b> Sitting around campfire.					
<b>Pertinent Functional Enquiry</b>	Diabetes type 2 which she controls with diet. TIA 2 yrs ago and was given meds.					
<b>Non-Pertinent FE</b>	Non smoker History of Cardiac disease in family					
<b>Medical History</b>						
<b>Medications</b>						
<b>Allergies</b>						
<ul style="list-style-type: none"> <li>• Diabetes x 10 years</li> <li>• TIA 2 yrs ago</li> </ul>	<ul style="list-style-type: none"> <li>• Lisinopril</li> <li>• ASA</li> </ul>					
• None						
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>
Initial	4, 4, 6	55	18	180/105	Cool and Clammy	95% BG 4.4
All others	Same	Same	Same	Same	Same	Temp 37.9°C
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/ Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils Right 7mm Left 4mm. Facial droop on Right side. Able to protect airway. Slurred speech.	Clear to bases, shallow breaths.	Soft, non-tender,	Mild paralysis to right leg	Mild paralysis right arm. Right arm drifts down during FAST approach	NAD
<b>SPECIAL INFORMATION</b>						
Timings – Onset 15 minutes prior to SAR Tech arrival. Transit to Stroke center 1 hr 20 minutes. Transit time to closest hospital without Stroke center is 5 minutes. <b>Have SAR Tech review the actual phone numbers, locations and names of Stroke Centers in AOR.</b>						



<b>Scenario:</b> 2.1 SOB with History of Asthma/COPD Mild/Moderate	
<b>Problem:</b> A 40-year-old fisherman SOB from Asthma – medications ran out.	
<b>Patient:</b>	40 year old male fisherman
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>2.1 SOB with history of asthma/COPD.</li> </ul>
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>To determine if the patient fits into the SOB with a history of Asthma protocol.</li> </ul>
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Evacuate the patient to the helicopter.</li> <li>Assess the degree of difficulty the patient is in.</li> <li>Select the appropriate treatment plan.</li> <li>Assess the effectiveness of the Ventolin treatment</li> <li>Select the appropriate treatment plan if the initial treatment is not successful.</li> </ul>
<b>COMMENTS &amp; RECOMMENDATIONS</b>	
	<b>Y N N/A</b>
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize indications for SOB protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech integrate transport between medication administrations so there was no undue delay in the transport of the patient?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize he had to treat with Salbutamol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize he had to repeat the Salbutamol treatment?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>	
	<b>PLAN</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques
	<ul style="list-style-type: none"> <li>Severe respiratory distress. Anxious</li> <li>Pale, diaphoretic skin</li> <li>Difficulty speaking</li> <li>Wheezing respirations</li> <li>Radial pulse felt.</li> </ul>
<b>LOC</b>	Determine LOC using AVPU
<b>M</b>	N/A
<b>D+A</b>	No C-spine – Airway clear
<b>R</b>	Assess Breathing Look, listen, feel
<b>C</b>	Check for pulses
<b>H</b>	Rules out Hypo/Hyperthermia
<b>RBS</b>	Quick check for any other injuries, hands on
	<ul style="list-style-type: none"> <li>Alert</li> <li>Wheezing on expiration easily audible.</li> <li>Rapid radial pulse</li> <li>Norm thermic</li> <li>Skin pale, dry</li> <li>SpO<sub>2</sub> 85%</li> </ul>
<b>DECISION</b> – Patient is moderately SOB from an Asthmatic attack and fits the protocol for Salbutamol. Can initiate transport and follow up with Salbutamol treatment.	
<b>Protocol</b>	Vitals – baseline – AE = with wheezes on expiration, Salbutamol 5 mg nebs q 20 min x 3 doses.
<b>Procedures</b>	Chest Auscultation
<b>Secondary</b>	Complete head to toe once treatment initiated
	<ul style="list-style-type: none"> <li>P 110, R 28, BP 130/60, moderately SOB</li> <li>On auscultation has equal breath sounds bilaterally with decreased AE to the bases.</li> <li>Wheezing is louder on expiration</li> </ul>

**PATIENT INFORMATION SHEET**

<b>Scenario:</b> 2.2 SOB with History of Asthma Mild/Moderate							
<b>Problem:</b> A 40-year-old fisherman SOB from Asthma – medications ran out.							
<b>Mission:</b> You are dispatched on a Cormorant helicopter to a fishing vessel 140 miles off the coast of Nova Scotia. The patient has working deck side cleaning fish in the cool wind. He started having an asthma attack. The captain has no means of treating the problem and has called you for help. The seas are calm for your hoist to the vessel.							
<b>On approach:</b> On approach to the patient, he is sitting in the wheelhouse trying to catch his breath. He has a Ventolin inhaler in his hand, which is empty. There is not much space to move around.							
<b>Patient (Information):</b> <ul style="list-style-type: none"> <li>Due to his SOB, he can only speak in short sentences.</li> </ul>							
<b>HISTORY</b>							
<b>Hx C/C</b>	Can't breathe Started getting SOB while out in the cold air. He tried his inhaler and it would ease his breathing but then it ran out. His condition deteriorated while the helicopter was en route. <b>L</b> <i>In his lungs – can't breathe</i> <b>O</b> <i>1 hour ago</i> <b>T</b> <i>Gradually getting worse – just can't seem to calm down.</i> <b>A</b> <i>Anything I do makes me weak, can't breathe</i> <b>A</b> <b>R</b> <i>Nothing</i> <b>P</b> <i>Working in the cold</i>						
<b>Pertinent Functional Enquiry</b>	He has had reactions before but usually three puffs of the inhaler will stop the reaction. Today ran out after one puff. Thought he had another inhaler with him but must have left it at home. Resp: Short of breath. Has an asthma attack once a month or so relieved with his inhaler. 1 year ago was in the hospital for a bad attack when his puffer ran out. They gave him lots of Ventolin about 4 nebulized doses before he started feeling better. Luckily he did not have to be intubated. He was in the hospital for 3 days then. CVS: rapid pulse Skin: Warm, flushed.						
<b>Non-Pertinent FE</b>	CNS: unremarkable CVS: normal BP Resp: asthma with last attack GI/GU: nothing Musculo/skeletal: never had a broken bone before Endocrine: unremarkable						
<b>Medical History</b>							
<b>Medications</b>							
<b>Allergies</b>							
<ul style="list-style-type: none"> <li>Asthma – brought on by cold</li> <li>Ventolin inhaler</li> <li>Beclovent BID</li> <li>NKAM</li> </ul>							
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	4,4,6	110 reg	28 – deep	140/60	Pale, dry	85%	
1 <sup>st</sup> Salbutamol	4,4,6	110 reg	26 – deep	130/60	Pale, dry	88%	
2 <sup>nd</sup> Salbutamol	4,4,6	120 reg	26– deep	120/60	Pale, dry	88%	
3 <sup>rd</sup> Salbutamol	4,5,6	120 reg	22 – deep	120/60	Pale, dry	96%	
<b>#</b>	<b>Head</b>	<b>Neck</b>	<b>Chest</b>	<b>Abd</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Face, neck swelling	NAD - wheezy	Tight, wheezy, hard to breathe	soft x 4	NAD	NAD	NAD
1 <sup>st</sup> Salbutamol	Diminished swelling		Wheezy, louder, easier to breathe	Nausea decreasing	NAD	NAD	NAD
2 <sup>nd</sup> Salbutamol	Face normal	Neck normal	Air entry easily heard, slight wheezing at end exhalation	Nausea eased	NAD	NAD	NAD
3 <sup>rd</sup> Salbutamol	NAD	NAD	= AE to bases with low expiratory wheezes	No nausea	NAD	NAD	NAD
<b>SPECIAL INFORMATION</b>							
Patient does not improve until after the 2 <sup>nd</sup> Salbutamol.							

<b>Scenario:</b> 2.1 SOB with History of Asthma/COPD	
<b>Problem:</b> A 68-year-old man SOB from COPD and pneumonia.	
<b>Patient:</b>	68 year old male
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>2.1 SOB with history of asthma/copd.</li> </ul>
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>To determine if the patient fits into the SOB with a history of Asthma/COPD protocol.</li> </ul>
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Evacuate the patient to the helicopter.</li> <li>Assess the degree of respiratory distress the patient is in.</li> <li>Determine the cause of the patient's SOB</li> <li>Assess the effectiveness of the Ventolin treatment</li> <li>Select the appropriate treatment plan if the initial treatment is not successful.</li> </ul>
<b>COMMENTS &amp; RECOMMENDATIONS</b>	
	<b>Y    N    N/A</b>
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize indications for SOB protocol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech integrate transport between medication administrations so there was no undue delay in the transport of the patient?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize he had to treat with Salbutamol?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech obtain orders from ship's doctor for repeat Salbutamol en-route?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>	
	<b>PLAN</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques
	<ul style="list-style-type: none"> <li>Severe respiratory distress.</li> <li>Cyanosis, diaphoretic skin</li> <li>Inability to speak</li> <li>Wheezing respirations</li> </ul>
<b>LOC</b>	Determine LOC using AVPU
<b>M</b>	N/A
<b>D+A</b>	Determine if C-spine a concern Check airway
	<ul style="list-style-type: none"> <li>None</li> <li>No obstructions</li> </ul>
<b>R</b>	Assess Breathing
	<ul style="list-style-type: none"> <li>Wheezing easily audible.</li> </ul>
<b>C</b>	Check for pulses
	<ul style="list-style-type: none"> <li>Rapid radial</li> </ul>
<b>H</b>	
	<ul style="list-style-type: none"> <li>SpO<sub>2</sub> 90</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on
	<ul style="list-style-type: none"> <li>Skin cyanotic, diaphoretic.</li> <li>SaO<sub>2</sub> 85%</li> </ul>
<b>DECISION</b> – Patient is SOB from pneumonia aggravating his COPD. He fits the protocol for Severe SOB. SAR can initiate transport and follow up with a Ventolin treatment.	
<b>Protocol</b>	Vitals – baseline – AE = with wheezes on expiration, 100% O <sub>2</sub> BVM, Ventolin. Repeat Ventolin required with Ipratropium and Epi.
	<ul style="list-style-type: none"> <li>P 120, R 28, BP 140/60,</li> <li>Acutely SOB</li> </ul>
<b>Procedures</b>	Chest Auscultation
	<ul style="list-style-type: none"> <li>On auscultation has equal breath sounds bilaterally with decreased AE to the bases.</li> <li>Wheezing is louder on expiration throughout the chest. Crackles heard in right middle lobe.</li> </ul>
<b>Secondary</b>	Complete head to toe once treatment initiated

**PATIENT INFORMATION SHEET**

<b>Scenario: 2.1 SOB with History of Asthma/COPD</b>							
<b>Problem: A 68-year-old man SOB from COPD and pneumonia.</b>							
<b>Mission:</b> You are dispatched on a Cormorant helicopter to a cruise ship off the coast of Labrador.							
<b>On approach:</b> On board the cruise ship the doctor says he has a pneumonia patient who he needs hospitalization. He has been giving him Ventolin q4h to ease his breathing. If asked, he gives orders for repeat Ventolin if needed. You hoist the patient into the helicopter and start your 45 minute return flight. 10 minutes into the flight, patient is becoming more SOB.							
<b>Patient (Information):</b>							
<ul style="list-style-type: none"> <li>• Patient is in severe distress and cannot speak.</li> </ul>							
<b>HISTORY</b>							
<b>Hx C/C</b>		Can't breathe 10 minutes into the flight, the patient gets SOB. <b>L</b> <i>In his lungs – can't breathe</i> <b>O</b> <i>all week he has been SOB. Getting worse</i> <b>T</b> <i>Gradually getting worse – has coughing spells.</i> <b>A</b> <i>coughing spells leaves him SOB - brings up greenish sputum</i> <b>A</b> <b>R</b> <i>Ventolin helps but not as much as it usually does</i> <b>P</b> <i>I have a bad cold.</i>					
<b>Pertinent and Functional Enquiry</b>		He has had this cold for the past month. Last week he started coughing up green phlegm having a temperature, cold sweats. The ship doctor tried some antibiotics but they haven't helped. Just seem to be getting worse. Resp: Short of breath. Uses his inhaler every day and today the doctor has given him nebulized Ventolin. 1 year ago was in the hospital for the flu. Was intubated and in ICU for over a week. They had trouble getting him off the Ventilator. CVS: rapid pulse Skin: hot, flushed.					
<b>Non-Pertinent FE</b>		CNS: unremarkable CVS: normal BP Resp: asthma with last attack GI/GU: nothing Musculo/skeletal: never had a broken bone before Endocrine: unremarkable					
<b>Medical History</b>			<b>Medications</b>			<b>Allergies</b>	
<ul style="list-style-type: none"> <li>• Emphysema</li> <li>• Flu</li> </ul>			<ul style="list-style-type: none"> <li>• Ventolin inhaler</li> <li>• Beclovent BID</li> <li>• Clindamycin</li> </ul>			<ul style="list-style-type: none"> <li>• KNAM</li> </ul>	
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	4,4,6	110 reg	28 – deep	140/60	Cyanotic, Diaphoretic	85%	
1 <sup>st</sup> Ventolin	4,4,6	110 reg	28 – deep	135/60	Pale, diaphoretic	88%	
2 <sup>nd</sup> Ventolin /Ipratropium	4,4,6	120 reg	26 – deep	120/60	Pale, dry	88%	
3 <sup>rd</sup> Ventolin /Ipratropium	4,5,6	120 reg	28 – deep	120/60	Pale, dry	90%	
Epinephrine 0.3 IM	4,5,6	125 reg	24 – deep	130/70	Pale, dry	93%	
<b>#</b>	<b>Head</b>	<b>Neck</b>	<b>Chest</b>	<b>Abd</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Face, neck swelling	NAD - wheezy	Tight, wheezy, hard to breathe	soft x 4	NAD	NAD	NAD
Salbutamol	Diminished swelling		Wheezy, louder.	Nausea decreasing	NAD	NAD	NAD
Ipratropium	Face normal	Neck normal	Air entry easily heard, slight wheezing at end exhalation	Nausea eased	NAD	NAD	NAD
Epinephrine	NAD	NAD	= AE to bases with low expiratory wheezes	No nausea	NAD	NAD	NAD
<b>SPECIAL INFORMATION</b>							
Patient does not improve with salbutamol, requires Ipratropium and epinephrine.							

<b>Scenario:</b> SAR Sim – 2.2 Tension/Symptomatic Pneumothorax		
<b>Problem:</b> Hunter SOB. Found mid-way up Mount Benson, Elevation 1,000m. Patient presentation SOB right mid lateral chest pain, bruise, resp distress.		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>Male 40 years.</li> </ul>	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>Tension/Symptomatic Pneumothorax.</li> <li>O2 Pulse Oximeter possible. Needle Thoracotomy</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Treat as tension pneumothorax.</li> <li>Do not treat, transport only.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Know the indications of pneumothorax</li> <li>Know the difference between a pneumothorax and a Tension pneumothorax</li> <li>Recognize the progression of symptoms that would indicate deterioration.</li> <li>Know which side the pneumothorax is on.</li> <li>Know how to assess the trachea for deviation.</li> <li>Know the landmarks for insertion of a needle for decompression.</li> <li>Display ability to assemble all equipment for needle decompression.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
• Did the SAR Tech perform appropriate interventions during Primary Survey?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech recognize patient as having a tension pneumothorax?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech perform a chest decompression procedure?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech use BVM as early intervention?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech contact the EP for further orders/status?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	<ul style="list-style-type: none"> <li>Hillside, safe landing site</li> <li>Establish contact with patient</li> </ul>
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Alert, oriented, anxious</li> <li>Try to calm patient</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>No trauma, no pain</li> <li>Airway clear, O<sub>2</sub> sat 85%</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Increased resps, obvious resp distress</li> <li>Position patient to ease breathing</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Rapid regular radial</li> </ul>
<b>H</b>	Assess for hypothermia	<ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on Alert, oriented, anxious. Obvious resp distress. Pain right chest, patient winces on palpation of chest wall. Deep inspiration makes pain worse.	<ul style="list-style-type: none"> <li>Right mid lateral chest pain/bruising</li> <li>High Flow O<sub>2</sub></li> </ul>
<b>DECISION – Unstable, transport per SAR SVAC Procedures</b>		
<b>Vital Signs</b>	RR 28; P 120; BP 90/60;GCS 15/15; SP0 <sub>2</sub> 85	Patient's respiratory distress is increasing
<b>Critical History</b>	Slipped and fell landing on rifle striking right chest wall increasing SOB. Since accident, no present trauma history.	Unequal breath sounds – decreased air entry on right chest.
<b>DECISION –</b>		
<b>Protocol</b>	2.2 Tension / symptomatic pneumothorax	O <sub>2</sub> , pulse Oximeter
<b>Procedures</b>	Vitals q5, O <sub>2</sub> , pulse, Ox, needle thoracotomy	Needle decompression before transport in helicopter
<b>Secondary</b>	Monitor en route, contact EP	Contact EP

**PATIENT INFORMATION SHEET**

<b>Scenario:</b> SAR Sim – 2.4 Tension/Symptomatic Pneumothorax							
<b>Problem:</b> Hunter SOB							
<b>Mission: (Read to Student)</b> C130 dispatched to a hunter short of breath. Apparently the hunter has had a fall and injured his chest. The location is 50 miles north of Red Lake on Mount Benson, 1,000m elevation. The hunters are in a cabin. Cormorant will extract in 40 minutes.							
<b>On approach:</b> You see a patient sitting in chair splinting right chest wall with arm leaning to the right. Speaking in 2 – 3 word sentences. <b>Obtained from patient only if asked:</b> I was out hunting and I slipped and fell on my rifle. I felt pain right away. The pain is right near my right nipple. Initially it hurt a lot and then it hurt even more when I took a breath. It was hard to get my breath because of the pain. My breathing got worse so we radioed for help. My breathing is getting worse all the time. It feels like it is hard to get enough air.							
<b>HISTORY - Hard to breathe</b>							
<b>C/C</b>	Fell on rifle causing pain in right chest with increasing shortness of breath.						
<b>Hx C/C</b>	I fell on my rifle while we were out hunting. I felt pain immediately on the right front of my chest. Initially it hurt where I landed on my rifle, then it began to hurt more when I took a breath. The shortness of breath is much worse than it was at first.						
<b>Pain</b>	<b>L</b> right chest <b>O</b> an hour ago <b>T</b> "10/10" <b>A</b> breathing, palpation. <b>R</b> nothing so far <b>P</b>						
<b>Pertinent Functional Enquiry</b>	<ul style="list-style-type: none"> <li>• Pain at site of injury</li> <li>• Pain on breathing</li> <li>• Pain with palpation</li> <li>• Decreased breath sounds throughout the right chest.</li> <li>• Has never had any trouble with his breathing in the past</li> <li>• Has been a smoker for twenty years, one pack a day</li> </ul>						
<b>Non-Pertinent FE</b>	General: Good general health GU/GE: Periodic heart burn Periodic constipation						
<b>Medical History</b>							
<b>Medications</b>							
<b>Allergies</b>							
• Good General Health	• NKM						
• NKAM							
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	15 GCS	120 Reg	28 Shallow	90/60	Cyanotic, cool, dry	85%	
patient deteriorates	15 GCS	130 Reg	36 Shallow	80/60	Cyanotic, cool, dry	84%	
After 1 <sup>st</sup> decompression	15 GCS	120 Reg	28 Shallow	90/60	Cyanotic, cool, dry	85%	
After 2 <sup>nd</sup> decompression	15 GCS	90 Reg	24 Easy	110/60	Pink, cool, dry	93%	
<b>#</b>	<b>Head</b>	<b>Neck</b>	<b>Chest</b>	<b>ABD</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Facial engorgement	JVD, Slight tracheal shift to right	Pain right nipple area, discoloration Decreased AE to right chest. Difficult to breathe	Soft, non tender	Normal	Normal	Normal
patient deteriorates	No change	JVD Increase Tracheal shift	Pain right nipple area, discoloration. <b>No air entry to right lung</b> Difficult to breathe	Same	Same	Same	Same
After 1 <sup>st</sup> decompression	Decreased engorgement	JVD – slightly diminished, tracheal shift	Minimal air entry to right lung at base. No air mid and upper lung. Difficult to breathe.	Same	Same	Same	Same
2 <sup>nd</sup> decompression	Normal	No JVD	Air entry equal bilaterally and through to the bases	Same	Same	Same	Same
<b>SPECIAL INFORMATION</b>							
Recognize the patient is deteriorating and meets the indications for the tension pneumothorax protocol. Requires 2 <sup>nd</sup> decompression. Insert 2 <sup>nd</sup> needle laterally. If nothing is done patient deteriorates into respiratory and then cardiac arrest. If they use a BVM, it is very difficult to							

<b>Scenario:</b> Anaphylaxis – 2.3		
<b>Problem:</b> Hiker on the West Coast trail with anaphylaxis		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>23 year old male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>2.3 Anaphylaxis</li> <li>Rule out Hypoglycemia (4.2), and Altered LOC-NYD (4.1)</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Identify a patient presenting with S/S of Anaphylaxis secondary to bee sting and decide whether to initiate treatment on scene or transport and initiate enroute.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Identify management plan based on critical history and presentation of patient</li> <li>Differentiate allergic reaction versus anaphylaxis based on presentation</li> <li>Initiate treatment on scene while preparing logistics of transport</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Primary and provide the necessary interventions?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the limitations for transport and initiate treatment while transport was being arranged?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech administer the correct drugs and dosages by the correct routes?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech check blood sugar to rule out diabetic cause for collapse?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedure.	Identifies environmental concerns and elects to initiate treatment on-scene, then extract casualty.
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Responds to pain only. Recognize decreased LOC &amp; monitor</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>MOI does not suggest spinal trauma</li> <li>Stridor. Maintain airway, measure and insert OPA (patient will not tolerate).</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Shallow, rapid.</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Weak, carotid (absent radials)</li> </ul>
<b>H</b>	Assess	<ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>A/E = bilaterally, faint wheeze throughout</li> <li>Two stinger sites Lt. occipital</li> <li>Identified Medic Alert – Diabetic, Bee Sting Anaphylaxis</li> <li>Cold applied to sting sites if available.</li> <li>Urticaria face and neck, swelling around eyes</li> <li>Skin cool, moist.</li> </ul>
<b>DECISION –</b>		
<b>Primary</b>	Interventions to correct life threats found during assessment.	Attempts OPA. Provides oxygen. Cold applied to sting sites if possible. Position patient ¾ prone to maintain airway.
<b>Vital Signs</b>	Obtain manual vital signs and confirm with VSM and pulse oximeter.	Obtain vital signs q. 5 minutes (unstable). Document/record data collected.
<b>Critical History</b>	Obtain critical history and physical evidence.	Meets indications for Anaphylaxis protocol
<b>Protocol</b>	Anaphylaxis Protocol initiated on scene. Epinephrine 0.3 mg SC, Benadryl 50 mg IM, IV RL 100 ml/hr	Patient will respond to initial treatment (Epinephrine 0.3 mg SC, Benadryl 50 mg IM) Maintain IV NS 100ml/hr
<b>Procedures</b>	High flow O <sub>2</sub> , SC injection, IM injection, IV	Patient improves with treatment
<b>Secondary</b>	Perform further physical assessment and continue history en-route.	Critical assessments done and treatment started while preparations for transport underway.

PATIENT INFORMATION SHEET

<b>Scenario:</b> <b>Anaphylaxis – 2.3</b>						
<b>Problem:</b> <b>Hiker on the West Coast trail with anaphylaxis</b>						
<b>Mission:</b> You are participating in a helicopter training exercise when a call is received tasking you to respond to the West Coast Trail for a collapsed hiker. Time of event 1300H. No hazards are present. Outside temperature is 24 C. Once on scene you hike in approximately 0.5 km. Patient is lying supine under a makeshift tent. Companion tells you he was hiking and stung by several bees. He complained of difficulty swallowing, swelling tongue, SOB, nausea, dizziness and then collapsed. You can be extracted by hoist. Your flight time to hospital is 30 min.						
<b>On approach:</b>						
<b>Patient (Information given only if asked):</b> <ul style="list-style-type: none"> <li>• Patient is unable to verbalize coherent sentences.</li> <li>• Past Medical: Medic Alert (Allergy to Bee stings, Diabetic).</li> <li>• Medications: Epi-pen in the patient’s backpack (sealed, unused).</li> <li>• Other allergies unknown</li> <li>• Controls Diabetes with diet only</li> </ul> Patient will provide history following treatment.						
<b>Medical history:</b> <ul style="list-style-type: none"> <li>• Anaphylactic to bee stings. Healthy otherwise</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	<b>Bee Stings to left occipital Region</b>					
<b>Hx C/C</b>	<b>L</b> <i>Lt. Occipital area</i> <b>O</b> <i>sudden onset</i> <b>T</b> <i>burning, hot sensation</i> <b>A</b> <i>nausea, dizziness</i> <b>A</b> <i>none</i> <b>R</b> <i>laying supine, cold</i> <b>P</b> <i>Stung by bees while hiking Hx. reaction in past</i>					
<b>Pertinent Functional Enquiry</b>	<b>General:</b> Good health <b>CVS:</b> Palpitations after Epi <b>Resp:</b> SOB <b>GI/GU:</b> Nausea					
<b>No n-Pertinent FE</b>	<b>CNS:</b> Headache after Epi					
<b>Medical History</b>						
Anaphylactic to bee stings.						
Healthy otherwise						
<b>Allergies</b>						
Bee Stings (venom)						
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox/Findings</b>
Initial	1,2,4	108 weak, reg. carotid	28, shallow	75/40	Flushed raised rash in face. Pale, moist, cool	88% Blood sugar: 5.5
1st Epinephrine 0.3 mg IM	2,2,4	120 weak, reg. radial	22 shallow	85/60	Flushed raised rash, Pale, cool, moist	90% BG unchanged
2 <sup>nd</sup> Epi	3,3,5	120 weak, reg radial	20 shallow	100/72	Pale, cool	92% BG unchanged
IV RL 1L bolus	4,5,6	110, stronger reg.	18 easier	110/80	Pale, drying up, warm	96% BG unchanged
Diphenhydramine IV/IM	4,5,6	110, strong, reg.	18 easy	120/80	Pale, dry, warm	97% BG unchanged
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils equal (4mm). Edema around eyes. Sting sites occipital, tongue swollen. Urticaria	= AE, clear to bases faint wheeze throughout	Soft, c/o nausea, slight distension noted	Normal appearance	Normal appearance	Nothing noted
Subsequent: After Epinephrine	Unchanged. Tongue less swollen Unchanged	No wheeze	Unchanged	Distal pulses easily felt	Equal grips	No pain
Subsequent: All others	Reduction in edema Tongue Normal	Reduction in rash	Unchanged	Unchanged	Unchanged	Unchanged
<b>SPECIAL INFORMATION</b>						
Ensure each dose of Epi is drawn up in individual syringes. This avoids overdosing while pushing syringe.						



<b>Scenario: TRAUMA 3.1 C</b>		
<b>Problem: Pelvic &amp; Femur Fracture, Hemorrhagic Shock, C Spine</b>		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>38 year old male pilot</li> </ul>	
<b>Protocols &amp; Procedures:</b>	3.1 Hemorrhagic Shock <ul style="list-style-type: none"> <li>7.3 Spinal Injury Management</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to complete a full assessment at the scene and initiate protocol prior to extraction or provide only critical interventions and rapid extraction with further procedures aboard helicopter.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Rapid extraction is preferred as Helicopter is on scene and readily available.</li> <li>Early administration of O<sub>2</sub>.</li> <li>Consideration should be given to early auscultation of the chest at the scene following the RBS as this is impossible once aboard the helicopter.</li> <li>Pulse oximetry should be interpreted with consideration given to poor peripheral circulation and reduced hematocrit due to hypovolemia.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
Does the SAR Tech recognize the patient as unstable?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Despite the absence of neck and back pain, did the SAR Tech immediately institute spinal precautions?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech rapidly immobilize the leg fracture (ie blanket splint) to facilitate rapid transport?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech apply Protocol 3.1 Hemorrhagic Shock once en route?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Establishes environmental concerns to casualty outcome and elects to perform rapid extraction
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Alert &amp; orientated</li> </ul>
<b>M</b>	Heck for active bleeding	<ul style="list-style-type: none"> <li>No signs of external active bleed</li> </ul>
<b>D+A</b>	Determine if C-spine a concern Check airway	<ul style="list-style-type: none"> <li>MOI suggests high index of suspicion for spinal trauma. Airway clear.</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing is rapid but appears adequate in depth. Provide 100% O<sub>2</sub>.</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Weak, radial pulse</li> </ul>
<b>H</b>	Rule out Hypo/Hyperthermia	<ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Unstable pelvis with pain on Lt iliac crest compression</li> <li>Swelling, deformity to Lt thigh with absent pedal pulse in Lt foot.</li> </ul>
<b>DECISION – Unstable, initiate minimum stabilization and transport</b>		
<b>Primary</b>	Interventions to correct only critical life threats found during assessment. Immobilization of c-spine. Pelvic & leg #'s stabilized and packaged for rapid transport	Rapid extraction of casualty by hoist to helicopter. Stabilizes pelvis and attempts to place Lt leg in anatomical position with successful return of weak pedal pulse in Lt foot.
<b>Vital Signs</b>	Obtain vital signs manually at scene Obtain via VSM & pulse oximeter aboard helicopter.	Vital signs suggestive of hypovolemia IV and fluid challenge en route
<b>Critical History</b>	Obtain critical history and pertinent information during mission	No contraindications to protocol found
<b>Protocol</b>	Hypovolemic protocol, fluid bolus.	BP improves after fluid bolus. Maintain IV at 100ml/hr after BP improves
<b>Procedures</b>	Initiate early spinal motion restriction procedures. Appropriately notify receiving facility of findings & interventions	Casualty stable en route Receiving facility prepared for patient arrival
<b>Secondary</b>	Perform further physical assessments & continue history en route	Documentation of treatment and findings

**PATIENT INFORMATION SHEET**

<b>Scenario: TRAUMA 3.1 C</b>						
<b>Problem: Pelvic &amp; Femur Fracture, Hemorrhagic Shock, C Spine</b>						
<b>Mission:</b> CH149 crew returning from air show demonstration tasked by RCC to return to location in response to an airplane crash in the Abbotsford area. The aircraft is a Snowbird with 2 persons on board. Both ejected from the jet prior to the crash, and landed in an open field near the airport. The 38-year-old pilot ejected late, his chute failed to deploy fully, and he landed hard in the field. The other crewmember is present and uninjured. It is 1400 hr. on a clear, hot, dry summer day.  Your helicopter is able to land near the patient. The Snowbird is burning 2 km. away with fire crews in attendance. The nearest trauma hospital is 10 minutes away by air.						
<b>On approach:</b> You find a pilot screaming in pain holding his pelvis/left leg 6" shorter rotated inward. No bleeding visible.						
<b>Patient (Information given only if asked):</b> Remains conscious throughout mission <ul style="list-style-type: none"> <li>• Casualty has difficulty remembering events just prior to accident</li> <li>• Moans with pain if injuries manipulated</li> <li>• Denies diabetes, hypertension, cardiac, lung, liver renal, seizure disorders.</li> <li>• Denies current use of medications</li> <li>• Indicates allergies to penicillin &amp; clindamycin</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	Femur fracture, pelvic fracture					
<b>Hx C/C</b>	Pilot ejected from plane, chute failed, striking ground.					
<b>Pain</b>	<b>Pelvic</b>			<b>Femur</b>		
	L left hip			L Lt thigh		
	O after crash			O felt snap in leg on impact		
	T sharp, aching, 5/10			T sharp, grinding 8/10		
	A feeling of split in two			A numbness in Lt foot		
	A movement			A movement		
	R nothing relieves pain			R keeping leg still		
	P hard chute assisted landing			P hard chute assisted landing		
<b>Pertinent Functional Enquiry</b>	<b>General:</b> general health recently <b>CNS:</b> Pain pelvis left leg nausea <b>CVS:</b> CP, palpitations <b>Resp:</b> Feels S.O.B. <b>GI/GU:</b> nausea, last meal, lunch 1200 hrs					
<b>Non-Pertinent FE</b>	<b>Musculo-Skeletal:</b> Pelvic pain, left leg pain <b>General:</b> Good general health <b>Skin:</b> Excellent <b>CNS:</b> Normal without deficits <b>CVS:</b> Without heart disease <b>Resp:</b> Without lung disease <b>GI/GU:</b> Stomach of cast iron <b>Endocrine:</b> Without diabetic history					
<b>Medical History</b>		<b>Medications</b>		<b>Allergies</b>		
• Healthy		• None		• Penicillin, Clindamycin		
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>
Initial set	4, 5, 6	112 reg.	24 adequate	85/60	Pale, cool, dry	unobtainable
After fluid bolus	4, 5, 6	100 reg.	20 easy	95/55	Pink, warm, dry	98%
All others	4, 5, 6	96 reg.	20 easy	100/55	Pink, warm, dry	99%
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils equal bilat. Sluggish. No pain in neck	=AE, clear to bases	Pain Lt side pelvis with compression	Swelling/deformity Lt thigh Pulseless foot	= grips = movement	No pain
All others	Pupils equal bilat, brisk No pain in neck	No change	No change	No change	No change	No pain
<b>SPECIAL INFORMATION</b>						
May consider analgesia but due to significant risk of hypotension should use extreme caution. NO NSAIDS.						

<b>Scenario:</b> SAR SIM 3.1 D – Hemorrhagic Shock 3.1 / TXA 3.2		
<b>Problem:</b> Tug Boat worker with partially amputated lower Left leg		
<b>Patient:</b>	30 year old male	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>3.1 Hemorrhagic Shock</li> </ul>	
<b>Dilemma:</b>	Once on board SAR Tech advised that helicopter would not be on scene for over an hour as it is being tasked on a separate mission. Boat trip back to shore 3 hours.	
<b>Key Points:</b>	<ol style="list-style-type: none"> <li>Stop the Arterial Bleed</li> <li>Fluid replacement to treat hypotension</li> <li>TXA indicated</li> <li>O<sub>2</sub></li> </ol>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
• Did the SAR Tech perform the appropriate primary survey and provide the necessary intervention?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech gather sufficient history to determine that the injury was an accident?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR obtain medical information from the crew medical records?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech treat the hypovolemia with the appropriate protocol treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech slow IV once BP at 90, palpable radial or improved mental status?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
• Did the SAR Tech provide on-going patient care?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>PRIMARY</b>		
	<b>Plan</b>	<b>Outcome</b>
<b>LOC</b>	Determine using AVPU	Responds to pain - GCS 2,3,4
<b>M</b>	Check wound for active bleeding	Arterial bleed will not stop requires TK,
<b>D+A</b>	Rule out D spine, airway clear	
<b>R</b>	Open airway. Look, listen, feel	Increased rate of respirations
<b>C</b>	Assess pulses radial and carotid	Fast Strong carotid, no radial pulse
<b>H</b>	Assess for hypothermia	Patient is cold
<b>RBS</b>	If dressing not checked until now, arterial bleed found.	Requires TK, check perfusion in distal limb.
<b>DECISION</b> – Patient unstable. Intervention to stop the one arterial bleed and remove patient off cold deck before continuing with case. Over an hour on scene before extraction.		
<b>Vital Signs</b>	Obtain manual vital signs	<ul style="list-style-type: none"> <li>Document and record data collected</li> </ul>
<b>Critical History</b>	Obtain history and physical evidence, complete Head to Toe	
<b>DECISION – Treat using hemorrhagic Shock and TXA protocol</b>		
<b>Protocol</b>	Hemorrhagic shock	Fluid Bolus for patient may be started once initial vital signs done and primary survey interventions are complete. Fluid treatment incorporated with rest of call management.
<b>Procedures</b>	O <sub>2</sub> – IV – fluid bolus titrated to patient’s blood pressure. Dressing and splinting of leg	Stop bleeding and splint leg. Check perfusion in distal limb.
<b>Secondary</b>	Perform further physical assessment and continue history	

**PATIENT INFORMATION SHEET**

<b>Scenario: SAR SIM 3.1 D – Hemorrhagic Shock 3.1 / TXA 3.2</b>						
<b>Problem: Tug boat worker with amputated lower left leg</b>						
<b>Mission:</b> RCC tasks your Buffalo to assist a 30 year old tugboat worker. The patient is located 100 miles off the coast of BC on a 50’ tug. He was working on the log boom when a cable got wrapped around his leg as the boom was floating away from the tug. The cable cut 2/3 through his left lower leg before the captain could back the tug releasing cable tension allowing the worker to remove the cable. He was able to climb onto the tug deck. The ship’s captain tells you that the patient is lying on the deck. The flow of blood is almost stopped. The patient is semi-conscious and in a lot of pain. 15 minutes prior to parachuting into the water RCC advises that it will be 1 hour before pickup by helicopter.						
<b>On approach:</b> You find a male patient lying supine on the deck of the vessel. The leg is at right angles with a blood soaked towel wrapped tightly around it. It is 22 <sup>o</sup> warm and sunny with no wind.						
<b>Patient (Information given only if asked):</b> Patient was working on the boom and got his leg caught in the cable as the boom was floating away from the boat. The cable cut 2/3 through his left lower leg before the captain could back the tug releasing cable tension allowing the worker to remove the cable. He was able to climb onto the tug deck.						
<b>HISTORY</b>						
<b>C/C Leg</b>	Patient was working on the boom and got his leg caught in the cable as the boom was floating away from the boat. He was initially in a lot of pain, but has since decreased in LOC and only responds to pain when limb is moved.					
<b>Hx C/C</b>	<b>L</b> Lower left leg <b>O</b> 2 hours ago <b>T</b> Sharp intense pain 9/10 when moving limb <b>A</b> Aggravated by any movement <b>A</b> <b>R</b> Pain radiates up to knee <b>P</b> Up and down left leg					
<b>Pertinent Functional Enquiry</b>	<ul style="list-style-type: none"> <li>Medical info available from captain crew records</li> <li>Initially lots of bleeding and arterial bleed when wound checked</li> <li>Was not dizzy, had no chest pain, no lightheadedness prior to incident</li> </ul>					
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>No stress related problems</li> <li>A fit 30 year old family man, no med problems</li> <li>Father of 1</li> <li>Non smoker</li> </ul>					
<b>Medical History</b>			<b>Medications</b>		<b>Allergies</b>	
<ul style="list-style-type: none"> <li>Except for the occasional cold the last time patient was hospitalized was 15 years ago to remove his appendix</li> </ul>			<ul style="list-style-type: none"> <li>None</li> </ul>		<ul style="list-style-type: none"> <li>None</li> </ul>	
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>
Initial	2, 3, 4	120	24	70/52	Cold, clammy skin	92
After 1 <sup>st</sup> 500 ml	2, 3, 4	110	20	85/60	Cold, clammy skin	92
After 2 <sup>nd</sup> 500 ml	2, 4, 4	100 weak radial	18	90/60	Cold, clammy skin	92
TXA	3, 4, 5	100	18	95/70		92
<b>#</b>	<b>Head/ Neck</b>	<b>Chest</b>	<b>ABD/ Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pale, diaphoretic	AE = Clean to base	Soft no masses	Left leg cut 2/3 through just below left knee	No radial pulse	NAD
After 1 <sup>st</sup> 500 bolus	Pale				No radial pulse	NAD
After 2 <sup>nd</sup> 500 bolus	Pale				Weak radial	NAD
<b>SPECIAL INFORMATION</b>						
Urinary catheterization may be considered for long transport.						

<b>Scenario:</b> TRAUMA 3.3 A Burns		
<b>Problem:</b> Campground accident with burns		
<b>Patient:</b>	22 year old female	
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>3.2 Burns</li> <li>R/O SOB protocol</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to complete a full assessment at the scene and initiate protocol prior to extraction or provide only critical interventions and rapid extraction with further procedures aboard helicopter</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>The casualty has severe burns to lower limbs and smoke inhalation concerns.</li> <li>Early O<sub>2</sub> administration with assisted ventilation is required.</li> <li>Early cooling of burns with appropriate solutions should be performed with careful attention to removal of clothing as it may be adhering to skin.</li> <li>Initiate IV en route and follow protocol for fluid administration with consideration to USAISR Rule of Tens</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
Did the SAR Tech perform an appropriate primary and intervene for all life threats immediately?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech recognize the need for rapid extraction and facilitate this efficiently?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech initiate the appropriate protocol for this call (3.3 Burns)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech monitor vitals with VSM & pulse oximeter throughout this mission?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech calculate correct BSA 36%?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Did the SAR Tech do anything for pain relief?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Alert and orientated</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	Determine if C-spine a concern  Check airway	<ul style="list-style-type: none"> <li>No indications to suspect spinal injury.</li> <li>Able to protect own airway, hoarseness evident.</li> <li>Recognize potential for developing airway compromise.</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing is rapid and appears adequate in depth but labored.</li> <li>Administer 100% O<sub>2</sub>. Non-rebreather.</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Radials equal bilaterally = Pedals.</li> <li>Check distal to burns Pedals.</li> </ul>
<b>H</b>	Assess for hypothermia	<ul style="list-style-type: none"> <li>Pt is feeling chilled</li> </ul>
<b>RBS</b>	2 <sup>nd</sup> / 3 <sup>rd</sup> degree burns to both legs anterior and posterior up to proximal thighs.	<ul style="list-style-type: none"> <li>Applies cling wrap as appropriate.</li> <li>Considers early auscultation to determine if edema is present and to determine A/E prior to restrictive conditions in helicopter.</li> </ul>
<b>DECISION –</b>		
<b>Primary</b>	Casualty has difficulty breathing with hoarseness and cough. Remove any clothing and initiate cooling to BSA	<ul style="list-style-type: none"> <li>Breathing is from pain, not from inhalation injury.</li> </ul>
<b>Vital Signs</b>	Obtain via VSM and pulse oximeter aboard helicopter. If delay in equipment arrival, obtain manually at scene	<ul style="list-style-type: none"> <li>Vital signs stable. Q-5 vitals</li> </ul>
<b>Critical History</b>	Obtain critical history and pertinent information during mission	<ul style="list-style-type: none"> <li>No contraindications to protocol found.</li> </ul>
<b>DECISION –</b>		
<b>Secondary</b>	Perform further physical assessment and continue history en route	Initiate 3.3 Burn Protocol
<b>Protocol</b>	Establish and maintain IV rate as per USAIR rule of tens. Patient weighs 50 kg.	40% x 10 = 400cc (1 drop/second)
<b>Procedures</b>	Dress with plastic wrap. Appropriately notify receiving facility of findings and interventions.	Casualty begins to shiver after 10 minutes cooling. Stop cooling.
<b>Protocol</b>	Control pain with two doses of MS	Pain from 10/10 to 5/10 to 2/10. Must have vitals between medication administrations.

**PATIENT INFORMATION SHEET**

<b>Scenario:</b> TRAUMA 3.3 A Burns							
<b>Problem:</b> Campground accident with burns							
<b>Mission:</b> You are tasked to respond to a lakeside campground only accessible by air. Helicopter can land on the shore by the tent site. A 22-year-old female has been injured at the campground site. Information provided to RCC via radiotelephone from the campsite indicates that the woman is conscious but in severe pain from burns to both legs. Patient burnt when lighting campfire with gasoline. The fire is out. Warm, sunny day. Flight time back to hospital is 30 minutes.							
<b>On approach:</b> You find the patient sitting by the fire with soaked towels wrapped around her legs. She looks in extreme pain. The fire is now out. Her school friends are present; they radioed for medical help.							
<b>Patient (Information given only if asked):</b> Remains conscious throughout mission. <ul style="list-style-type: none"> <li>• Denies current use of medications.</li> <li>• Indicates allergy to penicillin.</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b>	<b>Leg Burns - pain</b>						
<b>Hx C/C</b>	She was pouring some gas on the wood to get it going and she jumped back when it flared up. Gas spilled onto her pant legs catching fire. It took about 5 minutes to put out the fire by rolling on the ground. <b>L</b> Ant/post 2 <sup>nd</sup> / 3 <sup>rd</sup> degree burns both legs <b>O</b> 1 hour before your arrival <b>T</b> Getting worse, excruciating 10/10 <b>A</b> Difficulty breathing <b>A</b> Movement <b>R</b> Nothing relieves pain <b>P</b> Accident with fire-pit						
<b>Pertinent Functional Enquiry</b>	Blisters and swelling has occurred during the last 30 minutes. Some difficulty breathing and anxiety followed this. She did not breathe in any smoke. It hurts to bend or move her legs.  Her asthma comes on from spring pollen. Her attacks usually start with tightness around her chest and it starts to become harder to get air in. If she uses her inhaler right away, she can control it. She hasn't used it yet, as she does not feel this is an attack. Her legs just hurt a lot. <b>Resp:</b> Increased resp due to pain						
<b>Non-Pertinent FE</b>	Generally in good health, no heart disease or family history of heart problems. No Diabetes, or COPD in family history. Never had seizures.						
<b>Medical History</b>							
<b>Medications</b>							
<b>Allergies</b>							
• Seasonal related asthma	• Ventolin puffer – 2 puffs prn • Pulmicort inhaler – 2 puffs od						
• Penicillin							
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
Initial	4, 5, 6	104 Reg	28 shallow	110/80	Warm, pale, dry	92% pain 10/10	
After fluids	4, 5, 6	112 Reg	30 shallow	120/80	Warm, pale, dry	94% pain 10/10	
After MS first and second dose	4, 5, 6	104 Reg	30 shallow	120/80	Warm, pale, dry	96% pain 5/10-2/10	
<b>#</b>	<b>Head</b>	<b>Neck</b>	<b>Chest</b>	<b>ABD / Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pink, warm dry 4, 5, 6	NAD	A/E to bases, clear. As per ABS	NAD	2 <sup>nd</sup> / 3 <sup>rd</sup> both legs, anterior & posterior up to proximal thighs	NAD	NAD
Subsequent	Pink, warm dry 4, 5, 6	NAD	No evidence of pulmonary edema	NAD	Dry, sterile dressings in place	NAD	NAD
<b>SPECIAL INFORMATION</b>							
Patient will require two doses of morphine to control the pain. Second dose should be given during air transport.							

<b>Scenario:</b> PAIN 3.5 B	
<b>Problem:</b> Dislocated shoulder and Fractured Elbow	
<b>Patient:</b> <ul style="list-style-type: none"> <li>28 yr old male fractured elbow/dislocated shoulder</li> </ul>	
<b>Protocols &amp; Procedures:</b> 3.5 Pain	
<b>Dilemma:</b> <ul style="list-style-type: none"> <li>The patient has a fractured elbow and dislocated shoulder. SAR must choose the appropriate pain management drug for this patient.</li> <li>The SAR Tech should decide patient is stable and complete a full assessment at the scene.</li> <li>Patient is allergic to Ibuprofen, requires pain management for severe pain</li> <li>Should perform a full assessment to determine known cause of pain before treating with pain protocol.</li> <li>Obtain sufficient evidence to rule out c-spine precautions.</li> </ul>	
<b>Key Points:</b> <ul style="list-style-type: none"> <li>Given the time of incident and response time patient is stable and therefore a full assessment can be done on this patient.</li> <li>Must obtain sufficient Hx and vital signs to rule out contraindications of the pain medications.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>	
	<b>Y N N/A</b>
• Did the SAR TECH initiate protocol before extraction?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR TECH obtain a complete history?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR TECH splint arm?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
• Did the SAR TECH use for pain management?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>	
<b>PRIMARY</b>	
	<b>PLAN</b>
<b>Scene</b>	<b>OUTCOME</b>
	Evaluation of scene in accordance with SAR rescue procedures
<b>LOC</b>	Determine responsiveness using A.V.P.U. <ul style="list-style-type: none"> <li>Patient alert. No intervention required</li> </ul>
<b>M</b>	N/A <ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	No C spine, Airway clear <ul style="list-style-type: none"> <li></li> </ul>
<b>R</b>	Open airway, Look listen, feel <ul style="list-style-type: none"> <li>Breathing adequate</li> </ul>
<b>C</b>	Check pulse <ul style="list-style-type: none"> <li>Fast radial pulse</li> </ul>
<b>H</b>	Rules out Hypo/Hyperthermia <ul style="list-style-type: none"> <li>Normothermic</li> </ul>
<b>RBS</b>	Quick check for any other injuries. <ul style="list-style-type: none"> <li>Deformed Leftshoulder and fractured elbow. Has distal circulation in am.</li> </ul>
<b>DECISION</b> – Patient meets the indications for pain protocol. SAR Truck available for transport to hospital. Immobilize injury and treat for pain prior to extraction.	
<b>Vital Signs</b>	Obtain manual vital signs <ul style="list-style-type: none"> <li>Document and record data collected</li> </ul>
<b>Critical History Secondary</b>	Obtain history and physical evidence, complete Head to Toe Perform physical assessment <ul style="list-style-type: none"> <li>Patient stable can perform a complete history before treating. Full physical assessment reveals anterior dislocation of right shoulder and a closed fracture of his right elbow. – able to splint with SAM splint and body splint</li> </ul>
<b>Protocol</b>	Pain protocol, chooses to initiate IV and deliver meds to help with the extrication. Ketorolac, Dimenhydrinate, MS <ul style="list-style-type: none"> <li>Fluid Bolus for patient may be started once initial vital signs done and primary survey interventions are complete. Fluid treatment incorporated with rest of call management. Pain reduces 8/10-3/10</li> </ul>
<b>Procedures</b>	O <sub>2</sub> – IV – fluid bolus titrated to patient’s blood pressure. Splint and immobilize arm and shoulder. <ul style="list-style-type: none"> <li>Stop bleeding and splint leg. Check perfusion in distal limb.</li> </ul>

PATIENT INFORMATION SHEET

<b>Scenario:</b> PAIN 3.5 B						
<b>Problem:</b> Dislocated shoulder and Fractured Elbow						
<b>Mission:</b> While conducting confined area jumps SAR Tech landed in the trees, SAR Tech was initially hung up. His arm got tangled on a branch when going through the trees and heard a “snap”. The parachute slipped off the treetop dropping him to the ground and twisting his arm and shoulder out. The SAR Tech fell approximately 8 feet to the ground. He landed on his feet but was off balance and landed awkwardly. SAR Truck available for extraction, 15 minutes to hospital.						
<b>On approach:</b> You find the patient sitting at the base of the tree holding his left arm. There is a bulge on his left shoulder.						
<b>Patient (Information given only if asked):</b> <ul style="list-style-type: none"> <li>Remains conscious throughout mission</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	Left shoulder and arm hurts					
<b>Hx C/C</b>	While going through the trees, his arm got tangled on a branch then he heard a “snap”. The parachute slipped off the treetop dropping him to the ground and twisting his arm and shoulder out. The SAR Tech fell approximately 8 feet to the ground. He landed on his feet but was off balance and landed awkwardly.					
<b>Left shoulder pain</b>	<table style="width:100%; border:none;"> <tr> <td style="width:50%; vertical-align: top;"> <b>Shoulder dislocation</b>  <b>L</b> Left shoulder deformity and pain  <b>O</b> when landing.  <b>T</b> sharp pain to left shoulder 8/10  <b>A</b> movement  <b>R</b> nothing relieves pain completely, splinting arm  <b>P</b> Dropping to the ground twisted his arm at an awkward angle popping his shoulder out.                 </td> <td style="width:50%; vertical-align: top;"> <b>Fractured elbow</b>  <b>L</b> Left elbow deformity - closed  <b>O</b> when landing.  <b>T</b> sharp pain 8/10  <b>A</b> movement  <b>R</b> nothing relieves pain completely – pain radiates to his hand – has good circulation  <b>P</b> Getting caught in a tree branch when landing                 </td> </tr> </table>	<b>Shoulder dislocation</b> <b>L</b> Left shoulder deformity and pain <b>O</b> when landing. <b>T</b> sharp pain to left shoulder 8/10 <b>A</b> movement <b>R</b> nothing relieves pain completely, splinting arm <b>P</b> Dropping to the ground twisted his arm at an awkward angle popping his shoulder out.	<b>Fractured elbow</b> <b>L</b> Left elbow deformity - closed <b>O</b> when landing. <b>T</b> sharp pain 8/10 <b>A</b> movement <b>R</b> nothing relieves pain completely – pain radiates to his hand – has good circulation <b>P</b> Getting caught in a tree branch when landing			
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<b>Pertinent Functional Enquiry</b>	<p>He wasn't happy how the landing was working out. Coming through the trees he reached out with his left hand and his forearm caught in a branch. It twisted his elbow snapping it. While trying to free himself, the parachute slipped off the top and he fell to the ground; this tore his shoulder out.</p> <p><b>Endocrine:</b> no diabetes, or hypoglycemia  <b>Musculo</b> first time fracture or dislocation  <b>Skeletal:</b> no previous fractures, bone diseases</p>					
<b>Non-Pertinent</b>	Muscle cramps if he does not get enough salt when hiking					
<b>Medical History</b>	<b>Medications</b>					
• NAD	• Tylenol					
	<b>Allergies</b>					
	• Morphine					
<b>PHYSICAL FINDINGS</b>						
	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>
Initial Set	4,5,6	100 reg	24 adequate	150/60	Pale, cool	98% pain 8/10
Ketorolac	4,5,6	90 reg	24 adequate	130/60	Pale, cool	98% pain 8/10
	<b>Head/</b>	<b>Chest</b>	<b>Abd / Pelvis</b>	<b>Upper Ext</b>	<b>Lower Ext</b>	
Initial	Pupils equal bilat, brisk		soft, non-tender warm core temp	Dislocated left shoulder Fracture left elbow Circulation present		
Splinting	Pupils equal bilat, brisk		soft, non-tender	Splinted		
<b>SPECIAL INFORMATION</b>						
Should give Gravol. If not Pt becomes very nauseas.						
<b>Allergic to morphine</b>						



<b>Scenario: Medical 4.1 D Altered LOC - NYD</b>		
<b>Problem: Unconscious Hiker</b>		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>55 year old Male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	4.1 Adult Altered LOC - NYD <b>BP &gt; 90mmHg</b> <b>Blood glucose 5.5</b>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to treat at the scene, or initiate transport and treat en route.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Considers Cardiac arrest pre-arrival due to the Hx given</li> <li>Considers other potential causes for Altered LOC, despite pinpoint pupils and Hx of substance abuse</li> <li>Attempts to obtain a clear understanding of patient's Hx</li> <li>Practices cautious examination given Hx of patient</li> <li>Initiates protocol 4.2 based on presentation and Hx</li> <li>Provides airway control, assisted ventilations and 100% O<sub>2</sub></li> <li>Pulse Oximetry monitoring</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
		<b>Y N N/A</b>
<ul style="list-style-type: none"> <li>Did the SAR Tech initiate the appropriate protocol and procedures?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Does the SAR Tech identify in the Primary that intervention is required (ie assisted ventilations)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech identify the appropriate time for extraction (ie after treatment)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech consider the other possible causes of unconsciousness, such as head injury, stroke, alcohol, epilepsy, etc?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Safe to complete primary survey
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Does not respond to verbal or pain stimuli</li> </ul>
<b>D+A</b>	Determine if C-spine a concern.  Check Airway	<ul style="list-style-type: none"> <li>No suspicion of spinal injury – trauma denied</li> <li>Airway is obstructed partially by tongue. Jaw maneuver to correct. OPA or Nasal Trumpet</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing is slow and very shallow. BVM with 100% O<sub>2</sub></li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Weak radial pulses</li> </ul>
<b>H</b>	Assess for hypothermia	<ul style="list-style-type: none"> <li>Pt is cold to touch. Temp 36°</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cold, moist</li> <li>No signs of trauma</li> <li>Poor peripheral perfusion</li> <li>Notable cyanosis in extremities</li> </ul>
<b>DECISION – To stay on scene to further assess (V/S &amp; Critical Hx)</b>		
<b>Primary</b>	<ul style="list-style-type: none"> <li>Maintain secure scene</li> </ul>	<ul style="list-style-type: none"> <li>Airway/Respiratory support. Safe environment.</li> </ul>
<b>Vital Signs</b>	<ul style="list-style-type: none"> <li>Obtain via VSM &amp; pulse oximeter</li> </ul>	<ul style="list-style-type: none"> <li>Vital signs suggestive of moderate hypoxia</li> </ul>
<b>Critical History</b>	<ul style="list-style-type: none"> <li>Obtain critical history and pertinent information during mission</li> <li>Establishes Hx and supportive evidence on examination of Narcotic use</li> </ul>	<ul style="list-style-type: none"> <li>Suggests Narcotic Overdose</li> <li>No contraindications to protocol found</li> </ul>
<b>DECISION – Establishes need to initiate protocol prior to extraction. To treat as per Protocol 4.1</b>		
<b>Protocol</b>	<ul style="list-style-type: none"> <li>Adult Altered LOC-NYD 4.1</li> </ul>	<ul style="list-style-type: none"> <li>LOC improves after Narcan admin</li> </ul>
<b>Procedures</b>	<ul style="list-style-type: none"> <li>Initiate early and continue procedures for moderate hypoxia and drug overdose throughout mission</li> <li>Appropriately notify receiving facility of findings &amp; interventions</li> </ul>	<ul style="list-style-type: none"> <li>Casualty responds to TX and stabilizes prior to extraction from trail.</li> </ul>
	O <sub>2</sub> , BG, IV	<ul style="list-style-type: none"> <li>Treat findings accordingly</li> </ul>
<b>Secondary</b>	Will complete secondary en route to hospital	<ul style="list-style-type: none"> <li>Documentation of findings completed head to toe</li> </ul>

PATIENT INFORMATION SHEET

<b>Scenario: Medical 4.1 D Altered LOC - NYD</b>						
<b>Problem: Unconscious Hiker</b>						
<b>Mission:</b> After searching for 3 hours the SAR Techs on board the helicopter found a lost hiker lying face down in valley and decide to hoist him as he appears unresponsive. Overnight temperature was 15 degrees and he was dressed in jeans and a heavy jacket.						
<b>On approach:</b> The patient is brought into the helicopter on a hoist. The patient is lying in a flaccid state ¾ prone. Breathing is slow, shallow and noisy.						
<b>Patient (Information given only if asked):</b>						
<ul style="list-style-type: none"> <li>• Remains with decreased consciousness throughout mission until Narcan provided</li> <li>• No known medications</li> <li>• No indicates of allergies</li> <li>• No history of trauma</li> </ul>						
<b>Medical history:</b>						
<ul style="list-style-type: none"> <li>• Unknown</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	<b>Unconscious hiker</b>					
<b>Hx C/C</b>	He left for a hike two days ago and did not return at the appointed time. Search was launched 3 hours ago. After a 20 minute hoist the patient is now in the helicopter.					
	<b>L</b> <i>unconscious</i>					
	<b>O</b> <i>Went for a hike and got lost</i>					
	<b>T</b> <i>NAD</i>					
	<b>A</b> <i>drug abuse</i>					
	<b>A</b> <i>hypoxia</i>					
	<b>R</b>					
	<b>P</b> <i>narcotic overdose</i>					
<b>Pertinent Functional Enquiry</b>	<b>All information obtained from patient when awake.</b>					
	<ul style="list-style-type: none"> <li>• He has been just fine.</li> <li>• He smokes more than a pack a day.</li> </ul>					
<b>Non-Pertinent FE</b>						
<b>Medical History</b>		<b>Medications</b>		<b>Allergies</b>		
<ul style="list-style-type: none"> <li>• Illicit drug use</li> <li>• Hep "C" positive</li> </ul>		<ul style="list-style-type: none"> <li>• None</li> </ul>		<ul style="list-style-type: none"> <li>• NKDA</li> </ul>		
<b>PHYSICAL FINDINGS</b>						
#	LOC	Pulse	Resp	BP	Skin	Pulse Ox/ Finding
Initial	1, 1, 1	100 reg. carotid	06, shallow	95/P	Pale, cool, moist	88% with O2 BG: 5.5
After O <sub>2</sub>	1, 1, 1	100 reg.	06, shallow unassisted	100/80	Pale, cool, moist	96% with O2 BG: 5.5
After Narcan 0.8 mg SC	3, 4, 5	96 reg.	12 shallow unassisted	100/80	Pale, warm, dry	98% with O2 BG: 6.0
En-Route	4, 5, 6	92	16 easy	110/60	Pink, warm, dry	98% with O2 BG: 6.0
#	Head/Neck	Chest	ABD Pelvis	Lower Ext	Upper Ext	Back
Initial	Peripheral cyanosis, grey pupils equal, pinpoint	=AE, clear	Soft, non-tender all quadrants	Peripheral cyanosis/grey	Peripheral cyanosis/grey. Evidence of needle marks, bilaterally	NAD
After BVM, O <sub>2</sub> , & OPA	Pupils equal, pinpoint	=AE, clear to bases	Same as above	Improved coloration throughout	Improved coloration throughout	NAD
After Narcan	Pupils equal, 4mm and brisk	=AE, clear to bases	Same as above	Same	Pink, good motor, pulse and sensation	NAD
<b>SPECIAL INFORMATION</b>						
Patient fits the protocol for Altered LOC - NYD. Responds after Narcan.						
If an IV is initiated Narcan dose will be 0.4 mg						
Pt is not hypothermic but is cold and requires warming to prevent further heat loss.						

<b>Scenario: Hypoglycemic Emergency 4.2 A</b>		
<b>Problem: Diver presenting with decreased LOC. Hypothermia with hypoglycemia</b>		
<b>Patient:</b>	• 50 year old male	
<b>Protocols &amp; Procedures:</b>	4.2 Diabetic 5.1 Hypothermia	
<b>Dilemma:</b>	• Identify a patient presenting with S/S of hypoglycemia, hypothermia (moderate 34 <sup>0</sup> C)	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>• Initiate critical interventions at the end of the primary to begin treating suspected hypothermia.</li> <li>• Identify management plan based on critical history and presentation of patient</li> <li>• Identifies hypothermia as possible cause of hypoglycemia – cold stress induced?</li> <li>• Rules out diving related illness (ie embolus or decompression problems)</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
		<b>Y N N/A</b>
• Did the SAR Tech perform an appropriate Primary & intervene for <b>all</b> life-threats immediately?	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
• Upon completion of the RBS did the SAR Tech find the Medic Alert tag?	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
• Given the circumstances did the SAR Tech elect to stay on scene and manage the potential hypothermia and diabetic emergency on the scene?	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Identifies environmental concerns and recognizes the cold is a problem but not an imminent threat to patient or rescuer. It is safe to complete primary survey
<b>LOC</b>	Determine LOC using AVPU	• Responds to pain only (incoherent, withdraw, eyes stay closed)
<b>M</b>	N/A	•
<b>D+A</b>	Determine if C-spine a concern, Check airway	• MOI does not suggest spinal trauma. Airway presents with Stridor. Maintain airway, measure and insert OPA (patient will not tolerate).
<b>R</b>	Assess Breathing	• Shallow, rapid. Simple face mask 10 LPM. A/E = bilaterally to bases
<b>C</b>	Check for pulses	• Weak, carotid (absent radials)
<b>H</b>	Rules out Hypo/Hyperthermia	• Normothermic
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>• Medic Alert bracelet - Diabetic</li> <li>• Fruity odor on breath</li> <li>• Extremities are cold to touch</li> <li>• Skin cool, moist, pale</li> </ul>
<b>DECISION</b> – elects to provide treatment on-scene, stabilize and then extract casualty. He must remove wet suit, dry patient, move to warm environment		
<b>Primary</b>	Interventions to correct only critical life threats found during assessment.	Position patient ¾ prone to maintain airway. Cover and active re-warming.
<b>Vital Signs</b>	Obtain vital signs q. 5 minutes (unstable). Auscultate chest Document/record data collected.	Obtain vitals Q-5 record. A/E = to bases
<b>Critical History</b>	Obtain critical history and physical evidence.	Information enough to initiate protocol
<b>DECISION</b> – enough evidence has been gathered to support the initiation of the Hypoglycemic Protocol		
<b>Protocol</b>	• Hypoglycemic Protocol initiated on-scene	<ul style="list-style-type: none"> <li>• 2 x 250 ml bolus of glucose</li> <li>• Switch to IV RL 100 ml/hr.</li> <li>• Patient will respond to initial treatment</li> </ul>
<b>Procedures</b>	<ul style="list-style-type: none"> <li>• Whole body re-warming of patient and prevention of further heat loss to environment</li> <li>• O<sub>2</sub> simple race mask</li> <li>• VSM</li> <li>• IV</li> </ul>	<ul style="list-style-type: none"> <li>• Wrap pt. in warm blankets and Geratherm</li> <li>• Initiate whole body warming when rectal temp is below 35°C.</li> <li>• Increase PAO<sub>2</sub> sats.</li> </ul>
<b>DECISION</b> – Transport is initiated		
<b>Secondary</b>	<ul style="list-style-type: none"> <li>• Transport initiated as a priority as soon as possible following initial treatment.</li> <li>• Further physical assessment and complete history while en route.</li> </ul>	Transport per SAR protocol to evacuate. Patient stays stable
	• Complete head to toe rechecking patient	Continuous monitoring of patient
	• Contact receiving facility	Facility prepared pre-arrival

## PATIENT INFORMATION SHEET

<b>Scenario:</b> Hypoglycemic Emergency 4.2 A						
<b>Problem:</b> Diver presenting with decreased LOC. Hypothermia with hypoglycemia						
<b>Mission:</b> You are involved as a member of a dive team on a Divex in the Florida Keys. As you complete your dive and climb back aboard the dive boat, you observe other divers gathered around a diver lying on the deck, shivering. They state he was unable to surface on his own, and was combative and confused when brought on board 15 minutes ago.						
<b>On approach:</b> Patient is now lying supine on the deck, and shivering uncontrollably. Time of event 1600H. No hazards are present; outside temperature is 26 <sup>o</sup> C (water 18 <sup>o</sup> C). Patient is wearing lightweight neoprene vest and shorts. Patient appears to have decreased L.O.C.						
<b>Patient (Information given only if asked):</b>						
<ul style="list-style-type: none"> <li>• Patient is unable to verbalize coherent sentences. Right wrist - Medic Alert (IDDM)</li> <li>• The ascent was normal; depth of dive 25', bottom time 20 min. First dive of the day.</li> <li>• Patient will provide history <b>following</b> treatment.             <ul style="list-style-type: none"> <li>○ Past Medical: IDDM 8 yr., hypertension 2 yr.</li> <li>○ Medications: Novalin 70/30 20 units bid, Captopril 35 mg od</li> <li>○ Allergies: wool, contact dermatitis</li> </ul> </li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	<b>Decreased LOC and Cold</b>					
<b>Hx C/C</b>	Patient became incapacitated underwater and required assistance. Once on the surface he was combative and confused.					
	L <i>Primarily extremities</i>					
	O <i>Gradual onset</i>					
	T <i>Cold</i>					
	A <i>Nausea, dizziness</i>					
	A <i>None</i>					
	R <i>Whole body re-warming</i>					
	P <i>While diving in cold water (18<sup>o</sup>C)</i>					
<b>Pertinent Functional Enquiry</b>	<b>General:</b> Not usually combative. He ate breakfast 2 hrs ago. <b>CNS:</b> Patient can get aggressive and irrational when his sugars get low <b>CVS:</b> Gets occasional chest pain, palpitations, fainting NYD <b>Resp:</b> <b>GI/GU:</b> Nausea, vomiting, heartburn, after last meal <b>Endocrine:</b> Recent history of excessive sweating					
<b>Non-Pertinent FE</b>	<b>General:</b> Fever, recent weight changes, stress at work and home <b>Skin:</b> Rashes when wears wool clothing <b>CNS:</b> Leg cramps <b>CVS:</b> Is under investigation for possible cardiac problem - NYD, ankle swelling <b>Resp:</b> Susceptible to respiratory infections					
<b>Medical History</b>		<b>Medications</b>			<b>Allergies</b>	
<ul style="list-style-type: none"> <li>• IDDM – 8 yrs</li> <li>• Hypertension 2 yrs</li> </ul>		<ul style="list-style-type: none"> <li>• Novalin 70/30/ 20u bid</li> <li>• Captopril (Capoten) 35mg od</li> </ul>			<ul style="list-style-type: none"> <li>• Wool – contact dermatitis</li> </ul>	
<b>PHYSICAL FINDINGS</b>						
#	LOC	Pulse	Resp	BP	Skin	Pulse Ox/ Findings
Initial	1, 2, 4	68 weak reg. radial	12, shallow	94/50	Pale, moist, cold	PA O2 no reading BG: 2.0 mmol/L Rectal temp: 34 <sup>o</sup>
150 ml bolus of Glucose	1, 2, 4	110 weak, reg. radial	20, easy, shallow	96/60	Pink, warm, dry	92% BG: 3.8 mmol/L Rectal temp: 36 <sup>o</sup>
second IV glucose 150 ml bolus	4, 5, 6	92, strong reg.	18, easy	100/70	Pale, moist	98% BG: 7.0 mmol/L Rectal temp: 37 <sup>o</sup>
5 min. post treatment IV RL 100 ml/hr	4, 5, 6	92 strong, reg.	18, easy	100/70	Pale moist	98%
#	Head/Neck	Chest	ABD Pelvis	Lower Ext	Upper Ext	Back
Initial	Pupils equal bilat (3mm) No trauma to neck	= AE, clear to bases.	Soft, c/o nausea	Decreased ROM, cold	Decreased ROM, cold	No discomfort
Should employ whole body warming	Unchanged	= AE, clear to bases. No evidence of pulmonary edema	No change	Distal pulses easily felt	Unchanged	No change
<b>SPECIAL INFORMATION</b>						

<b>Scenario: 4.3 Suspected Adult Narcotic Overdose</b>			
<b>Problem: Plane Crash Victim. Narcotic OD. Leg Fracture</b>			
<b>Patient:</b>	45 year old male		
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>4.3 Suspected Adult Narcotic Overdose</li> <li>Spinal Motion Restriction</li> <li>Fracture Management</li> </ul>		
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Identify based on scene assessment a trauma patient presenting with decreased LOC and history suggesting narcotic overdose.</li> </ul>		
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Consider all causes of decreased LOC and treat for respiratory depression and airway management on scene</li> <li>Identify management plan based on critical history and presentation of patient</li> <li>Manage fracture injury following treatment guidelines using traction</li> </ul>		
<b>COMMENTS &amp; RECOMMENDATIONS</b>			
	<b>Y</b>	<b>N</b>	<b>N/A</b>
• Did the SAR Tech identify the appropriate protocol and procedures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Does the SAR Tech identify in the Primary that intervention is required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the SAR Tech identify the appropriate time for extraction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the SAR Tech carry out and execute and appropriate Tx Plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the SAR Tech understand and complete the protocol as required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Treatment Plan</b>			
<b>PRIMARY</b>			
	<b>PLAN</b>	<b>OUTCOME</b>	
<b>Scene</b>	Evaluate using SAR Rescue Techniques		
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>No response 1, 1, 1 GCS</li> <li>Recognize decreased LOC and monitor</li> </ul>	
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>	
<b>D+A</b>	Determine if C-spine a concern  Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>Does not suggest high index of suspicion for spinal trauma</li> <li>May elect to rule out spinal precautions</li> <li>Noisy, stertorous</li> <li>Reposition airway, measure and insert OPA. May attempt suction. Patient accepts OPA.</li> </ul>	
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Shallow, inadequate. Rate 4</li> <li>Manually ventilate at 20/min. 100% O<sub>2</sub>. BVM</li> </ul>	
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Strong radial pulse</li> <li>Check and compare distal circulation on lower extremities = pulses</li> </ul>	
<b>H</b>	Assess	<ul style="list-style-type: none"> <li>Pt is cold</li> </ul>	
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Closed # Lt femur, distal pulse present</li> <li>Skin cool, slight cyanosis (lips), pale, damp</li> <li>A/E = bilaterally, clear to bases</li> <li>Pupils = /pinpoint</li> <li>Temp stabilization of fracture site</li> </ul>	
<b>DECISION –</b>			
<b>Primary</b>	Intervene to correct critical life threats to airway and breathing found during assessment.	<ul style="list-style-type: none"> <li>No change in LOC</li> </ul>	
<b>Vital Signs</b>	Obtain vital signs q.5 minutes (unstable).	<ul style="list-style-type: none"> <li>Document /record data collected</li> </ul>	
<b>Critical History</b>	Obtain critical history and physical evidence	<ul style="list-style-type: none"> <li>Determine protocol use</li> </ul>	
<b>DECISION –</b>			
<b>Secondary</b>	Transport initiated as a priority as soon as possible following treatment. Physical assessment and complete history while en route	<ul style="list-style-type: none"> <li>Initiate NYD</li> <li>Narcotic O/D protocol</li> </ul>	
<b>Protocol</b>	Narcotic O/D Protocol on scene, 0.8 mg Narcan SC (or 0.4mg IV). Repeated twice with response (improvement).	Patient will not respond to initial treatment. GCS = 4, 4, 6 following second dose of Narcan IV NS 100 ml/hr. If Narcan given IV (0.4mg over 1 minute) to a maximum of 10mg.	
<b>Procedures</b>	Manage fracture injury.	Provides minimal stabilization. Monitor distal pulse. May elect to employ KTD once en route	

**PATIENT INFORMATION SHEET**

**Scenario:** 4.3 Suspected Adult Narcotic Overdose  
**Problem:** Plane Crash Victim. NYD – Narcotic OD. Leg Fracture

**Mission:**  
 Joker 417 with two SAR Techs on board is tasked to search for an ELT going off near the Vermilion Airport. You locate the ELT and penetrate the area. As you approach the Twin Otter aircraft you note that there is minimal damage to the plane and pilot appears to have set up a makeshift camp near a clearing. You find the pilot supine on the ground, unresponsive. Time of event 1500H. The plane has been missing for 6 hours.

**On approach:**  
 An open drug kit is found lying close by. There is an empty medication bottle (Demerol) in the kit.

**Patient (Information given only if asked):**

- Demerol (Meperidine), Prescription (for emergency use only – Take 1 tablet q.4H) dated 3 months prior. 50 x tablets 100mg, bottle is empty.

**Medical history:**

- Past medical unknown
- Medications unknown
- Allergies unknown

HISTORY																	
<b>C/C</b>	<b>Unconscious</b>																
<b>Hx C/C</b>																	
	<table border="0"> <tr> <td><b>L</b> Respiratory depression</td> <td><b>Femur</b></td> </tr> <tr> <td><b>O</b> Post ingestion of narcotic</td> <td><b>L</b> Left thigh</td> </tr> <tr> <td><b>T</b></td> <td><b>O</b> Felt (heard) snap in leg on impact</td> </tr> <tr> <td><b>A</b> Decreased LOC</td> <td><b>T</b></td> </tr> <tr> <td><b>A</b> Unchanged</td> <td><b>A</b> movement</td> </tr> <tr> <td><b>R</b> Ventilated at 20/min</td> <td><b>A</b></td> </tr> <tr> <td><b>P</b> Possible O/D narcotic</td> <td><b>R</b> Demerol relieves the pain</td> </tr> <tr> <td></td> <td><b>P</b> plane crash</td> </tr> </table>	<b>L</b> Respiratory depression	<b>Femur</b>	<b>O</b> Post ingestion of narcotic	<b>L</b> Left thigh	<b>T</b>	<b>O</b> Felt (heard) snap in leg on impact	<b>A</b> Decreased LOC	<b>T</b>	<b>A</b> Unchanged	<b>A</b> movement	<b>R</b> Ventilated at 20/min	<b>A</b>	<b>P</b> Possible O/D narcotic	<b>R</b> Demerol relieves the pain		<b>P</b> plane crash
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<b>P</b> Possible O/D narcotic	<b>R</b> Demerol relieves the pain																
	<b>P</b> plane crash																
<b>Pertinent Functional Enquiry</b>	<ul style="list-style-type: none"> <li>He was flying to a lake and suddenly lost power. He found this small clearing to crash land in. The patient crawled out of the plane and set up a small camp.</li> </ul>																
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>Unknown</li> </ul>																

Medical History	Medications	Allergies
<ul style="list-style-type: none"> <li>unknown</li> </ul>	<ul style="list-style-type: none"> <li>bottle of Demerol is empty</li> </ul>	<ul style="list-style-type: none"> <li>unknown</li> </ul>

**PHYSICAL FINDINGS**

#	LOC	Pulse	Resp	BP	Skin	Pulse Ox
Initial	1, 1, 1	100 reg carotid	6, shallow	95/P	Pale, cool, moist, cyanosis	88% BG: 4.6mmol
After O <sup>2</sup>	1, 1, 1	96 reg	6, shallow unassisted	100/60	Pale, cool, moist	96% with Oxygen
1 <sup>st</sup> Narcan	1, 1, 1	96 reg	6, shallow unassisted	100/80	Pale, warm, dry.	98% with O <sub>2</sub>
IV RL 500 ml bolus	1, 1, 1	96 reg	08, shallow unassisted	100/80	Pink, warm, dry. No cyanosis in extremities	98%
2 <sup>nd</sup> Narcan	4, 5, 6	92	16 easy	110/60	Pink, warm, dry	98%

#	Head/Neck	Chest	ABD/Pelvis	Lower Ext	Upper Ext	Back
Initial	Peripheral cyanosis, grey Pupils equal bilat, (pinpoint)	= AE, clear	Soft, non-tender all quadrants	Closed fractured femur. Rotated inward	Peripheral cyanosis/grey Evidence of needle marks bilateral	No trauma noted
After BVM, O <sub>2</sub> & OPA	Pupils equal bilat, pinpoint	= AE, clear to bases	Same as above	Improved coloration through out	Improved coloration through out	No trauma noted
1st Narcan	Pupils equal bilat, pinpoint	= AE, clear to bases	Same as above	Same as above	Same as above	No trauma noted
IV RL 500ml bolus	Same as above	Same as above	Same as above	Same as above	Same as above	
2 <sup>nd</sup> Narcan	Pupils equal bilat, 4mm and brisk	= AE, clear to bases	Same as above	Pink, Good motor, pulse and sensation Leg splinted.	Moves with purpose	No trauma noted

**SPECIAL INFORMATION**  
 Patient has overdosed from taking too much of his Demerol for his fractured femur. He responds to the Narcan. SAR Tech should titrate second dose of Narcan for effect. Geratherm or other heating methods should be employed.

<b>Scenario: 4.4 - Seizure</b>			
<b>Problem: 45 YOM Crewmember with Multiple Seizures – Head Injury</b>			
<b>Patient:</b>	<ul style="list-style-type: none"> <li>Unconscious 45 YOM – seizure</li> </ul>		
<b>Protocols &amp; Procedures:</b>	<ul style="list-style-type: none"> <li>4.4 Seizure</li> </ul>		
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>Identify a patient in status epileptics.</li> </ul>		
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>Identify management plan based on critical history and presentation of patient.</li> <li>Initiate treatment on scene</li> </ul>		
<b>COMMENTS &amp; RECOMMENDATIONS</b>			
	<b>Y</b>	<b>N</b>	<b>N/A</b>
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Primary and provide the necessary interventions?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech utilize available resources to gather medical history from the crewmembers?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech treat the seizures with the appropriate protocol treatment?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech repeat Midazolam for the subsequent seizure?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>Did the SAR Tech protect the patient during seizures?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Treatment Plan</b>			
<b>PRIMARY</b>			
	<b>PLAN</b>	<b>OUTCOME</b>	
<b>Scene</b>	Evaluate using SAR Rescue Techniques	Ejects to initiate treatment on-scene, then extract casualty.	
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Unresponsive</li> </ul>	
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>	
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>MOI does not suggest spinal trauma.</li> <li>Suctions airway. Inserts OPA. Noisy – fluid in oropharynx</li> </ul>	
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing adequate</li> </ul>	
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Strong radials</li> </ul>	
<b>H</b>	Assess for hypothermia/hyperthermia	<ul style="list-style-type: none"> <li>Norm thermic</li> </ul>	
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Simple face mask 10 LPM. Positions ¾ prone. Protects patient. Seizures during RBS.</li> </ul>	
<b>DECISION – stay and complete V/S &amp; C. Hx.</b>			
<b>Primary</b>	Interventions to correct life threats found during assessment.	<ul style="list-style-type: none"> <li>Suctions liquid from airway.</li> <li>Inserts OPA.</li> <li>Provides oxygen.</li> <li>Positions patient on side.</li> </ul>	
<b>Vital Signs</b>	Obtain manual vital signs and confirm with VSM and pulse oximeter.	<ul style="list-style-type: none"> <li>Obtain vital signs q5 minutes (unstable).</li> <li>Document &amp; record data collected.</li> </ul>	
<b>Critical History</b>	Obtain critical history and physical evidence.	<ul style="list-style-type: none"> <li>Critical assessments done and seizure treatment done prior to transport. Should be done promptly.</li> <li>Meets indications for Seizure protocol.</li> </ul>	
<b>DECISION – Treat using Seizure Protocol</b>			
<b>Protocol</b>	Seizure protocol 4.4 initiated at the scene.	Patient will respond to 1 <sup>st</sup> Midazolam. Seizes again during transport, but responds to second dose of Midazolam.	
<b>Procedures</b>	<ul style="list-style-type: none"> <li>Suction</li> <li>OPA insertion</li> <li>High flow O2</li> <li>VSM with Blood Glucose</li> <li>Midazolam administration</li> <li>IV RL @ 100ml</li> </ul>		
<b>Secondary</b>	Perform further physical assessment and continue history on en route.	Documentation of findings. Notification if able.	

**PATIENT INFORMATION SHEET**

<b>Scenario: 4.4 – Seizure</b>						
<b>Problem: 45 YOM Crewmember with Multiple Seizures – Head Injury</b>						
<b>Mission:</b> Outcast 910 is tasked to medevac a 45 YOM from a 50 foot F/V 100 miles off St Johns'. The captain states his crewmember has had a several seizures lasting anywhere from 2-3 mins. This morning they saw him trip and hit his head on the floor. He was out for about a minute, and then seemed OK. It's a beautiful day; SAR Techs have up to 1hr 10 mins on scene and 1hr transit to hospital. SAR Techs are hoisted to the stern of the vessel.						
<b>On approach:</b> Patient is found below decks in a bunk. He has a decreased LOC, decorticate posturing on pain stimulus.						
<b>Patient (Information given only if asked):</b>						
<ul style="list-style-type: none"> <li>• Patient had finished partying last night and went to bed in the early hours.</li> <li>• He woke up this AM. On his way to the bathroom he fell and hit his head. He was out for about a minute. He came to and stated he was fine. He started to have seizures 1 hour ago.</li> <li>• He has been seizing every 10 minutes since, each seizure lasting 2-3 minutes</li> </ul>						
<b>Medical history is available from HR office on Mainland via radio.</b>						
<ul style="list-style-type: none"> <li>• Never had seizures to captain's knowledge.</li> <li>• Allergies - penicillin</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	<b>Started Seizing about half an hour ago.</b>					
<b>Hx C/C</b>	<ul style="list-style-type: none"> <li><b>L</b> Seizures for one hour</li> <li><b>O</b> One hour ago</li> <li><b>T</b> Generalized motor seizure in decerebrate posture</li> <li><b>A</b> Noisy respirations, cyanosis during seizures</li> <li><b>A</b> Every 10 minutes seizure lasting 2 – 3 min</li> <li><b>R</b> Stops on its own then restarts</li> <li><b>P</b> Began half an hour after hitting his head.</li> </ul>					
<b>Pertinent Functional Enquiry</b>	<ul style="list-style-type: none"> <li>• Co-worker knows him well and provided information</li> <li>• Normally active with no apparent health problems</li> <li>• Was not dizzy, had no chest pain, no lightheadedness</li> <li>• Normally healthy</li> </ul>					
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>• Smoker</li> </ul>					
<b>Medical History</b>		<b>Medications</b>		<b>Allergies</b>		
• None		• None		• None		
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox/ Finding</b>
Initial	1, 1, 1	110, strong regular	20, not effective when seizing	150/80	Cyanosis, pale, cool, clammy	85% Temp: Normal BG 5.2
1 <sup>st</sup> Midazolam	1, 1, 1	88	12	160/85	Pale	90%
Transport started	2, 2, 4	92	16	165/85	Pink, warm, dry	95%
Subsequent Seizure	1, 1, 1	120	Not effective when seizing	Can't take	Cyanotic	82%
2 <sup>nd</sup> Midazolam	1, 1, 1	96	12	175/85	Pale	92% BG 4.4
Subsequent	2,3,4	94	12	180/87	Pale, dry	94% BG 4.4
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Pupils unequal (R-4 mm L-3mm) both reactive. Hematoma left temple	=AE, Coarse to base	Soft, warm.	Normal appearance decerebrate posturing when GCS checked	Bruise from L forearm. decerebrate posturing when GCS checked	Normal appearance
Subsequent	Same	Same	Same	Same	Same	Same
Subsequent	Same	Same	Same	Same	Same	Same
<b>SPECIAL INFORMATION</b>						
The patient has a subdural bleed and will continue to have a seizure until two doses of Midazolam are given. Patient has unequal pupils and decerebrate posturing.						



<b>Scenario:</b> ENVIRONMENTAL 5.1 A		
<b>Problem:</b> Hypothermia Man Overboard		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>55 year old male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	5.1 Hypothermia	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must treat the patient gently, especially given his previous cardiac history.</li> <li>The SAR Tech must decide whether or not to re-warm and which rewarming measures will be taken.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>The hypothermic patient is at risk for ventricular fibrillation, especially when combined with a previous cardiac history.</li> <li>Ambient temperature is a factor in its effect on fluid therapy unless warm fluid (RL @ 43 C) can be administered in the field.</li> <li>Early administration of O<sub>2</sub> in the field may be of benefit but could risk exacerbation of hypothermia with central cooling unless it can be provided via a heat-treat device. Other warming devices to be used early</li> <li>With respect to handling hypothermic patients gently, effort should be made to provide a smooth flight to hospital.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Primary &amp; intervene for <b>all</b> life-threats immediately?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the need for rapid extraction &amp; facilitate this efficiently?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the risk of rough handling and move the patient as gently as possible?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the environmental restrictions on providing oxygen &amp; fluid therapy at scene without warming?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech correctly classify the degree of hypothermia and initiate appropriate treatment?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Functional Enquiry with pertinent questions given priority?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures	Establishes need to extract immediately
<b>LOC</b>	Determine LOC using AVPU Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>Eyes are open. Pt. is confused and obeys commands.</li> </ul>
<b>D+A</b>	Determine if C-spine a concern	<ul style="list-style-type: none"> <li>No suspicion of spinal injury – trauma denied</li> <li>Airway clear</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing is rapid but appears adequate in depth</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Weak, carotid pulse</li> </ul>
<b>H</b>	Assess for hypothermia	<ul style="list-style-type: none"> <li>Moderate hypothermia</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cold, wet</li> <li>No signs of trauma</li> <li>Shivering violently</li> <li>Poor peripheral perfusion</li> </ul>
<b>DECISION</b> – recognizes hypothermia and the need to get the casualty out of the cold environment as soon as possible. Needs to accomplish this while treating the casualty as gently as possible to avoid myocardial irritation.		
<b>Primary</b>	Calm casualty, ensures rest, keep warm & comfortable.	Patient calms, feels better, warmer
<b>Vital Signs</b>	Obtain via VSM & pulse oximeter aboard helicopter.	Vital signs suggestive of moderate hypothermia
<b>Critical History</b>	Obtain critical history and pertinent information during mission	No contraindications to protocol found
<b>Protocol</b>	Hypothermia 5.1	LOC & temperature improve
<b>Procedures</b>	Treat gently to reduce risk of myocardial irritation in middle aged casualty with cardiac history. Initiate rewarming with appropriate equipment. Continue procedures for whole body rewarming throughout mission. Appropriately notify receiving facility of findings & interventions	Casualty responds to treatment and stabilizes en route.
<b>Secondary</b>	Obtain rectal temperature Obtain further history	Suggests moderate hypothermia, risk of severe. Obtains functional inquiries

**PATIENT INFORMATION SHEET**

<b>Scenario: ENVIRONMENTAL 5.1 A</b>							
<b>Problem: Hypothermia Man Overboard</b>							
<b>Mission:</b> 413 Cormorant Standby crew tasked by RCC to respond to a MAYDAY call from a sailboat 100 miles off Nova Scotia coastline. You are 1 hour until on scene and locate the sailboat. You hoist to the boat and find one 55 year old male onboard. He is wet, cold and does not have a survival suit on. He is by himself. Your flight time to hospital is 45 minutes.							
<b>On approach:</b> Your 55 year old male patient is huddled on the deck. He is wearing wet work clothes, with no head covering. He is shaking violently. He opens his eyes as you approach, but appears to be confused. The wind is picking up as the weather deteriorates. The male is unable to assist in preparation for hoisting to the helicopter. Between confusion and shivering, he is unable to function.							
<b>Patient (Information given only if asked):</b>							
<ul style="list-style-type: none"> <li>• 55 years old</li> <li>• Remains conscious throughout mission</li> <li>• Complains of severe cold and shivering violently</li> <li>• Indicates an MI two years ago with quadruple bypass</li> <li>• Indicates allergy to penicillin once his LOC improves.</li> </ul>							
<b>Medical history:</b>							
<ul style="list-style-type: none"> <li>• MI with quadruple bypass</li> <li>• Hypertension</li> <li>• High cholesterol</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b>	<b>Cold</b>						
<b>Hx C/C</b>	Sailboat hit broadside by a large wave and he went overboard. He was able to pull himself back on board with his tether.						
	<b>L</b> 100 miles of Nova Scotia coastline						
	<b>O</b> 1 1/2 hours ago						
	<b>T</b> painful, numbing						
	<b>A</b> fatigue, inability to stop shivering						
	<b>A</b> wind blowing						
	<b>R</b> nothing						
	<b>P</b> immersed in cold water						
<b>Pertinent Functional Enquiry</b>	Generally in good health.						
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>• One MI two years ago</li> <li>• Quadruple bypass after MI</li> <li>• No chest pain recently</li> <li>• Smoker, trying to cut down and quit</li> <li>• Both parents died in early 60's from cardiac problems</li> <li>• Eats well, with occasional indigestion and gas problems</li> <li>• Recent cough and cold</li> <li>• Occasional headaches when stressed</li> </ul>						
<b>Medical History</b>			<b>Medications</b>			<b>Allergies</b>	
<ul style="list-style-type: none"> <li>• MI with quadruple bypass</li> <li>• Hypertension</li> <li>• High cholesterol</li> </ul>			<ul style="list-style-type: none"> <li>• Altace 5 mg OD</li> </ul>			<ul style="list-style-type: none"> <li>• Penicillin</li> </ul>	
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Rectal Temp</b>	<b>Pulse Ox</b>
Initial	3, 4, 6	50 reg. carotid	26, adequate	95/P	Pale, cold, wet Lips Cyanosis	32°	Cannot obtain BG 4.8
Rewarming	4, 4, 6	60 reg.	28, easier	100/60	Pale, cool, dry Less Cyanosis	34°	96%
All others	4, 5, 6	60 reg.	24 easy	100/80	Pink, warm, dry No cyanosis	36°	96%
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD/Pel vis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>	
Initial	Peripheral cyanosis. Pupils equal, sluggish. No pain, no in drawing in neck.	=AE, clear	Soft, non-tender all quadrants	Peripheral cyanosis	Peripheral cyanosis	No Pain	
After O <sub>2</sub> external warming	Pupils equal, brisk					No Pain	
<b>SPECIAL INFORMATION</b>							
Discuss minimizing pt movement as it may induce V fib. Discuss Norwegian heater, Geratherm, and cas bag.							

<b>Scenario:</b> ENVIRONMENTAL 5.2		
<b>Problem:</b> Hyperthermia		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>44 YO male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	5.1 Hyperthermia	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must initiate rapid cooling prior to transport.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>The hyperthermic patients' morbidity and mortality is reduced with rapid cooling.</li> <li>Pt exhibits signs of Exertional Heatstroke and must be removed from environment.</li> <li>Check Blood Glucose early to rule out other treatable causes.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y    N    N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Primary &amp; intervene for <b>all</b> life-threats immediately?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech immediately remove pt from the elements?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the need to initiate rapid cooling immediately?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech Take care not to overcool and cause reflex hypothermia. Should stop active cooling at around 39°C to avoid overshooting target temp of 37°C?</li> </ul>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech correctly classify the degree of hyperthermia and initiate appropriate treatment?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Functional Enquiry with pertinent questions given priority?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures	Establishes need to remove pt from environment and start cooling process
<b>LOC</b>	Eyes are open. Pt. is confused and obeys commands.	<ul style="list-style-type: none"> <li>Recognize possible decreased LOC &amp; monitor</li> </ul>
<b>M</b>	N/A	<ul style="list-style-type: none"> <li></li> </ul>
<b>D+A</b>	No suspicion of spinal injury – trauma denied Assess airway	<ul style="list-style-type: none"> <li>Airway clear</li> </ul>
<b>R</b>	Breathing is deep and adequate	
<b>C</b>	Rapid, full radial pulse	
<b>RBS</b>	Hot dry skin No signs of trauma	
<b>DECISION</b> - recognizes hyperthermia and the need to get the casualty out of the environment as soon as possible. Initiate cooling process immediately.		
<b>Vital Signs</b>	Obtain via VSM manually	Vital signs suggestive of heatstroke.
<b>Critical History</b>	Obtain critical history and pertinent information.	No contraindications to protocol found
<b>Secondary</b>	Obtain rectal temperature	40.6°C Suggests heatstroke.
<b>Protocol</b>	Hyperthermia	LOC & temperature improve
<b>Procedures</b>	Remove pt from environment Initiate rapid cooling (remove clothing as required, wet skin and fan, cool packs on neck, axillae and groin) Administer O2 Check Blood Glucose Administer IV 250 ml bolus	Casualty responds to treatment and stabilizes en route.

**PATIENT INFORMATION SHEET**

<b>Scenario:</b> ENVIRONMENTAL 5.2							
<b>Problem:</b> Hyperthermia							
<b>Mission (Read to Student)</b> You are on exercise in a southern locale. You are returning from training and see a male wearing running gear slumped on the sidewalk. He seems in distress. The ambient temperature is 30°C with a humidity index of 42°C. You have all you med gear with you in the vehicle. Patient is on a main street with shops and restaurants close by.							
<b>On approach:</b> As you approach you see he seems confused and is sitting with his head drooped and breathing rapidly. There is a pool of vomit beside him.							
<b>Patient (Information given only if asked):</b> <ul style="list-style-type: none"> <li>• 44 years old</li> <li>• He was out for a run and after half an hour he started feeling faint, confused and nauseous.</li> <li>• He just arrived last night to start his vacation and had a late night partying.</li> <li>• Denies drug use but did drink a fair amount of the free beer at his hotel.</li> <li>• Denies diabetes, hypertension, lung, and liver renal, seizure disorders.</li> <li>• Indicates no allergies</li> </ul>							
<b>HISTORY</b>							
<b>C/C</b>	Heat Stroke						
<b>Hx C/C</b>	Decided to go for a run despite the intense heat as he usually runs 3-4 times a week back home in Canada. <b>L</b> Entire body <b>O</b> Came on 30 minutes into his run, 5 minutes prior to you arriving <b>T</b> General malaise. Never experienced this before. <b>A</b> Cramps, Headache, N&V, dizziness and short of breath. <b>A</b> Extreme heat <b>R</b> nothing relieves it <b>P</b> Running						
<b>Pertinent Functional Enquiry</b>	Generally in good health. <ul style="list-style-type: none"> <li>• Woke up feeling dehydrated.</li> </ul>						
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>• Non Smoker</li> <li>• Both parents died in early 60's from cardiac problems</li> </ul>						
<b>Medical History</b>							
<ul style="list-style-type: none"> <li>• Shoulder surgery 14 years ago.</li> <li>• Chronic Lower Lumbar pain x 10 years.</li> </ul>	<b>Medications</b>						
	<ul style="list-style-type: none"> <li>• Takes Ibuprofen 800 mg a day</li> </ul>	<b>Allergies</b>					
	<ul style="list-style-type: none"> <li>• Nil</li> </ul>						
<b>PHYSICAL FINDINGS</b>							
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox</b>	
INITIAL	4, 4, 6	120 radial	26 deep, effective	95/P	Flushed, hot and dry	93% 40.6°C BG 4.2 mmol	
If removed from heat and given O2	4, 5, 6	110 radial	23 deep	95/50	Flushed, hot and dry	96% 40.2°C	
Active cooling initiated	4, 5, 6	100 radial	20 easier	98/55	Hot and moist	96% 39.2°C	
IV RL 250 ml bolus	4, 5, 6	90 radial	18	105/65	Sweaty	96% 38°C	
All others	4, 5, 6	80 reg	18	110/70	Sweaty	96% 37.5°C	
<b>#</b>	<b>Head/</b>	<b>Neck</b>	<b>Chest</b>	<b>ABD / Pelvis</b>	<b>Lower Ext</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Hot and dry. Pupils equal.	No pain, no JVD or indrawing	= AE, clear	Soft, non-tender all quadrants Cramping	Hot and dry. Cramping	Hot and dry	No pain
After O <sub>2</sub> and cooling	Improvement	No change	No change	Cramping decreasing	Cramping decreasing	Moist	
<b>SPECIAL INFORMATION</b>							
Patient will not tolerate oral fluids as he still feels nauseous. Should administer IV fluids as per protocol. Take care not to overcool and cause reflex hypothermia. Should stop active cooling at around 39°C to avoid overshooting target temp of 37°C.							

<b>Scenario:</b> ENVIRONMENTAL 5.3		
<b>Problem:</b> Acute Mountain Sickness		
<b>Patient:</b>	<ul style="list-style-type: none"> <li>25 year old male</li> </ul>	
<b>Protocols &amp; Procedures:</b>	5.3 High Altitude Illness <ul style="list-style-type: none"> <li>5.1 Hypothermia</li> <li>4.2 Hypoglycemic Emergency</li> </ul>	
<b>Dilemma:</b>	<ul style="list-style-type: none"> <li>The SAR Tech must decide whether to descend to the cabin and wait out the arriving weather system while monitoring &amp; treating or to execute a rapid descent and extract the casualty as soon as that option is available.</li> </ul>	
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>The casualty ascended even after the initial onset of symptoms. He is now at 9,000 ft.</li> <li>The arrival of a low-pressure storm front could increase “relative altitude” even at the cabin elevation and may be detrimental to casualty outcome if allowed to remain.</li> <li>Consideration should be given to early auscultation of chest for pulmonary edema at the scene following the RBS as this may be difficult once packaged &amp; transported</li> <li>Pulse oximetry should be interpreted with consideration given to reduced oxygen in the atmospheric envelope &amp; possible pulmonary edema.</li> <li>Hypoglycemia should be ruled out as a contributing factor to the patient’s condition.</li> </ul>	
<b>COMMENTS &amp; RECOMMENDATIONS</b>		
	<b>Y N N/A</b>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Primary &amp; intervene for <b>all</b> life-threats immediately?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the need for rapid extraction &amp; facilitate this efficiently?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech recognize the environmental restrictions on rapid descent and initiate treatment on scene?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech rule out diabetes as a contributing factor?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech consider chest auscultation early in the mission?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Did the SAR Tech perform an appropriate Functional Enquiry with pertinent questions given priority?</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Treatment Plan</b>		
<b>PRIMARY</b>		
	<b>PLAN</b>	<b>OUTCOME</b>
<b>Scene</b>	Evaluation of scene in accordance with SAR rescue procedures	Evaluates environmental concerns vs casualty prognosis and elects to perform rapid descent to cabin with hoist extraction at earliest opportunity en route.
<b>LOC</b>	Determine LOC using AVPU	<ul style="list-style-type: none"> <li>Opens eyes and responds to verbal stimuli</li> <li>No problem now. Will monitor regularly.</li> </ul>
<b>M</b>	N/A	•
<b>D+A</b>	Determine if C-spine a concern Open Airway. Look Listen Feel	<ul style="list-style-type: none"> <li>No suspicion of spinal injury – trauma denied</li> <li>Airway is open &amp; clear</li> </ul>
<b>R</b>	Assess Breathing	<ul style="list-style-type: none"> <li>Breathing is rapid but appears adequate in depth Consider 100% O<sub>2</sub> – May delay if hazards and/or environmental conditions contraindicate use.</li> <li>Fine patchy rales bilateral lung fields</li> </ul>
<b>C</b>	Check for pulses	<ul style="list-style-type: none"> <li>Strong radial pulses</li> </ul>
<b>H</b>	Assess for hypothermia	<ul style="list-style-type: none"> <li>Pt is cold.</li> </ul>
<b>RBS</b>	Quick check for any other injuries, hands on	<ul style="list-style-type: none"> <li>Pale, cool &amp; dry. Cyanosis of lips.</li> <li>Restlessness &amp; anxiety</li> <li>Attempts to ambulate reveal unsteadiness &amp; staggering (ataxia)</li> </ul>
<b>DECISION</b> –Establishes S/S of AMS & elects to provide High flow Oxygen if supply will not have cooling effect on casualty. Prepares for rapid descent to < 6,500 ft. Critical history and assessment indicate need to initiate treatment. Descent will be delayed by packaging and preparation of toboggan rigging, so protocol initiated prior to leaving.		
<b>Primary</b>	Calm casualty; ensure rest, keep warm & comfortable. Realize patient will not be able to walk out.	
<b>Vital Signs</b>	Obtain manually at scene. Follow-up with VSM and pulse oximeter as soon as available. Obtain blood sugar reading.	Vital signs suggestive of AMS. Blood sugar ruled out as contributor to problems.
<b>Critical History</b>	Obtain critical history and pertinent information during mission	No contraindications to protocol found
<b>Protocol</b>	Initiate High Altitude Illness – AMS (QL6A) Protocol	S/S subside with treatment and as descent is executed
<b>Procedures</b>	Acetazolamide 500 mg PO IV RL at 100 ml/hr Appropriately notify receiving facility of findings & interventions	Casualty responds to treatment and improves en route. Catheterization not required as patient needs to void.
<b>Secondary</b>	Perform further physical assessments & continue history en route	Decreased urine output over last 4 hours

## PATIENT INFORMATION SHEET

<b>Scenario: ENVIRONMENTAL 5.3</b>						
<b>Problem: Acute Mountain Sickness</b>						
<p><b>Mission:</b> CH149 Standby crew tasked by RCC to an elevation of 9,000 ft. in the North Eastern Rockies of BC. A 25 year old male on a Hike &amp; Ski trip with a group of friends has become acutely ill several hours after rapidly ascending to an elevation of 14,000 feet. The group was dropped off by helicopter one day earlier at the rendezvous site that is close to the overnight cabin where they are staying. (8,000 ft)</p> <p>It is late in November; the temperature at altitude is -8°C. Due to weather the Cormorant can only drop you off at a spot that will require a two hour ascent to the casualty's location. Rescue equipment can be dropped closer to scene by the Buffalo but SAR Tech insertion is too risky at this location. For extraction it will take two hours to descend to &lt; 6,500 ft. on skis with toboggan. The Cormorant will RV with you at that point for Air Evac.</p>						
<p><b>On approach:</b> After hiking to the patient's location, you find three hikers huddled around their friend. They have made a temporary shelter from the wind. The patient is awake and looking at you.</p>						
<p><b>Patient (Information given only if asked):</b></p> <ul style="list-style-type: none"> <li>• Remains conscious throughout mission</li> <li>• Quite nauseated with some vomiting prior to SAR Tech arrival</li> <li>• Very weak</li> <li>• Diabetic, well managed with insulin, diet and exercise</li> <li>• Denies hypertension, cardiac, lung, liver renal, seizure disorders.</li> <li>• Indicates alcohol use the night before</li> <li>• Indicates continued ascent after onset of initial symptoms</li> <li>• Uses prochlorperazine (stemetil) in the early morning as prophylactic.</li> <li>• This happened last year but not as bad.</li> </ul>						
<p><b>Medical history:</b></p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Previous AMS</li> </ul>						
<b>HISTORY</b>						
<b>C/C</b>	<b>Headache, SOB</b>					
<b>Hx C/C</b>	Headache		SOB			
	<b>L</b>	frontal	<b>L</b>	chest		
	<b>O</b>	2 hrs ago	<b>O</b>	10 mins ago		
	<b>T</b>	dull pounding, 7/10	<b>T</b>	mild		
	<b>A</b>	dizziness, nausea, fatigue	<b>A</b>	exertion		
	<b>A</b>	exertion	<b>A</b>	mild non-productive cough		
	<b>R</b>	nothing	<b>R</b>	rest		
	<b>P</b>	assent	<b>P</b>	assent		
<b>Pertinent Functional Enquiry</b>	<p>Generally in good health before the trip. Previous AMS on similar trip last year. Diabetes is well managed with Insulin, diet and exercise.</p> <ul style="list-style-type: none"> <li>• No recent cough or cold</li> <li>• Alcohol use last night</li> <li>• Not sleeping well last two nights</li> <li>• Drinking lots of coffee and cocoa</li> <li>• Using anti-nausea medication (stemetil) as a precaution after last years' experience</li> </ul>					
<b>Non-Pertinent FE</b>	<ul style="list-style-type: none"> <li>• Family history of heart disease</li> </ul>					
<b>Medical History</b>		<b>Medications</b>			<b>Allergies</b>	
<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Previous AMS</li> </ul>		<ul style="list-style-type: none"> <li>• Insulin – Humulin N 12 u AM - Humulin R 8 u AM; Sliding scale PM</li> <li>• Prochlorperazine 30mg q4h prn (stemetil)</li> </ul>			<ul style="list-style-type: none"> <li>• Nil</li> </ul>	
<b>PHYSICAL FINDINGS</b>						
<b>#</b>	<b>LOC</b>	<b>Pulse</b>	<b>Resp</b>	<b>BP</b>	<b>Skin</b>	<b>Pulse Ox/ Findings</b>
Initial	4, 4, 6	100 reg.	28 adequate	130/88	Pale, cool, dry Lips cyanosis	90% BG: 5.6 mmol/L Temp: Normal

After O <sub>2</sub> and 500 mg Acetazolamide	4, 4, 6	100 reg.	24, adequate	130/85	Pale, cool, dry, no cyanosis	93% BG: 5.6 mmol/L
1 <sup>st</sup> hour of transit	4, 5, 6	96 reg.	20, easier	125/80	Pale, warm, dry	94% BG: 5.6 mmol/L
After descent to 6,000 ft	4, 5, 6	86 reg.	18 easy	120/80	Pink, warm, dry	96% BG: 5.6 mmol/L
<b>#</b>	<b>Head/Neck</b>	<b>Chest</b>	<b>ABD</b>	<b>Lower</b>	<b>Upper Ext</b>	<b>Back</b>
Initial	Peripheral cyanosis Pupils 3 mm. bilat, sluggish	=AE, faint rales at bases only	Soft, non-tender all quadrants	Peripheral cyanosis	Peripheral cyanosis	NAD
Subsequent	Pupils equal bilat, brisk	Rales diminished	same	NAD Pink, warm, dry	NAD Pink, warm, dry	NAD Pink, warm, dry

### SPECIAL INFORMATION

Pt shows some improvement after one hour of descent time but is still ataxic. Must descend to < 6,500 ft. for significant improvement.



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### 3.0 EQUIPMENT





### 3.1 SAR Kit Change Record (2014 – present)

-----2020-----

Change #

**2001 (Jan 30)** Delete 6510-01-606-7097 Dressing, Chest Wound Seal, Valved (UOM = EA) from the following medical kits (ROLE 1, AE, PHCI, Ambs, DART, Dive Team, Navy, MO/PA/Med Techs, SAR and Combat-Trauma kits) and replaced by adding 6510-01-658-7745 Chest Seal with Valve 2.0 no Pad or Cap.  
**6510-01-658-7745** Sam Chest Wound Seal (Valved)

Change #

**2002 (Feb 7)** Delete NS 6515-01-235-2649 SUPPORT CERVICAL SHORT 'STIFNECK' LARGE OPENING IN FRONT FOR AIRWAY ACCESS from the following SAR Medical Kit and replace by adding NS **6515-01-305-2457** SUPPORT, CERVICAL, using a 1:1 replacement.

Remove 6515-21-903-0732 STETHOSCOPE (COMBINATION TYPE) BLACK "LITTMANN CLASSIC II" from the following medical kits and replace by adding NS **6515-01-673-7560** STETHOSCOPE CLASSIC III 27 INCH BLACK TUBE LITTMANN.

Change #

**2003 (Apr 23)** Delete 6515-CF-002-7985 MASK, FACE, INFANT, RESUSCITATION AND ANESTHESIA, SILICONE from the SAR medical kits and replace by adding **6515-22-606-5378** FACE MASK, INFANT, RESUSCITATOR, DISPOSABLE.

Change #

**2004 (May 14)** AIRWAY SUPRAGLOTTIC, ADULT, SIZE 4 (Part # 8704000) **6515-01-618-8278** will remain in the Pen Kit. The following Airway Supraglottic (i-gels) will be relocated/added to the O2 Kit:  
AIRWAY SUPRAGLOTTIC PEDIATRIC SIZE 2. (Part # 8202000) **6515-99-361-3111**  
AIRWAY SUPRAGLOTTIC PEDIATRIC SIZE 2.5 (Part # 8225000) **6515-99-391-2691**  
AIRWAY SUPRAGLOTTIC, ADULT, SIZE 3 (Part # 8703000) **6515-01-619-7360**  
AIRWAY SUPRAGLOTTIC, ADULT, SIZE 4 (Part # 8704000) **6515-01-618-8278**  
AIRWAY SUPRAGLOTTIC, ADULT, SIZE 5 (Part # 8705000) **6515-01-621-2401**

Add Bag Urine Collection Part # (RUS 4539-32) **6515-01-680-8649** to O2 Kit.

Add Catheter 14 Gauge, 3.35 Shipping and Storage Container **8145-01-682-0894** as well as Cap-Plug Protective-Dust and Moisture Seal **5340-01-682-0499** is added to Pen Kit packing list. Available through Pharmacy, Box of 100 each.

Add IV Catheter, BD Isyte Autoguard BC, 18 Gauge **6515-CF-002-8702** Part # 382544 & IV Catheter, BD Isyte Autoguard BC, 22 Gauge **6515-21-912-7074** Part # 382523 to Sup Kit Child Birth (11). Remove/Delete 6515-CF-002-8710 Catheter IV Dual Port Safety 18G x 1.25 & 6515-CF-002-8706 Catheter IV Safety 22G x 1 in Dual Port Catheters.

Change #

**2005 (TBC)**

-----2019-----

Change #

**1901 (Feb 22)** A safer decompression needle NS **6515-01-541-0635** ARS NEEDLE, HYPODERMIC FOR DECOMPRESSION, 14G, and 3.25IN. Remove NS6515-CF-002-0794 from kits.

Change #

**1902 (July 11)** Deployed Air Rescue Treatment System (DARTS) is ready to release to service. NS numbers will be confirmed and amended. DARTS program was delayed; Coastal Pen Kit required immediate repairs, SOA and DAR to resolve. TBC.

Change #

**1903 (Sept 19)** Equipment (NSN) Changed on Packing List  
**6515-01-541-0635** Catheter IV, Teflon, orange, 14 x 3.25  
**6515-01-632-8083** Patch, Stabilizer for EZ-IO  
**6505-21-895-1673** Acetaminophen (Tylenol) 325mg tablets  
**6505-CF-001-7492** Glucose gel (Oral dextrose) 40 % 31 gm tube  
**6505-CF-002-9104** Nitroglycerin (NTG) 0.4mg/dose (200 dose spray canister)  
**6515-CF-002-9034** Optimum Splint traction device OTD  
**6515-CF-002-8742** Container Sharps 1.5 in X 6 in  
**6515-CF-002-7588** Gloves exam (Med)  
**6515-CF-002-7589** Gloves exam (LARGE)  
**6515-CF-002-7590** Gloves exam (XL)  
**6515-CF-002-5030** Gloves, Esteem SMT, Sterile, Size 8  
**6515-CF-002-7226** Gloves, Esteem SMT, Sterile, Size 8.5  
**7210-21-870-6172** Casualty Blanket (heavy weight Space blanket)

Change #

**1904 (Oct 5)** Remove NS 7210-21-865-2581 Blanket Emergency/Rescue (-60 Deg F) weatherproof Bright Color 56"WX84"L from the following medical kits, and replace by adding NS **7210-21-870-6172** Blanket Emergency / Rescue (-60 Deg F) weatherproof bright color 56"WX84"L Air-spotting folds to Pocket Size, using a 1:1 replacement ratio.

Remove NS 6515-CF-002-7605 Tube Catheter Extension (Coloplast Product) for Urinary Collection from the following SAR medical Kits. The replacement product **RUS4539-32** PSCN **6515-20-A0U-0391** comes complete with the 18" extension tube.

Change #

**1905 (Oct 19)** IO Power Driver, hand held (Red) **6515-01-590-8589** drill replaces all black drills. Black drills are for training purposes only, change NSN from black drill to red drill.

Change #

**1906 (Nov 6)** CTOMS is now authorized to sell the Ready-Heat **6532-01-538-1525**. Products once again in the Canadian jurisdiction, shortage situation should end. The medical license expired.

Change #

**1907 (Dec 2)** IV catheters standardized; IV Catheter, BD Isyte Autoguard BC 16, 18, 20 and 22 Gauge implemented and adopted. There were three different brand names all with their own techniques. Moved to one piece of equipment with one standard.

**6515-01-686-3123** IV Catheter, BD Isyte Autoguard BC, 16g (Part # 382557)

**6515-CF-002-8702** IV Catheter, BD Isyte Autoguard BC, 18g (Part # 382544)

**6515-CF-002-8703** IV Catheter, BD Isyte Autoguard BC, 20g (Part # 382534)

Advanced Supraglottic Airway (i-gel) is implemented into the SAR Pen Kit; King Air Advanced Airway's removed/deleted from all operational kits and returned to the pharmacies soonest.

- AIRWAY SUPRAGLOTTIC PEDIATRIC SIZE 2. (Part # 8202000) 6515-99-361-3111
- AIRWAY SUPRAGLOTTIC PEDIATRIC SIZE 2.5 (Part # 8225000) 6515-99-391-2691
- AIRWAY SUPRAGLOTTIC, ADULT, SIZE 3 (Part # 8703000) 6515-01-619-7360
- AIRWAY SUPRAGLOTTIC, ADULT, SIZE 4 (Part # 8704000) 6515-01-618-8278
- AIRWAY SUPRAGLOTTIC, ADULT, SIZE 5 (Part # 8705000) 6515-01-621-2401

-----2018-----

Change #

- 1801 (Jun 1) Add Medium (6515-CF-002-7588) and XL (6515-CF-002-7588) exam gloves to all glove places. Also added NSN for Geratherm and components.
  - Geratherm Re-Warming Blanket 6532-01-596-1253
  - Geratherm AC power adapter 6130-01-600-0763
  - Geratherm Battery 6135-01-517-6060

Change #

- 1802 (Oct 5) Medical Equipment packing list has been updated. Replace all CONTAINER, SHARPS, TRANSPORTABLE NS 6515-CF-002-8742 currently in circulation & in any medical kit with NS 6530-20-011-4406 DISPOSAL CONTAINER, HYPODERMIC NEEDLE AND SYRINGE, 0.15L. Additionally the Accu-Check Aviva and its control solutions is replaced by the respective Contour Next items in SAR medical kits NS 6630-CF-002-9326.

Change #

- 1803 (Dec 18) Remove IV (Knubley Ripper) Pole from all medical kits; Request sent to Diane Bergeron in Ottawa.

-----2017-----

Change #

- 1701 (March 22) Remove for disposal all TALON EZ IO (NSN 6515-CF-002-8898) from SAR penetration kits. Replace with: IO Power Driver (NSN 6515-01-571-3152). Ensure each SAR Tech Pen kit is equipped with a Power Driver, needle sets, 25mm, 45mm and stabilizer patch IAW amended ST kit lists published on Div Surg Website.

- 1702 (March 22) Remove all Intra-nasal injection syringes, (6515-CF-002-8362) from ST Penetration kits(Drug kit) IN injection. This route discontinued from SAR Tech use at this time.

- 1703 (March 22) Order Contour Next Blood Glucose analyzer, (if you haven't yet)
  - 6630-CF-002-9326 ANALYZER, BLOOD GLUCOSE, HAND-HELD
  - 6550-CF-002-9329 SOLUTION, LOW CONTROL (LEVEL 1), FOR GLUCOSE MONITOR 6630-CF-002-9326
  - 6550-CF-002-9330 SOLUTION, NORMAL CONTROL (LEVEL 2), FOR GLUCOSE MONITOR 6630-CF-002-9326
  - 6550-CF-002-9331 SOLUTION, HIGH CONTROL (LEVEL 3), FOR GLUCOSE MONITOR 6630-CF-002-9326
  - 6550-CF-002-9328 TEST STRIPS, FOR GLUCOSE MONITOR 6630-CF-002-9326

and upon receipt, familiarize unit ST's with its use. Remove Glucose Analyzer, True to Go. It is discontinued by Manufacturer. Equip SAR Tech Med kits with Contour Next.

Change #

- 1601 Add 5" Clearlink extension from pen/sup kits  
Remove 5" Interlink extension from kits
- 1602 Add 37" Medication admin IV set to kits x 2
- 1603 Real Splint re-introduced to SAR kit list (identified requirement)
- 1604 Nex Splint is to be removed from all SAR kits. Remove 6515-01-570-3316
- 1605 NSN Changes for IV Cathelons –See new kit list #'s when ordering.
- 1606 Remove the following ventilation masks from Pen and O2 kits:  
Mask Child 6515-21-897-6434  
Mask Adult 6515-21-897-6433  
Add following replacement masks to Pen and O2 kits:
  - a. Bi-Mask Child 6515-CF-002-9451 1
  - b. Bi-Mask Adult Small -Yellow 6515-CF-002-9452 1
  - c. Bi-Mask Adult Large -Purple 6515-CF-002-9453 1
- 1607 Remove the following 3 obsolete items from the Pen kit:
  - a. 6515-CF-001-7496 Tube restraint
  - b. 6515-01-452-5833 Connector ventilator
  - c. 6515-CF-001-9479 Cannula Blunt Plastic 17 G

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1501	Add NS 250ml bag x 2 per pen kit	
1502	Remove NS 1000ml bag per pen kit	
1503	Remove Asherman Chest Seal	
	Add Sam Chest Seal (valve + non-valved) pen/triage	
1504	Remove skin stapler Pen kit	6515 CF-000-7809
	Replace with disposable skin stapler	6515-CF-001-8103
1505	Remove all Interlink IV tubing	
	Replace with Clearlink IV tubing pen/sup kit	6515-CF-002-9076
1506	Add EZ IO Talon Pen kit	6515-CF-002-8898
1507	Add Blunt needle 18g x 1.5"	
1508	Remove 18g 1.5" needle	
1509	Remove Dexamethasone tabs 4 mgs pen kit	6505-21-912-4732
1510	Remove Epi pen and Epi pen JR pen kits	
1511	Remove Dextrose 10% 250ml bag	
1512	Add D 10 50% prefilled syringe Pen	6505-CF-002-7857
1513	Add Optimum Traction Device	6515-CF-002-9034
	(to replace Kendrick Trac device on condition)	
1514	Add Cassettes refill "Buddylight" IV warmers	6515-01-542-4545
1515	Needle IO 45mm Humerous	651-C-002-9076
1516	Triage tag Black (deceased)	6515-CF-002-9039
1517	Sensor SPO2 disposable (stick-on)	6515-CF-002-9105 (Box of 24)
1518	Add Catheter IV dual port 18g x 1.25"	6515-CF-002-8710;
	And Catheter IV dual port 22g x 1in.	6515-CF-002-8706
1519	Add Hypothermia Blanket, Geritherm	

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Amendments to Unit SAR Tech Medical Kit lists: (to correlate to J4 ST Med kit list)	Quantity	NSN
1. Add PEP drugs: Emtricitabine200mg/ Tenofovir 300mg Tab	30	6505-CF-002-8890
2. Add PEP Raltegravir Potassium 400mg Tab	60	6505-CF-002-8891
3. Add Lidocaine 2% inj 20 Mg/ml 5ml vial	2	6505-CF-0026095
4. Add Needle 22G x 1in	3	6515-CF-002-8695
5. Add Needle 25G x 1.5 in	3	6515-CF-002-8699
6. Add Syringe, hypodermic 2.5 to 3ml	3	6515-CF-284-2686
7. Add Hypodermic syringe 10 cc (increase to)	5	6515-01-356-8511
8. Add Tranexemic Acid liq inj 100mg /10ml Amp	2	6505-CF-002-1954
9. Add Ringers Lactate 1000ml bg	1	6505-21-855-3742
10. Remove Penta span 10% Remove Penta span 10%		

