

Team# _____ Cycle # _____ Scenario #1

NO.	SCENE/PRIMARY SURVEY	FINDINGS
1	Did the team TAKE CHARGE of the situation? (remained calm themselves?)	<input type="checkbox"/>
2	Did the team wear protective GLOVES?	<input type="checkbox"/>
3	Did the team ASSESS for HAZARDS?	<input type="checkbox"/>
4	Did the team ensure the saw was off?	<input type="checkbox"/>
5	Did the team CALL OUT FOR HELP?	<input type="checkbox"/>
6	Did the team ASK for SITUATION HISTORY?	<input type="checkbox"/>
7	Did the team DETERMINE the NUMBER OF CASUALTIES?	<input type="checkbox"/>
8	Did the team ID SELF and OBTAIN CONSENT?	<input type="checkbox"/>
9	Did the team WARN THE CASUALTY NOT TO MOVE?	<input type="checkbox"/>
10	Did the team CONTROL C-SPINE to prevent movement?	<input type="checkbox"/>
11	Did the team ASSESS LEVEL OF CONSCIOUSNESS?	<input type="checkbox"/>
12	Did the team ASSESS AIRWAY?	<input type="checkbox"/>
13	Did the team ASSESS BREATHING?	30 breaths per minute, Rapid, Shallow
14	Did the team attempt to Coach BREATHING?	Coaching help settle, slow increases to next vitals
15	Did the team apply SpO2 Monitor? (Circulation)	96% on Room Air
16	Did the team ASSESS PULSE? (Circulation)	<input type="checkbox"/>
17	Did the team ASSESS SKIN CONDITION (Circulation)	<input type="checkbox"/>
18	Did the team PERFORM A RAPID BODY SURVEY?	<input type="checkbox"/>
19	Did the team APPLY absorbant and sterile DRESSINGS to the BLEED on the Right Hand?	Severe Bleed on Right Hand with blood dripping
20	Did the team apply pressure or have the patient apply pressure?	<input type="checkbox"/>
21	Did the team reposition the patient and/or elevate the injury above the heart?	<input type="checkbox"/>
22	Did the team IMMEDIATELY COVER WITH A BLANKET for shock and warmth?	<input type="checkbox"/>
23	Did the team ACTIVATE EMS/AMBULANCE?	<input type="checkbox"/>
24		Total of SCENE/PRIMARY SURVEY 0

JUDGES NOTES:

This section is active for the first 3 minutes of the scenario only!

During these first 3 minutes, the competitor may perform the actions that are both listed here and in the Secondary Survey. After the 3 minutes, the competitor is eligible to receive marks only in the Secondary Survey and no marks may be awarded in this Primary Survey.

JUDGES DO NOT TALLY MARKS FROM YOUR OWN SHEETS!

Judges MUST check the box for each task, an unchecked box is an uncompleted task.

Score Sheet for Patient #1 - ""

SECONDARY SURVEY		
Actions in this section may be performed by the competitors at ANY point in the scenario. After the 3 first minutes, this section and beyond are the only areas that points shall be awarded Actions in this section may be done <u>in any order</u> .		
NO.	HISTORY OF THE PATIENT	FINDINGS
25	Did the team ask about SYMPTOMS	Glove got caught in wood saw in shop, 4 fingers amputated
26	Did the team ask about ALLERGIES?	None
27	Did the team ask about MEDICATIONS?	Ventolin
28	Did the team ask about MEDICAL HISTORY?	Asthma
29	Did the team ask about LAST ORAL INTAKE?	2 hours ago - Chicken Fingers
30	Did the team determine INCIDENT HISTORY?	Was working with a wood saw and glove on R hand got caught, severing 4 fingers.
1st Set of VITAL SIGNS		FINDINGS
31	Did the team check LEVEL OF CONSCIOUSNESS?	Alert
32	Did the team indicate level on Glasgow Coma Scale (GCS)	GCS 15
33	Did the team check RESPIRATIONS?	30 Breaths per Minute (*Coached down to 20 then speeds up again*)
34	Did the time give ALL INFO (rate, rhythm, depth)	Rapid, Regular, Shallow
35	Did the team check PULSE?	124
36	Did the team give ALL INFO (Rate, Rhythm, Strength)	124bpm, Regular, Strong
37	Did the team check SpO2?	96% on Room Air
38	Did the team check BLOOD PRESSURE	140/89 On Auscultation
39	Did the team check SKIN CONDITION/TEMP?	Pale, Cool, Clammy
40	Did the team check PUPILS?	4mm PEARL
HEAD TO TOE EXAMINATION		FINDINGS

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41	Check SCALP/HEAD?	No Findings	<input type="checkbox"/>
42	Check both EYES?	No Findings	<input type="checkbox"/>
43	Check NOSE?	No Findings	<input type="checkbox"/>
44	Check CHEEBONES?	No Findings	<input type="checkbox"/>
45	Check MOUTH?	No Findings	<input type="checkbox"/>
46	Check JAW?	No Findings	<input type="checkbox"/>
47	Check both EARS?	No Findings	<input type="checkbox"/>
48	Check NECK?	No Findings	<input type="checkbox"/>
49	Check both COLLARBONES?	No Findings	<input type="checkbox"/>
50	Check both SHOULDERS?	No Findings	<input type="checkbox"/>
51	Check RIGHT ARM? (*MUST REMOVE GLOVE TO GET POINT*)	Stable, Amputation of 4 fingers at knuckles	<input type="checkbox"/>
52	Check LEFT ARM?	Stable, No Findings	<input type="checkbox"/>
53	Check CHEST?	No Findings	<input type="checkbox"/>
54	Did the team auscultate the chest? (PRO TEAMS MUST IN 6 POINTS TO COMPLETE TASK)	Air Entry Equal Bilateraly Apex to Base	<input type="checkbox"/>
55	Check ABDOMEN?	No Findings	<input type="checkbox"/>
56	Did they Palpate the 4 Quadrants of the abdomen?	Soft, Non-Tender	<input type="checkbox"/>
57	Check BACK?	No Findings	<input type="checkbox"/>
58	Did the Team auscultate the back? (PRO TEAMS MUST IN 6 POINTS TO COMPLETE TASK)	Air Entry Equal Bilateraly Apex to Base	<input type="checkbox"/>
59	Check PELVIS?	No Findings	<input type="checkbox"/>
60	Check RIGHT LEG?	Stable, No Findings	<input type="checkbox"/>
61	Check LEFT LEG?	Stable, No Findings	<input type="checkbox"/>
Total of SECONDARY SURVEY			0

Score Sheet for Patient #1 - ""

AMFR ASSESSMENT CONTINUTED			
Actions in this section may be performed by the competitor at any point in the scenario.			
NO.	RIGHT HAND ASSESSMENT - OPQRST	FINDINGS	
62	Did the team ASK about ONSET?	Sudden	<input type="checkbox"/>
63	Did the team ASK about PROVOKES?	People Touching, Movement of Arm	<input type="checkbox"/>
64	Did the team ASK about QUALITY?	Severe Sharp	<input type="checkbox"/>
65	Did the team ASK about REGION/RADIATION?	None	<input type="checkbox"/>
66	Did the team ASK if anything brings RELIEF?	"Nothing Helps"	<input type="checkbox"/>
67	Did the team ASK about SEVERITY?	10/10	<input type="checkbox"/>
68	Did the team ASK about TIME?	5 minutes ago	<input type="checkbox"/>
RE-ASSESSMENT of VITAL SIGNS (2nd Set) / and GENERAL PATIENT CARE (after 10 min into Scenario)		FINDINGS	
69	Did the team IMMEDIATELY NOTE the CHANGE in LEVEL OF CONSCIOUSNESS?		<input type="checkbox"/>
70	Did the team Update EMS? (advised EMS is on route)		<input type="checkbox"/>
71	Did the team RE-ASSESS AIRWAY?	Patent	<input type="checkbox"/>
72	Did the Team prepare to insert an airway? (Must Be Proper Measuring Before)	DO NOT ALLOW team to insert	<input type="checkbox"/>
73	Did the team RE- ASSESS BREATHING?	Shallow & Rapid	<input type="checkbox"/>
74	Did the team RE-ASSESS PULSE? (Circulation)	weak, rapid,regular	<input type="checkbox"/>
75	Did the team RE-check LEVEL OF CONSCIOUSNESS? (2nd Set)	Verbal - Eye opening to voice confused verbal responses	<input type="checkbox"/>
76	Did the team indicate level on Glasgow Coma Scale (GCS)	GCS 12 (E3, V4, M5)	<input type="checkbox"/>
77	Did the team RE-check RESPIRATIONS? (2nd Set)	18, shallow, regular	<input type="checkbox"/>
78	Did the team RE-check SpO2? (2nd Set)	95% on Room Air	<input type="checkbox"/>
79	Did the team RE-check PULSE? (2nd Set)	130, weak, regular	<input type="checkbox"/>
80	Did the team RE-check BLOOD PRESSURE? (2nd Set)	100/62 by Auscultation	<input type="checkbox"/>
81	Did the team RE-check SKIN CONDITION/TEMP? (2nd Set)	Pale, Cool, Clammy	<input type="checkbox"/>
82	Did the team RE-check PUPILS? (2nd Set)	4mm PEARRL	<input type="checkbox"/>
Total of AMFR ASSESSMENT CONTINUED PAGE			0

Score Sheet for Patient #1

FIRST AID CARE/ TREATMENT			
Actions in this section may be performed by the competitor at any point in the scenario.			
NO.	Care for INJURY #1 - 4 Finger Amputation (Right Hand)	FINDINGS	
83	Did the team LEAVE the initial dressing on, placing others ovetop?		<input type="checkbox"/>
84	Did the team assess circulation to the thumb PRIOR to bandaging?	CSM intact	<input type="checkbox"/>
85	Did the team SECURE the dressing with no visible sections of the original injury seen?		<input type="checkbox"/>

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86	Did the team RE-CHECK CIRCULATION AFTER BANDAGING	CSM Intact	<input type="checkbox"/>
87	Did the team ELEVATE and secure the arm using a ST JOHN TUBULAR ARM SLING?		<input type="checkbox"/>
88	Did the team re-check the circulation after applying the ST JOHN TUBULAR ARM SLING ?	CSM Intact	<input type="checkbox"/>
Care for Amputated Fingers		FINDINGS	
89	Did the team Removed the fingers from the glove?		<input type="checkbox"/>
90	Did the team wrap each finger in moist dressings individually?		<input type="checkbox"/>
91	Did the team placed the wrapped finger in a bag/on with Ice/Coldpack?		<input type="checkbox"/>
92	Did the team label each finger with the name, time, identify each finger?		<input type="checkbox"/>
93	Did the team keep the Fingers with the patient?		<input type="checkbox"/>
RE-ASSESSMENT of VITAL SIGNS (3rd Set)		FINDINGS	
96	Did the team RE-check LEVEL OF CONSCIOUSNESS? (3rd Set)	Pain Responsive - Trap squeeze	<input type="checkbox"/>
97	Did the team indicate level on Glasgow Coma Scale (GCS)	GCS 11 (E2, V3, M5)	<input type="checkbox"/>
98	Did the team RE-check RESPIRATIONS? (3rd Set)	12, Shallow, Regular	<input type="checkbox"/>
99	Did the team RE-check PULSE? (3rd Set)	144, Rapid, Shallow	<input type="checkbox"/>
100	Did the team RE-check SpO2? (3rd Set)	91% Room Air	<input type="checkbox"/>
101	Did the team RE-check BLOOD PRESSURE? (3rd Set)	91/50 by Auscultation	<input type="checkbox"/>
102	Did the team RE-check SKIN CONDITION/TEMP? (3rd Set)	Pale, Cool, Clammy	<input type="checkbox"/>
103	Did the team RE-check PUPILS? (3rd Set)	5mm PEARRL	<input type="checkbox"/>
SHOCK & GENERAL CARE			
104	Was Oxygen Initiated appropriately (MUST BE NRB@15Lpm to Recieve Points)		<input type="checkbox"/>
105	Did the team REASSURE the patient about their OWN CARE?		<input type="checkbox"/>
	Did the Team Call and Update 911/EMS?		<input type="checkbox"/>
106	Did the teams keep the bag clean and prevented cross contamination	*Removed gloves between Patient and bag, No blood on bag*	<input type="checkbox"/>
107	Were GLOVES EFFECTIVE THROUGHOUT? (Torn gloves MUST be replaced!)		<input type="checkbox"/>
		Total of FIRST AID/TREATMENT	0

Score Sheet for Patient #1

NO.	RECORDING for Patient #1 - PART 1	
108	Was ALL of the patients PERSONAL INFORMATION recorded?	<input type="checkbox"/>
109	Was the INCIDENT TIME AND DATE recorded?	<input type="checkbox"/>
110	Was the INCIDENT LOCATION recorded?	<input type="checkbox"/>
111	Was the INCIDENT HISTORY (Accurately) recorded?	<input type="checkbox"/>
112	Was the patients ALLERGIES (None) recorded?	<input type="checkbox"/>
113	Was the patients MEDICATIONS (Ventolin MDI) recorded?	<input type="checkbox"/>
114	Was the patients MEDICAL HISTORY (Asthma) recorded?	<input type="checkbox"/>
115	Was the LAST ORAL INTAKE (Ate 2 hour before incident) recorded?	<input type="checkbox"/>
116	Was the patients INITIAL LEVEL of CONSCIOUSNESS (Conscious) recorded?	<input type="checkbox"/>
117	Was the TIME of the CHANGE in LEVEL OF CONSCIOUSNESS *10 minutes into scenario* recorded?	<input type="checkbox"/>
118	Was the PATIENT'S Continued SEMI CONSCIOUS state recorded? (Verbal then Pain responsive)	<input type="checkbox"/>
119	Was the ONSET (Sudden) recorded?	<input type="checkbox"/>
120	Was the PROVOCATION (Movement/Pressure) recorded?	<input type="checkbox"/>
121	Was the QUALITY (severe, sharp) recorded?	<input type="checkbox"/>
122	Was the REGION (Right Hand/Fingers) recorded?	<input type="checkbox"/>
123	Was the RADIATION (None) recorded?	<input type="checkbox"/>
124	Was the RELIEF (None) recorded?	<input type="checkbox"/>
125	Was the SEVERITY (10/10) recorded?	<input type="checkbox"/>
126	Was the TIME (5 minutes Prior) recorded?	<input type="checkbox"/>
Total of RECORDING/ DOCUMENTATION - PART 1 ONLY		Total of RECORDING/ DOCUMENTATION - PART 1 ONLY
		0

Score Sheet for Patient #1

NO.	RECORDING for Patient #1 - PART 2	
Vital Signs MUST be the CORRECTED #s & HAVE the TIME recorded, to be awarded points !!!		
127	Was 1st set of vital signs - LEVEL OF CONSCIOUSNESS recorded	<input type="checkbox"/>
128	Was 1st set of vital signs - RESPIRATIONS recorded?	<input type="checkbox"/>
129	Was 1st set of vital signs - PULSE recorded?	<input type="checkbox"/>
130	Was 1st set of vital signs - BLOOD PRESSURE recorded?	<input type="checkbox"/>
131	Was 1st set of vital signs - SKIN CONDITION recorded?	<input type="checkbox"/>
132	Was 1st set of vital signs - PUPILS recorded?	<input type="checkbox"/>
133	Was 1st set of vital signs - SpO2 recorded?	<input type="checkbox"/>
134	Was 2nd set of vital signs - SpO2 recorded?	<input type="checkbox"/>

135	Was 2nd set of vital signs - LEVEL OF CONSCIOUSNESS recorded	<input type="checkbox"/>
136	Was 2nd set of vital signs - RESPIRATIONS recorded?	<input type="checkbox"/>
137	Was 2nd set of vital signs - PULSE recorded?	<input type="checkbox"/>
138	Was 2nd set of vital signs - BLOOD PRESSURE recorded?	<input type="checkbox"/>
139	Was 2nd set of vital signs - SKIN CONDITION recorded?	<input type="checkbox"/>
140	Was 2nd set of vital signs - PUPILS recorded?	<input type="checkbox"/>
141	Was 3rd set of vital signs - LEVEL OF CONSCIOUSNESS recorded	<input type="checkbox"/>
142	Was 3rd set of vital signs - RESPIRATIONS recorded?	<input type="checkbox"/>
143	Was 3rd set of vital signs - PULSE recorded?	<input type="checkbox"/>
144	Was 3rd set of vital signs - SpO2 recorded?	<input type="checkbox"/>
145	Was 3rd set of vital signs - BLOOD PRESSURE recorded?	<input type="checkbox"/>
146	Was 3rd set of vital signs - SKIN CONDITION recorded?	<input type="checkbox"/>
147	Was 3rd set of vital signs - PUPILS recorded?	<input type="checkbox"/>
148	Was the APPLICATION OF OXYGEN recorded?	<input type="checkbox"/>
149	Was the TYPE OF OXYGEN DELIVERY DEVICE & FLOW RATE recorded?	<input type="checkbox"/>
150	Was the Ruleout of C-SPINE recorded?	<input type="checkbox"/>
151	Was the PRE-BANDAGING CIRCULATION of the RIGHT ARM recorded?	<input type="checkbox"/>
152	Was the BANDAGES used to Dress the Right Hand recorded?	<input type="checkbox"/>
153	Was the ARM SLING for the RIGHT Hand recorded?	<input type="checkbox"/>
159	Was the POST-BANDAGING CIRCULATION of the RIGHT ARM recorded?	<input type="checkbox"/>
160	Was the Application of a BLANKET OVER the patient recorded?	<input type="checkbox"/>
162	Was the NOTIFICATION OF EMS WITH TIME recorded?	<input type="checkbox"/>
163	Was the Name(s) of the first aid team LEGIBLY recorded?	<input type="checkbox"/>