

Mountain Rescue Casualty Card

(to be completed as fully as possible by first aider, and to remain with casualty on transfer)

Personal Details

Name:
Date of Birth:
Home Address / Telephone:

Next of Kin Details

Name:
Relationship:
Telephone:
Address:

Medical Details

Known Allergies:

Past Medical History:

Medications:

Last fluid / food consumed:

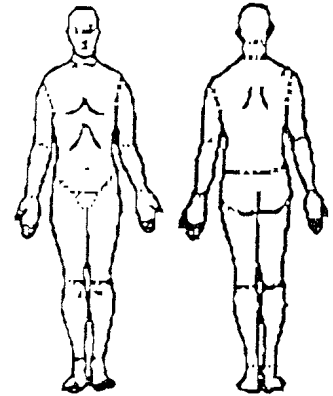
Description of Accident / Complaint

Time:
Description:

Injury / Illness Report

Nature and extent of injuries / illness:
(please indicate wound, fracture, pain or other opposite)

Treatment given to date (if any):



Vital Signs

Time	Level of Consciousness (Alert, responds to Verbal stimulus, responds to Pain, Unresponsive)	Heart Rate Full/weak? Regular/irregular? (normal adult = 60-80/min)	Respiratory Rate Laboured? Shallow/Deep? Regular/Irregular? (normal adult = 12-20/min)	Blood Pressure (normal for systolic BP = approx. 100 + Age)	Capillary Refill (normal = less than 2 secs)	Skin Colour and Temperature	Pupillary Reaction Normal = equal and reacting to light. If not please specify

Other Information

First Aid

This information is intended to serve as a 'memory jogger' only. You should attend a recognised First Aid course at least once every three years. Rescue Emergency Care (REC) first aid courses are specifically focused on an outdoor environment. See the MCI website (www.mountaineering.ie) for details of courses.

SCENE ASSESSMENT

Ensure that it is safe to approach the casualty, and deploy body substance isolation procedures if possible (eg. latex gloves).

PRIMARY ASSESSMENT

Airway (with **c-spine** control) – Ensure that the casualty's airway is patent using a head tilt-chin lift manoeuvre (spinal injury not suspected) or a tongue-jaw lift (spinal injury suspected). Check to make sure the airway is clear and unobstructed. Remove any obvious obstructions if it is safe to do so (ie. there is no possibility of obstructions being pushed deeper into the airway).

Breathing – Check respiratory function, ie. breathing rate, depth, regularity, clarity. The decision on whether to commence CPR is discussed below.

Circulation – Check pulse characteristics, ie. rate, strength, regularity. The decision on whether to commence CPR is discussed below. Check for bleeding and control severe blood loss as soon as possible using direct pressure. If this fails, use indirect pressure. Check capillary refill time at the extremities (eg. nail beds). Assess skin colour and temperature. Note any cyanosis.

Disability – Assess level of consciousness using the AVPU scale (alert, responds to verbal, responds to pain, unresponsive). Check for pupillary reaction. Check sensory and motor function of all extremities. Note any obvious fractures.

SECONDARY ASSESSMENT

Perform full casualty examination:

Start from the head and work downwards, checking for blood/other body fluid, deformities, pain, obvious wounds, swelling, bruising, tenderness, medic-alert jewellery, limb function etc..

Treat Injuries:

Do the best you can using the resources available to you. Do **not** attempt to move the casualty if you suspect spinal injury, unless you are fully practiced in spinal lifting techniques. Treat for shock if necessary.

Promote Recovery:

Ensure that the casualty is kept warm and reassured. Place a casualty with a reduced level of consciousness in the safe airway position (recovery position) if it is safe to do so. It is acceptable to give a conscious casualty hot drinks if surgery will not be necessary. Use plenty of dry warm clothing, sleeping bag, survival bag / survival shelter / tent. Consider moving to a more sheltered location if it is safe to do so.

HYPOTHERMIA

Possible signs and symptoms: physical and mental lethargy, slurred speech, shivering (early stages), cyanosis, uncharacteristic behaviour, dizziness, blurred vision, feelings of warmth and denial that anything is wrong, stupor, collapse.

Treatment: give hot sweet drinks and energy food, use additional dry clothing (especially hat and outer shell layer), find a sheltered location, use survival bag, sleeping bag, tent etc., use a fit party member to share body warmth, do **not** give alcohol, do **not** rub the casualty.

Caution: If one party member is suffering from hypothermia, it is likely that others in the party may also be suffering to a greater or lesser degree - including yourself! Be aware of the 'bigger picture'!

LOWER LEG INJURY

Lower leg injury is an extremely common injury for walkers, and therefore warrants particular mention here. In the mountain environment the treatment basically consists of bandaging any open wound to prevent blood loss and minimise the risk of infection, re-aligning the limb to a neutral position if possible, and immobilising it. Typically, the limb will be immobilised by splinting it to the 'good' leg. Circulatory, sensory and motor function in the limb (particularly distal to the fracture site) should be checked initially, immediately after every intervention made, (ie. after moving the limb, after bandaging, after splinting etc.), and periodically thereafter. The vital signs of the casualty should be monitored carefully.

Upper leg injury (eg. fractured femur) is less common but more serious, and may require treatment for shock, as internal blood loss into the tissues of the thigh can be severe. Strong muscle spasms/cramps may occur, causing severe pain and possible distortion of the fractured limb.

CPR IN THE MOUNTAIN ENVIRONMENT

The decision on whether to commence CPR on a non-breathing pulseless casualty in a mountain environment is never easy. You should be aware that:

- 1) Depending on your location, it may be several hours before medical help is available.
- 2) Once you have commenced CPR it should be continued until you are physically unable to continue (eg. exhaustion).
- 3) If you commence CPR it will prevent you from calling for help for, or assisting, any other injured party members.

