



MAHATMA GANDHI UNIVERSITY
of
MEDICAL SCIENCES & TECHNOLOGY
JAIPUR

VAC 03

**ATLS INSTRUCTOR
COURSE**

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Sponsoring Body: India Education Trust

ATLS® Course Eligibility

Course	Essential Qualifications	Desirable Qualifications
ATLS® Provider course for Doctors (3 Days)	MBBS / BDS	Should be working in Emergency care and treating Trauma Patients
ATLS® Instructor course for Doctors (2 Days)	Successful completion of the Student Course and be identified as having Instructor Potential.	Working in the field of Trauma Care and should be willing to be a part of instructor core and also willing to spare time for future ATLS courses as Instructor

ATLS® instructor course is a two day course which includes-

1. Interactive lectures and microteaching presentations
2. Group discussion and triage scenarios
3. Skill station teaching and practice teaching skill stations
4. Initial assessment (moulage) station teaching and practice teaching initial assessment stations

Course Registration

Fill in the Registration Form and mail it with your non-refundable payment of fee to the address mentioned in the registration form.

Please make the Bank draft as per the details mentioned in the registration form. No form will be accepted without full payment.

Wire Transfer: You can also pay through Wire Transfer. Please contact us for bank details.



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The primary survey (ABCD) is the cornerstone of the initial assessment of the trauma patient. Repeat the primary survey frequently to identify any deterioration in the patient's status that indicates the need for additional intervention.

Objectives

By the end of this interactive discussion, you will be able to:

Explain the importance of preparation prior to trauma patient arrival.

Evaluate the mechanism of injury to determine the patient's potential injuries.

Identify the correct sequence of priorities for the assessment of a multiply injured patient.

Apply the principles of the primary and secondary surveys to the assessment of a multiply injured patient.

Discuss the importance of reevaluating a patient who is not responding appropriately to initial resuscitation and management.

Recognize patients who require transfer to another facility for definitive management.

Case Scenario Progression

Primary survey reveals:

- Obvious facial trauma and mumbling incoherently.
- Decreased breath sounds, L chest; no visible neck veins
- Minimal bleeding; open L femur fracture; L chest bruising; possible pelvic fracture
- Localizes to pain with upper extremities; moans to painful stimuli; does not open eyes



Review Objectives

By the end of this interactive discussion, you will be able to:

Explain the importance of preparation prior to trauma patient arrival.

Evaluate the mechanism of injury to determine the patient's potential injuries.

Identify the correct sequence of priorities for the assessment of a multiply injured patient.

Apply the principles of the primary and secondary surveys to the assessment of a multiply injured patient.

Discuss the importance of reevaluating a patient who is not responding appropriately to initial resuscitation and management.

Recognize patients who require transfer to another facility for definitive management.

Key Learning Points

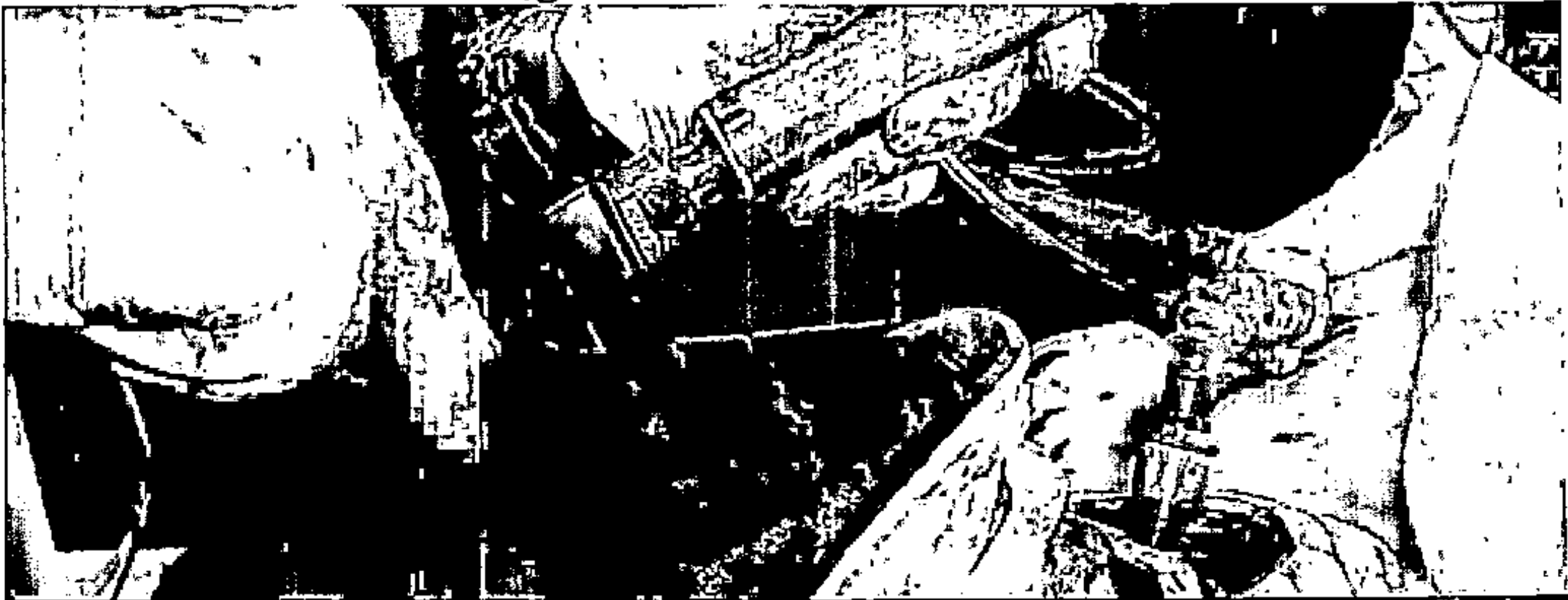
The initial management of the injured patient requires:

- coordination with prehospital providers
- preparation for receiving the patient
- anticipation of injuries based on the mechanism of injury

The evaluation of all trauma patients follows a precise algorithm

Patients who exceed the capability of the institution should be identified rapidly and process for transfer begun.

Evaluate the patient according to priority using the ABCDEs.



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The earliest priorities in managing the injured patient are to ensure an intact airway and recognize a compromised airway.



Objectives

By the end of this interactive discussion, you will be able to:

Identify different clinical situations in which airway compromise is likely to occur.

Recognize the signs and symptoms of acute airway compromise in a trauma case scenario.

Determine factors that may lead to a difficult airway.

Apply the ATLS airway algorithm to a case scenario involving a patient with a difficult airway.

Define the term *definitive airway*.

Key Learning Points

One of earliest priorities is recognizing a compromised airway.

All trauma patients should receive supplemental oxygen.

Risk of airway compromise and difficult airway management can be predicted.

Alterations in mental status (agitation, combativeness, confusion, or obtundation) may indicate the need for airway management.

A definitive airway (cuffed tube in trachea below vocal cords) should be obtained in cases of airway compromise.



Shock

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The first step in the initial management of shock is to recognize its presence. The diagnosis of shock is based on clinical recognition of the presence of inadequate tissue perfusion and oxygenation.

Activate Windows
Go to Settings to activate Windows.

Shock

Objectives

By the end of this interactive discussion, you will be able to:

- Apply the ATLS principles to the management of a trauma patient with shock.
- Recognize the signs and symptoms of shock.
- Evaluate a patient case scenario to determine the possible causes of shock.
- Discuss the changes that may be seen on initial investigations of a patient with shock.
- Evaluate the efficacy of initial fluid management of a patient in shock.
- Discuss the impact of special patient factors on the management of shock.

Review Objectives

By the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a trauma patient with shock.

Recognize the signs and symptoms of a trauma patient in shock.

Evaluate a patient case scenario to determine the possible causes of shock.

Discuss the changes that may be seen on initial investigations of a patient with shock.

Evaluate the efficacy of initial fluid management of a patient in shock.

Discuss the impact of special patient factors on the management of shock.

Shock

Key Learning Points

Hemorrhage is the most common cause of shock after injury.

No single laboratory test and no single vital sign on its own can diagnose shock.

Massive blood loss may produce only minimal acute decrease in hemoglobin and hematocrit.

Major soft tissue injuries and fractures can be associated with significant hemorrhage.

The patient's response to initial fluid therapy will help guide subsequent therapy.

A variety of special conditions may affect the patient's response to shock and the management of it (e.g., age, medication use).



Thoracic Trauma

Tenth Edit



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Thoracic Trauma

Thoracic injury is common in polytrauma patients and can be life-threatening, especially if not promptly identified and treated during the primary survey.

Thoracic Trauma

Objectives

By the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a patient with thoracic trauma.

Recognize the important life-threatening injuries in a patient with thoracic trauma.

Evaluate the case scenario of a patient with thoracic trauma to identify immediate life-threatening injuries.

Discuss the clinical findings and adjunctive studies that may be useful during the secondary survey in a patient with thoracic trauma.

Thoracic Trauma

Potential Life Threat	Clinical Presentation/Findings	Treatment	Pitfalls
Simple Pneumothorax	+/- shortness of breath No hypotension Diagnosis by chest x-ray	Chest tube drainage	Could become tension pneumothorax if untreated
Hemothorax	Dullness to percussion Diagnosis by chest x-ray	Chest tube drainage	Could become massive hemothorax
Flail Chest and Pulmonary Contusion	May see paradoxical movement of chest wall More commonly presents with pain and poor respiratory excursions	Oxygen Analgesia Intubation if necessary	Progressive respiratory failure
Blunt Cardiac Injury	ECG changes	Cardiac monitoring Therapy based on clinical status	At risk for clinically significant dysrhythmias
Traumatic Aortic Disruption	May be asymptomatic Multiple possible radiographic findings	Endovascular or open surgical repair	Blood pressure control important prior to definitive therapy
Traumatic Diaphragm Injury	Respiratory distress Obscured left diaphragm border Evidence of abdominal viscera in chest	Operative repair	Concomitant pulmonary contusion may mask diaphragm injury
Esophageal injury	Chest pain; mediastinal air on imaging; crepitus delayed fever	Operative repair	Delayed diagnosis

Review Objectives

By the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a patient with thoracic trauma.

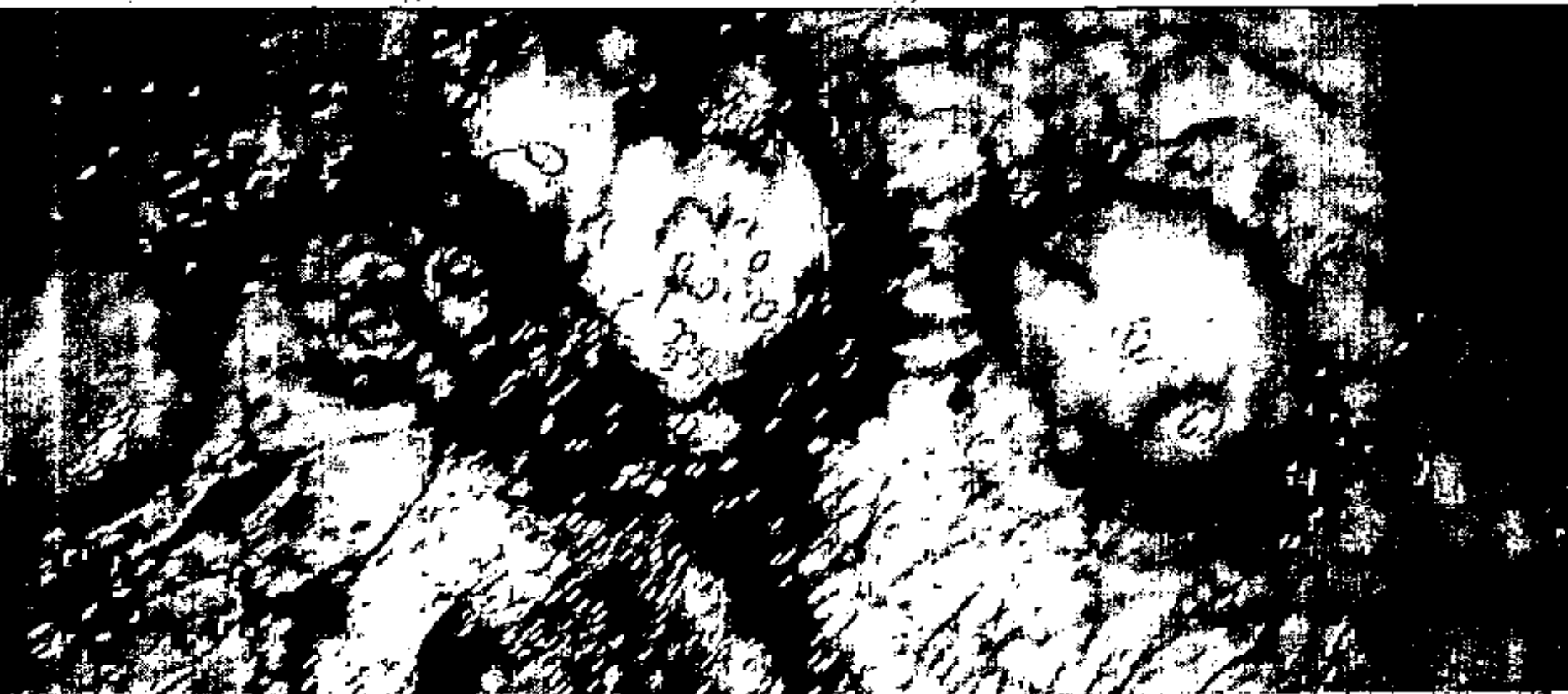
Recognize the important life-threatening injuries in a patient with thoracic trauma.

Evaluate the case scenario of a patient with thoracic trauma to identify immediate life-threatening injuries.

Discuss the clinical findings and adjunctive studies that may be useful during the secondary survey in a patient with thoracic trauma.

Key Learning Points

1. It is important to recognize thoracic life-threatening problems in polytrauma patients.
2. Most immediate thoracic life-threatening problems can be recognized without special testing and may be treated with:
 - airway control
 - decompression and/or
 - fluid resuscitation
3. Potential life-threatening problems can become immediate life-threatening problems if untreated (e.g., a simple pneumothorax can become a tension pneumothorax).



Abdominal and Pelvic Trauma

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Abdominal and Pelvic Trauma

When uncontrolled or unrecognized, blood loss from abdominal and pelvic injuries can result in preventable death.

Abdominal and Pelvic Trauma

Objectives

By the end of this interactive discussion, you will be able to:

- Identify the anatomic regions of the abdomen that are critical in assessing and managing trauma patients.
- Discuss the risk for abdominal and pelvic injuries based on the mechanism of injury.
- Identify patients who require surgical consultation and possible surgical and/or catheter-based intervention.
- Determine appropriate diagnostic procedures to ascertain if a patient has ongoing hemorrhage and/or other injuries that can cause delayed morbidity and mortality.
- Formulate an acute management plan for abdominal and pelvic injuries utilizing a case scenario.
- Discuss the importance of early identification and emergent management of pelvic hemorrhage.

Review Objectives

By the end of this interactive discussion, you will be able to:

Identify the anatomic regions of the abdomen that are critical in assessing and managing trauma patients.

Discuss the risk for abdominal and pelvic injuries based on the mechanism of injury.

Identify patients who require surgical consultation and possible surgical and/or catheter-based intervention.

Determine appropriate diagnostic procedures to ascertain if a patient has ongoing hemorrhage and/or other injuries that can cause delayed morbidity and mortality.

Formulate an acute management plan for abdominal and pelvic injuries utilizing a case scenario.

Discuss the importance of early identification and emergent management of pelvic hemorrhage.

Key Learning Points

1. Mechanism of injury is critical when considering abdominal and/or pelvic injury.
2. Thorough examinations of the chest, abdomen, and pelvis (anterior, lateral; posterior, and perineum) are required to avoid missing significant injuries.
3. Appropriate diagnostic procedures should be employed.
4. Surgical intervention is assessed via clinical findings and the patient's response to management.
5. Early identification and emergent management of pelvic hemorrhage can be lifesaving.



Head Trauma

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Head Trauma

The primary goal of treatment for patients with suspected traumatic brain injury is to prevent secondary brain injury.

Head Trauma

Objectives

By the end of this interactive discussion, you will be able to:

Recognize the GCS score that corresponds to a severe head injury and indicates a comatose patient.

Identify the different types of intracranial bleeding seen on CT that are associated with traumatic brain injury.

Discuss the role of supplemental oxygen and systolic blood pressure maintenance in limiting secondary brain injury.

Describe the management of intracranial hypertension associated with the mass effect of blood or brain swelling.

Discuss the indications for early, rapid transfer to a center equipped to manage a patient with brain injury.

Review Objectives

By the end of this interactive discussion, you will be able to:

Recognize the GCS score that corresponds to a severe head injury and indicates a comatose patient.

Identify the different types of intracranial bleeding seen on CT that are associated with traumatic brain injury.

Discuss the role of supplemental oxygen and systolic blood pressure maintenance in limiting secondary brain injury.

Describe the management of intracranial hypertension associated with the mass effect of blood or brain swelling.

Discuss the indications for early, rapid transfer to a center equipped to manage a patient with brain injury.

Key Learning Points

GCS score is an objective, reproducible measurement of brain injury severity.

GCS of 8 or less is considered severe and indicative of a comatose patient.

Consider a CT scan of the head for any trauma patient with suspected traumatic brain injury.

Initial management of intracranial hypertension includes:

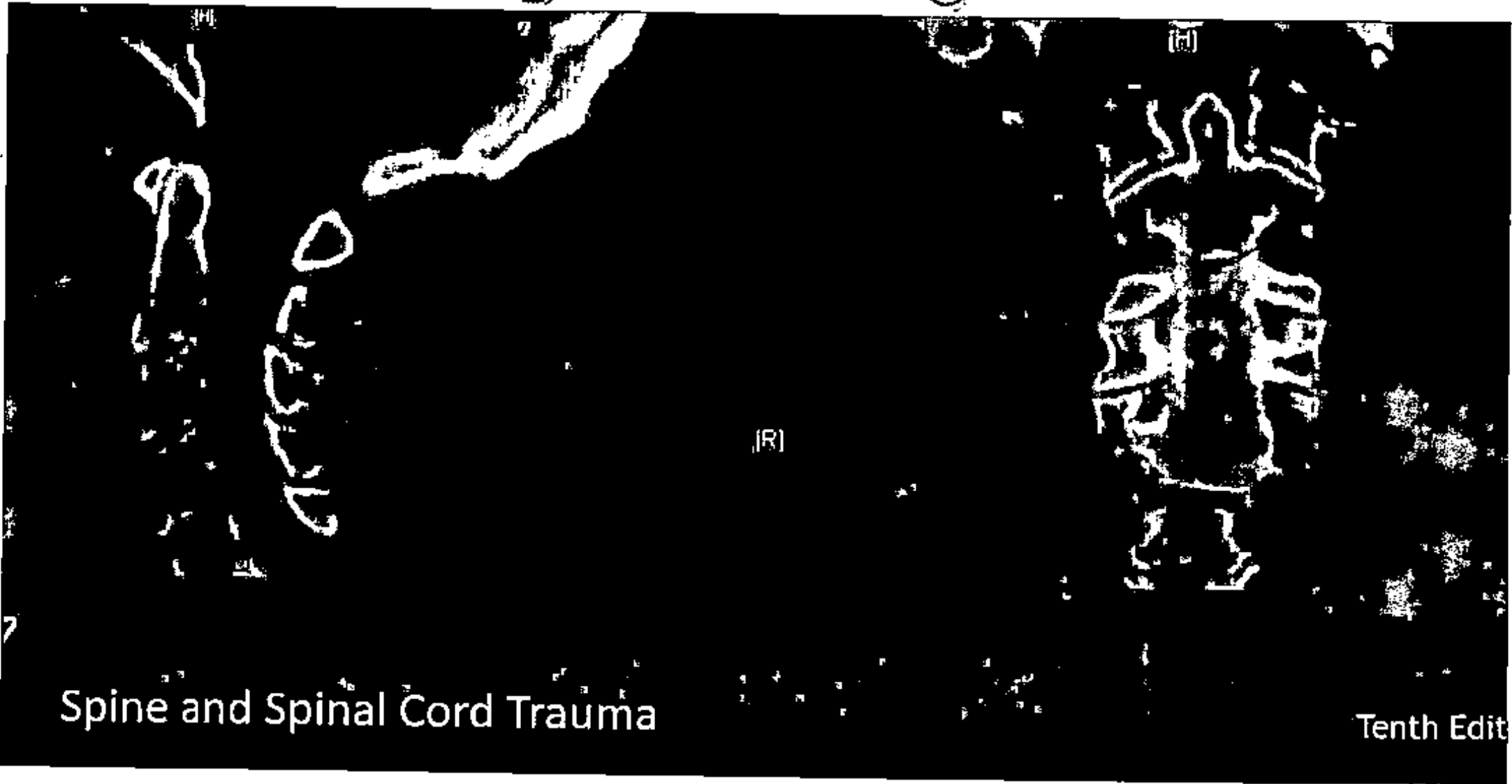
- elevation of the head of bed
- sedation
- selective administration of mannitol and hypertonic saline

Key Learning Points

Minimize secondary brain injury by:

- adequate oxygenation (supplemental oxygen)
- ensuring brain perfusion: SBP > 100 mm Hg (age 50-69) or > 110 mm Hg (15-49 and older than 70)

If no neurosurgical capability, consider early, rapid transfer



Spine and Spinal Cord Trauma

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Spine injury can occur with both blunt and penetrating trauma, and with or without neurological deficits, it must be considered in all patients with multiple injuries. These patients require restriction of spinal motion to protect the spine from further damage until spine injury has been ruled out.

7 Spine and Spinal Cord Trauma

Objectives

By the end of this interactive discussion, you will be able to:

- Apply the ABC principles of ATLS when assessing a patient for spine injury.
- Identify a common mechanism and type of spinal injury.
- Describe the typical signs and symptoms of a patient with a spinal cord injury.
- Describe the technique and importance of documentation of a potential spinal injury.
- Describe the appropriate initial treatment of patients with spinal injuries.
- Determine the appropriate disposition of patients with spine trauma.

Spine and Spinal Cord Trauma

Review Objectives

By the end of this interactive discussion, you will be able to:

Apply the ABC principles of ATLS when assessing a patient for spine injury.

Identify a common mechanism and type of spinal injury.

Describe the typical signs and symptoms of a patient with a spinal cord injury.

Describe the technique and importance of documentation of a potential spinal injury.

Describe the appropriate initial treatment of patients with spinal injuries.

Determine the appropriate disposition of patients with spine trauma.

Spine and Spinal Cord Trauma

Key Learning Points

Attend to the life-threatening injuries identified in the primary survey while minimizing movement of the spine.

Assume possible spinal injury until clinical and/or radiographic evaluation can be completed (decision tools such as Canadian C-Spine Rules or NEXUS may be used).

Be as specific and accurate as possible when describing and documenting the level of neurologic injury (ASIA tool is extremely useful).

High spinal cord injuries may be associated with respiratory failure and/or neurogenic shock, which must be addressed prior to transfer.

Consider obtaining early consultation with a spine surgeon when a spinal injury is suspected and/or detected.



Musculoskeletal Trauma

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Musculoskeletal Trauma

Injuries to the musculoskeletal system are common in trauma patients. The delayed recognition and treatment of these injuries can result in life-threatening hemorrhage or limb loss.

Musculoskeletal Trauma

Objectives

By the end of this interactive discussion, you will be able to:

Explain the significance of musculoskeletal injuries in patients with multiple injuries.

Outline the priorities of the primary survey, resuscitation and secondary survey of patients with extremity injuries.

Identify the adjuncts needed in the immediate treatment of life-threatening extremity hemorrhage.

Explain the principles of the initial management of limb-threatening musculoskeletal injuries.

Activate Windows
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Review Objectives

By the end of this interactive discussion, you will be able to:

Explain the significance of musculoskeletal injuries in patients with multiple injuries.

Outline the priorities of the primary survey and resuscitation of patients with extremity injuries.

Identify the adjuncts needed in the immediate treatment of life-threatening extremity hemorrhage.

Describe key elements of the secondary survey of patients with musculoskeletal trauma.

Explain the principles of the initial management of limb-threatening musculoskeletal injuries.

Key Learning Points

Hemorrhage from long bone fractures can be significant

Early splinting helps to control blood loss, reduce pain, and prevent further neurovascular compromise and soft tissue injury

Early weight-based dosing of antibiotics for patients with open fractures

Compartment syndrome is a clinical diagnosis, and the treatment is fasciotomy.



Thermal Injuries

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Dermal Injuries

The most significant difference between burns and other injuries is that the consequences of burn injury are directly related to the extent of the inflammatory response to the injury.

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Objectives

By the end of this interactive discussion, you will be able to:

Discuss the potential risks to the airway of patients with burn injuries.

Discuss resuscitation strategies for patients with burns.

Estimate the extent of a simulated patient's burn injury.

Describe the appropriate management of burn injuries, including circumferential burns.

Discuss the proper handover method for patients with burns.

Describe management of patients with hypothermia, including rewarming risks.

Describe the tissue effects of cold injury.

Describe the initial treatment of patients with tissue injury from cold exposure.

Thermal Injuries

Objectives

By the end of this interactive discussion, you will be able to:

- Discuss the potential risks to the airway of patients with burn injuries.
- Discuss resuscitation strategies for patients with burns.
- Estimate the extent of a simulated patient's burn injury.
- Describe the appropriate management of burn injuries, including circumferential burns.
- Discuss the proper handover method for patients with burns.
- Describe management of patients with hypothermia, including rewarming risks.
- Describe the tissue effects of cold injury.
- Describe the initial treatment of patients with tissue injury from cold exposure.

Key Learning Points

The most significant difference between burns and other injuries is that the consequences of burn injury are directly linked to the extent of the inflammatory response to the injury. This drives the rate and amount of edema formation.

The airway can become obstructed not only from direct injury (e.g., inhalation injury), but also from the massive edema resulting from the burn injury. Edema is typically not present immediately, and signs of obstruction may initially be subtle until the patient is in crisis.

In contrast to resuscitation for other types of trauma in which fluid deficit is typically secondary to hemorrhagic losses, burn resuscitation is required to replace the ongoing losses from capillary leak due to inflammation.

Key Learning Points

A fresh burn is a clean area that must be protected from contamination.

Ensure that there are flow sheets documenting the patient history, injury, IV fluids given, and urinary output. The flow sheet should be sent with the patient on transfer.

Although rapid rewarming is essential for management of frostbite and hypothermia, reperfusion can cause physiologic changes that need to be managed.



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Pediatric Trauma

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Injury remains the most common cause of death and disability in childhood. Injury morbidity and mortality surpass all major diseases in children and young adults, making trauma the most serious public health and health care problem in this population.



Objectives

By the end of this interactive discussion, you will be able to:

Identify the initial priorities of trauma assessment and management for children.

Describe the most appropriate interventions for managing difficult airways in pediatric trauma patients.

Recognize the most common causes of cardiac arrest in children.

Identify methods for obtaining venous access in children.

Discuss how to determine drug and fluid dosages in children.

Evaluate for nonaccidental trauma in a pediatric trauma case.



Review Objectives

By the end of this interactive discussion, you will be able to:

Identify the initial priorities of trauma assessment and management for children.

Describe the most appropriate interventions for managing difficult airways in pediatric trauma patients.

Recognize the most common causes of cardiac arrest in children.

Identify methods for obtaining venous access in children.

Discuss how to determine drug and fluid dosages in children.

Evaluate for nonaccidental trauma in a pediatric trauma case.

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Key Learning Points

The initial priorities of trauma assessment and management are the same for children and adults.

Surgical cricothyroidotomy is generally considered to be unsafe in small children (<12) due to the small size of the cricothyroid membrane and proximity to vocal cords. Needle cricothyroidotomy is preferred as a temporizing solution until other preparations are made.

Hypoxia and respiratory compromise are the most common causes of cardiac arrest in children.

Emergent venous access in children can be difficult. If unable to obtain peripheral access, intraosseous access should be obtained immediately.



Key Learning Points

Determination of weight is essential to pediatric trauma care in order to dose drugs and guide fluid and blood resuscitation. This can be accomplished by history, length-based resuscitation tape, or specialty stretchers with integrated scales.

Blunt solid organ injury in pediatric patients is usually managed non-operatively by a surgeon unless the patient is hemodynamically unstable or there are other indications for surgery.

Non-accidental trauma is a significant source of injury in children and has a higher mortality rate than corresponding accidental injuries. Specific injury patterns exist that should heighten concerns. Clinicians must have a high index of suspicion and report these cases appropriately.



1

Geriatric Trauma

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Geriatric Trauma

When managing geriatric patients with trauma, the effects of aging on physiological function and the impact of preexisting conditions and medications cannot be overemphasized.

1

Geriatric Trauma

Objectives

- By the end of this interactive discussion, you will be able to:
- Describe common mechanisms of injury seen in older adults.
 - Apply the ATLS principles to the management of an elderly trauma patient.
 - Understand the physiologic changes that occur with aging and how they affect the geriatric patient's injury and response to trauma.
 - Understand the common signs and causes of elder maltreatment.



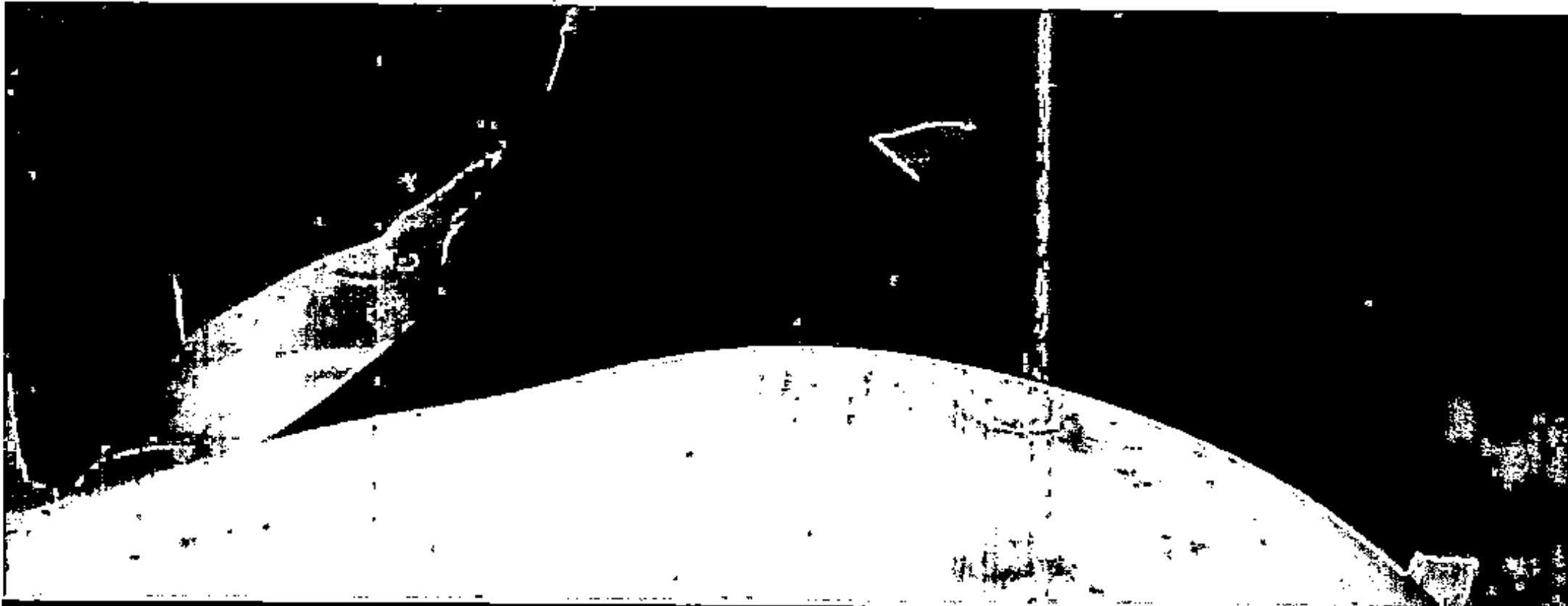
Review Objectives

By the end of this interactive discussion, you will be able to:

- Describe common mechanisms of injury seen in older adults.
- Apply the ATLS principles to the management of an elderly trauma patient.
- Understand the physiologic changes that occur with aging and how they affect the geriatric patient's injury and response to trauma.
- Understand the common signs and causes of elder maltreatment.

Key Learning Points

- Aging populations require an understanding of the special features and needs of elderly trauma patients.
- Decreased physiologic reserve and preexisting medical conditions can influence their outcomes.
- Understanding elderly patient anatomy and physiology is key to appropriate care
- Recognize the warning signs and impact of elder maltreatment



2 Trauma in Pregnancy and Intimate Partner Violence

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2

Trauma in Pregnancy and Intimate Partner Violence

Although pregnancy causes alterations in normal physiology and responses to injury and resuscitation, the sequence of the initial assessment and management of pregnant patients remains the same as for all trauma patients.

2 Trauma in Pregnancy and Intimate Partner Violence

Objectives

By the end of this interactive discussion, you will be able to:

Recognize that the approach to the care of pregnant trauma patients is the same as for all other trauma patients.

Identify the physiologic changes of pregnancy and their impact on the successful resuscitation of the mother and her pregnancy.

Determine management priorities regarding mother and fetus in a trauma case scenario.

Identify when to administer RH immunoglobulin therapy.

Recognize signs of intimate partner violence as a potential cause of injury in a pregnant trauma patient.

2

Trauma in Pregnancy and Intimate Partner Violence

Review Objectives

By the end of this interactive discussion, you will be able to:

Recognize that the approach to the care of pregnant trauma patients is the same as for all other trauma patients.

Identify the physiologic changes of pregnancy and their impact on the successful resuscitation of the mother and her pregnancy.

Determine management priorities regarding mother and fetus in a trauma case scenario.

Identify when to administer RH immunoglobulin therapy.

Recognize signs of intimate partner violence as a potential cause of injury in a pregnant trauma patient.

2

Trauma in Pregnancy and Intimate Partner Violence

Key Learning Points

The goals and approach to the care of pregnant patients are the same as for other trauma patients: Utilizing the ABCDE approach of the primary survey to identify and treat life-threatening problems, followed by the thorough head to toe assessment of the secondary survey.

Knowledge and understanding of the physiologic changes of pregnancy are key to the successful resuscitation of the mother and her pregnancy.

Fetal outcome is dependent upon successful maternal outcome; resuscitate mother first, and then assess the fetus.



3

Transfer to Definitive Care

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3

Transfer to Definitive Care

The decision to transfer a patient to another facility for definitive care is influenced by the identified and suspected injuries, the expected progression of these injuries, and the capabilities on hand to expeditiously diagnose and treat them, especially the potentially life-threatening injuries.

3

Transfer to Definitive Care

Objectives

By the end of this interactive discussion, you will be able to:

- Identify injured patients who require transfer to definitive care.
- Describe the responsibilities of the referring and receiving doctors during the process of timely transfer.
- Identify patients who require further timely imaging and/or stabilization before transfer.
- Recognize the need to provide ongoing care during transfer.

3

Transfer to Definitive Care

Review Objectives

By the end of this interactive discussion, you will be able to:

- Identify injured patients who require transfer to definitive care.
- Describe the responsibilities of the referring and receiving doctors during the process of timely transfer.
- Identify patients who require further timely imaging and/or stabilization before transfer.
- Recognize the need to provide ongoing care during transfer.

3

Transfer to Definitive Care

Key Learning Points

Physicians must assess and realize the capabilities of their institution prior to the arrival of a traumatically injured patient.

Because patient outcome is directly related to time elapsed between injury and appropriate definitive care, transfer agreements between institutions should be established and understood prior to their need for implementation.

Life-threatening injuries should be treated prior to transfer, to the extent possible with the capabilities of the transferring facility.

Mode of transportation should be determined by patient acuity and transport availability. Appropriate personnel should be available for the safe and expeditious care of patients.

3

Transfer to Definitive Care

Key Learning Points

Transfer to definitive care should not be delayed for additional radiographic studies or to prepare for procedures that the transferring institution is not a to perform.





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ATLS® Student Course Schedule

Mahatma Gandhi University
Medical Sciences & Technology,
Jaipur

Day 1,

0700 - 0730 REGISTRATION / FACULTY
MEETING/ BREAKFAST

0730 - 0745 WELCOME & INTRODUCTION

0745 - 0805 ATLS® COURSE OVERVIEW

0805 - 0845 INITIAL ASSESSMENT &
MANAGEMENT (Interactive Discussion)

0845 - 0900 INITIAL ASSESSMENT &
MANAGEMENT DEMONSTRATION

0900 - 0915 CRITIQUE & DISCUSSION

0915 - 0930 Break

0930 - 1000 AIRWAY AND VENTILATION
MANAGEMENT (Interactive Discussion)

1000 - 1030 SHOCK (Interactive Discussion)

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Day 1,

- 1110 **THORACIC TRAUMA (Interactive Discussion)**

- 1140 **ABDOMINAL & PELVIC TRAUMA (Interactive Discussion)**

- 1210 **PEDIATRIC TRAUMA (Interactive Discussion)**

- 1245 Lunch

- 1645 **PRACTICAL SKILLS SESSIONS**

Skills Stations 60 minutes each for Stations

Station	Skills Stations Name	Faculty
Station I	Basic/Advanced Airway Management	
Station II	Breathing	
Station III	Circulation	
Station IV	Pediatric Airway and Surgical Cricothyrotomy	

Day 1, continued

1645-1700 Break

1700-1740 **PRETEST GROUP DISCUSS FACULTY**

1740-1750 **DAY'S SUMMARY/ADJOURN (Faculty Meeting)**

TRAUMA (Interactive Discussion)

0900 - 0915

Break and move to skills sta

0915 - 1315
STATIONS

PRACTICAL
each Rotations 60 min

SK

<u>Skill Station</u>	<u>Skills Stations Name</u>	<u>Faculty</u>
Station V	Disability	
Station VI	Adjuncts	
Station VII	Secondary Survey	
Station VIII	Initial Assessment Practice and Team Training	

2,
- 0730

GOOD MORNING

- 0800
ussion)

HEAD TRAUMA (Interactive

- 0830

MUSCULOSKELETAL

UMA (Interactive Discussion)

- 0900

SPINE and SPINAL CORD

1315 - 1400

Lunch

Practical Skills Stations Rotation Schedule				
Time	Group A	Group E	Group C	Group D
0915 - 1015	Station V	Station VI	Station VII	Station VIII
1015 - 1115	Station VI	Station VII	Station VIII	Station V
1115 - 1215	Station VII	Station VIII	Station V	Station VI
1215 - 1315	Station VIII	Station V	Station VI	Station VII

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- 1430 **GERIATRIC TRAUMA – (Inter-
e Discussion)**

- 1500 **THERMAL INJURIES – Inter-
e Discussion**

1530 **TRAUMA IN PREGNANCY –
active Discussion**

- 1540 **Break**

- 1610 **TRANSFER TO DEFINITIVE
3 - Interactive Discussion**

1710 **TRIAGE SCENARIOS Discus-**

1720 **DAY'S SUMMARY / ADJOURN
(Faculty Meeting)**

Day 3,

[0630 – 0800]

- Moulage Patients
- All patient models and assistants]

0730 – 0800
assistants

Faculty meet with patients ar

0800 -1100

SKILLS STATIONS

(See page 9 and 10 for rotation s
ules)

Written Test

- Coordinator

Initial Assessment Skills Stations

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0 - 0800 Faculty meet with patients and as-
sistants

10 - 1100 **SKILLS STATIONS**
(See page 9 and 10 for rotation schedules)

Written Test
• Coordinator

Initial Assessment Skills Stations

Patient #1

Patient

Patient #3
Patient #4

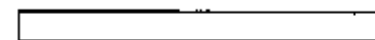
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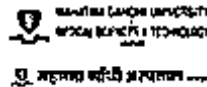
11 - 1130 **Post course Faculty Meeting**

Participants
1130 - 1200
GROUP PHOTO

Selection of Instructor Cou
SUMMARY/CLOSURE

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American College of Surgeons

ATLS® INDIA

ATLS® Instructor Course

Schedule

Mahatma Gandhi University Medical Sciences & Technology,

Jaipur

DAY 1-

12:30-13:00	Registration & Lunch, Mentee Meeting
13:00-13:30	Welcome, Introduction & Course Overview
13:30-14:15	Adult Teaching & Learning
14:15-14:35	Interactive Teaching
14:35-15:15	Demonstration of Interactive Discussion
15:15-15:35	Questioning Techniques
15:35-15:50	Break
15:50-16:25	Feedback
16:25-16:45	Micro Session Review and Micro Session Preparation
16:45-18:15	Interactive Lecture Microteaching sessions

(See rotation schedule) 6 IP candidates

ROTATION SCHEDULES- MICROCOURSE TEACHING

0-13:30 Welcome, Introduction & Course
 view
 0-14:15 Adult Teaching & Learning
 5-14:35 Interactive Teaching
 5-15:15 Demonstration of Interactive Dis-
 ion
 5-15:35 Questioning Techniques
 5-15:50 Break
 0-16:25 Feedback
 5-16:45 Micro Session Review and Mi-
 session Preparation

 5-18:15 Interactive Lecture Microteaching
 ons

**(See rotation schedule) 6 IP candi-
 dates**

ROTATION SCHEDULES- MICRO- TEACHING

DAY 2-

07:15 – 07:30 Welcome and Review
 of Day #1
 07:30-08:30 Interactive Lecture Micro
 teaching sessions
 08:30-09:00 Principles of Teaching a
 chomotor Session
 09:00-09:15 **Break**
 09:15-10:00 Skill Station Demonstr
 tion and Preparation for Teaching
 10:00 – 11:30 Practice Skill Stat
 (See Schedule)
 11:30-12:00 **LUNCH**

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14:05-14:30 Initial Assessment
Preparation

14:30-16:00 Initial Assessment Practice
(See Schedule)

16:00-16:15 Looking Back, Looking For-
ward

16:15-16:30 Course Summary, Closure
and Student Evaluations

16:30-17:00 Post Course Faculty

④ Meeting

ROTATION SCHEDULES- SKILLS STATIONS

Station I	Airway
Station II	Breathing
Station III	Circulation
Station IV	Disability