CHRONIC JOINT PAIN HISTORY TAKING

Action	**Marks available**
Brief intro – name, position, consent, confidentiality	2
Patient name, age, occupation	3
(H)PC – GOLDEN MINUTE	3
Brief hx of: 1. Pain 2. Stiffness 3. Swelling 4. Neurovascular 5. deformity	 4 1 1 1 1
Inflammatory disease features: • Dry/gritty eyes • Ulcer – mucous membranes • Raynaud's • Skin/nail changes/photosensitivity • Chest pain	4
Red flags: • Night pain • Weight loss • Haematuria	2
PMH	1
DH	1
FH	1
SH –e.g. primary carer of relative	1
ICE –what do you think caused it/is wrong What are you particularly concerned about What do you want to happen from here	1
Summarise	3
Screening	1
Thank you – I shall pass on relative information to the doctor	1
General marks	
Good rapport	1
Attentive listening, verbal and non-verbal cues	2
Structure and signposting	3
TOTAL MARKS	(38)

OSCE MARKSHEET FOR EXAMINATION OF THE HANDS AND WRISTS

Action	**Marks available**
Introduction, confidentiality and consent	1
Determines location of problem and negotiates appropriate undressing (elbows visible)	1
Places patients hand on pillow, ensures they are comfortable and asks about tenderness	1
LOOK	
Skin Asks patient to touch shoulder so elbows are visible Comments on any lesions	2
With hands pronated:	
Comment on skin on forearms, wrists, hands and fingers: erythema, thinning, purpura, sclerosis, telangiectasia, scars, rashes AND INFERENCES	4
Nails changes: Pitting, onycholysis, ridging and cracks. Nail fold vasculitis	4
Muscle bulk - interossei	1
Systematic evaluation of joints – wrists, MCP, PIP, DIP Swelling – bony/soft tissue and why Subluxation Alignment Deformities – swan neck/ boutonierrres Distribution (ask patient to lift hand off pillow to emphasise deformity)	4
Calcium deposits, heberdon's/bouchards nodes, Rheumatoid nodules	1
Ask patient to turn hands over and comment on pain	1
With hands supernated:	
Scars for Carpal tunnel decompression	1
Thenar/ hypothenar eminences	1
Squaring/Z-thumbs	1
Asks 3 questions	
Offers a reasons diagnosis (differential)	1
TOTAL MARKS	(24)

OSCE PRACTICE FOR HIP

Action	**Marks available**
General marks	
Wash hands	1
Introduction, consent	1
Explanation relating to patient and examiner	3
Expose both limbs	1
"if time I would examine:" 1. Both sides 2. Joints above and below 3. Neurological	1
LOOK	
(with the patient standing)	
Anterior, lateral and posterior	1
Mentions: 1. Deformity 2. Scars 3. Swelling 4. Muscle wasting	4
Assess and comments on **gait** (limp/antalgic/use of aids/obvious leg length discrepancy)	2
FEEL	
Asks for consent and **tenderness**	2
Temperature (both hips) with back of hand	1
Palpates(just affected sides) and vocalises: 1. ASIS 2. Iliac crest 3. Sacroiliac joint 4. Greater trochanter	5
Mentions: **B** ony landmarks (covered above) **E** ffusion **S** welling **T** emperature (covered above) **T** enderness (covered above)	2
MOVE	
Trendelenburg test: • Assess both legs - Good leg first • "if i had time 30 seconds" • +ve test would imply weak adductors e.g gluteus medius AND inference e.g. surgery	3
Extension (just bad leg) – active, passive and resisted while supporting patient (resistance given against upper leg)	3
(with patient on couch)	3
Flexion – active, passive and resisted	3
Abduction/adduction – active passive and resisted while supporting both iliac spines with forearm.	3

OSCE MARKSHEET FOR KNEE EXAMINATION

Action	**Marks available**
Introduction, confidentiality and consent	1
Determines location of problem and negotiates (appropriate) undressing	1
With patient standing:	
Look from anterior, lateral and posterior view: Skin – scars, rashes erythema Posture and symmetry (genu valgus/varus) Muscle bulk Bony structures	3
With patient on couch: Posture and symmetry (fixed flexion) Joint swelling	1
Feel Temperature Bony landmarks - Head of fibula, tibial tuberosity, patella tendon, patella (all around), joint line, condyles Behind knee for effusion/cysts	3
Effusion Patella tap OR sweep test	2
Move Flexion – active and passive feeling for creptitus Extension – active and passive (hyperextension >15^{o})	2
Cruciate ligaments Posterior – posterior sag/push on tibia Anteror draw test/Lachman's	2
Collateral ligaments – 15^{o} flexion and apply medial/lateral pressure	2
Function Assess gait	2
TOTAL MARKS	(19)

PRESCRIBING SKILLS MARKSHEET

Action	**Marks available**
Prescription	
Checks name and hospital number	1
Explains from page is one off prescriptions only	1
Mentions allergies (or lack of)	1
Fills in correct section of drug chart	1
DRUG NAME (CAPITALS)	2
Dose (correctly find in BNF) and correct annotation of units (e.g. micrograms)	2
Route	1
Time to be given (circles appropriate boxes)	1
Date and sign	1
(extra information written where appropriate)	
Pharmacology	
1. Describe mechanism of action of paracetamol - brain specific COX I and COX II inhibitor	2
2. Effects of paracetamol – analgesic and anti-pyrexic (not anti-inflammatory due to brain specificity)	2
3. Caution: hepatic impairment, renal impairment or alcohol dependence	1
TOTAL MARKS	(16)

OSCE MARKSHEET FOR SHOULDER EXAMINATION

Action	**Marks available**
General marks	
Wash hands	1
Introduction, consent	1
Explanation relating to patient and examiner	3
Expose both limbs	1
"if time I would examine:" 1. Both sides 2. Joints above and below 3. Neurological	1
LOOK	
Anterior, lateral and posterior	1
Mentions: 1. Deformity 2. Scars 3. Swelling 4. Muscle wasting 5. Scapula winging 6. Asymmetry	6
FEEL	
Asks for consent and **tenderness**	2
Temperature (both arms) with back of hand	1
Palpates(just affected sides) and vocalises: Sternoclavicular joint → clavicle → AC joint → acromion → Spine of scapula → medial border →inferior angle → lateral border Greater tuberosity Corocoid process	5
Mentions: **B** ony landmarks (covered above) **E** ffusion **S** welling **T** emperature (covered above) **T** enderness (covered above	2
MOVE	
Flexion – active passive and resisted (correct hand positioning – upper arm – during resisted movement)	3
Extension – active, passive and resisted	3
Abduction –active passive and resisted	3
Adduction – active, passive and resisted	3
Internal rotation (elbows tucked in and flexed to 90^{o}) – active, passive and resisted	3
External rotation – active passive and resisted	3
Appropriate summary and differential diagnosis	3
TOTAL MARKS	(45)

OSCE MARKSHEET FOR SPINE EXAMINATION

Action	**Marks available**
Introduction, confidentiality and consent	1
Determines location of problem and negotiates (appropriate) undressing	1
Look	
Posterior – muscle wasting, asymmetry or scoliosis Lateral – normal cervical and lumbar lordosis and thoracic kyphosis	3
Feel (wash hands and ask about tenderness)	2
Feel down the spinal processes, over sacroiliac joints. Feel paraspinal muscles for tenderness	2
Move	
Lumbar Schobers test – assess lumbar flexion/extension –place 3 fingers on lower back and ask patient to touch toes, fingers should move apart Extension –lean backwards	2
Lateral flexion – ask patient to run hands down side	1
Neurological: Straight leg raise Sciatic stretch test Dorsi flexion of big toe Peripheral pulse Reflexes and sensation – knee jerk (L3-4), Achilles tendon(S1-S2), Plantar (stoke key from heel, along lateral side and across ball of foot)	4
Thoracic With patient sitting on couch, fix pelvis and twist to each side to assess thoracic rotation Place hands on patients ribs while they take a deep breath to assess chest expansion	2
Cervical Flexion/extension – bring head to chest and then tilt head backwards Lateral flexion – bring ear to shoulder (ensure no shoulder movement) Lateral rotation – ask patient to look over each shoulder	3
Neurological: Reflexes – Supinator(C5-6), biceps(C5-6), triceps(C7-8)	3
Valid differential diagnosis/reasoning	1
Thank you and wash hands	1
TOTAL MARKS	(26)

TRAUMA HISTORY TAKING MARKSHEET

Action	**Marks available**
Brief intro – name, position, consent, confidentiality	2
Patient name, age, occupation, hand dominance	4
(H)PC – GOLDEN MINUTE	3
When, where and how	
Brief hx of: 1. Pain (SOCRATES) 2. Stiffness 3. Swelling 4. Neurovascular 5. deformity	 4 1 1 1 1
PMH	1
DH	1
FH	1
SH –e.g. primary carer of relative	1
ICE –what do you think caused it/is wrong What are you particularly concerned about What do you want to happen from here	1
Summarise	3
Screening	1
Thank you – I shall pass on relative information to the doctor	1
General marks	
Good rapport	1
Attentive listening, verbal and non-verbal cues	2
Structure and signposting	3
TOTAL MARKS	(33)

SURGICAL SCRUBBING, GLOVING AND GOWNING

Action	**Marks available**
Enter the room and assess sterile environment	1
Remove any rings, watches or jewellery	1
Fix face mask – Pinch nose to mould mask to face and tie in a double knot at back.	1
Lay out sterile gown pack and gloves ensuring not to touch and contaminate the gown	1
Scrubbing	
Select scrub solution (usually iodine or chlorohexidine based)	1
Ensure sleeves are rolled as high as they'll go	1
Ensure water is warm, wet hands and apply 1 squirt of soap	1
Lather for 1 MINUTE starting from fingers down to elbows – small bubbles are better	1
Rinse hands from fingers to elbows	1
Take nail brush (add soap if necessary) and clean under all nails – 1 MINUTE.	1
Discard brush and rinse nail	1
Apply soap to hands and lather (small bubbles) from fingers to elbows for 3 MINUTES	1
Rinse	1
Dry – use half a towel for hands and half for forearms and dry using the DABBING technique	1
Discard towel appropriately	1
At no point should hands be below elbows	1
Gloving and Gowning	
Grasp gown by the insides of the shoulders and let it unfold – do not shake	1
Guide hands through arm holes by pushing arms upward and outwards – do not let arms exit the end of the sleeves.	1
Ask assistant to pull gown up over shoulders and loosely tie back ties.	1
Place glove palm down on wrist of gown	1
Unroll glove cuff so it covers gown sleeve. Use other hand to guide in.	1
Repeat on the other hand	1
Grasp toggle attached to gown ties – give toggle to assistant and spin round slowly. Once assistant has removed toggle tie securely	1
TOTAL MARKS	

EXAMINATION OF BLOOD PRESSURE

Action	**Marks available**
Wash hands	1
Introduction, consent	1
Explanation relating to patient and examiner	1
Ask if there is any reason why bp may be raised: • Coffee • Recent exercise • Medication	1
1. Preparation	
Explanation and consent Patient comfortable, arm preference Arm supported (pillow) Instruments at heart level	1 1 1 1
2. Apply cuff	
Appropriate size cuff (bladder to cover 2/3 arm) Tubes superior or off centre 2-3 cm above brachial pulse (find pulse first!) Loosely wrapped	1 1 1 1
3. Inflate cuff and estimate systolic	
Estimate systolic - Feel carotid pulse whilst inflating cuff Inflate 20-30mmHg above when pulse disappears	1 1
4. Position of stethoscope	
Over brachial artery	1
5. Deflate cuff	
Starting 20-30mmHg above estimated systolic slowly drop by 2-3mmHg/sec Systolic – onset of repetitive tapping sounds (at least two consecutive beats) Diastolic – Disappearance of sound, OR if sound never goes when it becomes muffled	1 1 1
6. Record	
Record finding drugs chart to the nearest 2mmHg Using arrows joined by a dotted line	1 1
Questions	
Normal blood pressure for a healthy adult? • 120/70	1
Thank patient	1
Pharmacology	
Name 2 types of blood pressure medication and explain their mechanisms?	4
What is one risk factor of diuretics?	1
TOTAL MARKS	

OSCE MARKSHEET FOR SPINE EXAMINATION

Action	**Marks available**
Wash hands	1
Introduction and consent	1
Determines location of problem and negotiates (appropriate) undressing	1
Look	
Posterior – muscle wasting, asymmetry or scoliosis Lateral – normal cervical and lumbar lordosis and thoracic kyphosis	3
Feel (wash hands and ask about tenderness)	2
Feel down the spinal processes, over sacroiliac joints. Feel paraspinal muscles for tenderness	2
Move	
Lumbar Schobers test – assess lumbar flexion/extension –place 3 fingers on lower back and ask patient to touch toes, fingers should move apart Extension –lean backwards	2
Lateral flexion – ask patient to run hands down side	1
Neurological: 1. Tone 2. Strength – hip, knee ,ankle and big toe – flexion and extension 3. Sensation – dermatomes 4. Reflexes – knee jerk (L3-4), Achilles tendon (S1-2), Babinskis 5. Pulses Special tests Straight leg raise Sciatic stretch test Femoral stretch test	8 2
Thoracic With patient sitting on couch, fix pelvis and twist to each side to assess thoracic rotation Place hands on patients ribs while they take a deep breath to assess chest expansion	2
Cervical Flexion/extension – bring head to chest and then tilt head backwards Lateral flexion – bring ear to shoulder (ensure no shoulder movement) Lateral rotation – ask patient to look over each shoulder	3
Neurological: 1. Tone 2. Strength – Ab/adduction of shoulder, flexion/extension of elbow, flexion/extension of wrist, power grip	8

and spreading fingers 3. Sensation – dermatomes 4. Reflexes - Supinator(C5-6), biceps(C5-6), triceps(C7-8) 5. Pulses	
Valid differential diagnosis/reasoning	1
Thank you and wash hands	1
TOTAL MARKS	

INJECTION PROCEDURE AND PRESCRIBING SKILLS

Action	**Marks available**
Wash hands	

Collect correct equipment:
• Kidney dish
• Suitably sized syringe
• Needles X2
  ○ Filtered needle (red)
  ○ Long thin / short (IM/SC)
• Alcohol swab X2
• Cotton wool/swab
• Medication ampule
• Sharps bin
• Gloves
	4

Preparation	
Check name on prescription chart	1
Check drug, dose, volume required and time last given from chart	1
Check expiry date on drug	1
Put gloves on	1
Open syringe and outer packaging of both needles	1
Place filtered needle on syringe	1
Sterilise ampule with alcohol wipe and snap open	1
Remove needle cover, insert into ampule and invert	1
Draw up required dose	1
Remove needle →sharps bin	1
Attach 2nd needle, expel excess air but leave cover on →place in kidney tray	1
Administration	
Check patients name both verbally and on their hospital wrist band	1
Check for allergies	1
Gain consent and ensure privacy	1
Select suitable injection site, alcohol swab and wait 30 seconds to dry	1
IM technique 1.Hold syringe like a dart and remove cap 2.Stretch skin to one side 3.Warn patient "sharp scratch" and insert at 90^0 4.Aspirate → gently depress → wait 2-3seconds →remove 5.Reassure patient and hold (don't rub) swab on site	4
SC technique 1. Remove cap from needle. 2. Pinch up area of skin with thumb & first finger 3. Insert injection at angle at 45^o 4. Depress plunger 5. Wait 2-3 seconds and remove 6. Hold swab on site	4
Place needle in sharps bin allowing with syringe	1
Sign, date and time on prescription chart	1

Dispose of gloves and wash hands	1
TOTAL MARKS	

HISTORY TAKING FOR ACHES AND PAINS

Action	**Marks available**
(most important to listen, respond to patients history and adapt appropriate screening questions – keep an eye out for red flags/ yellow flags/ NAI)	
Brief intro – name, position, consent, confidentiality	2
Patient name, age, occupation	3
(H)PC – GOLDEN MINUTE	3
Summarise and channel	1
Brief hx of: 1. Pain 2. Stiffness 3. Swelling 4. Neurovascular 5. deformity	 4 1 1 1 1
Inflammatory disease features: • Dry/gritty eyes • Ulcer – mucous membranes • Raynaud's • Skin/nail changes/photosensitivity • Chest pain	4
Red flags: • Night pain • Weight loss • Haematuria	2
PMH	1
DH	1
FH	1
SH –e.g. primary carer of relative	1
ICE –what do you think caused it/is wrong What are you particularly concerned about What do you want to happen from here	1
Summarise	3
Screening	1
Thank you – I shall pass on relative information to the doctor	1
General marks	
Good rapport	1
Attentive listening, verbal and non-verbal cues	2
Structure and signposting	3
TOTAL MARKS	

TEMPERATURE, PULSE AND RESPIRATION

Action	**Marks available**
Wash hands	1
Introduction, consent	2
Confirm patients name, hospital number and today's date → record on drugs chart	3
Explanation relating to patient and examiner	1
Is there any reason why pulse, respiration rate or temperature may be raised? • Exercise within 30 minutes • Medication/drugs/ caffeine • Hot/cold drink recently • Previous cardiac problems	2
Explanation of procedures and ask which arm they'd prefer you'd take pulse from	2
Turn thermometer on, place sterile cover over end and put under tongue. Explain that if it beeps just to leave it	1
Hold patients radial pulse on wrist, bring hand across chest and place other hand on back	1
Look at chest and count respiration rate for 30 seconds – don't tell patient what you're doing. Double your findings and REMEMBER!	1
Stay in same position and count pulse for 30 seconds. Double your findings and REMEMBER!	1
Remove thermometer once beeped – dispose of cover in clinical waste	1
Record pulse, respiration rate and temperature on drugs chart	3
Thank patient – any questions?	1
Questions	
Normal resting pulse for healthy adult? • 60-80bpm	1
Normal resting respiration rate for a healthy adult? • 12	1
Normal body temperature for a healthy adult? • 36.8 ±0.7 °C	1
TOTAL MARKS	

EXAMINATION OF THE KNEE

Action	**Marks available**
Wash hands	1
Introduction and consent	1
Determines location of problem and negotiates (appropriate) undressing	1
With patient standing:	
LOOK from anterior, lateral and posterior view: Skin – scars, rashes erythema Posture and symmetry (genu valgus/varus) Muscle bulk – quads, calves, hamstrings Bony structures	3
Assess gait	1
With patient on couch: Posture and symmetry (fixed flexion) Joint swelling	1
FEEL (ask about consent and tenderness) Temperature Bony landmarks - Head of fibula, tibial tuberosity, patella tendon, patella (all around), joint line, condyles Behind knee for effusion/cysts	1 1 3 1
Effusion Patella tap OR sweep test	2
MOVE Flexion • active • passive feeling for creptitus • Resisted (hand on calf)	2
Extension • active • passive (hyperextension >15^{o}) • resisted (hand on shin)	3
Cruciate ligaments: • Posterior – posterior sag/push on tibia • Anterior- draw test/Lachman's	2
Collateral ligaments – 15^{o} flexion and apply medial/lateral pressure	2
General	
If time I would examine joint above and below, both side and full neurological	1
Appropriate summary and diagnosis	1
TOTAL MARKS	

EXAMINATION OF HAND AND WRIST

Action	**Marks available**
Wash hands	1
Introduction, confidentiality and consent	1
Determines location of problem and negotiates appropriate undressing (elbows visible)	1
Places patients hand on pillow, ensures they are comfortable and asks about tenderness	1
LOOK	
Skin Asks patient to touch shoulder so elbows are visible Comments on any lesions	2
With hands pronated:	
Comment on skin on forearms, wrists, hands and fingers: erythema, thinning, purpura, sclerosis, telangiectasia, scars, rashes AND INFERENCES	4
Nails changes: Pitting, onycholysis, ridging and cracks. Nail fold vasculitis	4
Muscle bulk - interossei	1
Systematic evaluation of joints – wrists, MCP, PIP, DIP Swelling – bony/soft tissue and why Subluxation Alignment Deformities – swan neck/ boutonierrres Distribution (ask patient to lift hand off pillow to emphasise deformity)	4
Calcium deposits, heberdon's/bouchards nodes, Rheumatoid nodules, tophi	1
Ask patient to turn hands over and comment on pain	1
With hands supinated:	
Scars for Carpal tunnel decompression	1
Thenar/ hypothenar eminences	1
Squaring/Z-thumbs	1
FEEL	
Ask for consent and about tenderness	
Gently squeeze MCPJs	3
Bimanually palpate: Wrist (ulnar and radial styloid processes) →carpals → Metacarpals → MCPJs	1
With 2 fingers (pincer): proximal, mid and distal phalanges →PIPs (bouchards) and DIP (Heberdens)	1
Comment on whether swelling is bony, soft or boggy	1
Thenar/ hypothenar eminences	1

EXAMINATION OF HAND AND WRIST

Peripheral pulse - radial	1
MOVE	
Wrist: • Active flexion and extension • Passive – Prayer sign and inverted (radio/ulnar – wrist extension/flexion) • Active lateral flexion – wave • Pronation/ supination	4
Hand: • Spread fingers – finger abduction • Make fist – finger flexion • Extend just little finger – extensor digiti minimi (often first to rupture in RA) • Resisted pincer grip • Power grip strength	5

Neurological
• Radial
  ○ Sensation (first web space on dorsum of hand)
  ○ Extension of fingers at MCP
  ○ Extension of thumb
• Median
  ○ Sensation (distal index finger
  ○ Abductor pollucis brevis (thumb abduction) – whilst feeling thenar eminence
• Ulnar
  ○ Sensation (distal phalanx of pinky)
  ○ Hold piece of paper between fingers
	6

Special tests • Phalen's • Tinnels • Vascular – Allen's (don't bother doing unless specified)	1
Assess function – pick up coin/ do up button	1
Thank patient and reasonable summary/ diagnosis	2
TOTAL MARKS	

EXAMINATION OF HAND AND WRIST LOOK ONLY

Action	**Marks available**
Introduction, confidentiality and consent	1
Determines location of problem and negotiates appropriate undressing (elbows visible)	1
Places patients hand on pillow, ensures they are comfortable and asks about tenderness	1
LOOK	
Skin Asks patient to touch shoulder so elbows are visible Comments on any lesions	2
With hands pronated:	
Comment on skin on forearms, wrists, hands and fingers: erythema, thinning, purpura, sclerosis, telangiectasia, scars, rashes AND INFERENCES	4
Nails changes: Pitting, onycholysis, ridging and cracks. Nail fold vasculitis	4
Muscle bulk - interossei	1
Systematic evaluation of joints – wrists, MCP, PIP, DIP Swelling – bony/soft tissue and why Subluxation Alignment Deformities – swan neck/ boutonierrres Distribution (ask patient to lift hand off pillow to emphasise deformity)	4
Calcium deposits, heberdon's/bouchards nodes, Rheumatoid nodules	1
Ask patient to turn hands over and comment on pain	1
With hands supernated:	
Scars for Carpal tunnel decompression	1
Thenar/ hypothenar eminences	1
Squaring/Z-thumbs	1
Asks 3 questions	
Offers a reasons diagnosis (differential)	1
TOTAL MARKS	(24)

EXAMINATION OF A LUMP

Action	**Marks available**
Wash hands	
Introduction, consent	
Explanation relating to patient and examiner	
History	
• When did it appear? • How was it noticed • Other symptoms • Has it changed • Does it ever disappear • Any other lumps • What does patient think caused the lump?	
Inspection	
Postition	1
Colour	1
Palpation	
Ask about tenderness and consent	1
Temperature Tenderness Shape Size Surface Edge	1 1 1 1 1 1
Consistency: • Soft • Spongy • Rubbery hard • Stony hard	1
Fluctuation Translucency Pulsality Reducilbility Relation to surrounding structure	1 1 1 1 1
Percussion	
Resonance	1
Auscultation (listen with stethoscope)	
Bruit (narrowing of arteries	1
Questions	
Appropriate differential diagnosis	1
TOTAL MARKS	

BASIC LIFE SUPPORT

Action	**Marks available**
Procedure	
Check for danger	1
Sir/madam can you hear me Physically try to arouse patient (appropriately) Sir/madam can you hear me	2
"Patient is unresponsive – can I have some help"	1
Tilts head back and assesses airway	1
Checks carotid pulse whilst listening to breathing and looking at chest – at least 10 seconds	3
"Has help arrived?" – so start CPR whilst saying next point	1
Patient's condition, where, come back, resus equipment: "Call ambulance - unresponsive patient, no pulse/not breathing, OSCE area of JP hospital. Do this now and bring any resuscitation/ personal protective equipment you can find"	4
Landmark – from armpit to central sternum	1
30 compression – 5-6cm deep, 100-120rpm	3
2 Breaths – (use equipment if available) Hold nose, tilt back chin	2
Repeat until instructed to stop	1
Questions	
When would you stop? • Patient makes a conscious effort to self respire and central pulse returns • Ambulance crew arrive and take over • You become too exhausted	3
What is the breath/compression ratio? • 30:2	1
How deep and fast should the compressions be? • 100-120 per minute • 5-6 cm deep	2
TOTAL MARKS	