OBA NURSING ACADEMY · TRAUMA NURSING FUNDAMENTALS · OBA-TNF-2026

Course Syllabus

Trauma Nursing Fundamentals: Recognition, Resuscitation and the First Hour · OBA-TNF-2026 · 10.0 CPD hours · fully self-directed online

DOCUMENT CONTROL

- Programme: Trauma Nursing Fundamentals: Recognition, Resuscitation and the First Hour (OBA-TNF-2026)
- Audience: Student and Facilitator
- Version 1.0 | Issued 19/09/2026 | Review due 19/09/2027
- Provider: OBA Nursing Academy

SCOPE OF PRACTICE AND CURRENCY

- This programme is professional development. It is not a qualification, it is not a trauma life support course, and it does not authorise any learner to perform any procedure described in it. It is NOT and does not substitute for EMST, ATLS, ITLS, TNCC or any other trauma life support or trauma nursing certification - those are separate proprietary courses with their own providers, assessment and currency requirements. It does not place anyone in a trauma team. Knowledge is one of three requirements; the others are assessed competence and authorisation from your employer. Where your service's policy, procedure or major haemorrhage protocol differs from anything in this course, your service's document applies.
- Sources and their versions, retrieved 19/09/2026. Critical bleeding: National Blood Authority, Patient blood management guideline for adults with critical bleeding, VERSION 2.0 published 4 SEPTEMBER 2025 (a minor update to Good Practice Statement 5; the evidence search date remains 29 September 2021, and the guideline is under review). NOTE that PBM Modules 2 to 6 have been ARCHIVED by the NBA and must not be cited as current. Spinal: ANZCOR Guideline 9.1.6, APPROVED APRIL 2026, superseding the 2016 edition - if this contradicts your prior training, the guidance changed. Bleeding: ANZCOR Guideline 9.1.1. Deterioration: NSQHS Recognising and Responding to Acute Deterioration Standard, second edition, all thirteen actions.

NOT stated in this course, because they are local or because they belong to a prescriber: any medicine dose, rate, regimen or blood product dosing; age-specific paediatric vital sign ranges or weight-based calculations; your jurisdiction's trauma destination, bypass and transfer criteria; your service's major haemorrhage protocol, trauma call activation criteria and spinal clearance pathway. Every one of those has an authority, and it is not this course.

1. Programme overview

Trauma Nursing Fundamentals: Recognition, Resuscitation and the First Hour is a fully self-directed, entirely online professional development programme delivered through the OBA Nursing Academy learning management system. There are no scheduled classes, no live sessions and no clinical placement. Learners complete eleven modules at their own pace, followed by a case study assessment and a single summative assessment.

Who it is for

- Emergency department nurses, including those new to a trauma-receiving department and those who have never been part of a trauma call
- Nurses in rural, regional and remote services, where the trauma patient arrives before the team does and the nurse is frequently the most experienced clinician in the room
- Ward, theatre, recovery and critical care nurses who receive trauma patients after the resuscitation room, and who are the people most likely to find the injury nobody noticed
- Internationally qualified nurses, for whom the Australian trauma system, its destination criteria and its national guidelines are usually entirely new - and for whom some of what was taught overseas has since been superseded here
- Enrolled nurses, students and assistants working in emergency and acute settings, who are frequently the second pair of hands in a trauma resuscitation
- Educators and clinical nurse specialists preparing a service or a cohort for trauma reception

How it is delivered

- Fully self-directed. No scheduled classes, no live sessions, no clinical placement.
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a knowledge check.
- A case study assessment of five unfolding presentations, and a 60-item summative assessment.
- Five optional interactive practice tools, excluded from the claimable CPD figure.
- Three fillable workplace instruments: a trauma reception readiness check, a trauma documentation and handover audit, and a tertiary survey record.

Programme outcomes

On completion, learners will be able to:

1. Describe what an inclusive trauma system is, and explain why recognising that a patient needs a service this one is not - and moving them - is part of the standard
2. Explain injury as energy transfer, and state what mechanism does and does not tell you
3. Work through the 6 steps of the primary survey in order, stating what is assessed and what is done at each
4. Explain why catastrophic haemorrhage precedes the airway, and why airway management takes precedence over restriction of spinal motion
5. Apply ANZCOR's sequence for controlling external bleeding, and state why the tourniquet application time must be recorded and communicated
6. Describe compensated haemorrhagic shock, and explain why a normal blood pressure does not exclude significant haemorrhage
7. State the eight parameters the national critical bleeding guideline requires to be measured early and frequently, and the transfusion ratio floor
8. Describe the lethal triad and the nursing actions that interrupt it
9. Distinguish primary from secondary brain injury, and name the two causes of secondary injury that carry the most weight
10. State ANZCOR's current position on manual inline restriction of motion and cervical collars, and the harms the guideline names

11. Recognise the chest injuries that kill in minutes, and describe the reversible causes in traumatic cardiac arrest
12. Apply the paediatric, geriatric and pregnancy considerations, and explain why normal observations are weaker reassurance in each
13. Describe the tertiary survey, what gets missed and in whom, and what must be documented
14. Receive a structured trauma handover, and identify the information that exists nowhere else

2. Module structure

Module	Title	CPD hours	Knowledge check items
00	Orientation: How This Course Works	0.50	6
01	The Trauma System, and Where You Sit In It	0.50	7
02	Mechanism, Energy and the Injuries to Go Looking For	0.50	5
03	The Primary Survey: <C>ABCDE	0.75	7
04	Catastrophic Haemorrhage and Haemorrhage Control	0.50	6
05	Shock, Critical Bleeding and the Major Haemorrhage Protocol	0.75	7
06	Head Injury, Spine, and the Collar Question	0.75	6
07	Chest, Abdomen and Pelvis	0.50	6
08	Children, Older People and Pregnancy	0.50	6
09	The Secondary and Tertiary Survey, and Missed Injury	0.50	5
10	Handover, Documentation, Forensics and the Team	0.75	5
	Module subtotal	6.50	66
	Programme information documents	1.58	-
	Case study assessment (5 unfolding cases)	0.53	-
	Summative assessment	0.97	60
	CLAIMABLE CPD TOTAL	10.0	

Module hours are the measured time for that module's video, learner guide, knowledge check and workbook activity. Section 2 below shows how every figure in this table was measured.

Indicative workload, and how the CPD hours were arrived at

The CPD figure for this programme is not asserted. It is measured from the content: narration at 135 words per minute, reading at 130 words per minute for dense clinical prose, knowledge checks timed to include reading every rationale, and the assessments timed as measured

reading plus a stated decision allowance. Individual learners vary, and a learner who claims a different figure should claim their actual time.

Component	Measured time	How it was measured
Module videos (11)	93 min	Narration word count at 135 wpm
Student learner guides (11)	113 min	Guide word count at 130 wpm
Module knowledge checks (11)	110 min	Stem, options and every rationale, read and answered
Reflective workbook activities (11)	88 min	Writing time for the five prompts in each module
Programme information documents	95 min	Rendered page word counts at 130 wpm
Case study assessment	32 min	19 minutes measured reading plus 30 seconds per decision across 25 steps
Summative assessment	58 min	28 minutes measured reading plus 30 seconds per item across 60 items
MEASURED TOTAL	589 min (9.82 h)	Sum of the above
CLAIMABLE CPD	10.0 hours	The measured total, to the nearest half hour

The five optional practice tools - the primary survey sequencer, where is the blood going, handover under pressure, the collar question and the scope of practice self-check - add approximately a further 85 minutes. They are deliberately excluded from the claimable figure, because they are optional. A learner who completes them may claim that time as additional self-directed CPD.

Module 00 - Orientation: How This Course Works

How the programme is structured and assessed. The line this course holds and most trauma teaching does not - the nurse's numbers are in and the prescriber's numbers are out. Why this is not EMST, ATLS, ITLS or TNCC and must never be presented as though it were. How it differs from Trauma-Informed Care, which shares a word with it and nothing else. And the ten questions only your own service can answer.

Learning outcomes

- Describe the structure of the programme and how it is assessed
- State what this course is, and the four things it is not
- Explain the difference between the numbers a nurse owns and the numbers a prescriber owns
- Distinguish this programme from Trauma-Informed Care and from the other courses in the library
- Identify the questions only your own service can answer
- Locate the national documents this programme is built from

Key terms: scope of practice; EMST; ATLS; TNCC; major haemorrhage protocol; credentialling; local policy; CPD

Module 01 - The Trauma System, and Where You Sit In It

Australian trauma care is a system rather than a set of hospitals. What an inclusive trauma system is, how services are designated and verified, what the Australian Trauma Registry does with the record you write, and why recognising that a patient needs a service this one is not - and moving them - is part of the standard rather than an admission of failure. Plus what the golden hour actually is and is not.

Learning outcomes

- Describe what an inclusive trauma system is and why most services are not major trauma services
- Explain that designation, destination and bypass criteria are set jurisdictionally
- Describe the RACS Trauma Verification Program and the Australian Trauma Registry
- Distinguish primary from secondary transfer, and state when secondary transfer becomes a failure
- State what the evidence supports about time to definitive care, and what the golden hour is not
- Identify what NSQHS Action 8.13 requires of an organisation

Key terms: inclusive trauma system; designation; destination criteria; bypass; trauma verification; Australian Trauma Registry; secondary transfer; definitive care

Module 02 - Mechanism, Energy and the Injuries to Go Looking For

Injury is energy transferred to tissue, and the amount rises with the square of velocity. How mechanism raises the index of suspicion without ever diagnosing or excluding an injury, why blunt and penetrating trauma need different questions, the specific questions worth asking the paramedics before they leave, and why a fall from standing height in an older person on anticoagulants can be more serious than a high-speed crash in a fit young adult.

Learning outcomes

- Explain injury as energy transfer, and why velocity matters disproportionately
- State what mechanism does and does not tell you about a patient's injuries
- Distinguish the assessment priorities in blunt and penetrating trauma
- List the specific mechanism questions to ask before the ambulance crew leaves
- Explain why a low-energy mechanism can produce major trauma in particular patients
- Describe the injury patterns that particular mechanisms should make you go looking for

Key terms: kinematics; energy transfer; index of suspicion; blunt trauma; penetrating trauma; occult injury; entrapment; anticoagulation

Module 03 - The Primary Survey: <C>ABCDE

The primary survey in order, with catastrophic haemorrhage placed before the airway and the reason it belongs there. What is assessed and what is done at each step, why airway management takes precedence over spinal motion restriction, why blood pressure is assessed last, and the rule that overrides the whole sequence: if the patient deteriorates, you return to the start - not to where you were.

Learning outcomes

- Work through <C>ABCDE in order, stating what is assessed and what is done at each step
- Explain why catastrophic haemorrhage precedes the airway

- State the ANZCOR position that airway management takes precedence over spinal motion restriction
- Explain why blood pressure is the last circulatory sign assessed and the last to fall
- Apply the rule that deterioration returns you to the start of the primary survey
- Describe how preparation and a silent structured handover change the resuscitation

Key terms: primary survey; catastrophic haemorrhage; ABCDE; spinal motion restriction; GCS; exposure; hypothermia; reassessment

Module 04 - Catastrophic Haemorrhage and Haemorrhage Control

ANZCOR's guidance on controlling bleeding, applied to a trauma reception. Direct pressure first and why elevation was abandoned. When an arterial tourniquet is indicated, how it differs from the elastic band used for cannulation, and why the application time is a clinical measurement rather than paperwork. Haemostatic dressings, pelvic binders, and the four places blood hides when there is nothing on the floor.

Learning outcomes

- Apply ANZCOR's sequence for controlling external bleeding
- State why there is no evidence for elevating a bleeding part
- Describe when an arterial tourniquet is indicated, and how it is applied and escalated
- Explain why the tourniquet application time must be recorded and communicated
- Distinguish an arterial tourniquet from a venous (cannulation) tourniquet
- Name the four internal sites of major occult haemorrhage, plus the floor

Key terms: direct pressure; arterial tourniquet; haemostatic dressing; pelvic binder; occult haemorrhage; windlass; application time

Module 05 - Shock, Critical Bleeding and the Major Haemorrhage Protocol

Haemorrhagic shock and the Australian national guidance on critical bleeding. Why blood pressure falls last and compensation is not improvement. The eight parameters the guideline requires to be measured early and frequently - the nurse's list. The 2:1:1 ratio floor and what it is and is not. The lethal triad, and why hypothermia is the point of it nursing can most directly prevent. And the major haemorrhage protocol, which is the most important document in this module and is deliberately not in it.

Learning outcomes

- Describe compensated and decompensated haemorrhagic shock, and why blood pressure falls last
- State the eight parameters the critical bleeding guideline requires to be measured early and frequently
- State the transfusion ratio floor and explain what it is and is not
- Describe the lethal triad and the nursing actions that interrupt it
- Explain what a major haemorrhage protocol is, why it is local, and what a nurse must know about theirs
- State the tranexamic acid time window in trauma and why the time of injury is a clinical measurement

Key terms: haemorrhagic shock; compensation; major haemorrhage protocol; lethal triad; coagulopathy; hypothermia; ionised calcium; tranexamic acid

Module 06 - Head Injury, Spine, and the Collar Question

Primary brain injury happens at impact and nothing you do changes it. Secondary brain injury happens over the next hours, is caused by hypoxia and hypotension above all, and is almost entirely nursing-sensitive. Then the most counter-intuitive content in the programme: ANZCOR Guideline 9.1.6, approved April 2026, which recommends manual inline restriction of motion rather than a semi-rigid collar, names the collar's harms, and supersedes what many clinicians were taught.

Learning outcomes

- Distinguish primary from secondary brain injury and name the six causes of secondary injury
- Explain why hypoxia and hypotension are the two that matter most, and what that implies for nursing
- Report a GCS as three numbers and state the thresholds that change what happens
- State ANZCOR's current position on manual inline restriction of motion and cervical collars
- Name the harms of semi-rigid collars that ANZCOR identifies
- State the scope of ANZCOR 9.1.6 and where your service's protocol takes over

Key terms: primary brain injury; secondary brain injury; GCS; Cushing's response; manual inline restriction; cervical collar; ANZCOR 9.1.6; log roll

Module 07 - Chest, Abdomen and Pelvis

The five chest injuries found at B or found at post-mortem, and what a nurse does about each. Why tension pneumothorax is a clinical diagnosis that does not wait for a chest X-ray, why a massive haemothorax is a circulation problem presenting as a breathing problem, and why the abdomen is the commonest site of occult major haemorrhage. Then traumatic cardiac arrest, where the reversible causes are mechanical and are treated simultaneously.

Learning outcomes

- Recognise the five chest injuries that kill in minutes and describe the nursing response to each
- Explain why tension pneumothorax is treated on clinical grounds without imaging
- Distinguish massive haemothorax from tension pneumothorax on examination
- Explain why abdominal examination is unreliable in trauma and what follows from that
- Describe the reversible causes in traumatic cardiac arrest and how they are treated
- State the nurse's contribution in a traumatic cardiac arrest

Key terms: tension pneumothorax; massive haemothorax; flail chest; cardiac tamponade; occult haemorrhage; traumatic cardiac arrest; thoracostomy; FAST

Module 08 - Children, Older People and Pregnancy

Children compensate brilliantly and then decompensate abruptly, so hypotension is a very late sign. Older people may be shocked at a normal-looking blood pressure, have their tachycardia blunted by beta blockade, and bleed intracranially from a trivial mechanism. A pregnant patient is two patients, and the increase in blood volume means normal observations are weaker reassurance rather than stronger. Plus why this course states no paediatric vital sign ranges.

Learning outcomes

- Describe paediatric physiological compensation and why hypotension is a very late sign
- Explain the anatomical differences in children that change the injury pattern

- Describe how baseline blood pressure, beta blockade and anticoagulation change the older trauma patient
- Explain why a pregnant trauma patient is assessed as two patients and how the higher urgency governs
- Describe aortocaval compression and the nursing response to it
- State why this course gives no paediatric vital sign ranges or weight-based calculations

Key terms: paediatric compensation; anticoagulation; baseline blood pressure; aortocaval compression; left lateral tilt; frailty; non-accidental injury

Module 09 - The Secondary and Tertiary Survey, and Missed Injury

The secondary survey head to toe, front and back, with an AMPLE history. Then the tertiary survey - the repeated examination performed once the patient is awake and can tell you what hurts, which is where most missed injuries are actually found. What gets missed and in whom, why the nurse caring for the patient is the person most likely to find it, and why a tertiary survey that is not documented did not happen.

Learning outcomes

- Describe the secondary survey and when it begins
- Take and record an AMPLE history, and state why each element changes management
- Describe the tertiary survey, when it is performed and when it is repeated
- State which injuries are most often missed and in which patients
- Explain why the bedside nurse is frequently the person who finds a missed injury
- Describe what must be documented for a tertiary survey to be useful

Key terms: secondary survey; tertiary survey; AMPLE; missed injury; log roll; distracting injury; documentation

Module 10 - Handover, Documentation, Forensics and the Team

Structured handover received in silence, and why it is the only moment the pre-hospital story exists in one place. The eleven things a trauma record must contain, several of which exist nowhere else. Forensic evidence preserved around clinical care and never instead of it. Trauma team roles, closed-loop communication and graded assertiveness. Family presence. And the debrief, which takes ten minutes and is standard practice.

Learning outcomes

- Receive and give a structured trauma handover, and explain why it is received in silence
- List the elements of a trauma record and identify those that exist nowhere else
- Describe forensic evidence preservation that does not delay clinical care
- Describe trauma team roles, closed-loop communication and graded assertiveness
- Explain the evidence position on family presence during resuscitation
- Describe the purpose of a hot debrief and the support available to clinicians

Key terms: IMIST-AMBO; ISBAR; closed-loop communication; graded assertiveness; chain of custody; family presence; hot debrief; scribe

3. Assessment

Component	Type	Weighting	Attempts
Module knowledge checks (11)	Formative, immediate feedback with rationales	Not graded	Unlimited
Reflective workbook	Formative, self-directed	Completion required	n/a
Case study assessment	Formative, branching decisions with feedback	Completion required	Unlimited
Summative assessment	60 single-best-answer items	100% - pass mark 80%	2

Summative assessment blueprint

Module	Items
00	2
01	5
02	5
03	7
04	6
05	7
06	6
07	6
08	6
09	5
10	5
TOTAL	60

Pass mark is 80 per cent (48 of 60). Learners have 2 attempts. The certificate of completion is issued automatically on a pass.

4. Standards and regulatory mapping

Framework	Elements addressed	Where
NSQHS Recognising and Responding to Acute Deterioration Standard	All 13 actions (8.01 to 8.13) - individualised monitoring plans, escalation criteria including worry or concern, patient and family escalation, and rapid access to advanced life support	Modules 01, 03, 09 and 10
NBA Patient blood management guideline for adults with critical bleeding (v2.0, Sept 2025)	R1 to R7 and the good practice statements - the major haemorrhage protocol, the eight parameters measured early and frequently, the 2:1:1 ratio floor, blood warming, and the tranexamic acid window in trauma	Module 05

ANZCOR Guideline 9.1.6 (April 2026)	First aid management of suspected spinal injury - manual inline restriction of motion, the limited role of collars and their named harms	Module 06
ANZCOR Guideline 9.1.1	First aid management of bleeding - direct pressure, arterial tourniquets and haemostatic dressings	Module 04
ANZCOR Guideline 11.10	Resuscitation in special circumstances, including traumatic cardiac arrest and the management of tamponade	Modules 05 and 07
NSQHS Blood Management Standard	Identification, matching, administration and documentation of blood components, and the management of adverse reactions	Module 05
NSQHS Communicating for Safety Standard	Structured handover on arrival and at transfer, and the clinical record of the resuscitation	Modules 03 and 10
NSQHS Comprehensive Care Standard	Comprehensive care planning, pressure injury prevention in an immobilised patient, and falls risk after injury	Modules 06 and 09
NSQHS Clinical Governance Standard	Trauma audit, morbidity and mortality review, and the incident system	Module 10
RACS Trauma Verification Program; Australian Trauma Registry	External review of trauma services against agreed standards, and the national dataset that compares outcomes	Module 01
Work health and safety legislation (state and territory)	Standard precautions and eye protection in a high-splash environment, sharps in a crowded resuscitation, and manual handling during log rolls and transfers	Modules 03 and 10
NMBA standards for practice and Decision-making framework	The scope layer, applied to trauma-team roles and to credentialled procedures	Module 00 and the scope documents
Jurisdictional trauma system designation and destination criteria	Which patients go where, bypass rules and transfer pathways - stated by each state and territory, not by this course	Module 01

5. Scope of practice

This programme is written for a mixed audience. Every module identifies what each role may and may not do. The full activity-by-role matrix is published separately as the Scope of Practice Mapping document (facilitator) and the Student Scope of Practice Card.

THE RULE THAT GOVERNS THE PROGRAMME

- Completing this course does not authorise any learner to perform any procedure described in it.
- Knowledge is one of three requirements. The others are assessed competence and authority from the employer, or - for a family carer - individual instruction from a clinician for the person they care for.
- Where an organisation's policy is more restrictive than this course, the organisation's policy applies.

6. Resources and further reading

A full directory of Australian and Australasian organisations, with live links and a currency note, is published as the Further Reading and Organisation Directory. Four sources matter more than the rest and three of them are free. The National Blood Authority's Patient blood management guideline for adults with critical bleeding is the source of Module 05 - download the Quick Reference Guide, which is eight pages and carries every recommendation and good practice statement. ANZCOR Guideline 9.1.6, approved April 2026, is short and will probably contradict what you were taught about cervical collars. The NSQHS Recognising and Responding to Acute Deterioration Standard carries all thirteen actions, and Action 8.06 is worth reading twice because it makes worry or concern an escalation criterion in its own right. And the fourth is your own service's major haemorrhage protocol, which is the most important document in Module 05 and is deliberately not in this course. Note two currency points: the critical bleeding guideline is version 2.0 (4 September 2025) and is under review, while PBM Modules 2 to 6 have been ARCHIVED by the NBA and must not be cited as current. Nurse & Midwife Support (1800 667 877) is free, confidential and available 24 hours to nurses, midwives and students, including after a resuscitation that is still with you.

7. Completion and CPD

15. Complete all eleven module knowledge checks.
16. Complete the case study assessment.
17. Achieve 80 per cent or above in the summative assessment within 2 attempts.
18. The certificate of completion is then issued automatically, carrying the learner's name, the completion date, 10.0 CPD hours and a unique certificate identifier.
19. Registered and enrolled nurses should retain the certificate together with their reflective workbook as CPD evidence, as required by the NMBA registration standard.