

MODULE 7 · PRACTICE QUIZ

CHECK YOUR UNDERSTANDING

Six multiple-choice questions and one short scenario. Open-book — consult your Learner Guide and the three Reference Cards. Self-marked using the answer key on page 2.

Q1 Module 7 answers the fifth question of the critical-thinking chain. Which question is it?

- A) Why am I doing this?
- B) What could go wrong?
- C) What can be done to prevent things going wrong?
- D) If it still goes wrong, what will I do?

Q2 What is the correct order of the four steps of emergency response?

- A) Patient · Stabilise · Communicate · Group.
- B) Communicate · Patient · Stabilise · Group.
- C) Stabilise · Patient · Group · Communicate.
- D) Group · Stabilise · Patient · Communicate.

Q3 The “headless-chook” response happens when emergency preparation is missing. Which is *not* one of the typical failure modes named in the source material?

- A) People freeze.
- B) People deny what’s happening.
- C) People act in frantic, uncoordinated ways.
- D) People defer all decisions to the most senior person present, even on unrelated matters.

Q4 How does leadership style shift in an emergency?

- A) It stays consultative — team buy-in matters more under stress, not less.
- B) It shifts to directive / autocratic — clear, specific instructions with roles allocated, not volunteered.
- C) It shifts to whoever has the most first-aid training, regardless of role.
- D) Leadership dissolves — everyone acts on their own initiative.

Q5 Which is the correct rule for student phones during an incident?

- A) Students may use phones to contact whānau immediately, so families aren't worried.

- B) Phones are encouraged so students can take photos for the incident report.
- C) No use until the Activity Leader gives the all-clear; no photos, no messaging, no social media.
- D) Phones are confiscated permanently and returned at the end of term.

Q6 Why do near misses matter to emergency response?

- A) They don't — if no-one was hurt, there's nothing to learn.
- B) They're a free lesson — the same warning, without the cost — and should be debriefed, recorded, and acted on as if they were incidents.
- C) They must be reported to WorkSafe within 24 hours.
- D) They are only relevant if a parent complains.

MODULE 7 · PRACTICE QUIZ (CONT.)

SHORT SCENARIO & ANSWER KEY

One short-scenario question on emergency response, then the answer key with rationale for self-marking.

Q7 SHORT ANSWER — SCENARIO

SCENARIO

You're leading a Year-9 day hike. Two hours in, a student slips on a wet slab, falls roughly two metres, and is now lying face-down on the rock, conscious but disoriented and complaining of severe back pain. The group of 24 students is bunched up watching. One of your two co-staff is still 200 m further up the track with the front of the group; the other is with you. Phone signal is patchy. **Describe what you do in the first ten minutes, in order, using the four-step response order and the call hierarchy.**

ANSWER KEY

Q	ANSWER	WHY
1	D	Mod 7 is the fifth and final question of the critical-thinking chain — <i>If it still goes wrong, what will I do?</i> Mods 1–6 cover the first four (purpose, hazards, causes, prevention).
2	C	Stabilise → Patient → Group → Communicate. Site safety comes first (don't become a second casualty); the patient is treated only once the site is safe; the group is managed in parallel with patient care; escalation comes after the immediate situation is stabilised.
3	D	Freeze, deny, and act frantically are the three named failure modes. Over-deferring isn't one of them — the real risk is the opposite: people acting on their own initiative without coordination.
4	B	Normal operations are consultative; emergencies require directive / autocratic leadership. Same leader, context shift — people wait better than they decide under stress, so clear instructions and allocated roles save time and reduce harm.
5	C	No use until the Activity Leader gives the all-clear. The school contacts whānau, not students. Uncontrolled messaging causes more harm than it solves — rumour, partial info, photos online — all before facts are clear.
6	B	Near misses are the cheapest learning opportunity available — same warning, no cost. Treat them as incidents: debrief, record, act. (A) is wrong because the absence of injury is luck, not safety. (C) and (D) confuse near-miss learning with formal notification thresholds.
7	—	Sample answer.

Q	ANSWER	WHY
		<p><i>Step 1 · Stabilise.</i> Don't move the patient (suspected spinal). Move the rest of the group <i>back</i> from the wet slab to a safe area — one staff member with them. Identify any ongoing hazards (other students slipping on the same slab, weather, traffic).</p> <p><i>Step 2 · Patient.</i> Co-staff member with me at the patient. Primary survey — conscious, talking, complaining of back pain = treat as suspected spinal. Don't move them. Reassure, keep them warm, monitor breathing. Call 111 — ambulance / SAR. Have ICE info ready: location (track name + approximate GPS), nature of injury (fall ~2m, suspected spinal), 1 patient, what's been done.</p> <p><i>Step 3 · Group.</i> Other co-staff with main group plus a senior student helping. Count students. Keep them together, away from the patient and the slab. No phones — collect if needed. Give them a job (warm layers on, sit, eat). Send a runner up the track to get the front-of-group staff back down.</p> <p><i>Step 4 · Communicate.</i> Once 111 has what they need: Principal / DP to contact whānau. Brief the now-reunited staff team on the plan: ambulance ETA, group plan (continue or stop — almost certainly stop), media protocol (only Principal speaks). Write down times and decisions as I go.</p> <p><i>Leadership note.</i> Move to directive: clear, specific instructions. "You take the group back to that rock. You stay with me. You go up and get [name]!" Discussion suspended until the situation is stabilised.</p>