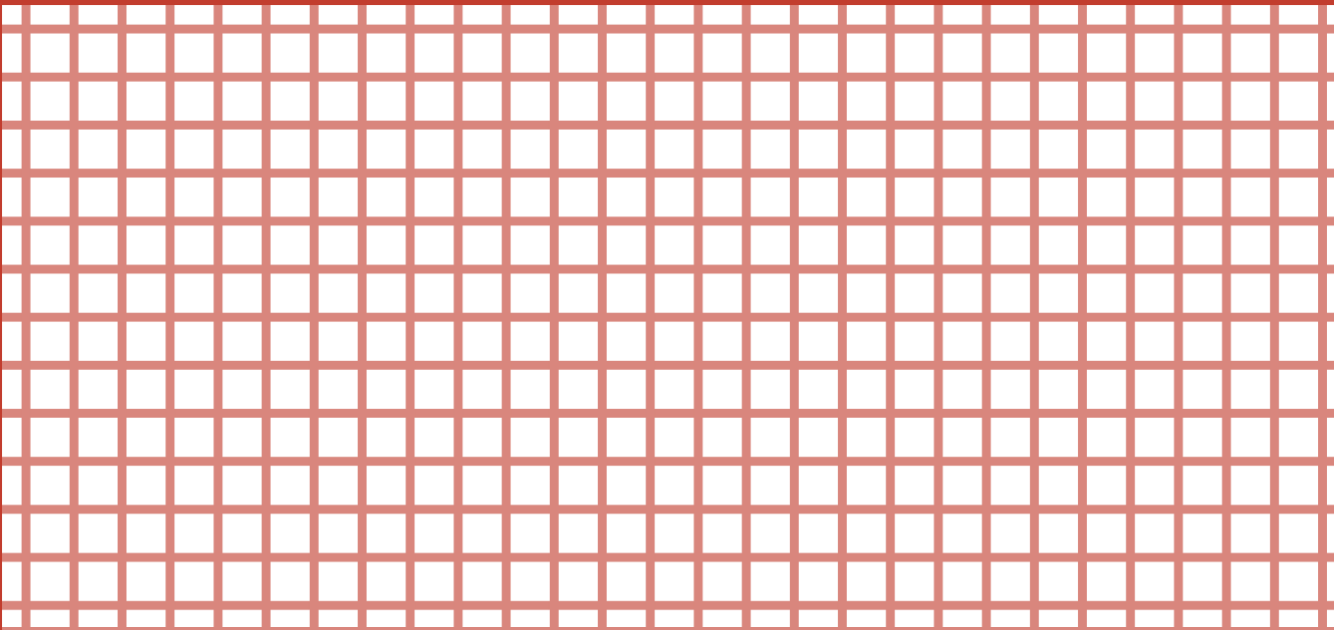




BATHROOM EMERGENCY GUIDE / BOOK 4 OF 11



The Red Book — Self Ambulance

Provide first aid, record useful observations, and hand over early.

Actual emergency?

Stop reading and use the local emergency number. In the EU, call **112**. If calling is unsafe, get to a safer place or ask a trusted person to call.

What this book is for

- What still works?
- What action preserves it?
- Who needs to take over?

What this book does

Route injury and illness and support the body while professional help is arranged.

What it hands off

Does not replace dispatch instructions, clinical diagnosis, or hands-on training.

Contents

- The first minute: preserve what still works
- Triage priority heatmap
- Adult: unresponsive and not breathing normally
- Unresponsive but breathing normally
- Choking — adult
- Wounds and bleeding
- Burns and scalds
- Suspected fractures and joint injuries
- Suspected spine, neck, or pelvic injury
- Chemical in eye or on skin
- Electrical injury
- Stroke — FAST
- Chest pain or severe breathlessness
- Anaphylaxis
- Poisoning
- Vital signs
- Pain is an alarm, not a damage display
- Pain without a red flag
- Self-care while waiting
- First-aid kit for an ordinary household

- Red flags — one is enough
- Optional reading — why some of these rules look like this
- The “golden hour”
- “Time is brain” — quantified, with the word *model* attached
- Self ambulance for non-physical emergencies
- Red-flag theorem, again

First aid is time management for biology. Keep air moving, limit blood loss, reduce heat or chemical injury, prevent a second fall or exposure, and hand the person to better-equipped help. Diagnosis is usually not the first job.

A measurement you take at home can improve the handoff — it gives the next person a number to work from. What it cannot do is certify that something dangerous is harmless; a reassuring reading has never once made a red flag go away. And when emergency help is on the way, speakerphone plus an unlocked door free both your hands and shorten the route to the person.

The first minute: preserve what still works

1. **Safety — do not create patient number two.** Do not enter smoke, gas, traffic, live electricity, violence, deep water, or chemical contamination. [amb . 1]
2. **Response — find out what still works.** Speak loudly and gently tap the shoulders.
3. **Call — externalize and parallelize.** Unresponsive, abnormal breathing, severe bleeding, or another red flag means **112**. Put the phone on speaker. If another person is present, point at them and assign the call.
4. **Breathing — normal is the decision point.** Look for normal breathing. Gasping is not normal breathing.
5. **Act — support the failing function.** Use the matching section below while the dispatcher guides you.

112 — one action box

Call. Speakerphone. State location. Answer questions. Follow instructions.

Do not combine this with “finish reading,” “find the perfect diagnosis,” or “drive first.” The call handler can dispatch help while coaching immediate actions.¹

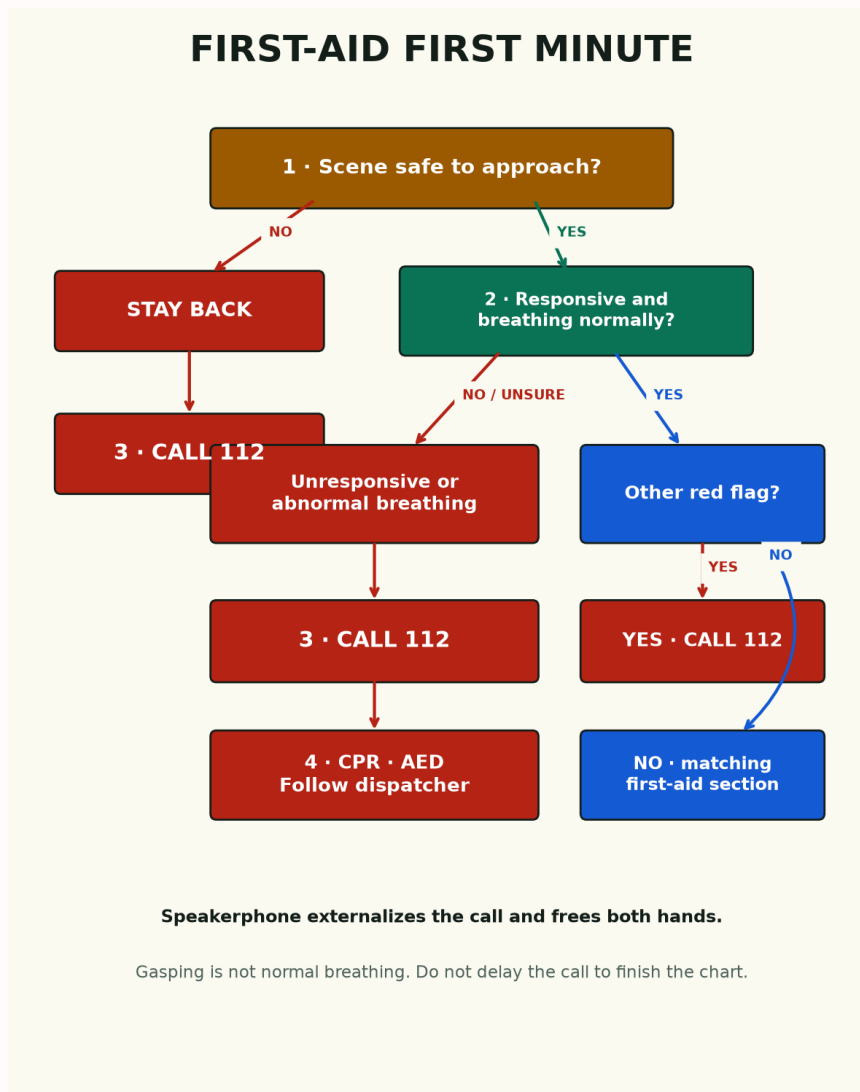
First-aid triage overview

[amb.fig.4]

What is the first-aid sequence from scene safety through escalation and monitoring?

LARGE PRINT / TEXT ROUTE FOLLOWS

FIRST-AID FIRST MINUTE



Triage priority heatmap

[amb.2]

The colours below describe response speed, not the worth of the person or a clinical triage category:

PRIORITY	EXAMPLES	ACTION
Red — immediate	abnormal breathing, unresponsive, severe bleeding, stroke sign, severe allergic reaction, major burn, collapse, acute poisoning	112 now

PRIORITY	EXAMPLES	ACTION
Orange — urgent	suspected fracture, deep wound, worsening infection, persistent vomiting, significant pain without red flag	urgent assessment / 116 117
Yellow — prompt review	persistent or recurrent symptoms affecting function	practice, pharmacy, or appropriate service
Green — self-care with monitoring	minor stable issue with no red flag	simple first aid, observe, escalate if worse

A green box does not exist when breathing might be abnormal, when a red flag might be present, when the condition is getting worse, or when you are seriously unsure what you are looking at. Uncertainty about something potentially serious is itself a reason to call, not a reason to award yourself a green badge.

Adult: unresponsive and not breathing normally

[amb . 3]

PRINCIPLE *call for help, then temporarily support circulation and oxygen delivery until normal breathing or professional help takes over.*

The depths, rates, and hand positions here are adult figures. CPR for a child or infant differs. If a child or infant is unresponsive and not breathing normally, call **112** on speaker and start immediately — then follow the dispatcher rather than stopping to look up the paediatric technique.

1. Call **112** on speaker. If another person is present, send them for an **automated external defibrillator (AED)**. A lone rescuer should not stop compressions to search for a distant device.
2. Begin **cardiopulmonary resuscitation (CPR)** with chest compressions in the centre of the adult chest: **100–120 per minute, 5–6 cm** deep, allowing the chest to rise fully after each push.
3. If trained and willing, use **30 compressions to 2 breaths**. The compressions move some blood; the breaths add oxygen. This is support, not a perfect imitation of a working heart and lungs.
4. If you are not giving breaths, continue chest compressions. Do not turn a difficult technique choice into no technique at all.

5. Switch rescuers when another person is ready. **Why:** fatigue quietly makes compressions shallower and slower; sharing also prevents one person becoming the entire rescue system.

Adult chest-compression location using head, chest, hips, and feet as landmarks

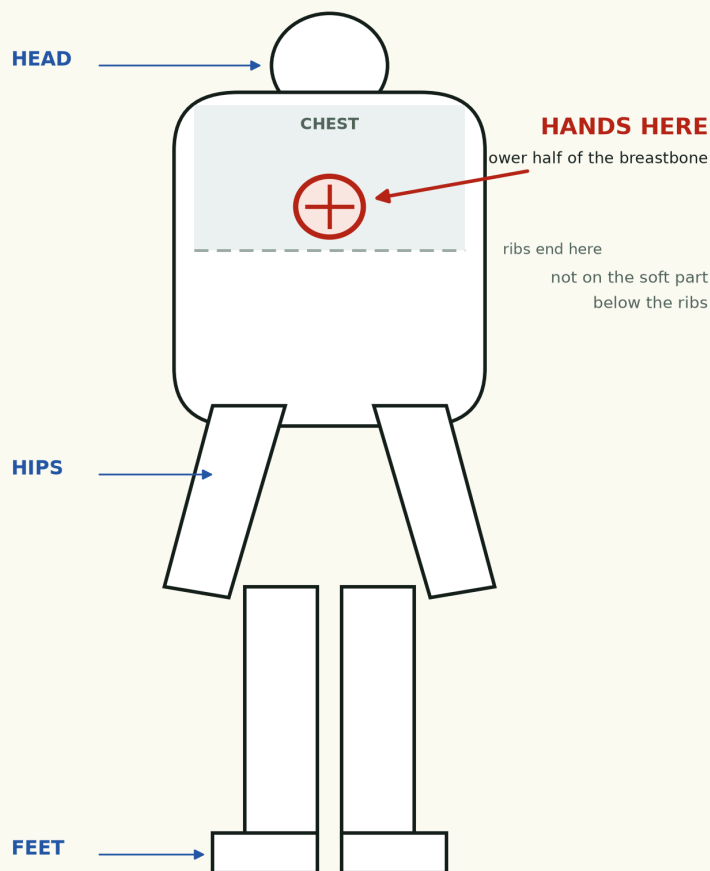
[amb.fig.2]

Where is the centre of an adult chest relative to the head, hips, and feet?

LARGE PRINT / TEXT ROUTE FOLLOWS

Adult chest-compression orientation

Person flat on a firm surface · kneel beside the chest



Hands together · shoulders above hands · push hard and fast · allow full recoil

The dispatcher can guide you. Keep the phone on speaker. Imperfect compressions are better than elegant inaction.²

AED

PRINCIPLE *it analyses the rhythm and shocks only when told to; it does not replace compressions*

AED means automated external defibrillator. It analyzes the heart rhythm through adhesive pads. It advises or delivers a shock only when its algorithm identifies a shockable rhythm. The shock may interrupt a dangerous electrical rhythm so an organized rhythm can resume; it is not a universal “reboot,” and it does not replace CPR.

1. Turn it on and follow the spoken or visual prompts.
2. Bare and dry the chest; attach pads exactly as pictured.
3. Make sure nobody touches the person during analysis.
4. If told to shock, say **clear**, look, and ensure nobody is touching them.
5. Resume CPR immediately after the prompt; follow the next instruction.

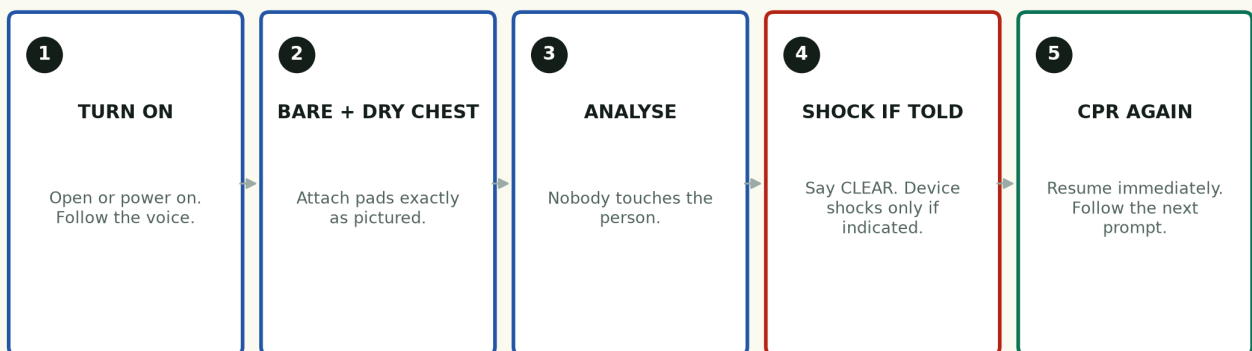
AED action sequence: turn on, attach pads, clear for analysis or shock, resume CPR

[amb.fig.1]

What should a lay rescuer do when an AED arrives?

LARGE PRINT / TEXT ROUTE FOLLOWS

AED — attach, listen, clear, continue CPR



An AED analyzes the rhythm. It does not shock every cardiac arrest and it does not replace compressions.

Unresponsive but breathing normally

[amb.4]

PRINCIPLE *create a stable, drainable airway position while help comes.*

Call **112**. If no major trauma prevents safe movement:

1. kneel beside the person; straighten the legs;

2. place the near arm bent upward, palm facing up;
3. bring the far hand across the chest and hold its back against the near cheek;
4. bend the far knee and pull the person toward you;
5. place the top leg at roughly a right angle, tilt the head back to keep the airway open, and position the mouth downward so fluid can drain.

Keep checking normal breathing. Do not give food or drink. If breathing becomes abnormal, roll them onto their back and start CPR.³

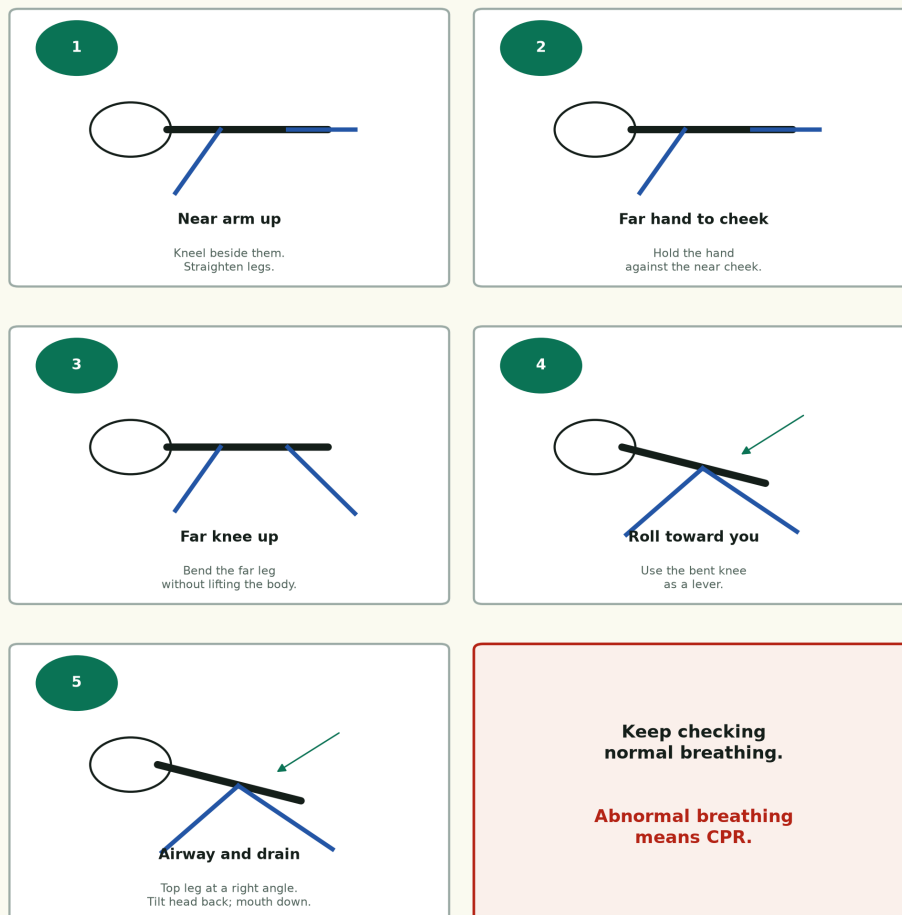
Five-step recovery-position orientation

[amb.fig.3]

How do the five recovery-position movements relate spatially?

LARGE PRINT / TEXT ROUTE FOLLOWS

Recovery position — unresponsive and breathing normally



Call 112 · do not give food or drink

Choking — adult

[amb . 5]

PRINCIPLE *an effective cough is already clearing the airway; when the cough fails, escalate from cough to back blows to abdominal thrusts.*

1. **Can they cough effectively?** Encourage coughing and watch for change. Do not use back blows, abdominal thrusts, or a finger sweep while the cough is still working — you would be interrupting the thing that clears airways best.
2. **Cannot cough, speak, or breathe — or the cough is failing?** Call for help and give **up to five firm back blows** with the heel of your hand between the shoulder blades, checking after each one.
3. **Still obstructed?** Give **up to five abdominal thrusts**.
4. **Still obstructed?** Call **112** if that has not happened yet, and keep alternating **five back blows and five abdominal thrusts** until the airway clears or the person stops responding.
5. **No blind finger sweeps.** Remove an object only when you can see it and reach it.
6. **If they become unresponsive, start CPR.**

Once the obstruction clears after thrusts or compressions, arrange medical assessment: those manoeuvres can injure on their own.²

For **your own** choking episode there is little good evidence for self-administered manoeuvres, so this page does not prescribe furniture. Call 112 on speaker if you can, unlock the door, make noise, and keep coughing while coughing still works.

Wounds and bleeding

[amb . 6]

PRINCIPLE *do not add harm. Reduce contamination or blood loss, protect what the body is already repairing, and escalate when the wound exceeds ordinary self-care.*

Minor wound

- wash or sanitize your hands — **why:** do not add a second contamination;
- rinse visible dirt with clean water — **why:** remove debris without grinding it deeper or adding harsh chemicals;
- cover with a clean dressing — **why:** protect the repair surface from friction and new dirt;
- seek medical advice for bites, punctures, contaminated wounds, retained objects, impaired movement or sensation, or infection signs;

- check whether tetanus protection needs review.

Severe bleeding

PRINCIPLE *stop blood loss while making the fewest additional injuries.*

1. Call **112**.
2. Press firmly and continuously on the wound with a dressing or clean cloth.
3. Keep the person warm and still.
4. If blood soaks through, maintain pressure and add material; do not repeatedly lift the first dressing to inspect your progress.
5. Leave embedded objects in place and press around them.

A dispatcher may give additional instructions, including use of a tourniquet when appropriate. Do not abandon direct pressure to search for perfect gear.⁴

Shock warning signs

PRINCIPLE *reduce demand, support temperature and circulation, and keep the handoff moving while professional help approaches.*

Pale or clammy skin, weakness, restlessness, confusion, rapid breathing, collapse, or severe thirst after injury or bleeding can indicate shock. Call **112**, keep the person warm and still, and follow the dispatcher. Do not wait for low blood pressure; you are not conducting a trauma conference.

Burns and scalds

[amb . 7]

PRINCIPLE *stop the source, assess severity, cool the burn without cooling the whole person, then protect the surface.*

- Stop the burning process and remove the person from danger.
- Cool a limited burn promptly with cool or cold running water for about **20 minutes**, while preventing whole-body chilling.
- Be especially cautious with large burns, infants, children, and frail people; call **112** and prioritize warmth as instructed.
- Remove jewellery or loose clothing near the burn, but not material stuck to skin.
- Cover loosely with a clean sterile non-fluffy dressing or suitable film.
- Do not use ice, butter, toothpaste, flour, creams, or burst blisters.

- Call **112** for severe or extensive burns, breathing injury, electrical or chemical burns, facial burns with breathing risk, or any serious concern.

The exact cooling advice varies slightly among guidelines; current DRK public guidance uses at least 20 minutes and strongly warns against hypothermia.⁵

Suspected fractures and joint injuries

[amb . 8]

PRINCIPLE *the body has usually chosen the least-worst position already. Support it; do not audition alternative geometry.*

Signs may include pain, swelling, deformity, inability to use the limb, or an open wound.

1. Do not straighten, test, or repeatedly move the injured area.
2. Support it in the position found using clothing, pillows, blankets, or other padding.
3. Cover an open wound with a clean dressing without pressing exposed bone.
4. Remove rings or tight items early only if easy and movement is minimal.
5. Call **112** for open fracture, severe deformity, major trauma, impaired circulation or sensation, spine/pelvis injury, or serious concern.
6. Otherwise arrange urgent medical assessment.

Improvised rigid splints can cause harm when applied badly. For a short wait, comfortable padding and stillness are often more useful than constructing a medieval orthopaedic device from magazines.⁶

Suspected spine, neck, or pelvic injury

[amb . 9]

PRINCIPLE *recognize that this rule applies. Unless immediate danger makes movement unavoidable, do not move, sit up, or test the person—support and call.*

After a major fall, collision, crush, diving injury, or trauma with neck/back pain, weakness, numbness, or altered consciousness:

- call **112**;
- ask the person not to move;
- support the head in the position found if safe and necessary;
- do not sit them up or “test” walking;
- move only to escape immediate danger or as instructed.⁷

Chemical in eye or on skin

[amb . 10]

Protect yourself. Remove contaminated clothing if safe and flush immediately with plenty of clean running water, directing runoff away from unaffected skin. For eye exposure, hold lids open and remove contact lenses only if easy. Call **112** for serious symptoms and contact a poison centre for substance-specific advice.

Do not neutralize one chemical with another. The bathroom is not a titration lab, no matter how persuasive the bottles look.⁸

Electrical injury

[amb . 11]

Do not touch the person until the power source is safely disconnected. Once you are clear of the current, **call 112** and keep rechecking response and breathing while help comes. Electricity that passed through a person can cause serious internal or cardiac harm even when the skin mark is small, which is why the call does not wait for a checklist of symptoms.

For **high-voltage** incidents, do not approach or attempt rescue at all until specialist personnel have made the scene safe.⁹

Stroke — FAST

[amb . 12]

- **F — Face:** one side droops?
- **A — Arms:** one arm weak or drifting?
- **S — Speech:** slurred, strange, or absent?
- **T — Time:** call **112 immediately** and note when the person was last known well.

Do not wait for several signs. One sudden FAST sign is enough to call. Do not drive the person yourself when emergency services are available.¹⁰

Chest pain or severe breathlessness

[amb . 13]

Call **112** for strong chest pressure or pain, severe breathlessness, cold sweat, collapse, pain spreading to arm/jaw/back, blue or grey colour, or serious uncertainty. Let the person rest in the position that makes breathing easiest. Do not drive yourself.¹¹

Anaphylaxis

[amb . 14]

Sudden breathing difficulty, throat or tongue swelling, collapse, or rapidly progressing symptoms after an allergen is an emergency.

- Use the person's prescribed adrenaline auto-injector immediately according to its instructions.
- Call **112**.
- Keep them lying down unless breathing is easier sitting up; do not let them stand or walk.
- Follow the dispatcher and device instructions for any further dose.

Antihistamines do not replace adrenaline in anaphylaxis.⁷

Poisoning

[amb . 15]

- Acute collapse, breathing difficulty, seizure, severe symptoms, or possible life-threatening exposure: **112**.
- Otherwise call a German poison information centre; gesund.bund.de maintains the official directory and explains when to use 112.
- Keep the package, label, plant, substance, or a photo available.
- Record amount and time if known.
- Do **not** induce vomiting and do not give a home "antidote" unless a poison specialist instructs you.
- For inhaled fumes, protect yourself and move to fresh air only if safe.¹²

Vital signs

[amb . 16]

PRINCIPLE *observe and record; a reading never clears a red flag by itself*

Home observations can help a dispatcher or clinician. They cannot reliably rule out an emergency.

OBSERVATION	HOW TO OBTAIN IT	URGENT MEANING
responsiveness	name, place, what happened	new confusion or unresponsiveness → 112
breathing	count visible breaths for a full minute if safe	abnormal, gasping, severe effort, blue/grey colour → 112

OBSERVATION	HOW TO OBTAIN IT	URGENT MEANING
pulse	wrist if easy; count for 30–60 seconds	collapse, chest pain, severe symptoms, very irregular feel → 112
temperature	thermometer	interpret with age, symptoms, and medical advice
oxygen saturation	pulse oximeter, warm still finger	low or falling value plus symptoms needs urgent assessment; do not rely on one reading
blood pressure	proper cuff and seated rest	severe symptoms outrank the number; repeated unusual readings need clinical advice
blood glucose	only if trained and relevant	follow the person's diabetes plan; altered consciousness/seizure → 112

Devices can be wrong because of cold fingers, movement, nail products, cuff size, poor circulation, battery, or user technique. A reassuring display is not a permission slip to ignore collapse, stroke signs, severe breathlessness, or chest pain.

The detachable **Observation and vital-sign log** in the Grey Book keeps time, change, actions, and readings together. Use it to improve the handoff, not to award yourself a green discharge badge.

Observation log

TIME	RESPONSE	BREATHING	PULSE/DEVICE	SYMPTOMS/ACTIONS

Pain is an alarm, not a damage display [amb . 17]

Pain is a protective experience, not a transparent window onto tissue. Its intensity matters, but so do onset, location, spread, rhythm, function, context, and associated signs. “Seven out of ten” is less useful than “sudden pressure, new at 14:10, spreading to the jaw, worse with effort.”

Before explaining the cause, describe the geometry:

PROPERTY	USEFUL DISTINCTION
onset	sudden / gradual / after a specific event
shape	point / band / diffuse area / travelling
time	seconds / steady / waves / repeatedly returning
relation	movement / breathing / food / urination / position / touch
function	can walk, speak, breathe, drink, think, or sleep?
companions	fever, weakness, numbness, rash, vomiting, bleeding, collapse

Sudden severe pain, chest pressure, severe abdominal pain, major injury, collapse, severe breathlessness, new neurological signs, pregnancy with severe pain, heavy bleeding or collapse, or serious uncertainty bypass the notebook and use urgent medical help. Otherwise stop the aggravating activity, support the body, note the onset, and use First Aid or **116 117** when prompt assessment is needed.

NRS pain scale — communication, not physiology

A 0–10 rating can help communicate experience:

RATING	PLAIN-LANGUAGE DESCRIPTION
0	no pain
1–3	present but relatively manageable
4–6	meaningfully interferes with activity or concentration
7–9	severe, dominates attention or function
10	worst pain the person can imagine or report

The number does not directly measure tissue damage, blood loss, oxygen, heart rate, or urgency. A person can have a dangerous condition with modest pain and severe pain without life-threatening injury.

Use change over time only as description:

$$\Delta P = P_{\text{now}} - P_{\text{earlier}}$$

Better pain description

Record **OPQRST** if useful:

- **O — Onset:** sudden or gradual; exact time?
- **P — Provokes/palliates:** movement, breathing, food, position?
- **Q — Quality:** pressure, burning, stabbing, cramping, aching?
- **R — Region/radiation:** where; does it spread?
- **S — Severity:** number plus effect on function?
- **T — Time:** constant, waves, worsening, recurring?

Add injury, pregnancy, fever, vomiting, weakness, numbness, rash, medication, and relevant medical history. This makes a better call than “my left side is being weird, please infer the plot.”

Pain log

TIME	LOCATION/QUALITY	0–10	ASSOCIATED SIGNS	ACTION/RESULT

Do not delay emergency help to complete the table. Paperwork must learn its place.

Pain without a red flag

[amb . 18]

Record location, onset, quality, what changed it, and a 0–10 rating if helpful. A pain number is communication, not triage. Contact a practice or **116 117** when the problem is urgent but not life-threatening, especially if pain is new, persistent, worsening, or impairing function.¹

Do not exceed labelled or prescribed medication doses. Check active ingredients to avoid accidentally taking the same medicine under two brand names. Ask a pharmacist when uncertain.

Self-care while waiting

[amb . 19]

- Use the position that is safest and most comfortable.
- Do not force a faint person to stand or walk.
- Keep the phone on speaker and within reach.

- Unlock access and contain pets if safe.
- Gather medication list, allergies, ID, and the time symptoms began.
- Keep the person warm without overheating.
- Do not give food or drink to someone with reduced consciousness, choking risk, severe nausea, or possible surgery unless instructed.
- Recheck responsiveness and breathing.
- Tell the dispatcher immediately if the condition changes.

Do not tell someone to “fight unconsciousness.” Keep them safe, monitor breathing, and call for help. Consciousness is not maintained by motivational speaking.

First-aid kit for an ordinary household

[amb . 20]

A practical kit may include:

- disposable gloves;
- sterile dressings and plasters;
- gauze, roller bandages, and triangular bandage;
- tape and blunt scissors;
- saline or clean water access;
- emergency blanket;
- CPR face shield if desired;
- thermometer;
- personal medication and written plans;
- current first-aid leaflet and emergency contacts.

Check expiry dates and replace used items. A kit hidden beneath twelve expired hotel shampoos is technically present and operationally fictional.

Red flags — one is enough

[amb . 21]

Stop categorizing and call 112

- **unresponsive**, or newly and severely confused;
- **not breathing normally** — gasping, severe effort, or blue or grey colour;
- **severe bleeding you cannot control**, or collapse after major blood loss;
- **one sudden FAST stroke sign**;
- **strong chest pressure**, severe breathlessness, or collapse;
- **severe allergic reaction** affecting airway, breathing, or circulation;
- **seizure**, severe poisoning symptoms, or a life-threatening exposure;
- **major trauma**, major burn, or a high-voltage incident;
- anything **getting rapidly worse**;
- **serious uncertainty** about whether this is dangerous.

One item is enough. Not most of them. Not a majority.

Call · speakerphone · state location · unlock the door · follow instructions.

Optional reading — why some of these rules look like this

[amb . 22]

Some of what follows could reasonably live in the Green Book, a first-aid course, or a moderately overcaffeinated physiology lecture. The editor wants it here for now.

That is not permission to finish an interesting model before calling for help. If an action section above applies, use it. Curiosity is optional; first aid is not.

The “golden hour”

[amb . 23]

PRINCIPLE *useful urgency, not a stopwatch*

Trauma teaching uses “golden hour” to make one point: serious bleeding, airway problems, and brain injury all do better with fast care. It is a teaching device, not a biological cliff that opens at minute 61. Nobody is timing you. The practical rule is simpler than the phrase suggests:

serious mechanism or red flag → call early → do not delay for perfect assessment, transport planning, or a final internet search.

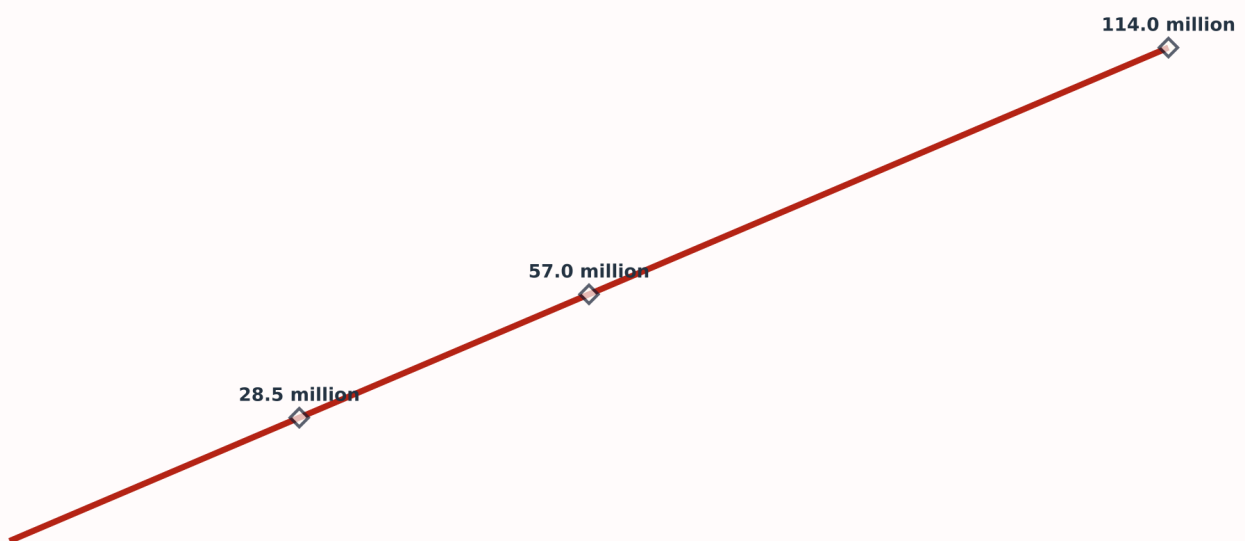
“Time is brain” — quantified, with the word *model* attached [amb . 24]

Time is brain — a model, not a bedside meter

[amb . fig . 5]

How does the literature-derived untreated-stroke model accumulate estimated neural loss over sixty minutes?

LARGE PRINT / TEXT ROUTE FOLLOWS



What to notice: The model rises linearly at 1.9 million neurons per minute; its purpose is urgency, not individual measurement.

Limit: Order-of-magnitude model estimate, not a measurement in an individual patient; practical action remains FAST and 112.

A widely cited 2006 calculation combined published estimates for forebrain neurons, typical large-vessel stroke volume, and stroke evolution time. For its modelled “typical” untreated large-vessel supratentorial ischemic stroke, it estimated losses on the order of **1.9 million neurons, 14 billion synapses, and 12 km of myelinated fibres per minute.**¹³

Those are order-of-magnitude model estimates, not tissue counts occurring on a bathroom display in one individual. Stroke type, vessel, collateral circulation, and treatment differ. The reliable lay conclusion is much shorter than the calculation: a

sudden FAST sign gets **112 now**, not a timer, spreadsheet, or request to finish the sentence first.

Self ambulance for non-physical emergencies

The structure “stabilize, assess, get help” also applies to psychological [amb.25] or situational crises, but the actions differ:

PHYSICAL FRAME	PSYCHOLOGICAL/SITUATIONAL EQUIVALENT
make scene safe	reduce means, audience, conflict, and sensory load
check response/breathing	check orientation, self-harm risk, and actual danger
direct pressure	grounding and one concrete support action
unlock the door	tell one safe person and permit access to help
call emergency service	112 for acute danger; crisis/medical service otherwise
monitor	better, same, worse, or new red flag?

A panic attack is not “emotional bleeding,” and the metaphor must not stand in for assessment. What actually carries across is the sequence, not the anatomy.

Red-flag theorem, again

[amb.26]

$$R = 1 \Rightarrow \text{call 112}$$

Read out loud: R is one yes/no light, and it comes on if **any** red flag is present. Not most of them. Not a majority vote. Any single one. That is the only job this notation has — it takes “if any of these, then call” and writes it in a form you cannot argue with at two in the morning.

Vital signs, pain scores, internet searches, and apparent calm can all add information. None of them reliably turn that light off for a lay reader. The card above is the working interface; the equation only admits that Boolean algebra is sometimes easier to negotiate with than yourself at two in the morning.

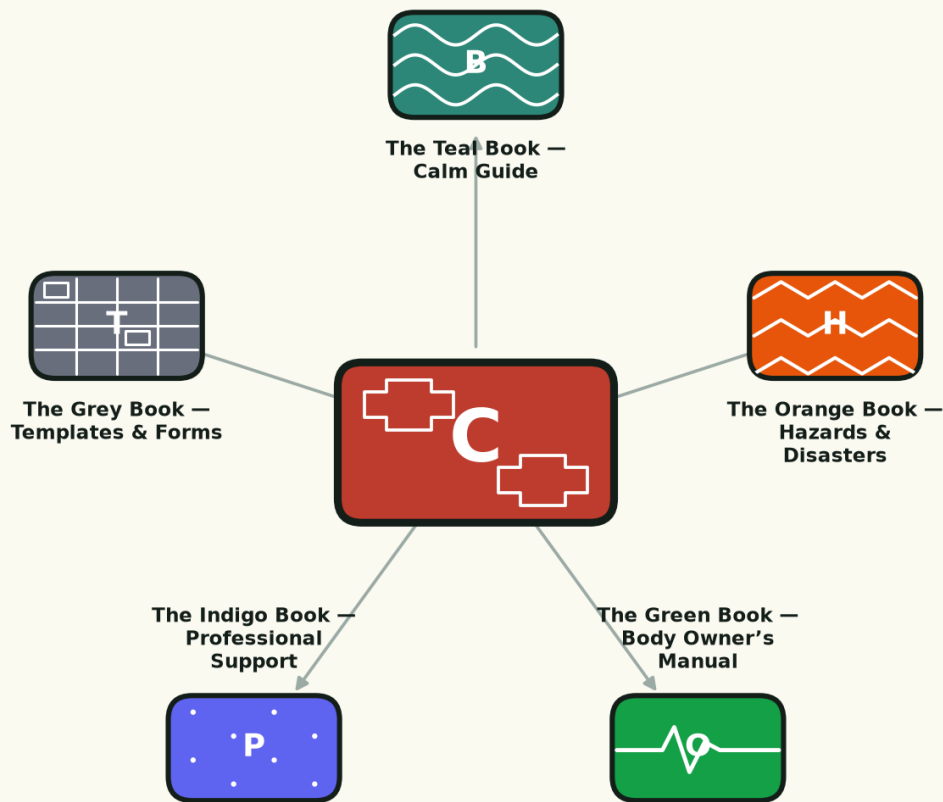
Where next?

C

You do not need to complete the shelf in order. Stay here while this is the primary problem; move when another title becomes more accurate.

- **B — The Teal Book — Calm Guide** — use it when that problem becomes primary.
- **H — The Orange Book — Hazards & Disasters** — use it when that problem becomes primary.
- **O — The Green Book — Body Owner's Manual** — use it when that problem becomes primary.
- **P — The Indigo Book — Professional Support** — use it when that problem becomes primary.
- **T — The Grey Book — Templates & Forms** — use it when that problem becomes primary.

You are here: C — The Red Book — Self Ambulance



Complete route names follow as text. Immediate danger bypasses this map.

Connections from C — The Red Book — Self Ambulance

1. gesund.bund.de, “Nummern für den Notfall”: <https://gesund.bund.de/notfallnummern>↔↔
2. European Resuscitation Council, *Guidelines 2025* and layperson guidance: <https://www.erc.edu/science-research/guidelines/guidelines-2025/guidelines-2025-english/>↔↔
3. German Red Cross, “Stabile Seitenlage”: <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/stabile-seitenlage/>↔
4. German Red Cross, “Starke Blutungen”: <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/blutungen-und-blutstillung/blutungen/>↔
5. German Red Cross, “Verbrennungen, Verbrühungen und Brandwunden”: <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/verbrennungen/>↔
6. German Red Cross, “Knochenbrüche”: <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/knochenbruch/knochenbrueche/>↔
7. Djärv T et al., “European Resuscitation Council Guidelines 2025 First Aid,” *Resuscitation* 215 Suppl 1 (2025): 110752. <https://doi.org/10.1016/j.resuscitation.2025.110752>↔↔
8. German Red Cross, “Verätzungen”: <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/veraetzungen/>↔

9. German Red Cross, "Stromschlag": <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/stromschlag/>↵
10. German Red Cross, "Schlaganfall": <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/schlaganfall/>↵
11. German Red Cross, "Herzinfarkt": <https://www.drk.de/hilfe-in-deutschland/erste-hilfe/herzinfarkt/>↵
12. gesund.bund.de, "Erste Hilfe bei Vergiftungen": <https://gesund.bund.de/erste-hilfe-bei-vergiftungen>↵
13. Saver JL, "Time is brain—quantified," *Stroke* 37 (2006): 263–266. The figures are literature-derived estimates for a modelled typical untreated large-vessel supratentorial ischemic stroke, not direct measurement in an individual patient. <https://doi.org/10.1161/01.STR.0000196957.55928.ab>↵