HLTAID003 Provide First Aid

1 Day Course
Assessment Learner Guide

Version 2
This document is protected by copyright and may not be reproduced or copied either in part or in whole nor used for financial gain without the express approval in writing by the owner, St John Ambulance Western Australia Ltd.

St John Ambulance Western Australia Ltd.
209 Great Eastern Highway
Belmont WA 6984

Telephone: (08) 9334 1222
Web: www.stjohnambulance.com.au

MODIFICATION HISTORY

<table>
<thead>
<tr>
<th>Superseded Version</th>
<th>New Version</th>
<th>New Version Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1</td>
<td>Version 2</td>
<td>July 2015</td>
<td>Dive Emergency Service (DES) Telephone number changed</td>
</tr>
<tr>
<td>Version 1</td>
<td>Version 1</td>
<td>April 2014</td>
<td>Document created</td>
</tr>
</tbody>
</table>
WOULD YOU LIKE TO VOLUNTEER WITH ST JOHN EVENT HEALTH SERVICES?

St John Event Health Services volunteers are a regular presence at many of Western Australia’s local and major events offering first aid assistance and safeguarding the health of the community.

Become an Event Health Services Volunteer

Being an Event Health Services volunteer is very rewarding work. You get the satisfaction of knowing you are helping others and making a difference in your community. Being an Event Health Services volunteer also creates many great opportunities.

The Event Health Services is made up of both adult and child members from all walks of life. To register your interest in becoming a volunteer simply call us on:

**T:** (08) 9334 1310  
**E:** volunteermemberservices@stjohnambulance.com.au  
**W:** www.stjohnambulance.com.au and click on volunteering
Table of Contents

INTRODUCTION .......................................................................................................................... 7
ACCESS AND EQUITY POLICY ................................................................................................. 7
PRIVACY STATEMENT ................................................................................................................ 7
FLEXIBLE LEARNING AND ASSESSMENT .............................................................................. 7
ASSESSMENT INFORMATION ..................................................................................................... 8
ASSESSMENT ............................................................................................................................. 8
REASSESSMENT ........................................................................................................................ 8
UNIT OF COMPETENCY .............................................................................................................. 8
PRINCIPLES OF FIRST AID ......................................................................................................... 9
CHAIN OF SURVIVAL .................................................................................................................. 10
ANATOMY AND PHYSIOLOGY .................................................................................................... 11
THE RESPIRATORY SYSTEM ...................................................................................................... 11
AIRWAY OBSTRUCTION DUE TO BODY POSITION ................................................................ 12
THE CIRCULATORY SYSTEM ....................................................................................................... 13
THE DIGESTIVE SYSTEM .......................................................................................................... 14
THE NERVOUS SYSTEM ............................................................................................................ 14
FIRST AID FACT SHEETS .......................................................................................................... 15
WELLBEING ............................................................................................................................... 15
DEBRIEFING .............................................................................................................................. 16
EVALUATION ............................................................................................................................... 17
INFORMATION FOR FIRST AIDERS .......................................................................................... 18
USEFUL LINKS ............................................................................................................................ 18
ABBREVIATIONS ........................................................................................................................ 19
TERMINOLOGY ............................................................................................................................ 20
BRONCHOSPASM ........................................................................................................................ 25
DEHYDRATION ............................................................................................................................ 26
RESUSCITATION OF A DROWNING VICTIM ........................................................................... 27
HEAD INJURIES ........................................................................................................................... 28
NECK AND SPINAL INJURIES ................................................................................................... 29
NECK INJURIES ......................................................................................................................... 29
SPINAL INJURIES ......................................................................................................................... 29
FRACTURES .................................................................................................................................. 30
BLEEDING ..................................................................................................................................... 31
EAR INJURIES ............................................................................................................................... 32
EYE INJURIES ............................................................................................................................... 33
BITES AND STINGS ..................................................................................................................... 34
POISONING .................................................................................................................................... 35
BRUISE (CONTUSION) .................................................................................................................. 36
NEEDLE STICK INJURY ................................................................................................................ 36
ANGINA ......................................................................................................................................... 37
FROSTBITE ..................................................................................................................................... 37
ALLERGIC REACTIONS .............................................................................................................. 38
DIABETES ....................................................................................................................................... 38
EPILEPSY..................................................................................................................................................38
AUSTRALIAN RESUSCITATION COUNCIL (ARC) GUIDELINES.........................................................39
ARC GUIDELINE 5.......................................................................................................................................40
ARC GUIDELINE 8.......................................................................................................................................44
SAFE WORK PRACTICES.........................................................................................................................47
SAFE MANUAL HANDLING.......................................................................................................................48
RESPECT...................................................................................................................................................49
REPORT OF THE INCIDENT ......................................................................................................................50
VERBAL REPORTING/HANDOVER ............................................................................................................50
BASIC DOCUMENTATION.........................................................................................................................50
I HAVE DONE MY BEST..............................................................................................................................51
Introduction
St John Ambulance Western Australia Ltd (St John), via The College of Pre Hospital Care, RTO #0392 wishes to advise all course participants of the following procedures in line with our Registered Training Organisation standards.

Access and Equity Policy
St John will ensure that a cross-section of the community have equitable access to participation and involvement in the benefits of training and assessment. This is achieved through the establishment of non-discriminatory participant selection procedures, allowing access for all members of the community.

Participants with a language or literacy difficulty should inform the enrolment or training staff so that appropriate assistance can be arranged. Participants with any other difficulty during the course should seek assistance from the trainer conducting the course. Failing satisfactory resolution of the problem, the Training Manager should be approached.

Privacy Statement
Your privacy is respected by St John.

Your personal information provided to us will be used in course administration and may be provided to training staff. We may also provide records of your first aid training certification to your employer if requested to do so. Your personal information will not be used for any purpose outside the Privacy Act guidelines.

If you have privacy concerns or would like to verify information held about you, please contact our Privacy Officer on (08) 9334 1222.

Flexible Learning and Assessment
Participants experiencing difficulties associated with attending classes or assessment sessions should discuss their problems with the trainer of the course so that alternative arrangements can be made e.g. if learners have difficulty completing the written components of the course they may give a verbal report to the assessor.

St John and its training staff will make every reasonable effort to ensure that participants are provided with flexible options for learning and/or assessment.
Assessment Information

Pre Learning
This Learner Guide should be read in conjunction with the St John Emergency First Aid Booklet. Reading both these documents will enable you to complete Assessment Activity 1 prior to attending the course.

Assessment
Each participant must negotiate an Assessment Plan prior to undertaking assessment activity. An Assessment Plan is the “what, when and how” of your assessments. It prepares you for the assessment. An Assessment Plan outlines assessment information such as date, method and reasonable adjustment strategies before the assessment.

Assessment is the process of collecting evidence about competency and making judgements on whether competence has been achieved to confirm that an individual can perform to the standard expected in the workplace.

Assessment structure:
1. knowledge assessment; and
2. skills assessment.

Participants can be deemed Requirement Met (RM) or Requirement Not Met (RNM) for their knowledge and skills assessments.

Overall assessment outcome is: Competent (C) or Not Yet Competent (NYC).

Reassessment
If the assessment criteria requirements have not been achieved, participants will have the opportunity to be reassessed, once, at no cost, within a six week timeframe from the date of their course.

Contact First Aid Service and Training on (08) 9334 1222 to book your reassessment session.

Unit of Competency
Unit(s) of competency are used as a benchmark in assessment. They can be accessed and downloaded from: http://training.gov.au/
Principles of First Aid

First Aid is the initial care of someone who is injured or ill.

Any attempt to provide First Aid is better than no First Aid at all.

1. **Assess the Situation:**
   - **LOOK:** History/signs;
   - **LISTEN:** Symptoms/history; and
   - **FEEL:** Signs.

2. **Decide on First Aid Management:**
   - **D** is for Danger: When assessing danger, you are checking whether it’s safe for yourself, bystanders and the casualty;
   - **R** is for Response: Are they conscious or unconscious? How do we check?
   - **S** is for Send for help: Call Triple Zero (000) for an ambulance or have someone do it;
   - **A** is for Airway: What can obstruct the airway? Remember, to **clear**, and then **open** the airway;
   - **B** is for Breathing: To check breathing we LOOK, LISTEN and FEEL for up to 10 seconds. What are we looking, listening and feeling for?
   - **C** is for Cardio Pulmonary Resuscitation (CPR); and
   - **D** for Defibrillation

3. **Arrange Medical Aid if Required**

   In every accident or emergency situation use the St John Action Plan DRSABCD.
Chain of Survival

In an emergency situation, immediate action needs to be taken to maximise a casualty’s chances of survival, particularly when there are no signs of life.

This Chain of Survival is the key to improving the survival rate from Cardiac Arrest in our community. Time is of the essence.

- **Early recognition and call for help**
  The ambulance must be called immediately to ensure that early defibrillation and advanced life support can commence without delay.

- **Early CPR**
  If Cardiopulmonary Resuscitation (CPR) is begun within 4 minutes of the heart stopping, oxygenation of the vital organs (such as the brain) is maintained.

- **Early defibrillation**
  If Cardiopulmonary Resuscitation (CPR) is given within 4 minutes and defibrillation within 8-12 minutes, there is a significantly improved chance of survival.

- **Post resuscitation care**
  Definitive treatment by the ambulance service, such as giving medication and stabilising the airway may increase chances of survival even further.
Anatomy and Physiology

The Respiratory System
The body needs a constant supply of oxygen to function. The act of breathing not only supplies this oxygen to the body but also expels waste gases such as carbon dioxide from the body.

The mechanics of breathing
The diaphragm and intercostal muscles expand the chest to draw air into the lungs. The air then crosses to the blood for transportation to the body. As the diaphragm and intercostal muscles relax, air is forced out of the lungs.

Absence of normal breathing
Respiratory distress syndrome is a potentially life-threatening medical condition where the lungs cannot provide enough oxygen for the rest of the body.

There are many causes /conditions that come under the umbrella of respiratory distress e.g. asthma, airway obstruction, hyperventilation, croup, and epiglottitis. (the epiglottis is a small piece of cartilage at the back of the tongue that closes the windpipe when food is swallowed). It presents as a difficulty in breathing and the psychological experience associated with such difficulty.

Signs and symptoms
May vary dependent on the form of respiratory distress, but often presents as; rapid shallow breathing, sharp pulling in the chest below and between the ribs with each breath, grunting sounds, flaring of the nostrils. Increased sweat on the forehead, with skin feeling cool and clammy and wheezing when breathing.

Anatomic and physiological differences between adults and children (airway)
A child’s airway is narrower than an adult and is more prone to blockage by blood or secretions. Children prefer to breathe through their nose so a nasal obstruction can cause respiratory distress. A child’s primary response to respiratory distress is to increase the rate and effort of breathing.

In infants the trachea is shorter, softer and more pliable and may be distorted by excessive backwards head tilt or jaw thrust so when opening the airway (in CPR), an infant’s head should be kept in a neutral position, the lower jaw supported at the point of the chin with the mouth maintained open.
Airway Obstruction Due to Body Position
When providing first aid for an unconscious casualty or casualty with an altered consciousness it is important to ensure their body position does not compromise their airway. This usually occurs when the casualty has their head slumped forward constricting the airway. The DRSABCD action plan ensures the airway is cleared of blockage and that the casualty is placed in the recovery position which maintains an open airway.

Positional asphyxia
Positional asphyxia is also a form of respiratory distress and occurs when the body position prevents someone from breathing adequately from an upper airway obstruction or a limitation in chest wall expansion, e.g. due to steering wheel compression or an unconscious casualty flopped forward i.e. in a car (as per picture below).

A person suffering from positional asphyxia is unable to move position to alleviate pressure and restriction.

Signs and symptoms:

- breathing difficulty or absent breathing;
- rapid pulse;
- blue around the lips, ear lobes and fingertips;
- convulsions; and
- if left untreated cardiac arrest and death.

Management:

- DRSABCD;
- remove cause and position the casualty to maintain their airway;
- resuscitate if necessary; and
- seek urgent medical aid.
The Circulatory System
The circulatory system is a complex circuit which enables blood to circulate throughout the entire body, transporting oxygen and nutrients to every cell in the body and collecting waste for elimination.

The heart provides the pumping action to keep blood flowing throughout the body. The heart is a muscular organ about the size of a fist which acts as a two sided pump, first relaxing and filling up with blood and then contracting to pump the blood to the arteries.

Blood
Blood is made up of:
- plasma – pale yellow liquid in which blood cells are suspended;
- red blood cells – carry oxygen;
- white blood cells – protect the body from germs; and
- platelets – form clots to stop bleeding.

Blood vessels
Arteries are large strong blood vessels that carry oxygen rich blood to all parts of the body. They subdivide into smaller blood vessels and capillaries which transport the blood to all parts of the body. After the cells receive oxygen from the blood the veins carry the blood, now low in oxygen, to the heart and then the lungs.

Circulation
Circulation begins and ends at the heart and consists of:
- pulmonary circulation – starting on the right side of the heart, blood is pumped to the lungs where it loses the carbon dioxide and absorbs oxygen, which then goes back to the left side of the heart; and
- systemic circulation – starting at the left side of the heart, blood is pumped to the body, where it delivers oxygen and removes carbon dioxide, and then returns to the right side of the heart.

Effects of bleeding
When injury occurs that results in internal or external bleeding the body tries to minimise blood loss. When a blood vessel is damaged it will contract to slow or stop blood through the wound and clots form to further restrict the bleeding. With continued blood loss the body has trouble compensating and blood pressure can drop. The casualty can show signs of shock at this stage.
The Digestive System
The digestive system converts food and liquid into nutrients and keeps the cells functioning.

Food moves from the mouth where saliva begins breaking the food down, through the oesophagus to the stomach where it is partly digested by gastric juices.

As food is expelled from the stomach it is mixed with other digestive juices from the pancreas (insulin), liver and gall bladder. These juices help break down the structure of food into simpler forms. Insulin helps control the blood sugar levels.

The Nervous System
The nervous system is made up of the brain, spinal cord and nerves.

Brain
The brain is the controlling organ of the body and regulates all body functions. Through the body’s network of nerves, the brain receives and transmits information as electrical impulses and chemicals.

Sensory and motor nerves
Sensory nerves, which transmit impulses from the body to the brain, relay information about touch, sight, sound, smell, taste, spatial awareness (the ability to be aware of oneself in space) and pain. Motor nerves control movement by initiating muscle contraction.

Spinal cord
The spinal cord is a large group of nerves which extends from the brain down the backbone through a canal in the spine. Nerves extend from the brain and the spinal cord to every part of the body. At each vertebrae of the spinal cord, two nerves branch out, one on each side of the body. In the upper part of the spinal cord, just below the brain are the autonomic centres for breathing and heart control.
THE FIRST AIDER

Wellbeing

First aid is the provision of initial care of a casualty with an illness or injury. First Aid skills are based on knowledge, training and experience. You may perform First Aid as part of your employment or you may find yourself in a situation where you are needed to use your skills to care for a sick or injured person until definitive medical treatment can be accessed.

Providing care in a high pressure emergency situation, can be draining and cause stress especially when children are involved. Even experienced First Aiders or personnel attending an emergency situation can experience unpleasant effects. People react differently and may display a variety of responses to an emergency situation, often not until after the event or some time later.

Signs and symptoms of stress:
- feelings of guilt, fear, shame;
- sweating;
- anxiety;
- increased heart rate; and
- high blood pressure.

Self-Care
Self-Care includes maintaining a healthy diet, eating regular meals, getting enough sleep and exercising. Avoid the use of alcohol and other drugs to either relax or keep going.

Any organisation you work for should have clear policies and procedures in place that ensure a safe, risk free environment. It is the responsibility of both the employer and employees to ensure all members of staff work together to create a workplace environment that is proactive and strives to recognise potential causes of stress so immediate action can be taken to reduce or eliminate stress and harm.
Debriefing

In a First Aid situation, once you have handed a casualty over to medical aid, there are a number of events that need to be addressed:

- cleaning up;
- occupational Health and Safety (OSH) issues;
- reporting requirements; and
- post incident debriefing.

Everyone will react differently after an incident. Reactions will vary according to the individual and the incident and a post incident debrief is an important part of the incident management process.

The purpose of the post incident debrief is:

- primarily to look after the individuals involved welfare, giving them the opportunity to discuss the emotions that they might have about the incident;
- bring the incident to a close;
- allows the provision of support to the First Aider;
- to provide information to prevent a similar incident from occurring in the future; and
- identification of any shortfalls in the emergency action plan.

The debrief may involve:

- gathering and documenting all relevant details regarding the incident, effectiveness of incident management process and first aid given;
- document any information relayed by the individuals involved; and
- providing advice on further assistance available i.e. counselling.

Remember not to lose sight of those who were involved in the incident including yourself and bear in mind the need for professional services.

Professional services may include:

- doctor;
- counselling service;
- clergy; and
- psychiatrist.

Remember
At the time you did the best you could do.
Evaluation

Evaluating an incident
Part of the process of continuous improvement and development for any organisation and individual is evaluation.

Evaluation can form part of the formal and informal de-briefing process. Evaluation of an incident can look at options or strategies that can be adapted to better workplace conditions. This can then prevent future stress and provide ways to eliminate or further reduce risks.

Within the evaluation process is the need to develop a personal stress management plan in consultation with a Supervisor or Manager, so you have a tool to constantly monitor your own personal stress levels and recognise the need for further assistance.

Most organisations will have procedures in place within their various departments that ensure that all plans e.g. First Aid Action Plan, Emergency Action Plan and Risk Management Plan etc. These plans can be evaluated for their effectiveness on an ongoing basis.

All plans should be compliant with:
- established first aid principles;
- Australian Resuscitation Council (ARC) Guidelines;
- organisational policies and procedures;
- Australian national peak bodies;
- industry standards; and
- state/territory legislation and regulations.

Evaluation of an incident is vital: It can help you now and in the future.
Information For First Aiders

Useful Links

The Australian Resuscitation Council (ARC)
What is it: The Australian Resuscitation Council (ARC) fosters and coordinates the practice and teaching of resuscitation, promotes uniformity and standardisation of resuscitation. The Australian Resuscitation Council (ARC) also publishes guidelines that cover all other aspects of First Aid management e.g. asthma, burns, anaphylaxis. [www.resus.org.au](http://www.resus.org.au)

Other helpful numbers:
- **Ambulance/Fire/Police** Telephone: for emergencies 000
- **Poisons Information Centre** Telephone: 13 11 26
- **Dive Emergency Service (DES)** Telephone: 1800 088 200
- **Health Direct Australia** Telephone: 1800 022 222
- **Asthma Foundation WA** Telephone: 9289 3600 [www.asthmafoundation.org.au](http://www.asthmafoundation.org.au)
- **Kidsafe WA** Telephone: 9340 8509 kidsafe@kidsafewa.com.au
- **ASCIA** [www.allergy.org.au](http://www.allergy.org.au)
- **Alcohol and Drug Information Service** Telephone: 9442 5000
- **Child Protection Unit** Telephone: 9340 8222
- **Mental Health Emergency Response Line** Telephone: 9224 8888
- **Royal Flying Doctor Service** Telephone: 1800 625 800 (Medical and Emergency calls only)
- **Rural link** (a specialist after-hours mental health telephone service for the rural communities of Western Australia) **Telephone:** 1800 552 002
Abbreviations

The following are common abbreviations that you may find useful:

- **DRSABCD**:
  - Danger;
  - Response;
  - Send for help;
  - Airway;
  - Breathing;
  - CPR;
  - Defibrillation.

- **CPR**: Cardio; Pulmonary; Resuscitation.

- **ARC**: Australian Resuscitation Council

- **O2**: Oxygen

- **AED**: Automated External Defibrillator

- **RICE**:
  - Rest;
  - Ice;
  - Compression;
  - Elevation.

- **TREND**:
  - Time;
  - Route of administration;
  - Effect;
  - Name of medication;
  - Dose.

- **WHS**: Work, Health and Safety

- **4 P’s**:
  - Preserve life;
  - Prevent further injury;
  - Promote recovery;
  - Protect the unconscious.

- **FAST** the Stroke acronym:
  - Facial weakness;
  - Arm weakness;
  - Speech difficulty;
  - Time to act fast.
Terminology

The following is an explanation of commonly used terminology:

- **Abdominal injuries:**
  - any injury to the area of the body between the chest and the pelvis; and
  - the abdomen contains the digestive organs e.g. stomach, intestines, the liver; and the urinary system organs e.g. kidneys, urethers, spleen.

- **Airway:**
  - the airway passage starts at the mouth or nose, through which air enters and leaves the lungs.

- **Airway obstruction:**
  - a blockage of the airway e.g. foreign body, trauma.

- **Allergic reaction:**
  - sensitivity to a substance foreign to the body e.g. bee venom, certain foods e.g. peanuts.

- **Altered or loss of consciousness:**
  - any state of awareness that differs from the normal awareness of a conscious person.

- **Anaphylaxis:**
  - the most severe form of allergic reaction that is potentially life threatening.

- **Asphyxia:**
  - a severe lack of oxygen.

- **Asthma:**
  - a chronic (long-term) lung disease that inflames and narrows the airways.

- **Bronchodilator:**
  - substance that dilates the bronchi and bronchioles, decreasing resistance in the respiratory airway and increasing airflow to the lungs.

- **Bronchospasm:**
  - a narrowing or constriction of the airways.
Terminology continued

- **Burn:**
  - an injury to the skin caused by heat, electricity, chemicals, radiation or friction.

- **Cardiac arrest:**
  - a sudden cessation of the pumping function of the heart with the loss of arterial blood pressure.

- **Casualty assessment:**
  - an evaluation of problems affecting a casualty as indicated by history, signs and symptoms as observed by the First Aider.

- **Culturally aware:**
  - being aware of and accepting of other cultures.

- **Danger:**
  - a source or an instance of risk or peril that will or likely to inflict injury or harm.

- **Duty of care:**
  - the legal duty owed by one person to another to act in a certain way. As a first aider, you have a duty of care towards your casualties to exercise reasonable care and skill in providing first aid treatment. The duty arises because you have knowledge and skills relevant to a medical emergency situation: and

  - if you choose to provide first aid assistance, you have a duty to use your knowledge and skills in a responsible way.

- **Envenomation:**
  - the injection of venom into the body by a bite or sting from an animal/insect.
Terminology continued

- **Environmental conditions:**
  - medical conditions caused by the environment e.g. hypothermia (body temperature falls below 35°C), hyperthermia (greatly increased body temperature), dehydration (loss of water and salts essential for normal body function), heatstroke (a life threatening condition in which body temperature is dangerously high).

- **First aid principles:**
  - preserve life, prevent illness, injury and conditions from becoming worse, promote recovery, and protect the unconscious

- **Fracture:**
  - a break in a bone.

- **Haemorrhage:**
  - the escape of blood from any part of the vascular system.

- **Hazard:**
  - a source or situation with the potential for harm in terms of human injury or ill-health, damage to property, the environment, or a combination of these. Relevant hazards may be classified under the headings:
    - biological hazards;
    - chemical hazards;
    - hazards associated with manual handling; and
    - physical hazards.
Terminology continued

- **Incident Report:**
  - a report that is completed after a first aid incident has occurred, and includes:
    - time;
    - description of injury / illness;
    - first aid management given;
    - incident details;
    - location; and
    - vital signs;
  - may include:
    - administration of medications: date, dose, person administering, time given; and
    - fluid intake / output.

  *Note: Documentation MUST meet organisational and legislatively requirements.*

- **Infection control:**
  - policies and procedures used to minimize the risk of spreading infections.

- **Life threatening:**
  - a disease/condition or injury that could cause death.

- **Manual handling:**
  - any activity that involves lifting, lowering, carrying, pushing, pulling, holding or restraining.

- **Medical aid:**
  - ambulance officer/paramedic, appropriately qualified health care professional e.g. Doctor.

- **Medical conditions:**
  - includes: cardiac conditions, epilepsy, diabetes, asthma, and other respiratory conditions.

- **Poisoning and toxic substances:**
  - a substance that, on ingestion, inhalation, absorption, application, injection may cause damage or functional disturbance to the body.
Terminology continued

- **Respiratory distress:**
  - the lungs cannot provide sufficient oxygen to the body.

- **Site management (first aid context):**
  - injury and accident identification and prevention (where possible) in a workplace or incident site.

- **Standard precautions:**
  - a strategy for reducing the risk of transmission of disease via blood, body fluids, mucous membranes and broken skin.
  - also includes safe handling of:
    - Personal Protective Equipment (PPE) e.g. gloves;
    - hand washing;
    - sharps e.g. Epipen;
    - medical waste e.g. bloody dressings; and
    - cleaning of equipment and First Aid area.

- **Substance misuse (drug abuse):**
  - use of a substance (drug) in which the user consumes the substance in amounts or with methods neither approved nor supervised by medical professionals.

- **Unconscious:**
  - lack of consciousness or responsiveness to people and other environmental stimuli.

- **Welfare (casually):**
  - ensuring the wellbeing of the casualty whilst in the care of the First Aider.

- **Workplace health and safety (WHS):** (Previously known as Occupational Health and Safety)
  - legislation that includes regulations and Codes of Practice that aims to:
    - prevent workplace death, injury and disease;
    - improve workers compensation arrangements; and
    - improve the rehabilitation and return to work of injured workers.
Bronchospasm

What is it:
It is a form of respiratory distress and is an abnormal contraction of the smooth muscle of the bronchi, resulting in an acute narrowing and obstruction of the airways. A generalised wheezing when exhaling (breathing out) usually indicates this condition. Bronchospasm is a chief characteristic of asthma and bronchitis.

Causes:
- asthma;
- upper respiratory infections;
- smoke inhalation;
- allergies;
- exercise;
- emotions; and
- irritants.

Signs & symptoms:
- noisy breathing (wheeze) usually when exhaling;
- difficulty speaking;
- increased breathing rate (trying to get more air into the lungs);
- flaring of the nostrils;
- blue around the lips, ear lobes and fingertips; and
- altered conscious state.

Management:
- DRSABCD;
- sit the casualty up and lean forward if conscious;
- reassure the casualty, tell them to take slow deep breaths – ensure they have adequate fresh air;
- assist promptly with administration of an inhaled asthma reliever medication (bronchodilator):
  - give 4 puffs of a blue or grey reliever inhaler (puffer) - use a spacer if available;
  - casualty takes a breath with each puff – give 4 puffs one at a time: casualty to take 4 breaths after each puff – wait 4 minutes;
  - use the person’s own inhaler if possible if not borrow one from someone if available;
  - if no improvement give another 4 puffs as above; and
  - give oxygen if available.
- ensure that an ambulance has been called: if little or no benefit within minutes of giving the asthma reliever medication:
  - keep giving 4 puffs every 4 minutes until medical aid arrives;
  - for adults with severe asthma, give 6-8 puffs every 5 minutes while waiting for medical aid; and
  - for children 4 puffs every 4 minutes is a safe dose.
Dehydration
Dehydration is the loss of water & essential electrolytes in the body. Vital organs like the kidneys, brain, and heart are all affected by dehydration. Dehydration occurs when there is less than the normal amount of water in the body (body weight is 80% approx. water).

Dehydration can result from:
- severe diarrhoea and/or vomiting;
- water deprivation;
- burns;
- diabetes; and
- heat exhaustion/stroke.

Signs & symptoms:
Mild:
- thirst;
- dry lips; and
- slightly dry mouth.

Moderate:
- very dry, sticky oral membranes;
- sunken eyes; and
- poor skin turgor (loss of skin elasticity, test on back of the hand).

Severe:
All signs of moderate dehydration plus:
- rapid, weak pulse;
- cold hands and feet;
- rapid breathing;
- blue lips; and
- confusion, lethargy, difficult to arouse

If not managed then complications may result e.g. shock, kidney failure, coma and death.

Management
- give clear fluids to sip if the casualty is conscious;
- if the casualty is vomiting, give ice chips/icy pole to suck; and
- medical aid if required i.e. severely dehydrated & unable to take any fluids.

Urine colour is a good indicator of dehydration.

Urine Colour Chart
Match the colour of the urine to the chart to check the hydration level.

- Well Hydrated
- Hydrated
- Need to drink more
- Dehydrated
- Very dehydrated
Resuscitation of a Drowning Victim

In drowning, a person gasping for air while trying to stay afloat may inhale only a small amount of water. The casualty usually has little water in the lungs because the muscles of the larynx (the tube-shaped organ in the neck that contains the vocal cords) close the airway to stop water entering.

However the spasm which prevents water going in also stops air, mucous plugs also form and as a result the casualty suffocates and becomes unconscious. Every second is vital in the management of drowning.

With infants or children if they are resuscitated quickly, there may be a better than 50% chance of saving an apparently drowned infant of child by giving CPR.

Management of drowning:

- DRSABCD;
- place into the Recovery Position;
- clear and open airway;
- check for breathing and response;
- provide CPR if necessary;
- give oxygen if available; and
- urgent medical aid.

Note:

- be prepared for vomiting, especially during recovery;
- be aware of spinal injury, but airway takes priority; and
- water in the lungs and the effects of cold can increase resistances to rescue breaths so you may need to breathe more firmly and slowly to get the chest to rise.

Initial positioning of casualty: With a drowning victim there is the potentially for water in the airway so place the casualty into the Recovery Position straight away, then clear and open the airway.

Late deterioration

Always carefully monitor the casualty after an apparently successful rescue. Complications following immersion victims are common, even in those who appear to be well following resuscitation. For this reason any immersion victim must always be assessed in hospital.
Head Injuries

The brain is the controlling organ for the whole body and as such injuries to the head are potentially dangerous and ALWAYS require medical attention. When a patient has a serious head injury there is always a possibility that the neck or spine may also be injured.

Fractures
Fractures may occur in the cranium (the portion of the skull enclosing the brain) at the base of the skull or in the face. Fractures can occur by either a direct force e.g. blow to the head or an indirect force e.g. a fall.

Concussion
Concussion is an altered state of consciousness, usually caused by a blow to the neck. The casualty may become unconscious when concussed but this is often momentary. The casualty may show symptoms such as being dazed or confused, complaining of a headache or dizziness. Usually a casualty will recover quickly from concussion but there is always a possibility of a more serious brain injury. Concussion can result from car accidents, falls and sporting injuries.

Compression
Compression is excess pressure on part of the brain. It may be caused by a depressed skull fracture where broken bones put pressure on or directly damage the brain. It can also be caused by a build-up of blood in the brain. A blow to the head that causes bleeding on the brain or the surface of the brain causes pressure to build up as the blood cannot escape from the closed space. This is a life threatening situation.

Assessment of head injuries
It is often difficult to make an assessment of the severity of a head injury. No head injury should be disregarded or treated lightly as there is a possibility of complications developing later. The casualty should always be advised to seek medical help.

The cause of the head injury is often the best indication of the severity of the injury.
Neck and Spinal Injuries

Neck Injuries
The upper spine is part of the neck. Management of spinal injuries are also relevant for neck injuries.

An injury to the neck should be suspected:
- when an unconscious patient has a head injury;
- when a patient has a serious head injury; and
- in any velocity accident where a force has been involved e.g. falls.

Spinal Injuries
Injuries to the spinal cord can be traumatic because resulting damage may be permanent. Adolescents and young adults tend to be the main casualties; however the elderly with bone disease could also be at risk.

Spinal injuries are always serious and must be treated with great care. Incorrect handling of a casualty can result in paralysis. Careful assessment and management will help minimise permanent disability and increase the casualty’s potential for recovery.

Twisting, compressing or bending the spine may worsen damage. Damage to the spinal cord may occur as a result of movement even if the cord is not injured initially. Take extreme care to maintain alignment of the spine by supporting the head and neck when moving a casualty. Use at least one helper to support the head if you need to move a casualty.
Fractures

A fracture is a break in the continuity of the bone and is defined according to type and extent of the fracture.

Types of fractures
- Complete: a complete fracture is where the bone is broken into at least two parts;
- Greenstick: may extend only partway through the bone, splitting the bone on one side and bending it on the other; and
- Comminuted: a fracture where there are more than two fragments.

Causes
Fractures are caused by either direct or indirect force. If a bone breaks at the point where it received the blow, it can be a direct fracture. An indirect fracture would be where the force of a blow travels through a part of the body and cause a fracture elsewhere e.g. if you fall and use your hand to break the fall, the force may travel along your arm and fracture your collarbone.

Complications
Any fracture can be complicated by injury to the adjoining muscles, blood vessels, nerves and organs. Fractures from large bones usually result in blood loss and shock.

Fracture classifications
Fractures are classified as closed, open or complicated.
- Closed: when a fracture is closed, the skin over the bone is not broken but there may be bleeding in the underlying tissue. Damage may occur to muscles and blood vessels as the area may swell due to internal bleeding;
- Open: open fractures are also called “compound fractures”. The skin over the bone will be broken and on occasions the bone may be protruding from the skin. There is a danger of infection from this type of fracture; and
- Complicated: both open and closed fractures may be complicated when there is injury to major nerves, blood vessels or organs. e.g. a broken rib puncturing a lung.
Bleeding

Bleeding is the loss of blood from the blood vessels. This can be external or internal (inside the body). With open wounds and blood loss the bleeding must be stopped and the possibility of shock and infection must be considered.

Bleeding from the major types of blood vessels:

- arteries - bright red and spurts;
- veins - dark red and pours; and
- capillaries – red and oozes.

There are several different external wound types associated with bleeding:

- abrasion;
- laceration;
- incision;
- avulsion;
- puncture; and
- amputation.

Abrasion

Is an open wound often caused by skin being scraped across a hard surface. The outer layer of skin and tiny underlying blood vessels are usually left exposed.

Laceration

A laceration is an open wound where the skin and underlying tissue is damaged. This type of wound can be caused by machinery or bites.

Incision

An incision is a cut usually made by something sharp like a knife. It can cause the skin, tissue and muscles to be severed.

Avulsion

This type of wound is caused when the skin and other soft tissue has partially or completely been torn away by a severe force.

Puncture

Caused by blunt or pointed instruments this wound affects the skin and underlying tissue.

Amputation

An amputation occurs when a part of the body such as a toe, finger, hand or leg is completely cut or torn off.
Ear Injuries

Ear injuries are common. Sports injuries and falls can damage the outer soft tissue, causing a bleed. A direct blow to the head or pushing something into the ear may result in internal injury to the ear drum.

Management of bleeding from the ear:
- DRSABCD;
- do not plug ear drum;
- do not administer drops of any kind;
- allow fluid to drain freely;
- place casualty on side with affected ear down;
- place a sterile pad between ear and ground; and
- seek medical aid.

Foreign objects in the ear
Foreign objects such as beads, stones and grass seeds can become lodged in the ear canal. Insects can also fly or crawl into the ear canal.

Management of foreign object in the ear:
- look in the ear and see how deeply the object is lodged;
- do not attempt to remove object; and
- seek medical aid.

Management of insect in the ear:
- gently pour some vegetable oil or water warmed to body temperature into the ear canal; and
- if insect does not float out, seek medical aid.
Eye Injuries

The eye is one of the most delicate and sensitive organs of the body. Any eye injury can be serious because it can damage the cornea (the transparent tissue forming the circular lens in front of the eye). The loss of sight can be a devastating experience and the eye can be injured very easily.

Burns to the eye
Burns to the eye can be caused by:
- chemicals (acids, caustic soda, plant juices);
- heat (flames or radiant heat);
- welding (flash or ultra violet light); and
- glues and solvents.

Penetrating eye injury
A penetrating eye injury is usually caused by a sharp object which has gone inside the eye or is protruding from the eye. This injury can cause serious damage and infection if not managed appropriately.

Wounds to the eye
Wounds to the eye can result from a direct blow e.g. a hit or by a fast moving object e.g. a ball. They can be painful and severe. These injuries can also result in lacerations and bruising around the eye. Lacerations can often bleed profusely in the area and are managed by placing a dressing on the area.

Foreign objects in the eye
Loose eyelashes, grit, sand, cosmetics, makeup, insects etc. are some of the foreign objects that may enter the eye. It is important that the casualty does not rub the eye as it may result in damage to the cornea and other parts of the eye. Do not attempt to remove the foreign object from the eye.

Embedded objects in the eye
An embedded object is one that cannot be easily removed by flushing the eye with saline or water. You should not attempt to remove any embedded object that is stuck in the eye.

Smoke in the eyes
Smoke in the eyes will probably cause the casualty pain and the eyes will look red and watery.
Bites and Stings

Animal bites and insect stings are painful and some can be potentially lethal. Bites and stings occur frequently in the garden at the beach and in the home. Most bites and stings are relatively minor but can be painful, however others can be deadly.

Spiders

In Western Australia the Red Back Spider can be harmful to humans. The female spider is identifiable by the prominent red stripe on the abdomen. The Red Back Spider can be found in most areas of Western Australia.

Box Jelly Fish

The box jelly fish has a large virtually transparent, square shaped body with tentacles draping from each of the four corners of the body. Each tentacle has millions of stinging cells and each of these cells contains a tiny dose of venom which “fires” into the skin on contact. The box jelly fish is predominant in the Pilbara and Kimberly regions of Western Australia.

Snakes

Dugite

A very large snake that has an extreme variation in colour from shades of olive to brown. Dugites are shy snakes that will retreat when disturbed. They shelter in ground burrows, under tree roots, hollow logs, rocks and under rubbish piles. They are often attracted to mice. They are found in the South West of Western Australia.

Tiger Snake

Tiger snakes have a wide flat looking head. Colour banding can vary from bold to indistinct and vary in colour from olive, brown to yellow. They are generally found in swamp areas around water courses and shelter in underground burrows, under large rocks or in hollow logs. Found mainly in the South West of Western Australia.

Death Adder

Easily recognised flat broad triangular shape head, body short and very thick, colour varies from dull grey through to reddish brown. Death adders usually bury in sand, soil or debris with just the top of the tail and head exposed. Found in the South West of Western Australia.

Gwardar

Also known as the Western Brown Snake. The body is slender and the neck is not that distinct from the body. Colour varies from shades of orange brown to completely plain. Can be mistaken for a black headed python. Shelters in burrows, under rocks and in logs. Found in the Lower South West of Australia.
Poisoning

A poison is any substance which causes harm to body tissues. Poisons can be ingested, inhaled, absorbed or injected into the body.

Ingested
Ingested poisons enter the body through the mouth (ingested/swallowed). Commonly ingested poisons include:

- food e.g. mushrooms;
- alcohol e.g. drinking large quantities;
- medications; e.g. taking in excess of normal dosage;
- household items e.g. cleaning materials; and
- plants e.g. oleander.

Management of ingested poisons:
- follow management of poisons but;
- do not induce vomiting;
- do not give anything by mouth; and
- wash or wipe corrosive substance off face and mouth.

Inhaled
Poisoning by inhalation occurs when a person breathes toxic fumes from a gas or burning solids or liquids. This can include:

- carbon monoxide e.g. car engine exhausts;
- gases e.g. methane in mines and enclosed spaces;
- chlorine e.g. swimming pools chemicals and
- fumes e.g. paint.

Management of inhaled poisons:
- follow management of poisons, but;
- move yourself and the casualty to fresh air;
- loosen tight clothing; and
- consider oxygen therapy, if necessary.

Absorbed
Absorbed poisons enter the body through the skin or mucous membranes. These poisons include: wet and dry chemicals, fertilisers, pesticides or any other substance that causes redness and irritation to the skin at the point of contact.

Management of absorbed poisons:
- follow management of poisons but;
- protect yourself by wearing protective clothing;
- ask the casualty to remove contaminated clothing (if possible); and
- flush the casualty’s skin with large amounts of water.

Injected
Injected poisons enter the body as a result of drugs injected into the body or a bite or sting from and animal or insect.
Other First Aid Emergencies

Bruise (contusion)
A bruise is an injury caused by the rupture of small blood vessels under the skin. It usually results from a knock or a blow to the body, causing discolouration of the outer skin and is accompanied by swelling and pain.

Management of a bruise:
- apply RICE management; and
  - Rest;
  - Ice;
  - Compression; and
  - Elevation.
- seek medical aid if the pain is not relieved.

Needle Stick Injury
Risk of an infection has occurred if:
- a needle contaminated with blood or bodily fluid has penetrated the skin;
- a wound has been caused by an instrument contaminated with blood or body fluid;
- a wound or skin lesion has been contaminated with blood or body fluid; and
- there has been mucous membrane or eye contact with contaminated blood or body fluid;

Management of a needle stick injury:
- if the skin is involved, wash area with soap and water or use an alcohol based gel;
- if the eye is involved, open eyes should be irrigated with saline or water for at least 5 minutes;
- fluids should be spat out of mouth and the mouth rinsed thoroughly with water several times; and
- seek referral to a Medical Practitioner,
Other First Aid Emergencies

Angina
Angina is a temporary chest discomfort or pain that typically comes on with exercise or emotional stress. It usually only lasts a few minutes. It occurs because the narrowed coronary arteries are unable to supply additional oxygen-carrying blood needed when the heart’s activity increases.

Frostbite
Frostbite occurs when the skin and underlying tissues become frozen as a result of below zero temperatures. There are two types of frostbite:

- **Superficial**: where the skin can be moved in relation to the underlying tissue; and
- **Deep**: is recognisable by the skin no longer being mobile in relation to the underlying tissue and the skin and tissues are sometimes frozen to the bone.

Management of superficial frostbite:
- **DRSABCD**;
- remove the casualty to a dry, warm place;
- rewarm the frostbitten area with body heat e.g. fingers under the armpits, hands over ears; and
- prevent the affected areas from freezing by ensuring the casualty stops the activity and dresses more appropriately.

Management of deep frostbite:
- **DRSABCD**;
- prevent further heat loss from the frozen part of the body and the rest of the body;
- handle the frozen tissue carefully to prevent further damage;
- do not rub the body, keep the casualty as still as possible;
- remove the patient to a warm dry place; and
- seek immediate medical aid.
Other First Aid Emergencies

Allergic Reactions
Allergic reactions usually occur when a person’s immune system reacts to something in the environment. Hay fever is one of the most common forms of an allergic reaction.

**Signs and symptoms of a mild allergic reaction:**
- tingling of the mouth;
- swelling of lips, eyes and face;
- hives, body rash, itching; and
- vomiting or abdominal pain.

If an allergic reaction becomes severe, manage as you would for a severe allergic reaction or anaphylaxis.

Diabetes
Diabetes is a disorder of the pancreas. The body breaks down food into sugars which are absorbed by the bloodstream. In a healthy person the pancreas produces insulin to convert these sugars in energy. In a person with diabetes the insulin production and function are impaired and sugar can build up in the blood causing the body cells to not receive the energy required.

**Type 1 diabetes**
Is thought to be caused by an auto immune process which causes a loss in insulin production.

**Type 2 diabetes**
Is associated with lifestyle factors such as obesity and also genetic factors.

People with diabetes may require insulin and other medication and must carefully monitor their diet and exercise.

Epilepsy
Epilepsy is a disorder of the brain characterised by the tendency to have recurrent seizures. Seizures are usually the result of sudden, brief, excessive electrical discharges in a group of brain cells. Sometimes seizures will involve the whole brain and sometimes only part of the brain.

Signs of seizures will vary depending on where in the brain the seizure starts and how far it spreads. Transient seizures can occur where loss of awareness and consciousness occur. Disturbances in movement, sensations, mood, mental function and behaviour can also occur.
To First Aid Training Organisations

At the most recent national meeting of the Australian Resuscitation Council (July 2012) it was identified that some confusion exists amongst first aid training organisations and providers as to the value of Rescue Breaths as an integral part of CPR.

On page 2 of the attached ‘Guideline 8 – Cardiopulmonary Resuscitation’, the Australian Resuscitation Council has stated that “If unwilling/unable to perform rescue breathing, then perform compression only CPR”. However, this is not an indication to remove rescue breathing and use of a resuscitation face mask from first aid and CPR training.

An individual who has been trained to perform mouth to mouth ventilation has a choice as to whether or not to perform the ventilation. It is not the intent of the flow chart wording to give training organisations a choice about whether or not to teach mouth to mouth ventilation.

The current Australian Resuscitation Council ‘Guideline 5 Breathing’ is attached and it outlines the need for rescue breathing, including the mouth to nose, mouth to mask and mouth to stoma techniques. Training in the use of a resuscitation mask is vital for the effective use of this device. A resuscitation mask is a required item in many standard workplace first aid kits and those who are completing first aid and CPR training for their role as a designated first aider must be assessed as competent in its use.

Most first aid courses for which a nationally recognised Statement of Attainment is issued are based on the ‘Apply First Aid’ Unit of Competence, HLTFA311A Clause 2.6 of the performance criteria for HLTFA311A is: “Provide first aid management in accordance with established first aid principles and Australian Resuscitation Council (ARC) Guidelines and/or State/Territory regulations, legislation and policies and industry requirements.”

The Australian Resuscitation Council reiterates the need to train people in rescue breathing and the use of a resuscitation mask as part of CPR training. If a Statement of Attainment is to be issued, these skills must be taught, practised and assessed in accordance with the requirement of the relevant Unit of Competence.

We thank you for your ongoing support and efforts in teaching first aid and CPR to the Australian community.
Breathing

This guideline is applicable to adults, children and infants

Normal breathing is essential to maintaining life. Victims who are gasping or breathing abnormally and are unresponsive require resuscitation.

Causes of ineffective breathing of acute onset:
Breathing may be absent or ineffective as a result of:
- direct depression of/or damage to the breathing control centre of the brain;
- upper airway obstruction;
- paralysis or impairment of the nerves and/or muscles of breathing;
- problems affecting the lungs;
- drowning; and
- suffocation.

Assessment of breathing
There is a high incidence of abnormal gasps (agonal gasps) after cardiac arrest. Lay rescuers and health care professionals should use a combination of unresponsiveness and absent or abnormal breathing to identify the need for resuscitation.

The rescuer should:
- **LOOK** for movement of the upper abdomen or lower chest;
- **LISTEN** for the escape of air from nose and mouth; and
- **FEEL** for movement of the chest and upper abdomen.

Movement of the lower chest and upper abdomen does not necessarily mean the victim has a clear airway. Impairment or complete absence of breathing may develop before consciousness is lost by the victim.

Rescue breathing
If the unconscious victim is unresponsive and not breathing normally after the airway has been opened and cleared, the rescuer must immediately commence chest compressions and then rescue breathing. Give 30 compressions and then two breaths allowing about one second for each inspiration following the Australian Resuscitation Council and New Zealand Resuscitation Council Basic Life Support Flowchart (Guideline 8 – Cardiopulmonary Resuscitation). If unwilling or unable to perform ventilations, rescuers should continue compression only CPR.

Mouth to mouth
Take a breath, open your mouth as widely as possible and place it over the victim’s slightly open mouth. Whilst maintaining an open airway pinch the nostrils (or seal nostrils with rescuer’s cheek) and blow to inflate the victim’s lungs. Because the hand supporting the head comes forward some head tilt may be lost and the airway may be obstructed. Pulling upwards with the hand on the chin helps reduce this problem.

For mouth to mouth ventilation, it is reasonable to give each breath in a short time (one second) with a volume to achieve chest rise regardless of the cause of cardiac arrest. Care should be taken not to over inflate the chest.

Look for the rise in the victim’s chest during each inflation. If the chest does not rise, possible causes are:

- obstruction in the airway (inadequate head tilt, chin lift, tongue or foreign material);
- insufficient air being blown into the lungs; and
- inadequate air seal around mouth and or nose.

If the chest does not rise, ensure correct head tilt, adequate air seal and ventilation. Following inflation of the lungs, lift your mouth from the victim’s mouth, turn your head towards the victim’s chest and listen and feel for air being exhaled from mouth and nose.

**Mouth to nose**

The mouth to nose method may be used where the rescuer chooses, the victim’s jaws are tightly clenched, or when resuscitating infants and small children.

The technique for mouth to nose is the same for mouth to mouth except for sealing the airway. Close the victim’s mouth with the hand supporting the jaw and push the lips together with the thumb. Take a breath and place your widely opened mouth over the victim’s nose (or mouth and nose in infants) and blow to inflate the victim’s lungs. You’re your mouth from the victim’s nose and look for the fall in the chest; listen and feel for the escape of air from the nose and mouth.

If the chest does not move, there is an obstruction, an ineffective seal, or insufficient air being blown into the lungs. In mouth to nose resuscitation a leak may occur if the rescuer’s mouth is not open sufficiently, or if the victim’s mouth is not sealed adequately. If this problem persists, use mouth to mouth resuscitation. It may be found that blockage of the nose prevents adequate inflation. If this occurs, mouth to mouth resuscitation should be used.

**Mouth to mask**

Mouth to mask resuscitation is a method of rescue breathing which avoids mouth to mouth contact by the use of a resuscitation mask. Rescuers should take appropriate safety precautions when feasible and when resources are available to do so, especially if a victim is known to have a serious infection (e.g. HIV, Tuberculosis, Hepatitis B virus or SARS).
Position yourself at the victim’s head and use both hands to maintain an open airway and to hold the mask in place to maximise the seal. Maintain head tilt and chin lift. Place the narrow end of the mask on the bridge of the nose and apply the mask firmly to the face.

Inflate the lungs by blowing through the mouthpiece of the mask with sufficient volume and force to achieve chest movement. Remove your mouth from the mask to allow exhalation. Turn your head to listen and feel for the escape of air. If the chest does not rise, recheck head tilt, chin lift and mask seal. Failure to maintain head tilt and chin lift is the most common cause of obstruction during resuscitation.

**Mouth to mask method**
(Reproduced courtesy of European Resuscitation Council)

**Mouth to neck stoma**
A person with a laryngectomy has had the larynx (voice box) removed and breathes through a hole in the front of their neck (stoma). A stoma will be more obvious when the victim is on the back for rescue breathing and the head is put into backward tilt. If a tube is seen in the stoma, always leave it in place to keep the hole open for breathing and resuscitation.

The rescuer should place their mouth over the stoma and perform rescue breathing as described above. If the chest fails to rise, this may be due to a poor seal over the stoma, or the victim having a tracheotomy rather than a laryngectomy thus allowing air to escape from the mouth and nose or a blocked stoma or tube. If stoma or tube is blocked use back blows and chest thrusts in an attempt to dislodge the obstruction. (Refer to Guideline 4 - Airway)
Risks
No human studies have addressed the safety, effectiveness or feasibility of using barrier devices to prevent victim contact during rescuer breathing. Nine clinical reports advocate the use of barrier devices to protect the rescuer from transmission of bacteria in controlled laboratory settings. The risk of transmission is very low and initiating rescue breathing without a barrier device is reasonable, if available rescuers should consider using a barrier device.

Full ARC guidelines including references and links can be found at
http://www.resus.org.au/
ARC Guideline 8

Cardiopulmonary Resuscitation

This guideline is applicable to adults, children and infants

Cardiopulmonary Resuscitation – (CPR)
Cardiopulmonary resuscitation is the technique of chest compressions combined with rescue breathing. The purpose of cardiopulmonary resuscitation is to temporarily maintain a circulation sufficient to preserve brain function until specialised treatment is available. Rescuers must start CPR if the victim is unresponsive and not breathing normally. Even if the victim takes occasional gasps rescuers should start CPR. CPR should commence with chest compressions. Interruptions to chest compressions must be minimised.

In victims who need resuscitation, bystander CPR dramatically increases the chance of survival.

Bystander CPR rarely leads to harm in victims who are eventually found to have suffered cardiac arrest: bystander CPR should be actively encouraged.

Compression ventilation ratio
Current consensus is that a universal compression-ventilation ratio of 30:2 (30 compressions followed by two ventilations) is recommended for all ages regardless of the numbers of rescuers present. Compressions must be paused to allow for ventilations.

No human evidence has identified an optimal compression-ventilation ratio for CPR in victims of any age.

Steps of resuscitation:
Initial steps of resuscitation are: DRSA BCD
- check for Danger (hazards/risks/safety);
- check for Response (if unresponsive);
- Send for help;
- open the Airway;
- check Breathing (if not breathing/abnormal breathing);
- CPR. Give 30 chest compressions (almost two compressions/second) followed by two breaths; and
- Defibrillate. Attach an AED (Automated External Defibrillator) if available and follow the prompts.

When providing 30 compressions (at approximately 100/min) and giving two breaths (each given over one second per inspiration), this should result in the delivery of five cycles in approximately two minutes.
Chest compressions only
If rescuers are unwilling or unable to do rescue breathing they should do chest compressions only. If chest compressions only are given, they should be continuous at a rate of approximately 100/min.

Multiple rescuers:
Where more than one rescuer is available ensure:
- that an ambulance has been called; and
- all available equipment has been obtained (e.g. AED).

Duration of CPR
Rescuers should minimise interruptions of chest compressions and CPR should not be interrupted to check for response or breathing. Interruption of chest compressions is associated with lower survival rates.
The rescuer should continue cardiopulmonary resuscitation until:
- the victim responds or begins breathing normally;
- it is impossible to continue (e.g. exhaustion);
- a health care professional arrives and takes over CPR; and
- a health care professional arrives and directs that CPR be ceased.

Risks
The risk of disease transmission during training and actual CPR performance is very low. A systematic review found no reports of transmission of hepatitis B, hepatitis C, human deficiency virus (HIV) or cytomegalovirus during training or actual CPR when high risk activities such as intravenous cannulation were not performed. If available, the use of a barrier device during rescue breathing is reasonable. After resuscitation all victims should be reassessed and re-evaluated for resuscitation related injuries.

Currency of CPR skills (ARC Guideline 10.1 – Basic Life Support Training):
- the optimal interval for retraining has not been established, but repeated refresher training is needed for individuals who are not performing resuscitation on a regular basis; and
- all those trained in CPR should refresh their CPR skills at least annually.
Basic Life Support

Dangers?

Responsive?

Send for help

Open Airway

Normal Breathing?

Start CPR
30 compressions : 2 breaths

Attach Defibrillator (AED)
as soon as available and follow its prompts

Continue CPR until responsiveness or normal breathing return

Full ARC guidelines including references and links can be found at
http://www.resus.org.au
Safe Work Practices

Risk assessment
The purpose of performing a workplace risk assessment is to identify risks to employees in order to create and maintain a safe working environment.

The results of a risk assessment should enable employers to make decisions about establishing appropriate prevention and control measures.

The risk assessment is performed in accordance with occupational health and safety legislation and relevant Commonwealth/State/Territory regulations or approved codes of practice for the control of hazardous substances in the workplace.

Potential hazards:
- incorrect storage of materials;
- wet or uneven floor surfaces;
- blocked exits;
- lack of access to fire extinguishers;
- badly maintained equipment or improper use of equipment;
- faulty/overloaded electrics; and
- inappropriate noise levels.

Eliminating/minimising risks:
If a risk assessment suggests there is a risk factor within the workplace, employers are obliged to establish appropriate procedures to minimise or eliminate the hazard/risk. These could include:
- employee training;
- establishing first aid facilities including safety showers and eye wash stations;
- provision of personal protection equipment; and
- developing and communicating emergency procedures and evacuation procedures for the workplace.

WorkSafe
WorkSafe is a division of the Department of Commerce, the Western Australian State Government agency responsible for the administration of the Occupational Safety and Health Act 1984. The principal objective of the Occupational Safety and Health Act 1984 is to promote and secure the safety and health of people in the workplace.

Safe Manual Handling

In an incident where you are required to provide basic emergency life support or Cardio Pulmonary Resuscitation (CPR), you may have to lift or move the casualty to a suitable position or location. An awareness of safe manual handling techniques can prevent injury to yourself.

When moving a casualty/heavy object:
- have a wide base of support — keep feet apart, point toes in the direction you are going to move, knees should be slightly flexed. This avoids using the small muscle in the back and uses the thigh muscles;
- keep object close to the body;
- keep object close to hip/pelvic area (centre of gravity);
- the line of gravity should always be vertical and should remain perpendicular to the ground. In other words, keep back straight while lifting and carrying;
- always plan your lift;
- it is easier to push or slide an object than lift;
- size up the load to be carried and get help (human or mechanical) if the load is too big, heavy or awkward; and
- bend the legs, keep back and arms straight, lift with leg muscles.

When providing basic emergency life support or Cardiopulmonary Resuscitation (CPR):
- kneel beside casualty, knees shoulder width apart;
- keep back straight, position your shoulders above casualty’s chest;
- lock elbows to keep arms straight; and
- use your body weight to provide compression by flexing the hips.

Moving a casualty into the recovery position:
- kneel beside casualty;
- place further arm at right angles to the body;
- place nearer arm across chest;
- lift nearer leg at knee so it is fully bent upwards. Support knee with hand;
- place hand behind knee and roll casualty away from you on to side while supporting head and neck (ensure the neck is well supported if neck or spinal injury is suspected);
- place side of face gently onto ground;
- keep leg at right angles with knee and foot touching the ground to prevent casualty rolling on to face; and
- place casualty hand palm down under face.
Respect

A casualty requiring first aid may feel quite vulnerable and may react in an unpredictable manner. As a first aider you need to treat every casualty with respect irrespective of their injury/illness. This means:

- speak calmly;
- introduce yourself;
- be aware and show sensitivity of cultural differences;
- ask for consent to provide first aid;
- reassure the casualty;
- keep them informed;
- ask for the history of the condition/injury;
- do not make judgements on the incident/illness/injury; and
- focus on the goal of providing first aid.

A casualty may feel uncertain about being touched or treated by a stranger who is of a different age group, race or gender. They may be stressed and upset by the injury or illness or may be under the influence of alcohol or other drugs.

Attempt to establish a rapport with the casualty, use their name. If at any time the casualty’s behaviour poses a threat to you, withdraw from the scene and if possible monitor from a safe distance until help arrives.
Report of the Incident

Verbal Reporting/Handover
In the event of an emergency a quick verbal report may be required to be given to your supervisor and or medical aid i.e. Paramedic.

When giving a verbal report or handover to medical aid or a supervisor, ensure that the information that you give is factual, concise, relevant and clear.

This verbal report should cover:
- What happened (events leading up to the incident)?
- How long ago did it happen?
- What first aid management has been given?
- What is the condition of the casualty now?
- Have they improved or deteriorated in the first aiders care?
- Casualty’s personal details (if known).

Basic Documentation
It is important that the First Aider fully documents all incidents when personnel seek advice or treatment relating to first aid and or social problems.

All documentation should be:
- accurate & legible;
- written at time of treatment;
- written in ink and never erased;
- if a mistake has been made, cross it out with a single line so that the original writing can still be read;
- sign and date the correction and then add the correct record; and
- correction fluids should not be used.

When completing documentation ensure that:
- facts are recorded as stated by the casualty/employee; and
- do not record opinions or hearsay.

If possible ensure that records concerning accidents are validated and signed by the casualty/employee involved.
I Have Done My Best
First Aiders render vital first aid skills to casualties at many and varied incidents which occur in the community every day.

First Aiders are well trained in their skills, however, they are human and following the rendering of first aid to a seriously injured casualty they may experience a feeling of "Could I have done more?" or "Did I do the right thing?"

The following points are written to help you as the First Aider, to cope during these times.

At the Scene
Remember the advantages of having obtained your first aid skills:
• the injured person is not left alone;
• the fear, loneliness and abandonment of the injured person, is reduced;
• the injured person is reassured by your presence and relaxes. This allows you to carry out your skills;
• you are able to instigate immediate lifesaving treatment;
• you have been trained in first aid and know how to treat and assist the injured person;
• your intentions are always to do what you believe is best for the injured person at the time, using your skills, knowledge, own common sense and intuition; and
• at the incident there was no room for the doubts and the "what ifs" that assail a person in everyday life, but instead just room for the confidence of the First Aider.

After the Scene is Over
You may:
• go through the stage of "let down" or the "aftermath" which in reality is a form of grieving.

You may:
• begin to question what you have done; and
• have doubts that will lower your self-esteem and self-confidence.
AT THIS TIME, REMEMBER:

"I HAVE DONE MY BEST"

You must:

Say, "I did the best I could at that time",

and

Say, "I have carried out my skill to the best of my ability and knowledge."

You are expected to do only the work of a First Aider at any incident, not that of a superhuman.

When you do your best as a First Aider, you have done your best. If you hadn't been there, what would have happened to the casualty?

The only time you had was 'right then' and the first aid actions that you rendered to the casualty were those that you believed to be the correct and proper thing to do at that time.

All professionals such as doctors, nurses and ambulance officers rely on their skills and knowledge, to do what is best for the casualty at the time of their intervention. At some time in their career, they have all had to say to themselves - "I have done my best".

Participate in a debrief of the incident so that you can evaluate the situation and plan any improvements you may need to make.

"I HAVE DONE MY BEST"

If you are ever concerned following the rendering of first aid to a casualty, please feel free to phone the first aid training department and speak to one of our training staff.

Telephone (08) 9334 1222