

St. John Ambulance Australia



Skills Maintenance and Re-examination Programme 1988

NAME
SIGNATURE
DIVISION ..
DATE

REMARKS

The District Training Committee commends this 1988 programme to St. John members and invites suggestions, comments at Training activities and/or in writing to District Training Committee, Skills Maintenance, St. John Ambulance C/- 285 LaTrobe Street, Melbourne.

Our objective is that as you work through this programme, you will be able to revise previous skills, and develop new skills in patient care to a standard level which will be obtained throughout St. John.

All the best for the year's work.

DISTRICT TRAINING COMMITTEE MEMBERS:

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ST. JOHN AMBULANCE AUSTRALIA
SKILLS MAINTENANCE AND
RE-EXAMINATION PROGRAMME - 1987/1988

INTRODUCTION:

The 1987/1988 District Skills Maintenance and Re-Examination Programme adopts and expands the innovative training concepts developed in the previous programme.

The expanded approach relates to the combined application of patient care in the home and first aid theory and practical skills to a series of practical incidents, which incorporate the use of St. John Casualty Report Form. (See sample page 73)

Distribution of the Programme including the training packages will be effected via:-

- Districts - District Surgeons in each State
- Regions - Staff Officers/Corps Superintendents, for Regional Staff.
- Corps - Corps Superintendents for Corps Staff.
- Divisions - Divisional Superintendents for Divisional Members.

PROCEDURE:

(A) St. John Members -

- (1) Each member will receive their own copy of the Programme.
The front cover of the Programme will be signed and dated on receipt.
- (2) Members will sign the Officer-in-Charge master issue sheet, (SMP 2877).
- (3) The programme is divided into two (2) sections (sections A and B). Each section consists of a theory and practical skills modules.

All the practical skills modules pertaining to the section must be practised and when mastery level is obtained, signed, before the practical incident pertaining to the complete section can be attempted.

NOTE:-

'AFA' refers to Australian First Aid SJAA 1984.
'CSH' Refers to the Care of the Sick in the Home SJAA
1981

- (4) When all the practical skills modules for the section have been completed (Mastery level reached), the person responsible for your training will issue you with a White Briefing Sheet and a Part-Completed White Casualty Report Form.

These sheets will contain the following :-

- History of the incident
- Name of Patient
- Address of Patient
- Time
- Complaint of Patient

- (5) Using the history stated on the Briefing and Casualty Report Form, the practical incident will be staged and you will treat the patient/s accordingly.
- (6) On completion of the incident, you will record your management under the appropriate treatment heading listed on the Casualty Report Form.
- (7) An overall training session on the incident will be conducted by the person responsible for training, and you will be able to check and record treatment in line with the Casualty Report Form Answer Sheet. Access to this Answer Sheet is via Training Personnel. This sheet will not be issued to members.

At the end of each section, a page headed "Management Notes" is provided for recording purposes during workshop segment.

- (8) The section, when satisfactorily completed, as per the training programme and Casualty Report Form Answer Sheet, will be signed and dated by the responsible person.
- (9) You cannot attempt the section practical incident until all the practical skills modules pertaining to that section have been signed as satisfactory.

(B) Officers/Training Personnel -

- (1) Unless exempted under General Regulations, all Officers/Members of St. John shall complete the Skills Maintenance and Re-Examination Programme to the standard prescribed.
- (2) The term "Training Personnel" refers to all Officers and/or a St. John member so designated to a training function. If professional training personnel are unavailable within divisions, then the Officer-In-Charge should communicate the name, qualifications etc. of a nominee to fill the role to the District Surgeon for consideration. All such requests will receive written advice.
- (3) All Officers and or designated training personnel are responsible and accountable for the modules of the training programme they have signed as being satisfactorily completed.
- (4) Practical skills items pertaining to the module being undertaken must be signed as satisfactory before the relevant section practical incident can be attempted.
- (5) The section practical incident will not be undertaken and assessed on the same day/night which the relevant practical skills modules have been taught.
- (6) If, on conclusion of the section practical incident Training Module the member is found to be unsatisfactory, then further training will be given, and another date and time for the assessment will be arranged.
- (7) On satisfactory completion of the section practical incident, sign and date the programme in the space provided at the end of the relevant section.

This programme belongs to all Officers and Members of the Brigade, and it's success depends on all of us working as a team. Your help, assistance and valued comments are always appreciated.

PROGRAMME APPLICATION - SUMMARY
TRAINING PERSONNEL

<u>ACTION</u>	<u>COMMENTS</u>
1. Select one section of the programme.	- Can select/start at any section.
2. Practical skills pertaining to the section modules are taught and assessed.	- Spread evenly over the training period. - Sign and date each practical skills module pertaining to the section when members reach a satisfactory standard as per the programme.
3. Issue the white Briefing for Practical Incident Sheet and the white Practical Incident Casualty Report Form (without treatment)	- Practical Incident Casualty Report Forms are marked section A and B to match the particular section being undertaken.
	<u>NOTE:</u>
	- DO NOT issue section Practical Incident Casualty Report Form to members :
	** On same day/night that the module practical skills to that section have been assessed.
	** If the module practical skills for the section have not been satisfactorily completed.
4. Stage the incident	- Members complete treatment details on the Practical Incident Casualty Report Form.

5. On completion of the Incident, Training personnel will conduct a workshop segment on the Practical Incident

- Use Practical Incident Casualty Report Form Answer sheet (pink) supplied (these are marked section A and B to match the particular section being undertaken). DO NOT issue this pink sheet.

- During training workshop, ensure members consult their own Casualty Report Form and compare same with Casualty Report Form Answer sheet.

- Space is provided within the programme (headed 'Treatment Notes') for members to use during workshop segment.

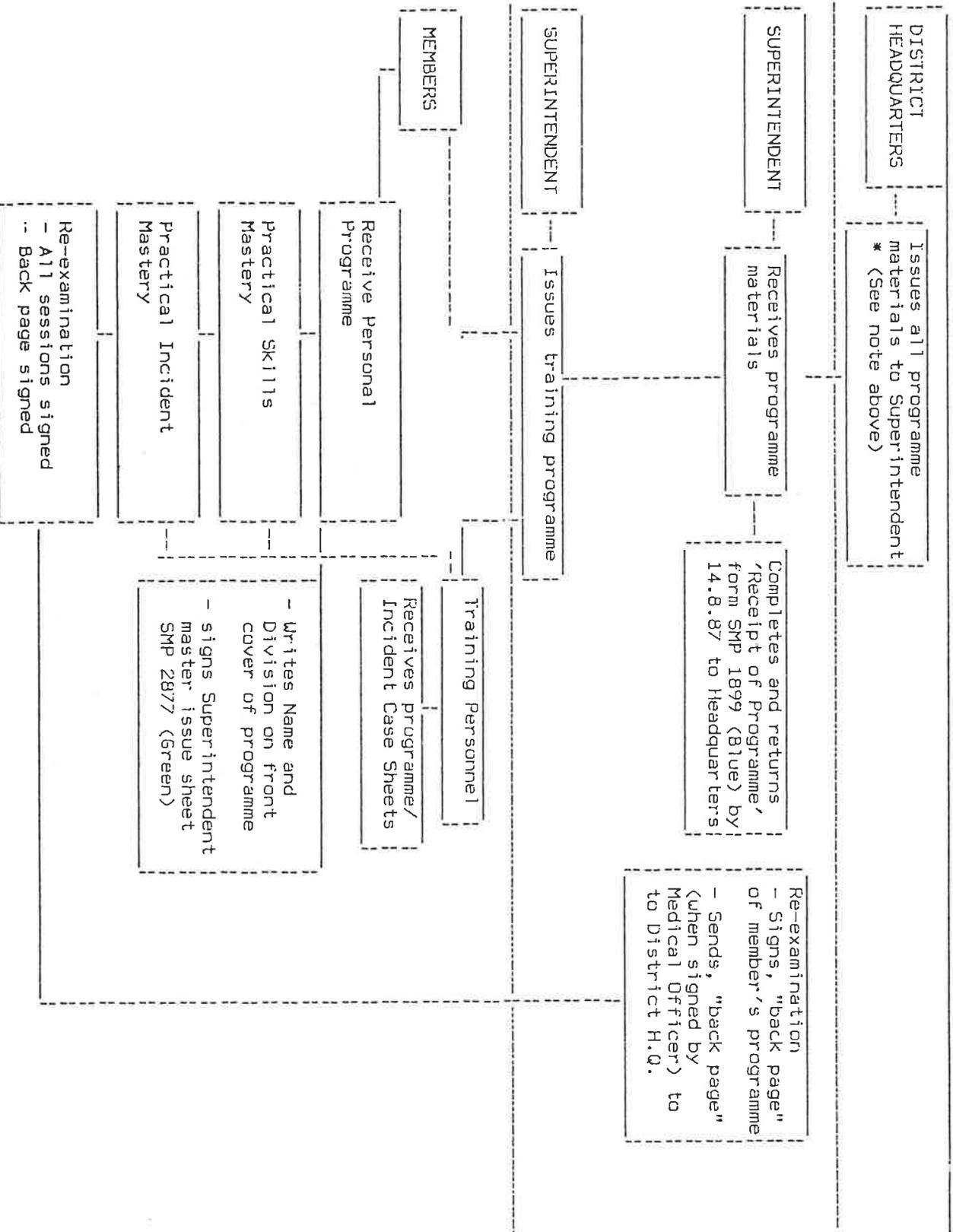
- If practical incident has been completed to the satisfactory performance standard, then sign and date the particular section of the members programme.

- If unsatisfactory, repeat incident.

- DO NOT proceed to the next section until the member has satisfactorily completed the section in hand.

* NOTE: Diagram illustrates for all Divisional Superintendents, Region Staff, Corps Superintendents. Please follow the same procedure for your respective staff.

PROGRAMME ADMINISTRATION - FLOW DIAGRAM :



ANNUAL RE-EXAMINATION :

- (a) Re-examination based on this programme will be held during the period June - July 1988 to comply with General Regulations 9.9 (i) and should NOT be conducted on same night as Annual Inspection.
- (b) Your training programme which you will keep in your possession and complete as the year progresses, must have all modules (skills and practical incidents) marked as satisfactory before the night of your re-examination.
- (c) The confirmation of completion of programme modules (back page) must be signed by you and your Superintendent prior to the re-examination.
- (d) On the night of your re-examination, the Medical Officer will firstly examine your Training Programme. If completed and satisfactory, you will then be asked to complete a practical incident incorporating skills selected at random from your Training Programme. C.P.R. may also be included each year.

This is a spot test to satisfy the Medical Officer that you have reached the required standard in practical skills application. Also, it is a check that those responsible for signing your programme have insisted on the appropriate standard being met.

- (e) The Medical Officer will then sign the confirmation of completion of re-examination section (back page) and this page will then be forwarded to District Headquarters by your Superintendent.
- (f) To meet the Brigade efficiency requirements for 1987, you must have your Training Programme completed before the night of the re-examination and attend the annual re-examination.

Members on 'reserve', Cadet Officers and Senior Cadets must also meet these requirements.

- (g) This is the only method of re-examination acceptable for 1988. No other examination will be accepted e.g., St. John Ambulance First Aid class examinations.

NOTE: This programme covers July 1987 - June 1988 and when satisfactorily completed you are:

- proficient to practise for 1988
- entitled to years efficiency for 1987 on BF.4.

RESPONSIBILITY FOR TRAINING PROGRAMME:

It is each individual member's responsibility to keep his/her own Programme up to date, have it signed as appropriate and present it at the annual re-examination.

A lost or misplaced Programme will result in you having to re-start a new Training Programme.

DISTRICT SURGEONS - AUSTRALIA
JULY, 1987

S E C T I O N 'A'

SECTION A

. MODULE 1

BRIGADE ORGANISATIONAL STRUCTURE AND SAFETY MANAGEMENT

- OBJECTIVE On completion of the Training Period and after studying the material listed below the Brigade Member will be able to complete the questionnaire following and apply the knowledge to the Sections Mock Practical Incident.
- 1.1 Outline the 4 annual requirements for Brigade efficiency for members, as laid down in General Regulation 7.1 (a).
 - 1.2 Outline the first aid responsibilities of a Brigade member as laid down in General Regulation 8.8.
 - 1.3 State the correct order of priorities of Basic Life Support for any emergency.
 - 1.4 List 4 categories of emergency personnel likely to be encountered by the Brigade First Aider at an accident scene.
 - 1.5 List 3 categories of risk likely to be encountered by the Brigade First Aider at an accident scene.
 - 1.6 Outline action to be taken by the Brigade member should s/he sustain personal injury in the course of performing duty.

BRIGADE ORGANISATION

Brigade members should, from time to time, re-aquaint themselves with the organisational structure under which they function. Keep in mind that we are an international organisation with a very long history of service to all people. To operate such an organisation, a large number of people are required and must work in an organised fashion. To do this we have a definite ranking structure. If this chain of command is used efficiently, the Brigade can operate with great benefit to the people who matter most - The Patients.

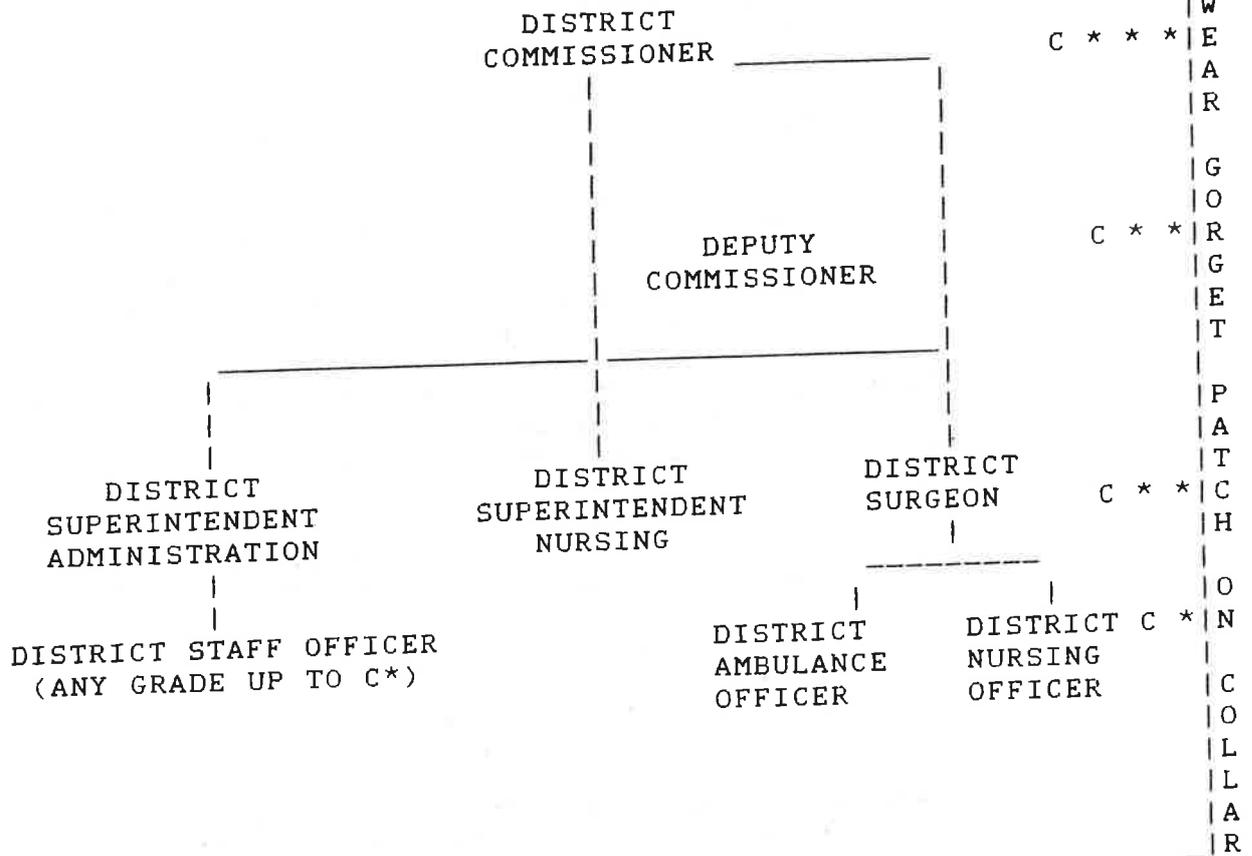
Revise this structure and write in the names of the Officers who hold positions in your District, Corps, Division.

(See Brigade structure and rank markings over sheet).

ST. JOHN AMBULANCE AUSTRALIA
BRIGADE STRUCTURE AND RANK MARKINGS

Rank Marking

C = Crown
* = Star



METROPOLITAN AND COUNTRY CORPS

CORPS SUPERINTENDENT	C	WEAR SILVER
CORPS SURGEON	C	BAR
CORPS NURSING OFFICER	* * *	ON
CORPS AMBULANCE OFFICER	* * *	SHOULD
CORPS STAFF OFFICER	* * *	-ER

DIVISIONS - AMBULANCE, NURSING AND COMBINED

DIVISIONAL SUPERINTENDENT	* * *
DIVISIONAL SURGEON	* * *
DIVISIONAL OFFICER	* *
DIVISIONAL AMBULANCE OFFICER	* *
DIVISIONAL NURSING OFFICER	* *
PROBATIONARY SURGEON/DIVISIONAL NURSE	*
SERGEANTS	
CORPORALS	
PRIVATES AND NURSING MEMBERS	

RESPONSIBILITIES OF A ST. JOHN FIRST AIDER

GENERAL REGULATION

7.1 EFFICIENCY REQUIREMENTS FOR ACTIVE MEMBERS

(a) In order to be returned efficient, active members of the Brigade must fulfil the following requirements during each year:

- (i) Pass a re-examination in First Aid.
- (ii) Be present at an Annual Divisional Inspection.
- (iii) Carry out their Brigade duties to the satisfaction of their Senior Officer.
- (iv) attend, if a member of a Division, at least twelve Divisional instructional meetings (see Regulation 9.4).

(Each day's attendance at an authorised training course or camp may count as one instructional meeting up to a maximum of six).

(b) Efficiency Requirements for Members on Reserve - Those serving on the Reserve, other than Officers appointed by the Grand Prior, are required to:

- (i) Attend six Divisional instructional meetings a year.
- (ii) Pass an annual re-examination in first aid (subject to Regulation 7.2).

Failure to comply with these requirements for two consecutive years will automatically entail discharge from the Brigade.

GENERAL REGULATION

8.8 RENDERING FIRST AID

It is the duty of members of the Brigade to render first aid, when necessary, irrespective of time of place and whether in uniform or not. Membership of the Brigade does not, however, confer upon individuals the right to take up a position in the streets or elsewhere on public or other occasions for the purpose of rendering first aid, nor to force their services upon persons who may be injured or in need of assistance.

Members will report in writing to the Officer-in-Charge of their Division every instance of first aid rendered by them, whether on or off duty.

Brigade Forms (Casualty Records) B.F.41, 42, 43 and 44 are to be kept as appropriate.

EMERGENCY MANAGEMENT SYSTEM

Priorities of Basic Life Support

Dangers		Self Bystanders Patient
Response		Conscious } }Patient Unconscious }
Airway		Clear Open
Breathing		Look, Feel, Listen
Circulation		Pulse Bleeding

Call an Ambulance:

DIAL 000 (or Emergency Number in your State).

Tell Controller:

What has happened
Where it has happened
Street Name, Street No., Suburb
How many patients
Condition of patient(s)

- Ensure that no further danger exists for patient or self
- if patient has to be moved urgently, serious complications may be reduced by dragging the patient rather than attempting to lift him/her.
- Ensure that all patients are assessed and treated according to accepted system of priorities.
Keep eyes and ears open for information, but avoid distress to the patient through careless comments.
- Ensure that appropriate medical aid is called at the earliest opportunity.
- Consider weather conditions, both heat and cold, and ensure that the patient's body heat is maintained.
Injuries should be exposed without unnecessary removal of clothing. * Discuss and demonstrate methods of removing a coat or shirt, trousers or skirt, shoes and socks etc. from an injured patient.

- Discuss responsibility for any personal property, valuables, etc., including spectacles, dentures, briefcase, shopping, watch, jewellery and money. Personal belongings should be handed over to a known relative accompanying the patient, or else entrusted to the ambulance crew. If any personal belongings are found after the patient has left the scene, hand them in at nearest Police Station.

- Before patient leaves the scene, check whether a relative or friend should be notified. Write down relevant details and check with ambulance crew regarding destination of patient so that this information can be given to relative. If contacting a relative or friend on behalf of patient, be tactful and brief - avoid giving "diagnosis" or "prognosis" and stress that these details must be sought from hospital concerned. Suggest that the hospital be contacted by telephone, or else advise relative to go to the appropriate casualty/emergency department.

- Brigade members should give a written casualty report to the casualty with a copy to their Division concerning any first aid treatment or advice given, whether on duty officially or not. Report should contain details of date, time, place, name of patient (if known) or "unknown male/female, approx. 50 years" (if name unknown), and any treatment or advice given.

INTERPERSONAL RELATIONSHIPS

Brigade members must be conscious of their responsibilities towards people other than the patient that they may be in contact with. These include relatives, friends, bystanders etc.

Relatives and friends of patients need to have a "Report" on the patient's condition as soon as possible. While being re-assuring, try not to give too much information, and refrain from prognostic statements as this is the prerogative of the doctor.

Bystanders at the scene of any incident need to be made to feel useful. Try and use them. If a bystander becomes a hindrance, the police should be called to assist.

At the scene of a large incident, police, ambulance officers and fire officers may be present. Brigade members must obey the instructions of members of these services. If handing a patient over to an ambulance officer, a history of the incident along with all details of the patients injuries and observations must be given.

SAFETY MANAGEMENT

Hazards that may be identified in the environment whilst treating a patient may be classified into the following three categories:

Obvious hazards

Potential hazards and

Hidden hazards.

- Eliminate - cut off electricity, cut off gas supply, remove obstructions, redirect traffic.
- Guard - protect work area from danger source (e.g. stop vehicles, bystanders provide protection from sun), wear appropriate personal protective equipment.
- Warn - Tell others of danger, erect warning sign if appropriate.

Unless holding specific exemption, all Brigade members shall comply fully with statutory Acts, regulations and codes. In addition, Brigade members have responsibilities at Common Law. In brief, The Common Law is the law that has evolved over a period of time from case judgements made by the judiciary.

Specifically, the Brigade member in the performance of work has a duty of care to all persons. The level of duty owed to a patient may be identified as that of "Special care".

A claimant at Common Law must show negligence. The Brigade member must ensure that he/she does all that is reasonable, within the respective members level of training, to safeguard the patient and others from injury or aggravation of injury. The member must therefore keep their skills up to date.

It is emphasized that Brigade First Aid equipment must be restricted to the approved list. Should any complications follow the use of unauthorized equipment, the Brigade member may be outside the normal protection of Brigade insurance policies.

A Brigade member if injured in the course of a duty must report that injury as soon as practicable, through the senior Brigade Officer responsible for the duty.

QUESTIONNAIRE

BRIGADE ORGANISATIONAL STRUCTURE AND SAFETY MANAGEMENT

1. Write down the names of the person occupying the following positions in the St. John Ambulance Brigade, your district.

(a) Commissioner _____

(b) District Superintendent _____
(Administration)

(c) District Superintendent _____
(Nursing)

(d) District Surgeon _____

(e) Divisional Superintendent _____

(f) Divisional Surgeon _____

2. Whilst returning from a social function, you notice a passerby who appears to be the victim of a sudden heart attack. Once you have handed the patient over to the appropriate care, you must write a report on the incident for your Divisional Records. Using fictional names and your imagination, briefly write a report of your attendance at such an incident.

3. Indicate briefly the steps you would take in handling a particular incident.

4. List the three categories of hazards that might be encountered in the environment; and briefly indicate how you would control these hazards.

MODULE 2

CARDIOPULMONARY RESUSCITATION

- OBJECTIVE : On completion of the training period and after practising the practical skills listed below (to the satisfactory performance level as per the module points/checklists) the Brigade member will be able to apply one or more of these skills to the sections mock practical incident :-

PRACTICAL SKILLS

- 2.1 Perform effective cardiopulmonary resuscitation for an adult.

Prescribed References:

Australian First Aid (A.F.A.)

Australian Resuscitation Council - Policy Statements (P.S.)

INCIDENT:

You are attending a private function when you see a middle aged person collapse. Examine the patient and treat accordingly. (Manikin must be used).

SKILLS CHECKLIST
CARDIOPULMONARY RESUSCITATION

SINGLE OPERATOR - ADULT

Satisfactory

CHECK LIST	Rationale	Tick
<u>DANGERS</u>		
<u>LOOK AROUND AND LISTEN FOR HAZARDS</u> If the patient is in a hazardous location he/she should be moved or the hazard removed before continuing		
(NO DANGERS)		
<u>YELL FOR HELP</u>		
<u>RESPONSE</u>		
<u>ASSESS RESPONSE TO:</u> Verbal Command e.g. Can you hear me? Open your eyes? What is your name?	AFA Pg.5	
Kneel beside patient's shoulders	AFA Pg.5	
Shake - by grasping the patient's shoulders		
(NO RESPONSE)		
<u>QUICKLY TURN THE PATIENT AWAY FROM YOU ONTO THE SIDE</u>	AFA Pg.44	
Place the farther arm at right angles to the body.		
Place the nearer arm across the chest		
Bend the nearer knee to bring the thigh at right angles to the hip.		
Place your hand under patient's neck and support head.		
Roll the patient onto his farther side		
Turn the face slightly downwards to ensure drainage of fluids.		

Check List Continued	Rationale	Tick
<u>AIRWAY</u>		
<u>CHECK FOR CLEAR</u>		
Open the mouth		
Look inside the mouth for foreign matter.		
Feel inside the mouth		
Scooping with fingers, being careful not to push matter further in		
Remove dentures only if loose		
(NOTHING APPARENT)		
<u>OPEN THE AIRWAY</u>		
Backward Head Tilt		
Place one hand on the forehead or top of the head		
Other hand to support the Jaw at the point of the chin		
Tilt the head backward (<u>NOT</u> the neck)		
Ensure face turned slightly downwards to enable fluids to drain from the mouth		
<u>BREATHING</u>		
<u>CHECK IF THE PATIENT IS BREATHING</u> by Observing for signs of respiration		
LOOK for movement of the lower chest and upper abdomen		
(NO MOVEMENT)		
LISTEN AND FEEL for the escape of air from the nose and mouth with your hand or cheek		
(NO EXPIRATION)		
FEEL, if necessary, for movement of lower chest and upper abdomen, however, movement here does not mean the patient has a clear airway.		

Check List Continued	Rationale	Tick
<p>(IF CHECKED, NO MOVEMENT) It may be difficult to hear movement of air if there is background noise so it is important to follow the sequence - Look, Listen and Feel</p>		
<p>(NO BREATHING)</p>		
<p><u>QUICKLY TURN THE PATIENT ONTO THE BACK AND COMMENCE EXPIRED AIR RESUSCITATION (E.A.R.) :</u></p>		
<p><u>KNEEL BESIDE THE PATIENT'S HEAD, OPEN THE AIRWAY:</u></p>		
<p>Backward head tilt - place the palm of one hand on the forehead</p>	<p>P.S.4.3.2 March '87</p>	
<p>Support the jaw using pistol-grip between the knuckle of the middle finger and the thumb</p>	<p>AFA Pg.53</p>	
<p>Firmly but gently tilt the head backwards (not the neck)</p>		
<p>Lift the jaw upwards and forwards at the same time</p>		
<p>Avoid excessive force</p>		
<p>When neck injury is suspected USE CARE</p>		
<p>The Airway ALWAYS takes priority over any injury, including a spinal injury</p>		
<p><u>SEAL THE NOSE</u> by pinching the nose with the thumb and index finger of the hand supporting the forehead or sealing with your cheek against patient's nostrils</p>	<p>AFA Pg.55</p>	
<p><u>TAKE A DEEP BREATH</u></p>		
<p><u>SEAL YOUR MOUTH OVER THE PATIENT'S</u></p>		
<p><u>SLIGHTLY OPEN MOUTH</u></p>		
<p><u>BREATHE OUT FIRMLY</u></p>		

Check List Continued	Rationale	Tick
<p>Give <u>FIVE</u> (5) <u>QUICK</u> <u>EFFECTIVE VENTILATIONS</u> (Full Breaths) With expired air <u>WITHIN TEN (10) SECONDS</u></p> <p><u>CHEST SHOULD BE SEEN TO RISE</u> indicating air has entered the lungs</p> <p><u>REMOVE MOUTH</u></p> <p><u>TURN HEAD TO THE SIDE</u></p> <p><u>OBSERVE CHEST FALL</u> without waiting for it to fall completely, at the same time <u>LISTEN AND FEEL FOR</u> <u>AIR BEING EXHALED</u></p>	<p>AFA Pg.54</p>	
<p><u>CIRCULATION</u></p> <p><u>CHECK FOR PRESENCE OF A PULSE</u> while maintaining backward head tilt with the hand on the fore- head the other hand checks for the carotid pulse</p> <p><u>USE THE FLAT PULPS</u> rather than the fingertips as the fingertips are less sensitive. (The thumb is not used as it is even less sensitive).</p> <p><u>USE TWO OR THREE FINGERS</u> <u>ALONG THE LINE OF THE CAROTID ARTERY</u> <u>BETWEEN THE ADAM'S APPLE AND</u> <u>THE LARGE MUSCLE OF THE NECK</u> <u>ENSURING NOT TO PRESS ON THE</u> <u>OPPOSITE CAROTID ARTERY</u> at the same time</p>	<p>AFA Pg. 9</p>	
<p>(PULSE ABSENT)</p> <p><u>TIMING</u> must reach this stage</p> <ul style="list-style-type: none"> - in correct sequence - DRABC - within 30 seconds of start 	<p>AFA Pg.64 & Pg.65</p>	

Check List Continued	Rationale	Tick
<u>RECOGNITION OF CARDIAC ARREST</u>	P.S. 6.2	
A collapsed victim has had a cardiac arrest if he/she is <u>UNCONSCIOUS</u> <u>NOT BREATHING</u> , and has <u>NO CAROTID PULSE</u>	March '87	
<u>COMMENCE CARDIOPULMONARY RESUSCITATION (C.P.R.)</u> Kneel beside patient's chest	AFA Pg.64 & Pg.65	
<u>EXTERNAL CARDIAC COMPRESSION (E.C.C.)</u>		
<u>LOCATE COMPRESSION SITE</u>		
<u>IDENTIFY MIDLINE OF STERNUM</u>		
<u>LOCATE UPPER BORDER</u> by feeling groove between collar bones		
<u>LOCATE LOWER BORDER</u> by feeling the lower ribs at the rib junction		
<u>INDENTIFY THE LOWER HALF OF THE STERNUM</u>		
<u>USE THE CALIPER METHOD TO LOCATE AND MARK THE CENTRE OF THE STERNUM</u>		
<u>PLACE THE FIRST FINGER OF EACH HAND</u> at the upper and lower borders of the sternum.		
<u>BRING BOTH HANDS DOWN</u> so that the <u>THUMBS REST ON THE CENTRE OF THE STERNUM.</u> The position for the hands is between the thumb and finger of the lower hand.		
<u>PLACE THE HEEL OF ONE HAND CENTRALLY OVER THE LOWER HALF OF THE STERNUM AGAINST THE CENTRAL MARKER THUMB</u>		
<u>KEEP PALM AND FINGERS OFF THE CHEST WALL.</u>		
<u>COVER FIRST HAND WITH OTHER HAND</u> either grasp the wrist of the lower hand with the thumb of upper or interlock the fingers of both hands		

Check List Continued	Rationale	Tick
<p><u>PRESS DOWNWARD THROUGH THE HEEL OF THE LOW HAND</u></p> <p><u>KEEP COMPRESSING ARM STRAIGHT AND VERTICAL</u> so your body weight is the compressing force</p> <p><u>LEAN FORWARD</u> so shoulders are vertically over the sternum</p> <p><u>PRESS FIRMLY</u> 4 - 5 cm (1 1/2" - 2")</p> <p><u>LEAN BACKWARDS</u></p> <p><u>PRESS RHYTHMICALLY</u> with equal time for compression and relaxation. Do not use rocking movements, thumps or quick jabs.</p> <p>The action is <u>COMPRESSION</u> rather than massage hence the unacceptability of the term external cardiac massage.</p> <p><u>PIVOT FROM THE HIPS</u> and not the knees</p> <p><u>RELEASE THE PRESSURE</u> to allow proper expansion of the chest but do not remove hands from the chest. Generate a pulse. Give 15 compressions immediately.</p> <p><u>COMPRESSION RATE</u> One press every 3/4 second i.e. at least 80 compressions BUT not more than 90 compressions/ min or 15 compressions in 10-12 seconds.</p> <p><u>TIMING</u> : To this stage in 60 seconds</p> <p><u>RATIO</u> : Interpose two (2) ventilations after every 15 compressions. After every 2 ventilations the hand that releases the jaw feels for the rib junction and keeps the place marked while the other hand which releases the head is on the lower half of the sternum against the marker fingers</p>	<p>AFA Pg.73</p> <p>AFA Pg.64</p>	

Check List Continued	Rationale	Tick
<p><u>CYCLES PER MINUTE:</u> 4 Cycles of 15:12 i.e. 60:8 per min</p> <p><u>ACHIEVE:</u> At the end of each minute at least 60 compressions and 8 ventilations must be achieve.</p> <p>Instruct the Member to continue for at least three minutes during which the effectiveness skills sheet "A" can be completed. (See Page 27)</p> <p><u>TIME LIMITS:</u> 15 Seconds Maximum each C.P.R. Cycle 10-12 Seconds for each 15 compressions 3-5 Seconds for position changes and 2 ventilations</p> <p><u>EFFECTIVE STANDARDS</u> 8-10 Ventilations/Minute 60 Compressions/Minute Rate of Compression 75-90 minute</p> <p><u>MONITOR EFFECTIVENESS</u> Regular Revival Checks (A.B.C.) After one Minute (i.e. 4 cycles) After every two Minutes thereafter (ie. 8 cycles)</p> <p>Continue until medical aid arrives (Pulse and respiration do not return with this incident).</p> <p>*** - must be satisfactory to gain an overall PASS</p> <p>All criteria, including the rates, should be evaluated by the observer. Dials, lights, print-outs, etc., should be used to supplement the observations of the observer, not replace them. At no time should evaluation be solely based on lights, dials, print outs, etc.)</p>	<p>AFA Pg.67</p>	

PRACTICAL SKILL MASTERED
 SIGNED
 DATE

EFFECTIVE SINGLE RESCUER CARDIO-PULMONARY RESUSCITATION

The minimum number of compressions to be achieved during C.P.R. is 60 per minute. Allowing for the time taken to give 2 ventilations and to change from E.A.R. position to E.C.C. position and back again with each cycle, only about 40 - 48 seconds remain in each minute in which to press 60 times.

The required speed to achieve this is at the rate of 80 - 90 per minute (A.F.A. Pg.73), with the maximum of 90 designed to allow adequate refilling of ventricles.

Therefore, each cycle of 15 compressions should take between 10 - 12 seconds allowing only 3 - 5 seconds for 2 ventilations and changing positions.

The complete cycle of 15 compressions and 2 ventilations should only take 15 seconds, with 4 cycles per minute giving a total of 60 compressions and 8 ventilations (A.F.A. Pg.67).

The skills check list is used to assess the compression speed criteria.

METHOD

Allow rescuer to perform first minute of C.P.R. to allow checking of techniques such as adequate inflation of lungs, correct hand position for compressions, etc. After first check for return of breathing and pulse at one minute (A.F.A. Pg. 68), prepare to use check sheet.

As rescuer continues, record on the dotted line the actual time shown as seconds on your watch at the end of one of the compression phases. (i.e. as the rescuers hands leave the chest, at the end of the 15th compression).

Next note time (in seconds) when the first press of the next compression phase occurs. Continue noting times of first and last compression of each phase until one minute has elapsed. Timing should be whilst rescuer is performing rather than waiting till watch zeroes and telling rescuer to start.

E X A M P L E

Record time of first compression							
Record time of last compression							
Record time of completion of last compression phase							
	5 *	5 *	6 *	7 *	7 *	*	
BREATHING PHASES	2	2	2	2	2	2	
Fill in, on this line, progressive readings of seconds elapsed for one minute	47	52 00	05 12	18 25	32 40	47	
COMPRESSION PHASES	8 15	7 15	7 15	8 15	15		

Include section of uncompleted cycle at end of 60 seconds

Then Complete Achievement Chart:

Total number of breaths	10	Total number of compression	[a] 60
Total elapsed time for breaths	30	Total elapsed time for compressions	[t] 30

Then Complete Assessment of Compression Application Rate Table:

ASSESSMENT OF COMPRESSION APPLICATION RATE

RATE (compressions) = $\frac{\text{Number of achieved [a] compressions} \times 60}{\text{Total elapsed time [t] of compression phases}}$
 (per minute)

$$\frac{[a] \times 60}{[t]} = \frac{60 \times 60}{30} = 120 \quad (\text{i.e. } \frac{3600}{30})$$

This shows that the time taken for ventilations and change over is too slow and the compression rate is too fast. The number of achieved breaths and compressions meet the required criteria yet the rate of 120 compressions per minute would reduce the chances of a successful resuscitation due to limited refilling of ventricles.

An example of preferred timing is as follows:

BREATHING PHASES		2 3		2 4		2 3		2 4		2 3		2	
Fill in, on this line, progressive readings of seconds elapsed for one minute	46	49	00	04	14	17	27	31	42	45	46		
			11		10		10		11		1		
COMPRESSION PHASES			15		15		15		15		2		

Total number of breaths 10 Total number of compression [a] 62
 Total elapsed time for breaths 17 Total elapsed time for compressions [t] 43

ASSESSMENT OF COMPRESSION APPLICATION RATE

$$\text{RATE (per minute)} = \frac{\text{Number of achieved [a] compressions} \times 60}{\text{Total elapsed time [t] of compression phases}}$$

$$\frac{[a] \times 60}{[t]} = \frac{62 \times 60}{43} = 87 \text{ (i.e. } \frac{3720}{43} \text{)}$$

Although it almost needs a pocket calculator to obtain exact results it will soon be recognised that anything in the range of 40 - 48 seconds for the 60 compression is acceptable without actually calculating the exact result. Likewise anyone achieving more than 60 compressions must give 2 extra ventilations thus achieving more than 70 compressions per minute, must be pressing too fast, as to achieve 70 compressions at the maximum rate of 90 per minute means achieving the 10 ventilations and changeovers under 13 seconds.

MODULE 3

THE NERVOUS SYSTEM AND UNCONSCIOUSNESS

- OBJECTIVE : On completion of the training period and after practising the practical skills listed below (to the satisfactory performance level as per the module points/checklists) the Brigade member will be able to apply one or more of these skills to the section's mock practical incident :-

PRACTICAL SKILLS

- 3.1 - Examination of a patient's pupils
- 3.2 - Examination of an unconscious patient
- 3.3 - Position a patient into the coma position
- 3.4 - Position a patient into the lateral position

STORES REQUIRED

- Torch
- Pencil and Paper
- Blanket

ANATOMY & PHYSIOLOGY OF THE NERVOUS SYSTEM

The nervous system co-ordinates all body activities.

The central nervous system consists of the brain and the spinal cord, which travels down the vertebral column. It processes information and sends out instructions.

The peripheral nervous system receives information and sends out instructions to the rest of body.

There are three kinds of peripheral nerves.

- (a) Motor nerves move muscles.
If the nerve is damaged, paralysis results.
- (b) Sensory nerves collect information from the outside world e.g. hearing, sight.
Damage to sensory nerves result in blindness, deafness, numbness etc.
- (c) Autonomic nerves run the automatic body functions e.g. heartbeat, digestion. Damage to these nerves results in loss of body control e.g. loss of bladder control.

Peripheral nerves can be damaged by:

- direct Trauma e.g. cut by knife, crush injury
- lack of oxygen e.g. tourniquet
- poisons e.g. alcohol abuse

UNCONSCIOUSNESS

A. Causes of altered consciousness.

1. Direct injury to or illness affecting the brain

- eg. - head injury
- strokes
- fits
- meningitis

2. Lack of oxygen to the brain :

- eg. - cardiac arrest
- irregular heart beat
- shock
- severe respiratory problems
- blocked airway

3. Poisons and Toxic products in the blood :

- eg. - diabetes
- kidney or liver failure
- overdose of alcohol or other drug

B. Methods of assessing level of consciousness in a sick or injured patient.

It is important to assess the level of consciousness regularly, as any change is most important. Therefore, whenever the level of consciousness is assessed, this must be written down.

There are 5 levels of consciousness.

1. Patient is alert, and answers questions sensibly, e.g. where are you?
2. Patient is drowsy, but responds to command. e.g. squeeze my hand, open your eyes.
3. Patient responds to touch, e.g. lightly touch the upper eyelashes, and the eyelid will flicker.
4. Patient responds only to pain, by groaning or moving limbs.
Check by - squeezing ear lobe
- squeezing base of finger nail.
5. Patient does not respond to pain.

GENERAL FIRST AID MANAGEMENT OF AN UNCONSCIOUS PATIENT

The general first aid management of an unconscious patient is the same no matter what the cause of the unconsciousness.

The patient needs:

1. Protection from danger
e.g. oncoming traffic.
2. A Clear Airway
This is best achieved with the patient on their side.
3. Treatment of any other injuries
e.g. splint fractures, cover wounds.
Remember that the patient may have spinal injuries.
4. Transfer to hospital, with an adequate record of all observations you have made.

The observation chart for an unconscious patient is usually referred to as a "Head Injury Chart" in hospitals.

Here is a sample.

TIME	PULSE	RESPIRATION	PUPIL SIZE		PUPIL REACTION		LEVEL OF CONSCIOUSNESS	REMARKS
			(R)	(L)	(R)	(L)		
1400	120	20	●	●	✓	✓	drowsy	
1415	120	20	●	●			responds to touch	vomiting clear fluid; Ambulance called 1420
1430	100	16	●	●	slow	✓	responds to pain	fit lasting 2 mins. Ambulance notified

EXAMINATION OF PUPILS

The pupils are the black areas at the centre of the coloured part (iris) of each eye. The pupils grow smaller (contract) when a light is shone into the eye, and become larger (dilate) when it gets darker.

The pupil reactions are controlled by the optic nerves, which run from the back of the eye to the back of the brain. Any damage to, or pressure on, these nerves will affect the pupils' reaction to light. Therefore, checking the pupils is a very easy way to check the extent of any brain injury.

If there is a severe brain injury, the pupils become large and stay large when light is shone into them. With less severe injury, the pupils may react slowly to light.

If there is an injury to one side of the brain only, then only one pupil will react slowly to light, while the other may react normally.

IF ONE OR BOTH PUPILS ARE LARGE, AND DO NOT REACT TO LIGHT, THE PATIENT NEEDS VERY URGENT HOSPITAL CARE.

Any patient who is unconscious, or who has lost consciousness but now recovered, must have the pupil reactions tested. It is essential to write down your observations every time you check the pupils.

CAUTION

The pupil may be abnormal after an eye injury, or if the patient is using drugs, some medications, or some kinds of eye drops. Some people always have one pupil larger than the other and some people have a glass eye.

3.1 EXAMINATION OF A PATIENTS PUPILS

Satisfactory

CHECK LIST	Tick																			
<ul style="list-style-type: none"> - Explain what you are going to do - Shade the patients forehead with one hand, and open one of their eyes. <p>Note the size of the pupil.</p> <ul style="list-style-type: none"> - Holding the torch about 15 cm (6") above the face, let the light sweep across the eye, from the outer corner of the eye into the pupil. <p>Observe the pupil reaction.</p> <p>N.B. You may need to repeat this several times to be certain of the response. If the pupil reaction seems abnormal, ask someone else to check it with you.</p> <ul style="list-style-type: none"> - Do the same for the other other eye. - Write down your observations. 																				
<p><u>EXAMPLES OF PUPIL REACTION CHART</u></p> <table border="1"> <thead> <tr> <th rowspan="2">Time</th> <th colspan="2">Pupil Size (●●●●●)</th> <th colspan="2">Reaction to Light</th> </tr> <tr> <th>(R)</th> <th>(L)</th> <th>(R)</th> <th>(L)</th> </tr> </thead> <tbody> <tr> <td>11.00</td> <td style="text-align: center;">●</td> <td style="text-align: center;">●</td> <td></td> <td></td> </tr> <tr> <td>11.15</td> <td style="text-align: center;">●●</td> <td style="text-align: center;">●</td> <td style="text-align: center;">slow</td> <td></td> </tr> </tbody> </table>		Time	Pupil Size (●●●●●)		Reaction to Light		(R)	(L)	(R)	(L)	11.00	●	●			11.15	●●	●	slow	
Time	Pupil Size (●●●●●)		Reaction to Light																	
	(R)	(L)	(R)	(L)																
11.00	●	●																		
11.15	●●	●	slow																	

PRACTICAL SKILL MASTERED

SIGNED

DATE

3.2 EXAMINATION OF AN UNCONSCIOUS PATIENT

Satisfactory

CHECK LIST	Tick
- DANGER PRESENT IN AREA	
- Response to shake and shout - "Are you alright". No response.	
- TURN PATIENT ONTO THE SIDE, facing away from you. (Refer Australian First Aid, p.44)	
- Check and clear airway.	
- Check for breathing.	
- Check for circulation.	
- Check for major external haemorrhage.	
- Make sure that the patient is lying securely on their side, with the face slightly downwards, and that they can't roll out of position. Continue your examination with the patient on their side.	
- Send for medical aid (but do not leave the patient alone).	
- Check pulse respiration skin colour	
- Check level of consciousness (response to command/touch/pain).	
- Check pupil response and size.	
- Exclude other injuries: look, feel and move all areas of the body in turn, checking for wounds, fractures etc. Treat any injury. Think of the possibility of spinal injury.	
- Check patient's pockets for identification, medication, "Medical Alert", bracelets etc. Ask any bystanders about what happened.	
- Record all observations.	
- Recheck pulse, respiration, level of consciousness, and pupils at least every 15 mins.	

PRACTICAL SKILL MASTERED

SIGNED

DATE

3.3 POSITION A PATIENT INTO THE COMA POSITION
(For a Patient Lying on the Back)

Satisfactory

CHECK LIST	Tick
- Kneel beside the patient.	
- Place the patient's nearer arm, palm up, under the buttocks.	
- Cross the farther leg over the near leg.	
- Cross the patient's farther arm across the chest, so that their hand rests on the nearer shoulder.	
- Support the patient's head and neck with your hand that is nearer the head.	
- Grasp the farther hip with your other hand	
- Rotate the patient towards you until he is lying on his side.	
- Support the weight of the patient in this position by resting him against your knees.	
- Gently lower the head by allowing the patient to roll slightly towards you, until the nearer elbow rests on the ground and supports the patient.	
- Remove the farther arm from under the body, starting at the shoulder.	
- Tilt the head back to ensure an open airway.	
- Place the hand of the patient's upper arm palm downwards on the ground, with the fingers under the chin.	
- Draw the upper leg up at a right angle to the body, allowing the bulk of the patient's weight to be supported.	
- Ensure the patient's mouth is open.	

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3.4 POSITION A PATIENT INTO THE LATERAL POSITION

Satisfactory

CHECK LIST	Tick
- Kneel near patient's hips.	
- Place patient's far arm out straight from shoulder.	
- Fold near arm across chest.	
- Flex near leg at knee.	
- Support the patient's shoulder neck and head with one hand.	
- Grasp the near knee with the other hand.	
- Rotate patient away from you, using the knee as a lever.	
- Draw upper leg towards patient's head so knee is flexed at right angles.	
- Place nearer arm across farther arm at level of elbow.	
- Tilt head and support jaw.	
- Turn face slightly downwards.	
- Check airway breathing and circulation.	

PRACTICAL SKILL MASTERED

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DATED

SECTION A

PRACTICAL INCIDENT MANAGEMENT NOTES

SECTION 'A' COMPLETED
- SATISFACTORY STANDARD OBTAINED

SIGNED

DATE

S E C T I O N ' B '

SECTION 'B'

MODULE 4

WOUNDS AND HAEMORRHAGE

- OBJECTIVE : On completion of the training period and after practising the practical skills listed below (to the satisfactory performance level as per the module points/checklists) the Brigade member will be able to apply one or more of these skills to the sections mock practical incident :-

PRACTICAL SKILLS

- 4.1 - Manage a patient with a wound
 - (a) Minor
 - (b) Major
- 4.2 - Manage a patient with external bleeding
- 4.3 - Manage a patient with bleeding from special sites
 - (a) Nose
 - (b) Tooth Socket
 - (c) Ear
- 4.4 - Manage an unconscious patient with external bleeding
- 4.5 - Manage a patient with internal bleeding

DEFINITION OF A WOUND

"A break in continuity of any tissue of the Body caused by injury or operation".

Types

1. ABRASION : superficial grazing, usually dirty, raw oozing area.
2. INCISED : caused by sharp object, clean edges, often bleed a lot.
3. LACERATED : caused by blunt or jagged objects, edges torn.
4. CONTUSED : bruising caused by a fall or severe blow.

5. PENETRATING:
 - STAB : small surface area, but may have damage to deep
 - GUNSHOT : structures.
6. AMPUTATION : a severed part/or limb.
7. BITES : jagged, penetrating, high risk of infection, e.g. animal.
8. BURNS
9. FRACTURES

Aims of Wound Treatment

- A. Control Haemorrhage.
- B. Prevent further damage to area.
- C. Prevent or minimise infection.
- D. Seek Medical Aid if necessary.
- E. Give on-going advice.

Wounds - General Rules of Treatment

1. Control haemorrhage. (See 4.2)
2. Explain procedure to patient and reassure.
3. Put patient and injured part at rest.
4. Cleanse wounds with :
 - (a) normal saline
 - (b) antiseptic - (as approved by your State).
 - (c) water (sterile if available).

(NOTE: Depending on type of wound this procedure may be omitted)

DO NOT USE COTTON WOOL ON OPEN WOUNDS.

5. Apply a dressing e.g.
 - (a) dry dressing
 - (b) non-stick (if open or weeping wound)
 - (c) dressing must be large enough to extend at least 2.5 cm beyond wound edges.

6. Bandage or tape.
7. Immobilise and Elevate if necessary.
8. Handle all wounds gently to prevent further damage.
9. Always remove rings, watches etc. from injured limbs.
10. Use good nursing procedure to prevent infection.
11. Watch for signs of shock.
12. When assessing a wound take into account:
 - (a) size of wound.
 - (b) how it happened.
 - (c) what area it is on
e.g. face, over wrist etc.
 - (d) what structures are underneath
this wound.
 - (e) what is this patient's medical
history e.g. diabetic.
13. Enter record of treatment.
14. Give ongoing advice.

MAJOR WOUNDS

As a general rule any large or deep incised or lacerated wounds, stab or gunshot wounds, etc. need prompt referral to medical aid after basic first aid. Such wounds may involve damage to underlying structures such as tendons or nerves, and may be associated with fractures. Prompt control of bleeding is important and such wounds should not be cleaned or painted by the first aider as this may complicate medical assessment procedures later.

Major Wound Care for Brigade Field Duties

1. Control any bleeding with direct pressure and elevation.
2. Secure padding in place with firm, even pressure bandage.
3. Immobilise any fractures and cover minor injuries.
4. Arrange for transfer of patient to medical aid by most appropriate means.

HAEMORRHAGE

What is haemorrhage?

- haemorrhage is bleeding.

Classification of bleeding

1. External - discharging via a wound.
2. Internal - into tissues/organs which can be concealed or revealed.

Types of Bleeding

- (a) Arterial - (systemic artery)
bleeding occurs in spurts, bright red in colour.
- (b) Venous - (systemic vein)
bleeding with a steady flow, dark red in colour.
- (c) Capillary - bleeding is small in volume, oozes from a wound.

NOTE: Regardless where the blood is coming from, in a baby/child all bleeding can be serious or fatal, because of the relatively low blood volume compared to their body weight.

e.g. Newborn - 3.5 kg - 80 mls/kg
Total blood volume - approximately 280 mls.

Adult - 70 kg
Total blood volume - approximately 6 litres.

This knowledge is important when having to triage, assess and treat at accidents.

How does our body help control bleeding?

1. Constriction and retraction of vessels
2. Coagulation (clotting)
3. Reduction in blood pressure (see A.F.A. page 89 for more details).

Signs and symptoms of bleeding

- faintness or dizziness
- restlessness, apprehension
- nausea
- thirst
- weak/feeble rapid pulse
- pale, face and lips
- cold and clammy skin
- rapid breathing

INTERNAL HAEMORRHAGE

- results from disease or injury.

1. Concealed

- e.g. tearing force - ruptured liver
- spleen
- pancreas

These bleeds may remain in the abdominal cavity
- extremely dangerous
- often fatal

- Recognition :
- very important, obtain history (if possible)
 - look for:-
 - evidence of a blow to the area
 - redness, swelling
 - guarding (rigidity of abdominal muscles)
 - general signs of reaction to blood loss.

2. Revealed

Blood from any body opening is an indication of possible internal bleeding (except normal menstruation)

- e.g. lungs: - blood is coughed up and is bright red and frothy.
- stomach: - blood is vomited. It often has the colour of coffee grounds or bright if severe.
- small intestines: - the blood is mixed with the motions, and due to digestive juices a black tarry appearance can be noticed about the bowel actions (melaena stools)
- large intestines: - motions may be red (no digestive juices)
- kidneys/
bladder: - blood in the urine gives it a red or smoky appearance

4.1 (a) MANAGE A PATIENT WITH A MINOR WOUND

Satisfactory

	CHECK LIST	Tick
Patient Care:	<p>Reassure patient</p> <p>Sit patient down (lie down if pale)</p> <p>Explain what you are going to do</p> <p>Take history of injury</p>	
Wound Examination:	<p>Look at wound</p> <p style="padding-left: 100px;">type</p> <p style="padding-left: 100px;">note:</p> <p style="padding-left: 100px;">size</p> <p style="padding-left: 100px;">check for foreign bodies.</p> <p>Position injured limb</p> <p style="padding-left: 100px;">e.g. support arm or leg etc.</p>	
Equipment:	<p>Collect equipment needed:</p> <p style="padding-left: 100px;">swabs</p> <p>* Check if patient has any allergies. solution</p> <p style="padding-left: 100px;">dressing</p> <p style="padding-left: 100px;">sticking plaster</p> <p style="padding-left: 100px;">bandage etc.</p> <p style="padding-left: 100px;">scissors</p>	
Procedure:	<p>Wash hands.</p> <p>Protect patient's clothing</p> <p>Clean wound using:</p> <p style="padding-left: 100px;">water (sterile if available)</p> <p style="padding-left: 100px;">normal saline or antiseptic (approved by your State).</p> <p>Clean wound thoroughly. (Swab from top to bottom)</p> <p>Use each swab for one wipe then discard.</p> <p>Dry with gauze.</p> <p>Apply suitable dressing.</p>	

	Check List Continued	Tick
	<p>Fix dressing in position with :</p> <ul style="list-style-type: none"> - sticking plaster - tape - or bandage etc. <p>Check patient's comfort.</p>	
Records	Fill out correct brigade forms	
On going Advice:	<ul style="list-style-type: none"> - Keep dressing dry - Remove in 24 hours - Re apply if necessary - If wound becomes very - red swollen throbs or red line up arm or leg etc appears or patient has an elevated temperature <p style="text-align: right;">SEE A DOCTOR</p> <ul style="list-style-type: none"> - Get a Tetanus injection or booster if needed. 	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.1 (b) MANAGE A PATIENT WITH A MAJOR WOUND

Satisfactory

CHECK LIST		Tick
Patient Care	Reassure patient Lie patient down Explain what you are going to do Ask how it happened when where	
Wound Examination:	Quickly assess wound - type - size - position of injury Immediately control bleeding as per Check List 4.2 If no bleeding present continue with this procedure. Position of injured limb or patient Protection of Wound - cover with sterile dressing :- (a) to help minimise infection (b) to prevent further injury Check Medical History Check if patient has any allergies	
Equipment:	Collect equipment needed: swabs If sterile solution dressing trays dressings available these sticking plaster should be used bandage scissors slings etc	
Procedure:	Wash hands Protect patients clothing Remove covering dressing Cont'd..	

	Check List Continued	Tick
	<p>Clean wound with swabs using: Sterile water Normal saline or (Antiseptic (approved by your State)</p> <p>Swab wound from top to bottom</p> <p>Use each swab for one wipe then discard</p> <p>Continue using as many swabs as necessary to clean wound</p> <p>Dry with gauze swabs</p> <p>Apply a suitable dressing e.g. - NON stick dressing e.g. - Burn dressing etc.</p> <p>Apply suitable padding if wound is likely to weep</p> <p>Fix dressing in position with - sticking plaster - tape - bandage etc.</p> <p>Check patients comfort</p> <p>Give nothing by mouth if patient needs: - sutures - tendon repair - anaesthetic - or is unconscious</p> <p>Check if patient needs a tetanus injection or booster etc.</p> <p>Records: Fill out correct brigade forms</p> <p>Fill out report to go on to hospital with patient.</p>	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.2 MANAGEMENT OF A PATIENT WITH BLEEDING

Satisfactory

CHECK LIST	Tick
<u>Look at wound</u>	
Check for foreign object eg. glass	
(No Glass)	
<u>Direct Digital Pressure</u> (See A.F.A. Page 94)	
Thumbs along edges, parallel to wound with fingers out stretched around limb or part.	
(Bleeding controlled)	
<u>Timing.</u> Must reach this stage within 10 secs of start.	
<u>Elevate the part</u> Limb elevated, whilst maintaining digital pressure.	
<u>Rest the Patient</u> Sit or lie patient down (which ever applicable to the injury). Maintain elevation and digital pressure.	
<u>Bandage affected area</u>	
- Dressing in place if available otherwise a pad for pressure.	
- Roller or triangular to cover pad	
NOTE Improvise if necessary if no prepared equipment available. (See page 145 - 147 A.F.A Book)	

Check List Continued	Tick
<p><u>Immobilization</u> Rest the injured part.</p> <ul style="list-style-type: none">- Arm - St. John sling- Leg - Instruct the patient not to move	
<p><u>Reassurance</u> is given from the moment of contact with the patient.</p>	
<p><u>Check affected area</u></p> <ul style="list-style-type: none">- has bleeding been controlled?- if not apply another pressure pad/bandage- check area below part bandaged : colour pulse sensation- ask patient if they are comfortable	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.3 CONTROL OF BLEEDING FROM SPECIAL SITES

A. NOSE

Satisfactory	
CHECK LIST	Tick
<ul style="list-style-type: none">- sit patient down on chair or ground, with head slightly forward - pinch off soft part of nose with finger and thumb for 10 minutes - instruct patient to breathe through mouth slowly, and gently spit any blood out - loosen tight clothing - instruct patient not to blow nose - place cold wet towels on neck and forehead - reassure patient continually - maintain a peaceful environment, with supply of fresh air. - seek medical aid if bleeding continues for more than 20 minutes.	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.3 CONTROL OF BLEEDING FROM SPECIAL SITES

B. TOOTH SOCKET

		Satisfactory
CHECK LIST		Tick
-	instruct patient to keep tongue clear of socket	
-	place a firm pad of gauze over the socket and instruct the patient to bite firmly on it	
-	instruct patient to keep pad in place for 1 hour	
-	instruct patient to seek medical aid if bleeding continues	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.3 CONTROL OF BLEEDING FROM SPECIAL SITES

C. EAR

Satisfactory	
CHECK LIST	Tick
<ul style="list-style-type: none">- do not plug ear canal - do not put in drops of any kind - allow fluid to drain freely - place the patient on the side with the affected ear downwards, even if the patient is conscious - place a clean pad between the ear and the ground - seek medical aid <u>urgently</u>	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.4 CONTROL AN EXTERNAL BLEED FROM AN UNCONSCIOUS PATIENT

Satisfactory

CHECK LIST	Tick
<p><u>Patient Approach</u> D.R.A.B.C. (See A.F.A. Page 40)</p> <p>NOTE: - An <u>unconscious</u> patient is always rolled on the side for A.B.C. and thus remains in that position for rest of examination if breathing and circulation are present</p> <p><u>Check for External Bleeding</u></p> <ul style="list-style-type: none">- a quick systematic approach is used to check for external blood loss.- Look and feel. <p><u>Discovery of Blood Loss</u></p> <ul style="list-style-type: none">- examine area- remove or cut clothing in that area to assess bleed correctly.- if no foreign object- apply direct pressure- elevate the part carefully <p><u>Control Bleeding</u></p> <ul style="list-style-type: none">- apply firm pad and bandage (improvise if necessary)- check below part bandaged if possible for circulation and colour <p><u>Regular Checks</u></p> <p>A.B.C. every 2 minutes as well as observe site bandaged for further blood loss</p>	

Cont'd....

Check List Continued	Tick
<p><u>Continuing Care</u></p> <ul style="list-style-type: none"> - monitor unconscious patient whilst on their side - take pulse, respirations - observe colour and any altered conscious state - record observations - check bleeding site - if bleeding noticed rebandage with another pad and bandage. <p>Note As long as the patient is unconscious they stay on their side to ensure airway is kept clear.</p>	

PRACTICAL SKILL MASTERED

SIGNED

DATE

4.5 MANAGEMENT OF A PATIENT WITH INTERNAL BLEEDING

Satisfactory	
CHECK LIST	Tick
<p><u>NOTE:</u> As no pressure can be applied to the bleeding part, manage as follows:</p> <ul style="list-style-type: none"> - maintain absolute rest for the patient - elevate the legs - loosen tight clothing - give nil by mouth - make patient comfortable - give oxygen if available (As per your State) - seek medical aid <u>urgently</u> - record vital signs e.g. pulse, respiration, altered conscious state. 	

PRACTICAL SKILL MASTERED

SIGNED

DATE

MODULE 5

BURNS

- OBJECTIVE : On completion of the training period and after studying the material listed below the Brigade member will be able to apply this knowledge to the sections mock practical incident.

- 5.1 Give examples of how different types of burns may be caused and state the difference between the effects of each type.
- 5.2 Using suitably-prepared diagrams, estimate the different percentages of surface area burned (rule of nines) and using the 'patient's hand' technique, estimate the total percentage area of scattered burns. The patient's hand equals approximately 1% of their body surface area.
- 5.3 Describe the differences between superficial and deep burns.
- 5.4 State the dangers associated with burns, i.e.
- the risk of infection
 - fluid loss and resultant shock
- 5.5 Describe how to treat:
- small thermal burns
 - large-area thermal burns
- 5.6 Describe the particular dangers to the airway associated with facial burns and burns sustained from fires in closed spaces.
- 5.7 Demonstrate the treatment of a burns patient. Use the "three B's and three C's" checklist.

DEFINITION OF A BURN Damage to skin and underlying tissue by heat:

- Types
- (i) Contact with dry heat, e.g. fire, heat-conducting materials.
 - (ii) Scalds
Contact with moist heat, e.g. hot liquids, steam.
 - (iii) Chemical Burns
Contact with corrosive acids, alkalis, combustible chemical powders, e.g. sulphuric acid, caustic soda, phosphorus.

(iv) Electrical Burns

Contact with flash from high-voltage electrical apparatus or cables.

(v) Friction

Caused by two skin surfaces rubbing together or by clothing/shoes/object rubbing against skin.

COMPLICATIONS

The Major Complications are Infection and Shock:

Burn injuries have an effect on skin and circulation. The risk of infection to the body is great with the loss of plasma from the circulating fluid. The shock process will increase.

SEVERITY

To estimate the severity of a burn, two important factors must be taken into account.

(a) The depth of the burn, i.e.

(i) Superficial

the outer layer of skin damaged

signs

skin is fiery red, possible swelling and blistering

symptom

severe pain

Healing is rapid with little or no scarring after recovery

(ii) Deep

the full thickness of skin is destroyed, also possible damage to underlying muscle and tissue in varying depths

signs

area brownish-black in colour, scarring of the deeper part like over-cooked joint of meat, possible exposure and scarring of underlying bone. Wound often black around edges.

symptoms

little or no pain is felt due to nerve endings in tissue being damaged.

Healing is slow and often produces scarring - if a limb is involved, partial loss of function or deformity may result.

- (b) The area of the wound is more important than the depth as there is more risk of infection, also the larger the area of the wound, the more circulating fluid is lost, producing a greater degree of shock. Shock is produced in superficial burns by pain and loss of plasma. Shock is produced in deep penetrating burns by loss of plasma and whole blood.

To estimate the area of the burn apply the rule of nines. Burns estimated to be more than 10% (or 5% in children, the elderly or the very ill) should be treated as serious and urgent medical treatment sought. This also applies with deep burns irrespective of area involved.

Burns are assessed as serious by three points:

- (i) depth - how deep the burn is
- (ii) area - how large the area of the body is burnt
(apply the rule of nines)
- (iii) special sites - face, fingers, toes, etc.

The special sites are classed as serious because the skin and tissue in these areas are so loose that scarring and contraction of healing could result in additional complications, i.e. partial or complete loss of power in burns to the joints, and deformity due to contraction in burns to the toes and fingers. In the case of burns to the face, the patient may inhale irritant gases, smoke or steam causing an obstruction in the airway which may require surgical treatment to assist in the patient's breathing. Also, with facial burns the eyelids swell greatly, causing virtual blindness for several days even though eyes are not damaged. The same extensive burns to the face, the eyes, nose, mouth and ears, may be damaged or completely destroyed.

TREATMENT

The aim of treatment of burns is to remove the patient from the cause of heat, and cool the injured area, to prevent infection, combat shock, and get the patient to medical aid as soon as possible.

AT THE INCIDENT:

- (i) cool the burns with cold water
- (ii) cover the wound with a non stick dry dressing
- (iii) secure with bandage

If area is large:

- (iv) use a large prepared sterile burns dressing or a sterile freshly-laundered sheet or pillow case to envelop the area.
- (v) soaked clothing, which has not stuck to the skin, should be removed but try not to remove clothes unnecessarily
- (vi) dressings should be applied over burnt clothing which has stuck to the burn area
- (vii) make sure the patient's airway is kept clear and breathing, circulation and depth of consciousness continually monitored. If patient is unconscious then transport in the Coma Position

SPECIAL CIRCUMSTANCES:

In cases where there is damage to the eyes, nose and mouth, special care should be taken.

In cases of electrical burns, ensure that the electricity is off and that there is adequate protection for the rescuer. If the electricity supply cannot be shut off then removal of the patient or part of the patient in contact should be done by using a dry wooden object. The rescuer should stand on a dry surface.

Note: In case of electric burns, the patient may have other conditions due to electric shock such as breathing stopped or fractures of bones due to being thrown by the electric force.

TREAT PRIORITIES FIRST:

In cases of chemical burns, source of heat should be removed. Corrosive acids and alkalis by immersion or flushing with water.

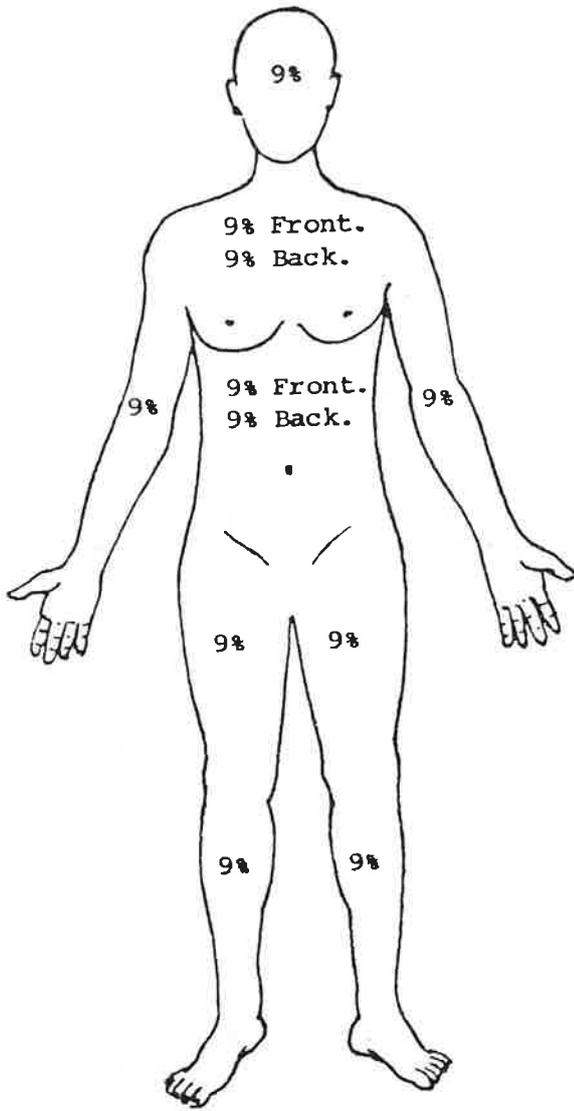
Note: In the case of burns from chemical powders, e.g. phosphorus and lime, special attention should be paid to the powder's reaction.

Phosphorus ignites when exposed to air. Immersion in water as for normal burns is adequate. In the dressing of phosphorus burns, the dressing and area of the burn should be kept wet due to the combustible reaction of air and phosphorus.

Lime when dissolved in water gives off heat, it should be removed from the wound before immersion in water.

SPECIAL NOTES:

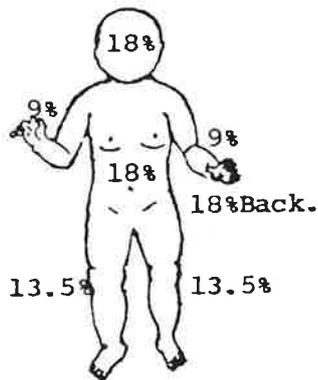
- i Observation of the patient is essential, ensuring the maintenance of clear airway and monitoring of breathing, circulation and conscious state.
- ii All burns are painful. Small burns are usually more painful than larger burns.
- iii Burn patients should be handled carefully to ensure that no further damage is done to the skin causing a greater degree of shock.
- iv Do not lower body temperature too far.
- v Remember that burn patients require urgent removal to hospital.



Rule Of Nines. (Adult)

The body surface that is burnt is very important in determining the seriousness of the burn. An approximate but reasonable accurate estimate of the amount of body surface burnt is determined by the rule of nines. This rule, which applies especially in adults and older children, divides the body into sections each of which constitutes 9% of the total area.

INFANTS AND YOUNGER CHILDREN:



Infants and younger children, a considerable greater portion of body is taken up by the head and the smaller portion by the lower extremities, accordingly, the rule is modified for these patients. In each case the rule gives a useful approximation of the body surface.

Rule of Assessment (Infants and Younger Children)

BURNS

THE 'THREE B'S AND THREE C'S' SYSTEM APPROACH

HISTORY:

Whilst attending a BBQ, you hear a person's cry for help. On investigation you find his/her clothing ablaze. TREAT THE PATIENT ACCORDINGLY.

EQUIPMENT:

One CPR manikin or similar doll, one blanket, one sheet, quantity of water in containers.

CHECK LIST		Satisfactory
ITEM	PROCEDURE	Tick
Burning stopped	Remove patient from heat/heat from patient Replace patient on ground (face down if possible) Extinguish fire on patient using blanket to smother flames Remove blanket when flames extinguished	
Breathing maintained	Open airway: - open mouth and clear - tilt head back - look - feel/listen Check breathing: - observe chest rise & fall - feel/listen (breathing present) Check pulse: - feel Carotid (pulse present)	

Cont'd/...

Check List Continued

Satisfactory

Item	Procedure	Tick
Body examined	Examine for priorities Haemorrhage - observe area - blood-soaked clothing Levels of consciousness - Command/touch/pain Fractures/injuries Estimate seriousness of burn - depth - surface area (TREAT INJURIES IN ORDER OF PRIORITY)	
TREATMENT OF BURNS: Cool	Apply cold running water to burnt area Remove clothing/items (down not up) that trap heat in Cut around clothing that is adhered to skin (Do not overcool patient)	
Cover	Apply sterile non stick dressing or clean sheet/pillow case to burnt area	
Carry	Use stretcher or other carry techniques (Do not walk patient) Obtain medical aid urgently	

Cont'd....

NOTES

Burn deaths do occur as a result of inhalation of smoke fumes.

Do Not:

- Delay medical care
- Break blisters
- Use creams, butter, flour, ointments
- Overcool or overheat patient
- Overlook other injuries

PRACTICAL SKILL MASTERED

SIGNED

DATE

MODULE 6

EXPOSURE TO TEMPERATURE CHANGES

- OBJECTIVE: On completion of the training period and after studying the material listed below the Brigade member will be able to complete the questionnaire following and apply the knowledge to the sections mock practical incident.

A. HEAT EMERGENCIES

Heat Exposure

The body maintains a central core temperature of 37°C and to maintain this constant temperature the body has a complex regulating device controlled from the hypothalamus in the brain. This regulating device includes heat loss from the expired breath, urine, faeces and skin. The skin is the most effective of the heat regulating organs and loses heat quickly due to evaporation, conduction, convection and radiation. However, if any part of this system fails, is overcome or damaged then the patient will suffer from heat exposure.

Heat exposure is a continuing process extending through the three stages

- i - heat cramps
- ii - heat exhaustion
- iii - heat stroke

(i) Heat Cramps

Heat cramps are characterized by severe muscle pains and cramps, especially in the legs and the abdomen. Because heat cramps may lead to heat exhaustion, the patient may complain of faintness, dizziness and marked weakness.

Treatment

- (a) replace salt by giving patient drinks containing a mixture of salt and water at a ratio of one half teaspoon of salt to 500 ml. of water or products such as - STAMINADE. No salt tablets should be given.
- (b) application of ice packs to cramped muscles for 15 - 20 minutes.
- (c) gentle stretching of the cramped muscles.

(ii) Heat Exhaustion

The patient may complain of generalized weakness and fatigue and may even faint. Helpful in identifying heat exhaustion is the pale, clammy skin of the patient. The skin temperature may feel normal or cool. The patient may be nauseated and may even vomit. The pulse is weak and rapid. Blood pressure is usually decreased, breathing is rapid and pupils may be dilated. The patient if conscious may also exhibit signs and symptoms of heat cramps.

Treatment:

- (a) move patient to cooler environment
- (b) loosen clothing and if possible sponge patient with cold water
- (c) if the patient is conscious give water with added salt (one half teaspoon salt to 500 ml. water). If no salt give water and plenty of it to drink.
- (d) treat any muscle cramp.
- (e) if fainting has occurred, place patient flat with feet raised or if still unconscious turn on side.

A PATIENT SUFFERING HEAT EXHAUSTION HAS A DEFINITE PALLOR WHICH IS IN MARKED CONTRAST TO THE REDDISH BLUSH AND DRY SKIN OF THE HEAT STROKE VICTIM

(iii) Heat Stroke

In contrast to heat exhaustion, heat stroke is an emergency of greater magnitude. Heat stroke, like heat exhaustion indicates poor acclimatization to excessive heat, usually associated with high humidity. The patient's body is unable to cope with the excessive heat and the heat regulation mechanism fails as sweating stops. It must be noted that heat stroke has a 25-50% mortality rate.

The cardinal signs of heat stroke are:

- (i) history of exposure to high temperatures
- (ii) a hot, flushed dry skin
- (iii) strong bounding pulse
- (iv) agitation, coma and seizures

These cardinal signs may be preceded by signs and symptoms of heat cramp and heat exhaustion. Occasionally a patient may continue to sweat freely.

Treatment:

- (a) remove to cooler place
- (b) remove all clothing
- (c) douse with cool water, cover with wet sheet
- (d) circulate air over patient by fanning
- (e) administer oxygen if possible

ALL PATIENTS WHO SUFFER HEAT EXPOSURE MUST BE HOSPITALIZED AS A MATTER OF URGENCY

B. COLD EMERGENCIES

Exposure to Cold

1. Cold by itself is not usually a problem unless it is extreme or the subject is scantily clad, ill, injured, undernourished, exhausted, elderly, on some anti-depressive drugs, etc.
2. Exposure to cold and wind - wind drives cold air through clothing and over exposed surfaces. Heat loss increases markedly.

Remember, the faster the wind, the cooler the patient will become, therefore get the patient out of the wind.

The effects of these conditions on a person depend on his/her physical state, clothing, food intake and mental state.

COLD, WIND AND WATER

Water makes intimate contact with skin and is a powerful conductor of heat. Misty rain removes heat as it evaporates from the body surface. Heavier rain removes heat as it flows over the body surface.

Water also ruins the insulatory value of clothing. Cotton when wet loses 90% of its insulating value, wool 50%.

The combination of cold, wind and rain is a potentially fatal mixture for the ill, infirm, elderly, injured or unwary.

SIGNS AND SYMPTOMS OF HYPOTHERMIA

It is not always easy to recognize the onset of hypothermia. Watch out for :

- (i) unexpected and unreasonable behaviour, often accompanied by complaints of coldness and tiredness
- (ii) physical and mental lethargy, including slowness to respond to or understand questions
- (iii) visual disturbances are common
- (iv) slurred speech

- (v) sudden shivering fits
- (vi) violent outbursts of unexpected energy, possible physical resistance to help, foul violent language
- (vii) falling
- (viii) collapse and coma
- (ix) slow pulse
- (x) slow weak respirations
- (xi) skin cold to touch

Treatment:

Principle - prevent further heat loss

- (a) stop where you are, provide shelter out of weather
- (b) remove wet clothing and dry patient off without excessive movement
- (c) dress in dry clothing
- (d) get patient into a sleeping bag or wrap neck to toe in polythene bags. Insulate above and below patient against wind and rain
- (e) optional treatment is to place patient, after drying, into sleeping bag naked and have other member of party strip and get in with him/her
- (f) if patient is conscious, give hot sweet (very sweet) drinks, glucose or condensed milk
- (g) if respiration ceases, perform EAR. Patients with cardiac or respiratory arrest merit extraordinary resuscitation efforts as cooling may prevent brain damage occurring rapidly
- (h) send distress signal or send for assistance. If isolated either stay together where you are or send for help. Leader must make decision
- (i) treat patient as a stretcher case, even if s/he seems to have recovered
- (j) keep head lower than body
- (k) if with hiking party assume all are likely exposure patients, therefore, shelter, warm food, rest

DO NOT TRY TO WARM BY:

- giving alcohol by mouth
- rubbing limbs and flesh
- placing hot water bottles, heated stones or electric blankets near patient, as these will cause severe burns due to poor diffusion of conducted heat by bloodless skin. There is also the risk of thawing limb tissue becoming gangrenous due to the blood being frozen thus unavailable to the partially thawed limb. All the above treatment is designed to do is prevent further loss of heat. The re-heating of the hypothermic patient takes hours under strict medical supervision.

Please remember that not just mountaineers suffer hypothermia. Patients who drown in cold water, patients who are in cold water for periods of time, the ill, the elderly and the poorly nourished also are very prone to cold exposure.

As St. John members we must be aware that if excessive cooling of burns patients who have lost the major heat regulating mechanism occurs, their skin will cause hypothermia which may be more dangerous than the burn. Also remember the patient lying on a street on a cold wet windy winter's night must also be prevented from developing hypothermia.

THE BEST TREATMENT FOR HYPOTHERMIA IS PREVENTION

FROSTBITE

Frostbite occurs when isolated parts of the body are exposed to prolonged or intense cold. The exposed part first becomes red and inflamed. The skin progressively turns grey or mottled, leading to white and waxlike with stiffening and hardening. As these changes occur the patient feels firstly, stinging and burning, followed by pins and needles sensation, then stiffness and loss of function.

Treatment:

- (a) gently remove clothing from affected area, eg. shoes and socks
- (b) remove any constrictions to limbs
- (c) rewarm part by covering with warm hand
- (d) cover damaged tissue with dry dressing
- (e) give patient hot sweet drinks
- (f) treat hypothermia

- (g) do not allow patient to smoke. (Nicotine causes constriction of blood vessels, further compromising blood flow to the affected part).
- (h) anticipate the severe pain a patient may feel as part thaws.
- (i) send to medical aid. Do not allow patient with frostbitten feet to walk.

DO NOT RUB OR CHAFE AFFECTED AREA

DO NOT APPLY SNOW

RE-HEAT ONLY UNDER MEDICAL DIRECTION

(See Overleaf for Questionnaire)

QUESTIONNAIRE
HEAT EMERGENCIES

Q1 WHAT IS THE STANDARD METHOD OF DETERMINING BODY TEMPERATURE?

Q2 WHAT IS HEAT CRAMP?

Q3 OUTLINE THE TREATMENT OF HEAT CRAMP

Q4 WHAT IS HEAT EXHAUSTION?

Q5 OUTLINE THE TREATMENT OF HEAT EXHAUSTION

Q6 LIST THE SIGNS AND SYMPTOMS OF HEAT STROKE

Q7 OUTLINE THE TREATMENT OF HEAT STROKE

Q8 WHAT IS THE MORTALITY RATE OF HEAT STROKE (AS STATED IN ARTICLE)?

Continued...

Q6 LIST THE SIGNS AND SYMPTOMS OF HYPOTHERMIA

Q7 OUTLINE THE TREATMENT OF HYPOTHERMIA

Q8 WHY MUST YOU NEVER PLACE HOT OBJECTS NEXT TO THE SKIN OF A HYPOTHERMIC PATIENT?

Q9 WHAT CONDITIONS MAKE A PERSON MORE SUSCEPTIBLE TO HYPOTHERMIA

Q10 WHAT HAPPENS WHEN FROSTBITE OCCURS?

Q11 OUTLINE THE CORRECT TREATMENT FOR FROSTBITE?

QUESTIONNAIRE

COLD EMERGENCIES

Q1 WHAT ARE THE THREE MAJOR FACTORS IN THE CAUSE OF HYPOTHERMIA
(ENVIRONMENT)?

Q2 LIST 10 CONTRIBUTING FACTORS WHICH INCREASE A PERSON'S CHANCES
OF SUFFERING HYPOTHERMIA

Q3 STATE HOW A STRONG WIND HELPS IN COOLING A PERSONS BODY

Q4 WHY IS WET CLOTHING SO DANGEROUS TO A TIRED PERSON IN A COLD
AND WINDY SPOT?

Q5 HOW EFFECTIVE IS WET COTTON AT INSULATING A BODY?

SECTION B

"TREATMENT NOTES"

SECTION B COMPLETED
- SATISFACTORY STANDARD OBTAINED

SIGNED

DATE

CASUALTY REPORT

St. John Ambulance Australia



LOCATION OF DUTY		TIME	DATE				
SURNAME OF CASUALTY		GIVEN NAMES	TITLE	AGE			
				SEX			
ADDRESS OF CASUALTY			POSTCODE				
COMPLAINTS/SYMPTOMS/HISTORY							
<p style="margin-left: 200px;"><i>SAMPLE</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; vertical-align: top;"> <p>LEVEL OF CONSCIOUSNESS</p> <p>FULLY CONSCIOUS <input type="checkbox"/></p> <p>CONFUSED/DROWSY <input type="checkbox"/></p> <p>UNCONSCIOUS <input type="checkbox"/></p> <p>PULSE _____</p> <p>RESP. _____</p> <p>PUPILS _____</p> </td> <td style="width: 30%; text-align: center; vertical-align: middle;"> </td> <td style="width: 30%; vertical-align: top;"> <p>KEY TO CODING</p> <p>A—ABRASION</p> <p>B—BURN</p> <p>C—CONTUSION</p> <p>D—DISCOLOURATION</p> <p>F—FRACTURE</p> <p>H—HAEMORRHAGE</p> <p>L—LACERATION</p> <p>P—PAIN</p> <p>R—RIGIDITY</p> <p>S—SWELLING</p> <p>T—TENDERNESS</p> </td> </tr> </table>					<p>LEVEL OF CONSCIOUSNESS</p> <p>FULLY CONSCIOUS <input type="checkbox"/></p> <p>CONFUSED/DROWSY <input type="checkbox"/></p> <p>UNCONSCIOUS <input type="checkbox"/></p> <p>PULSE _____</p> <p>RESP. _____</p> <p>PUPILS _____</p>		<p>KEY TO CODING</p> <p>A—ABRASION</p> <p>B—BURN</p> <p>C—CONTUSION</p> <p>D—DISCOLOURATION</p> <p>F—FRACTURE</p> <p>H—HAEMORRHAGE</p> <p>L—LACERATION</p> <p>P—PAIN</p> <p>R—RIGIDITY</p> <p>S—SWELLING</p> <p>T—TENDERNESS</p>
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FIRST AID ASSESSMENT AND OBSERVATIONS							
GENERAL OBSERVATIONS							
FIRST AID TREATMENT GIVEN							
REFERRAL FOR MEDICAL ADVICE							
HOSPITAL (BY AMBULANCE) <input type="checkbox"/>		HOSPITAL (BY CAR) <input type="checkbox"/>		OWN DOCTOR <input type="checkbox"/>			
SIGNATURE OF ST. JOHN MEMBER		DIVISION		DISTRICT			

White: to CASUALTY for DOCTOR

Pink: to DIVISION

Blue: Retained by MEMBER

I N D E X

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CONFIRMATION OF COMPLETION OF SKILLS MAINTENANCE

AND RE-EXAMINATION PROGRAMME - 1988

Name
(Please Print)

Division

Date Joined St. John

Member to Sign when Programme Completed

Date

The above Member has Completed the Programme to My Satisfaction

Signed Person Responsible for Training

Signed Divisional Superintendent) Delete
Corps Superintendent) as
Region Staff Officer) appropriate

TO BE COMPLETED ON ANNUAL RE-EXAMINATION NIGHT:

The above Member has completed the Programme to my
satisfaction and attended the Re-Examination Night

Signed (Dr.)

Corps Surgeon
(Please Print Name)

SUPERINTENDENT:

Please Forward This Page ONLY to the District Surgeon.

District Surgeon
1988 Training Programme
St. John Headquarters

(In Your State)