St John Ambulance Australia

SKILLS MAINTENANCE AND RE-EXAMINATION PROGRAMME 1991

NAME .....

SIGNATURE .....

DIVISION .....

DATE .....

St John Ambulance Australia

SKILLS MAINTENANCE AND RE-EXAMINATION PROGRAMME 1991

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		COMPLETED	
		Signature	Date
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REMARKS

The 1991 programme completes the cycle and I am delighted all States have now adopted the Skills Maintenance programme. It is written generously by the Victorian District Training Committee with input from interested persons or parties from other states. We are all grateful to Victoria for their efforts. The continued success of the programme will be dependent on positive, as well as negative, feedback. Offers to write modules would be appreciated.

The 1991 programme has a considerable segment on patient care in the home. The annual reappraisal of our Cardio-Pulmonary competency and ability to cope with the unexpected are important elements.

I wish you well with your planning, implementation and completion of this document.

Dr Leditschke
Chief Surgeon

VICTORIA DISTRICT TRAINING COMMITTEE MEMBERS

Sr B. Davis	(Barbara)	— Chief Nursing Officer
Mr W. Deakes	(Wayne)	— Corps Officer
Dr N. Fisher	(Nadine)	— Corps Surgeon
Mr J. I'Anson	(John)	— District Staff Officer
Mr G. Keane	(Gavan)	— Divisional Ambulance Officer
Sr D. McErlain	(Diana)	— Divisional Nursing Officer
Sr L. McMurtrie	(Lorraine)	— Divisional Nursing Officer
Mr P. McMurtrie	(Peter)	— District Officer
Dr J. Wassertheil	(Jeff)	— District Surgeon

INTRODUCTION

The 1991 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.

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

Districts	— District Surgeons in each State
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 Programme. The front cover of the Programme will be signed and dated on receipt.

2 The programme is divided into modules, with theory and practical skills components.

All the practical skills must be practised and, when mastery level is obtained, signed.

NOTE:
'AFA' refers to "Australian First Aid" Vol 1&2 1989.
'CSH' refers to "the Care of the Sick in the Home" SJAA 1981

(B) OFFICERS/TRAINING PERSONNEL

1 Unless exempted under General Regulations, all Officer/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.

5 If, on conclusion of the 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.

6 On satisfactory completion of the module, sign and date the programme in the space provided at the end of the relevant section.

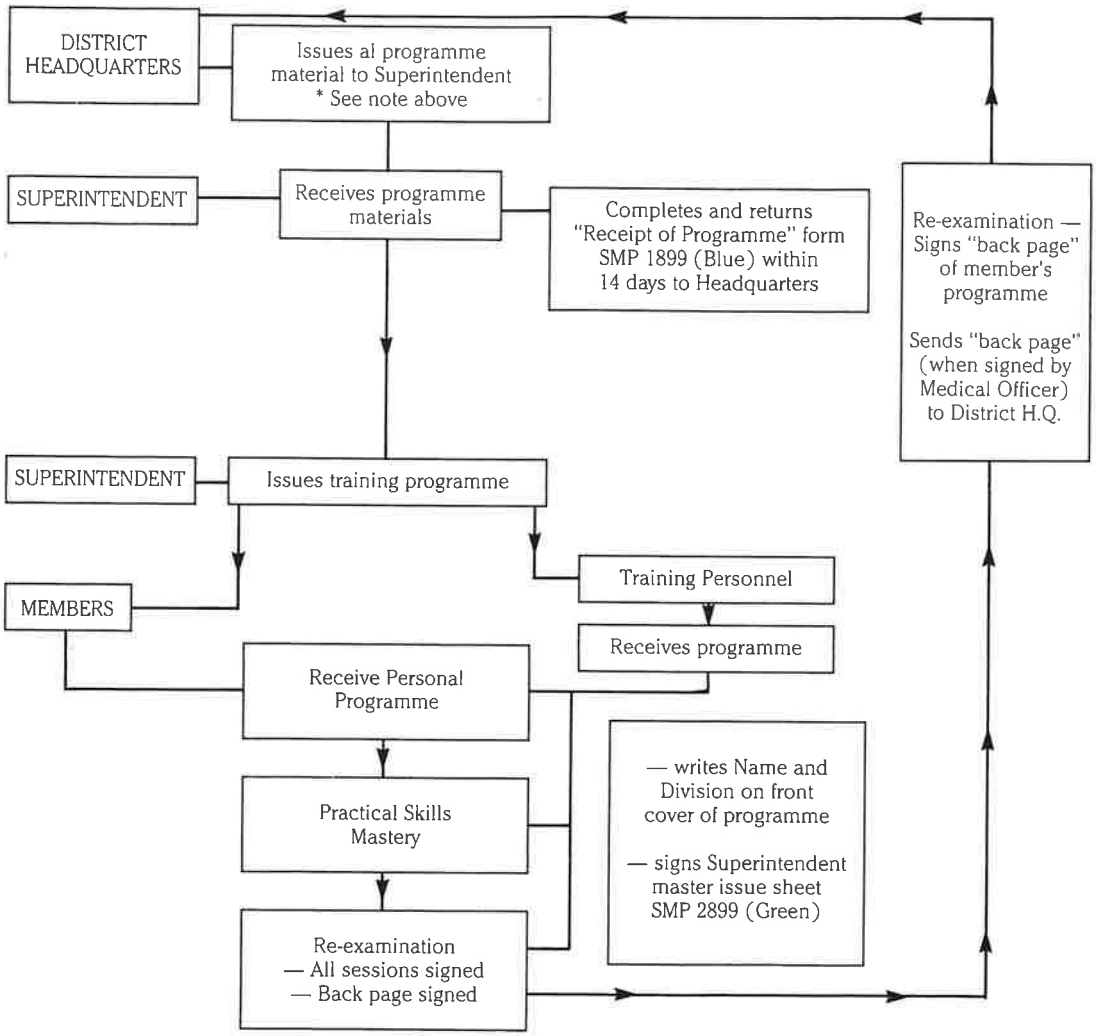
This programme belongs to all Officers and members of St Jonn and its success depends on all of us working as a team. Your help, assistance and valued comments are always appreciated.

PROGRAMME APPLICATION — SUMMARY FOR TRAINING PERSONNEL

ACTION	COMMENTS
1. Select one section of the programme.	— Can select/start any section.
2. Practical skills pertaining to 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.

*** NOTE:**
Diagram illustrates procedure for all **Divisional Superintendents and 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 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 ave al modules 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. should 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 Operations Branch efficiency requirements for 1991 you must have your Training Programme completed before the night of the 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 1991. No other examination will be accepted, e.g. St John Ambulance First Aid Class examinations.

NOTE: This programme covers January 1991 — December 1991.

RESPONSIBILITY FOR TRAINING PROGRAMME

It is each individual members' 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 your having to re-start a new Training Programme.

DISTRICT SURGEONS — AUSTRALIA
JANUARY 1991

MODULE 1

ANATOMY AND PHYSIOLOGY OF THE CIRCULATORY SYSTEM

PRESCRIBED REFERENCE:

Australian First Aid Vol. 1 & 2 1989
Supplementary Training Material

OBJECTIVE:

On completion of the training period, and after studying the material listed below, the St. John member will be able to complete the questionnaire following, and apply the knowledge to the section's practical incident.

SUPPLEMENTARY TRAINING MATERIAL:

The life of every tissue and organ in the body depends on their receiving an adequate supply of nourishment and oxygen, and the removal of the waste products which result from their activities. These functions are carried out by blood, and the heart and blood vessels are the mechanism by which a constant circulation of the blood throughout the body is maintained.

The blood is pumped by the heart along the arteries to the capillaries and is returned by the veins.

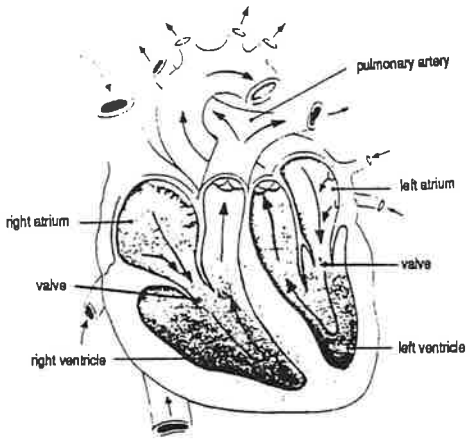
The Heart is a hollow muscular organ lying in the centre of the chest between the lungs and above the upper suface of the diaphragm. It is situated behind the sternum (breast bone) and extends outwards to the left. Being conical in shape, it is described as having a base, directed upwards and to the right, and an apex directed downwards and to the left. The Heart is divided by a partition or septum into right and left halves which do not communicate with each other. Each half consists of two chambers, an upper thin walled atrium and a lower thick walled ventricle. The atria act as receiving chambers for the pumps, and the ventricles as distributors.

Valves which permit blood to flow only from the atrium to the ventricle and prevent any back flow to blood in the opposite direction, are situated in the wall of the atrium passing into the ventricle.

Blood returns to the heart from the body tissues through the veins, which join together to form two large vessels, one from the upper, and the other from the lower part of the body. Blood from these two major vessels flows into the right atrium. Blood then flows into the right ventricle, and is pumped via the pulmonary artery to the lungs.

In the lungs an exchange of gases takes place and the re-oxygenated blood flows back to the left atrium of the heart via the pulmonary veins. The blood then flows into the left ventricle and is pumped out of the heart into the aorta for distribution around the body. (See Diagram 20.2, page 5 Vol. 2 *Australian First Aid*).

Arteries are thick walled vessels which carry blood away from the heart. Each time the heart contracts or pumps, it propels blood along the arteries, causing them to expand, and it is this expansion of the artery which is felt as a pulse. Veins are thin walled vessels in which blood flows back to the heart. Some veins have valves which prevent blood from flowing backwards.



The heart muscle itself requires a blood supply in order to function. This is supplied by the coronary arteries. These arteries are the first branches off the aorta, and arise just above the aortic valve. After passing through the capillaries in the myocardium (heart muscle) blood drains into the cardiac veins for return to the right atrium. These arteries also supply the conduction (or electrical) system of the heart with blood.

The Conduction System of the heart is the electrical system which activates the heart muscle and causes it to contract. The electrical current flows from the sino-atrial node (situated in the muscle of the right atrium) to the atrio-ventricular bundle (bundle of His) and is distributed via the Purkinje fibres to the left and right ventricle.

The sino atrial node is normally the pacemaker, and sends off electrical impulses at the rate of 60-80 times per minute in the adult heart.

The heart is a double pump in which two parts (or sides) pump in unison. Both atria contract together. This is followed by simultaneous contraction of both ventricles.

CARDIAC ARREST

The heart is said to have arrested (stopped) when a pulse cannot be felt at the carotid artery. That is, there is no output of blood from the left ventricle.

Main causes of this condition are:

1. Failure of the electrical conduction system of the heart.
2. Lack of adequate oxygen supply to the body.
3. Mechanical malfunction of the heart.

Sometimes the heart muscle moves in an unco-ordinated way and quivers. This quivering does not produce an output of blood from the left ventricle and therefore no pulse can be felt. This situation is termed Ventricular Fibrillation. If advanced life support facilities are available, a defibrillator can be used at this time, to reset the electrical contraction and output.

Cardiac standstill or asystole is said to occur when the heart muscle ceases to move. Therefore, no contractions and no output of blood occurs.

CARDIO PULMONARY RESUSCITATION

PRESCRIBED REFERENCE:

Australian First Aid Vol. 1&2 1989.
Australian Resuscitation Council — Policy Statements.

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 St. John member will be able to apply one or more of these skills to the section's practical incident.

PRACTICAL SKILLS:

Perform effective cardio pulmonary resuscitation for an adult.

PRACTICAL INCIDENT:

You are shopping at your local shopping centre when you see a middle aged person fall to the ground, apparently unconscious. Examine the patient and manage accordingly.

SKILLS CHECKLIST
CARDIO PULMONARY RESUSCITATION
SINGLE OPERATOR — ADULT

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
DANGERS Look around and listen for hazards. If the patient is in a hazardous location he/she should be moved or the hazard removed before continuing. (NO DANGERS) Yell for help		
RESPONSE Assess Response to verbal command: e.g. — Can you hear me? — Open your eyes. — What is your name? A.F.A. (1) Pg 30 Kneel beside patient's shoulders, shake gently by grasping the patient's shoulders as if trying to wake a friend from sleep. (NO RESPONSE) **Quickly turn the patient away from you onto their side.** A.F.A. (1) Pg 31 Place the far-side arm at right angle to the body. Place the other arm across the chest. Bend the nearer knee up. Place your hand under the patient's neck and support head. Roll the patient onto his farther side, turn the face slightly downwards to ensure drainage of fluids, vomitus, saliva etc. A.F.A. (1) Pg 32		
AIRWAY Check that airway is clear. Open patient's mouth. Look inside mouth for foreign matter. Scoop with fingers, being careful not to push matter further in. Remove dentures only if loose. (NOTHING APPARENT)		

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
Open the airway. A.F.A. (1) Pg 33 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 backwards. (NOT THE NECK) A.F.A. (1) Pg 33 Ensure face turned slightly downwards to enable fluids to drain from the mouth. **BREATHING** A.F.A. (1) Pg 34 Check if the patient is breathing by observing for signs of respirations. 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. (IF CHECKED, NO MOVEMENT) It may be difficult to hear movement of air if there is a background noise so it is important to follow the sequence — Look, Listen, Feel. (NO BREATHING) **Quickly turn the patient onto the back and commence expired air resuscitation (E.A.R.)** **Kneel beside the patient's head, open the airway.** Backward head tilt — place the palm of one hand on the forehead. A.F.A. (1) Pg 35 Support the jaw using pistol-grip between the knuckle of the middle finger and the thumb. Firmly but gently tilt the head backwards (not the neck). Lift the jaw upwards and forwards at the same time. Avoid excessive force.		

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
The Airway ALWAYS takes priority over any injury, including a spinal injury.		
Seal the nose A.F.A. (1) Pg 35		
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.		
Take a deep breath		
Seal your mouth over the patient's slightly open mouth		
Breathe out firmly A.F.A. (1) Pg 36		
Give **five (5) quick effective ventilations** with expired air **within ten (10) seconds.** A.F.A. (1) Pg 36		
Chest should rise indicating air has entered the lungs.		
Remove mouth		
Turn your head to the side		
Observe chest fall without waiting for it to fall completely, at the same time **listen and feel for air being exhaled.**		
A Laerdal Pocket face mask may be used if available and vinyl gloves donned prior to checking for foreign bodies in the mouth.		
CIRCULATION		
Check for presence of a pulse While maintaining backward head tilt with the hand on the forehead, the other hand checks for the carotid pulse. A.F.A. (1) Pg 39		
Use the flat pulps rather than the fingertips as the fingertips are less sensitive. (The thumb is not used as it is even less sensitive).		
Use two or three fingers along the line of the carotid artery between the adam's apple and the large muscle of the neck ensuring not to press on the opposite carotid artery at the same time.		
(PULSE ABSENT) A.F.A. (1) Pg 37		

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
Timing must reach this stage: — in correct sequence — DRABC — within 30 seconds of start		
RECOGNITION OF CARDIAC ARREST		
A collapsed victim has had a cardiac arrest if he/she is **unconscious, not breathing** and has **no carotid pulse.**		
Commence cardiopulmonary resuscitation (CPR) Kneel beside patient's chest. A.F.A. (1) Pg 39&40		
External cardiac compression (ECC)		
Locate compression site		
Identify midline of sternum		
Locate upper border by feeling groove between collar bones.		
Locate lower border by feeling the lower ribs at the rib junction.		
Identify the lower half of the sternum		
Use the caliper method to locate and mark the centre of the sternum		
Place the first finger of each hand at the upper and lower borders of the sternum.		
Bring both hands down so that the **thumbs rest on the centre of the sternum.** The position for the hands is between the thumb and finger of the lower hand.		
Place the heel of one hand centrally over the lower half of the sternum against the central marker thumb.		
Keep palm and fingers off the chest wall.		
Cover first hand with other hand. Either grasp the wrist of the lower hand with the thumb of upper or interlock the fingers of both hands.		
Press downward through the heel of the low hand		
Keep compressing arm straight and vertical so your body weight is the compressing force.		

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
Press firmly (4-5cm) for an adult casualty. (1½" to 2")		
Press rhythmically. Do not use rocking movements, thumps or quick jabs.		
The action is **compression** rather than massage, hence the unacceptability of the term external cardiac massage.		
Pivot from the hips and not the knees.		
Release the pressure to allow proper expansion of the chest but do not remove hands from the chest. Generate a pulse. Give 15 compressions immediately.		
Compression rate one press every ¾ second i.e. at least 80 compressions BUT not more than 90 compressions/min or 15 compressions in 10-12 seconds. A.F.A. (1) Pg 41		
Timing: To this stage in 60 seconds.		
Ratio: Interpose two (2) ventilations after every 15 compressions. A.F.A. (1) Pg 62		
Cycles per minute 4 cycles of 15:2 i.e. 60:8 per min A.F.A. (1) Pg 41		
Achieve: At the end of each minute at least 60 compressions and 8 ventilations must be achieved.		
Instruct the member to continue for at least three minutes.		
Time limits: A.F.A. (1) Pg 41 15 seconds Maximum each C.P.R. cycle. 10-12 seconds for each 15 compressions. 3-5 seconds for position changes and 2 ventilations.		
Effective standards: 8-10 ventilations/minute. 60 compressions/minute. Rate of compression 75-90 minutes.		
Monitor effectiveness: A.F.A. (1) Pg 42 Regular Revival Checks (A.B.C.) After one Minute (i.e. 4 cycles) After every two minutes thereafter i.e. 8 cycles		

CHECKLIST	SATIS-FACTORY	NOT SATIS-FACTORY
Continue until medical aid arrives (pulse and respiration do not return with this incident). *** Must be satisfactory to gain an overall pass. 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.)		

Practical Skill Mastered

Signed:.....

Date:.....

MANAGEMENT OF CHOKING CASUALTY

Conscious casualty

The choking casualty who is conscious should be encouraged to relax and breathe deeply, and to remove the foreign material by coughing. If the conscious casualty shows signs of partial airway obstruction, e.g. wheezing or stridor and/or laboured breathing, transport to hospital without delay, preferably by ambulance.

Attempt to dislodge the foreign body may result in complete airway obstruction. The victim will then become unconscious and breathing will cease.

Non-Breathing Casualty

The non-breathing casualty with an airway obstructed by foreign material may not be suspected until expired air resuscitation is attempted, e.g. by resistance to inflation and failure of the chest to rise despite correct head tilt and jaw support.

In the non-breathing casualty, where possible, position the casualty with the head lower than the body to maximise the effect of gravity:

— generate an increase in your expired air pressure to the blocked airway that may result in either partial or complete dislodgement of foreign material.

— if unable to inflate lungs pause to cause jolting sufficient to dislodge foreign material. e.g. Lateral Chest Thrusts, by pressure over the chest wall close to the armpits, which delivers a more sustained pressure to the blocked air passage, may assist in dislodging the foreign material and pose minimal risk to internal organs, before resuming your resuscitation efforts.

Explanation

Various abdominal thrust techniques, using forcible pressure over the abdomen, should not be used because they:

— may damage internal organs, especially liver, spleen or stomach.

— may precipitate regurgitation of stomach contents.

— would be dangerous in a pregnant casualty.

MODULE 2

SKELETAL INJURIES — FRACTURED JAW

PRESCRIBED REFERENCES:

Australian First Aid Vol. 1 1989
Supplementary Training Material

OBJECTIVE:

At the conclusion of this exercise the member will be able to manage an unconscious patient with a fractured lower jaw.

SUPPLEMENTARY TRAINING MATERIAL:

Airway management in patients with a fractured lower jaw

A fracture of the lower jaw may be life-threatening by causing airway obstruction if the patient is unconscious, or if the jaw is fractured on both sides.

Factors which may cause airway obstruction include:

— loss of support of the tongue
— bleeding
— swelling
— loose teeth
— bandaging

MANAGEMENT

— Do not apply an bandage

— The majority of jaw fractures require no first aid treatment. If the patient is conscious he should be allowed to assume the position of greatest comfort, which is usually sitting up and leaning forward. The patient may wish to support his own lower jaw.

The unconscious patient or a person with a threatened airway should be:

— turned on their side to ensure an open airway. It may be necessary to pull the lower jaw (mandible) forward, and thus the tongue forward, or to pull and hold the tongue forward holding it with a cloth.

— continually assess to ensure no airway obstruction.

— place any dislodged tooth in a container of milk or saliva as it may be able to be replaced in its socket.

SKILLS SHEET

A patient is brought into your first aid post who is unconscious and has a fractured lower jaw.

Demonstrate your management of the patient.

CHECKLIST	TICK
DANGERS	
RESPONSE — Shake and shout	
AIRWAY — Stable side position — Clear — Open	
BREATHING — Check	
CIRCULATION — Check	
EXAMINATION OF PATIENT	
(On your examination of the patient you find the signs of a fractured jaw.)	
FRACTURED JAW — Pull lower jaw forward if necessary to maintain an open airway.	
SEEK MEDICAL AID	
AIRWAY MANAGEMENT — An Oropharyngeal Airway may be used in all deeply unconscious patients to assist with airway management. (Refer Australian First Aid Vol. 2 1989 pg. 144)	

MODULE 3

MEDICAL EMERGENCIES

PART 1 — HEART CONDITIONS

PRESCRIBED REFERENCES:

Supplementary Training Material

OBJECTIVE:

At the end of this training segment, the St. John member should be able to recognise the differences between angina, coronary occlusion, and congestive cardiac failure, and be able to offer emergency First Aid care for these conditions.

SUPPLEMENTARY TRAINING MATERIAL:

I. Review of the heart

The heart is a muscular organ in the centre of the chest. It pumps blood around the body. (Refer section on Anatomy and Physiology — Circulatory System.)

II. Heart Disease — Cause and prevention

The heart is made of muscle, and therefore can be damaged by infection or poisons eg. alcohol. The **blood supply** to the heart can be blocked by the hardening of the arteries around the heart. This may lead to a heart attack — also known as coronary occlusion or myocardial infarction — which results in death of part of the heart muscle, and further deterioration of heart function.

Heart disease is more common in people who smoke, drink alcohol to excess, are overweight and underactive, and who have a high cholesterol level. Heart disease also runs in families.

To minimise your chances of heart disease you should:
— not smoke
— drink in moderation
— exercise for 20 minutes at least 3 times a week
— stay in the normal weight range
— have your blood pressure checked regularly

III. Angina

Angina is a cramp in the heart muscle, due to partial blockage of one of the coronary arteries. Angina usually occurs after exercise or exertion, when the heart beats more quickly and needs a greater blood and oxygen supply. However, because the artery is narrowed, extra blood can't get through and the heart muscle is starved of the extra oxygen it needs.

History

The patient will have a history of chest pain with effort, relieved by rest or medication. They may have had a heart attack previously.

Symptoms

— Central chest pain "like a weight on the chest", very severe, radiating to the back, jaw, neck and arm.
— Nausea
— Shortness of breath
— Feeling of doom.

Signs

Patients with heart pain look terrible, grey, sweating, breathing fast, hunched forward, rubbing the chest with their hand.

— Rapid, thready pulse
— Rapid respirations

Treatment

— Sit or lie patient in a position of comfort
— Loosen tight clothing
— Help patient take any prescribed medication — angina tablets under the tongue or a medicated patch to put on the skin. Give no more than 2 angina tablets.
— Give oxygen if it is available.

If the chest pain lasts more than 10 minutes, seek urgent medical aid.

If angina lasts more than 20 minutes, this episode of chest pain may not be angina but a heart attack.

Watch out for the patient getting worse.
They may get worse slowly, with the pulse rate rising, and colour and sweating failing to improve. They may deteriorate quickly, with sudden collapse or cardiac arrest.

IV Coronary occlusion

Coronary occlusion is the complete blockage of coronary artery, which deprives a section of the heart muscle of all its oxygen. This leads to **acute myocardial infarction** (death of heart muscle).

History, symptoms and signs are usually indistinguishable from those or an angina attack. An episode of angina unrelieved by rest or angina medication after 20 minutes is a heart attack, unless proven otherwise in hospital.

Occasionally a person with less dramatic and less intense chest pain will turn out to have had a coronary occlusion. If in doubt, seek medical advice.

Treatment

As for angina — Seek urgent medical aid.

Watch out for sudden collapse and for cardiac arrest.

Keep the patient under constant supervision, checking pulse, respirations and colour and documenting your findings.

V. Congestive Cardiac Failure

This is caused by a build up of blood in the left ventricle. This may be due to failure of a heart valve or weakness of the heart muscle. Blood builds up in the left ventricle, left atrium and then the lungs. As the blood flows slowly through the lungs, the plasma separates from the red cells and fills up the alveoli (air sacs). Because of this, gas exchange cannot take place, and the patient is starved of oxygen. This condition is also called **Pulmonary Oedema** (fluid on the lungs).

History

The patient may have a history of heart disease, with breathlessness at night when they lie down flat. Often congestive cardiac failure will come on suddenly and severely in the middle of the night.

Symptoms

— Severe shortness of breath
— Cough
— Chest tightness

Signs

— Very anxious & agitated
— Rapid distressed respirations
— Sweating
— Rapid pulse
— Pink, frothy sputum
— 'Grey' or cyanosed

Treatment

— Rest
— Loosen tight clothing
— Oxygen
— Urgent medical aid.

Congestive cardiac failure can also occur with failure of the right side of the heart. This results in swelling of the ankle.

SKILLS SHEET

PATIENT WITH CHEST PAIN

An elderly woman complaining of chest pain comes into your first aid station.

CHECKLIST	TICK
Settle patient down. Take her name and address — record them Ask the history — when did this pain start? 10 min ago. — What were you doing? — Where do you feel it? — What is the pain like? — Does it spread anywhere else? — Are there any other symptoms? — Has this happened before? — Are you on any medications? — Do you have a heart condition? (The patient says she had a heart attack 4 years ago, and has angina frequently) **Examination of patient** — anxious, agitated & worried — colour (grey or pale) — pulse (120 & weak) — respiration (24 & shallow) — conscious state normal — skin (cold and sweaty) **Diagnosis** Probably angina **Treatment** — rest, loosen clothing, reassurance — give oxygen if available by face mask or nasal prong — assist patient to take her Anginine tablets **Giving Anginine Tablet** — Tell patient what you are going to do — Wash hands — Select correct tablets — Check re allergies — Check "5 rights" — Undo bottle and shake 1 tablet into a spoon OR in top of bottle OR undo foil so patient can take out tablet(s) herself — Cap and replace bottle — Give to patient to place under her tongue (not to swallow it)	

CHECKLIST	TICK
— Watch patient take it — Record on history/record book — Observe patient for any reactions Assess — Response to medication — relief of anxiety — Check — pulse rate & rhythm — respiratory rate — skin colour — Ask if pain is easing (yes) After 10 minutes — repeat all observations & record. Make out a Casualty Record Sheet. When the patient is comfortable and confident she may leave.	

PART 2 — POISONS AND POISONING

PRESCRIBED REFERENCES:

Supplementary Training Material

OBJECTIVES:

Having studied this segment and discussed the topic with others, the St. John member will be prepared to give emergency care for the victims of acute poisoning by drugs, gases or venom.

SUPPLEMENTARY TRAINING MATERIAL:

Definition of Poison

A poison is any substance that may cause harm to the body. A substance may be a poison if taken into the body by one route but not another e.g. milk is harmless taken by mouth, but poisonous if injected into the veins.

Classification of Poisons

Poisons can be classified in several ways.

I. By route of entry into the body

— inhaled into the lungs — usually poisonous gases.
— ingested i.e. swallowed. These can be corrosive or non-corrosive poisons.
— injected i) by needle into veins or muscles
ii) by insect or animal bite
— absorbed into the body after being rubbed onto the skin, or taken under the tongue.

II. By physical form

— solid
— liquid
— gas

III. By effect on the body

— poisons may be **long-acting or short-acting.** e.g. snake venom causes problems for several days; carbon monoxide clears from the bloodstream after several minutes.

— poisons might be **centrally or locally acting.** Snake venom affects the whole body, a mosquito bite only affects the area immediately around the bite.

— poisons may act **quickly or slowly** — heroin causes symptoms immediately it is injected into a vein; a person who swallows weed-killer may have no symptoms at all for several days.

IV. By how it is administered

— **Accidental** ingestion of a poison occurs when the poison is in an unmarked or wrongly labelled container, or when the person does not realise the material is poisonous.

— **Deliberate** administration of a poison may be suicidal or murderous.

— **Negligence** may cause poisoning at home or at work.

— The poison might be administered as a **criminal** act, or it might involve a **breach of regulation.**

The First Aider involved in the care of a victim of poisoning must be particularly **observant** to assist investigations by medical staff or the police. After the patient is safe, the First Aider should, if possible, collect:

— sample of suspected poisoning agent, bottle etc.
— samples of any vomitus or urine passed by the patient at the scene.

Poisoning

I. General principles

— Avoid contamination of the First Aider
— Identify the poison — collect evidence from the scene.
— take history from bystanders.
— Remove the poison from the patient, or the patient from the poison.
— Seek medical aid
— Contact Poisons Information Centre — have the number recorded in your kit or diary for ready access.

II. Poisoning by Toxic Gases

How it happens

There are many toxic gases, including carbon monoxide, fumes from petrol and fumes from caustic & cleaning solutions eg. bleach.

Toxic gases may be inhaled.

At home — using chemicals, paint, glue or bleach in small, unventilated rooms e.g. toilet, shower, darkroom, shed (carbon monoxide poisoning from faulty car exhaust).

At work — industrial fumes, cleaning out old exhaust tanks etc. Dust from bags of cement and lime is dangerous also.

On the farm — inhaling pesticides and weed killers.

Symptoms and Signs

— stinging eyes and blurred vision.
— runny nose
— sore mouth, dry mouth
— cough, breathing difficulties, tightness in chest
— vomiting
— drowsiness, unconsciousness

Possible Long-term Effects

The patient who has inhaled toxic gases may have long-term lung complaints — like the World War I soliders who were gassed. The patient may also suffer permanent nerve or brain damage.

Prevention

— make sure that there is proper ventilation wherever chemicals are used.
— make sure that any leaks in car exhaust systems are checked.
— if you think you smell gas, don't investigate on your own.
— call for help **before** rescuing a patient overcome by gas when the gas is still leaking.

Treatment

Refer to Skills Sheet No. 1.

III. Ingestion of Corrosive Materials

Corrosive materials are materials which **burn** the flesh, mainly acidic or alkaline substances. They include bleach (acid) dishwasher powder (caustic), batteries from calculators (contain caustic soda which may leak out). Petrol based products are included in this group, because they burn the flesh and the mouth but also irritate & inflame the lungs if the fumes are inhaled.

How it happens

At home — Children will swallow these substances accidentally, especially dishwasher powder. Bleach and other household chemicals may be put into unlabelled containers, or old lemonade bottles. Adults may swallow acid or caustic liquids in a deliberate suicide attempt.

In the Garage — Petrol and kerosene may be swallowed while being siphoned from one container to another. NEVER DO THIS. Use a funnel, or a proper siphon.

At work — Many industrial chemicals are powerful corrosives.

Symptoms and Signs

Include: — burning and stinging of eyes (from the fumes)
— burns around the mouth
— severe pain in the mouth, mouth ulcers
— difficulty swallowing and/or breathing

Long-term Effects

The corrosive substance burns the sensitive mucous membranes of the mouth, oesophagus and trachea. These burns may cause severe scarring, with permanent difficulty in swallowing, breathing, and talking. The substance may burn a hole between the patient's trachea and oesophagus, causing terrible trouble.

Prevention

— keep all household chemicals out of reach of children.
— always label every container
— always use a proper siphon for siphoning petrol.

Treatment

Refer to Skills Sheet No. 2.

IV. Ingestion of Non-Corrosive Poisons

There is a huge range of non-corrosive poisons with a huge range of effects.

Once again, the poison may be taken accidentally or deliberately.

How it happens

Children may swallow their parent's tablets or drink a whole bottle of their own medicine. Children can also swallow an amazing variety of household products — from handcream, to antiseptics to rat poison.

Adults may accidentally take in a small amount of poison — the unusual taste soon alerts them that something is wrong.

Symptoms and Signs

These are as varied as the poisons themselves. Most poisons cause mild vomiting and/or diarrhoea and no serious or life threatening problems.

Some household products can be particularly dangerous for example:

— rat poison — causes bleeding
— weed killer — causes severe, even fatal liver damage
— iron tablets — an overdose of iron in children can be fatal.

Prevention

Every household should have a medicine cabinet, out of reach of children, with all medicines in it.

When buying tablets off the supermarket shelf, choose foil wrapped products.

Ask your chemist to put your tablets in child resistant containers.

Keep the garage and garden shed locked.

Don't put chemicals in drink bottles.

Remember that children can poison themselves at their grandparent's and next-door neighbours' houses just as readily as at their own home.

Treatment

Refer to Skills Sheet No. 3.

V. Poisons Absorbed through Skin

Several medicines and poisons are absorbed through the skin. Toxic effects occur mainly when very large doses are rubbed on frequently e.g. some mosquito repellents are harmful to small children.

Drugs and poisons can also be absorbed through the "mucous membranes" — the thin moist tissue lining the mouth and eyelids e.g. "Anginine" heart tablets are put under the tongue where they dissolve and pass directly into the bloodstream through the mucous membrane.,

If you suspect that someone has poison on their skin, wash the skin thoroughly and observe them while you contact the poison information centre.

VI. Bites and Stings

Refer *Australian First Aid* 1989 Vol. 1 pp 179-203

VII. Injected Poisons

Refer section on Drugs and Alcohol.

SKILLS SHEET NO. 1

INHALATION OF TOXIC GASES

You find your neighbour in his closed garage, slumped half in and half out of the driver's door of his car. The car engine is running and the garage smells very smoggy.

CHECKLIST	TICK
Say "Lie still. I'm a First Aider".	
Dangers Note dangers present, and remove them. Open doors and windows to let fumes escape. Call for help. Enter garage and turn off ignition of car. Leave garage and wait a few moments until you are sure that air has cleared. Enter garage, assist man from car to a safe place. Drag him if he is unconscious.	
Response — shake and shout	
While casualty is on his side:	
Airway — check and clear	
Breathing — is breathing present (yes)	

CHECKLIST	TICK
Circulation — is there a pulse (yes) — is there major bleeding (no) Patient begins to regain consciousness Stay with patient until medical aid arrives Attempt to take a history from the patient — What happened? — Had the car been faulty — Could it have been deliberate?	

Practical Skill Mastered

Signed .....

Date .....

SKILLS SHEET NO. 2

INGESTION OF CORROSIVE SUBSTANCE

You work in a photographic developing laboratory. A co-worker suddenly indicates that he has swallowed a mouthful of acid developing solution instead of his cup of tea.

He is holding his mouth and cannot talk.

CHECKLIST	TICK
Remove Danger — push the beaker of acid to the back of the bench, noting which one it was. **Remove Patient** — take the patient to a tap, and rinse his face well in flowing water. **Prevent Further Damage** — encourage the patient to rinse his mouth out several times with cool water and spit it out. — tell him not to swallow any water. — do not try to make him vomit. Call for medical aid **Assessment** — examine patient's face and mouth for burns.	

CHECKLIST	TICK
— observe vital signs — pulse — respiratory rate — colour — continually watch patient for development of complications — ask about pain on swallowing or difficulty breathing. — listen for the development of noisy breathing. **Identify Poison** — if the patient vomits, collect some to send to hospital — cover and label the beaker of developing fluid. **Think** how this and similar accidents can be avoided.	

Practical Skill Mastered

Signed .....

Date .....

SKILLS SHEET NO. 3

INGESTION OF NON-CORROSIVE SUBSTANCES

Your 5 year old daughter says "Mummy can I have some more lollies please?" passing over a (now empty) bottle of iron tablets.

CHECKLIST	TICK
Remove Danger — look in child's mouth and get her to spit out any extra tablets there. **Assess Drug Ingestion** — try to remember how many tablets were in bottle. — check floor for any tablets the child may have dropped. **Assess Child** — A.B.C. — watch for vomiting or abdominal pains — if the child vomits, collect some of the vomitus in jar.	

CHECKLIST	TICK
Call for help — ring Poisons Information Centre or your own doctor. — take child to medical aid or await ambulance.	

Practical Skill Mastered

Signed .....

Date .....

SKILLS SHEET NO. 4

TREATMENT OF A SNAKE BITE

STORES: Gauze/clean handkerchief
Crepe bandages
Splints
Bandages

You are in the bush and one of your companions feels something bite his ankle and sees a snake.

CHECKLIST	COMMENT	SATISFACTORY	
		TICK	DATE
Note colour, shape, size of snake if possible Look for snake Identify markings DO NOT attempt to catch or kill snake (DO NOT GET BITTEN YOURSELF) Save snake if it has been killed for later identification Rest and reassure patient Examine wound (NOTE: MAY NOT BE ANY WOUND DO NOT WASH WOUND) Apply small piece of gauze or clean handkerchief directly to wound or suspected bite site. (IF YOU HAVE EVER SEEN SKIN AFTER A CREPE BANDAGE HAS BEEN ON IT FOR A FEW HOURS, YOU WILL APPRECIATE HOW HARD IT WILL BE FOR THE DOCTOR AT THE HOSPITAL TO FIND THE EXACT AREA OF THE BITE)			

CHECKLIST	COMMENT	SATISFACTORY	
		TICK	DATE
Apply crepe bandage firmly to the leg, starting over the bite and extending it over the ankle, leg and thigh. Apply tension & pressure as for sprain Apply splint of any kind to the leg, and bandage it on firmly. DO NOT let casualty walk or exercise. Check pulse Check respiration Check general condition (WRITE DOWN THESE OBSERVATIONS) Send someone for an ambulance			

Practical Skill Mastered

Signed.....

Date.....

MODULE 4

ORGANISATION OF A DUTY

PRESCRIBED REFERENCE:

Supplementary Training Material

OBJECTIVES:

8.1 Having studied the training material, discussed the topic with others and satisfactorily answered the topic questions, the St. John Member will be able to organise and set up a Public Duty.

SUPPLEMENTARY TRAINING MATERIAL

Types of duties — (Operation's Branch Definition):

1. **District duties:**
   Organised by H.Q.
   — usually involving several Corps.
   — rooms and areas already selected.
   — people are allocated to these areas.

2. **Corps duties:**
   Organisd by Corps Staff.
   — usually involving several Divisions.

3. **Divisional Duties:**
   Organised by the Division
   — using its own personnel, but can ask for help from other Divisions.

Accepting a duty:

Information Needed:

1. Time
2. Date
3. Place
4. Duration of Duty
5. Map reference
6. Name of organisation in control
7. Name of person to contact re duty
8. Phone number of person to contact re duty
9. What type of function
10. Number of people expected to attend — participants, audience
11. What facilities available — room, lighting, water, toilets, etc
12. Has this function been held before
13. If so — what type of injuries then
14. Are meals available
15. Are facilities available to buy meals
16. Check communication facilities — phone, radio
17. What other organisations are involved — ambulance, police etc.
18. Medical facilities nearby and available at time of duty

Types of Duties — (re equipment needed):

As per regulations St. John members will at all times carry their own approved First Aid Kit.

On many large duties e.g. football finals, cricket, fun festivals, equipment will be provided for members to use, but you will also have your own kit in case back-up equipment is needed or you need to use it on the way to or from a duty.

Extras which may be needed:

Beach
— extra eye washing equipment,
— foot washing equipment,
— umbrellas.

Hills
— washing equipment (duty may be muddy),
— towels — blankets.

Marches
— extra drinks,
— extra water,
— extra equipment for treating blisters.

Fires
— extra eye washing equipment,
— foot washing equipment,
— extra paracetamol for headache,
— extra water to drink.

Athletics
— extra drinks,
— extra ice,
— extra strapping,
— crepe bandages.

(the above are some examples)

NOTE: Operations Branch Circular 7/89 lists items approved by the District Surgeon for addition to the standard kit list.

On Arrival at a Duty:

Working from Operations

Parked in Safe Position

Opening away from wind and weather

Safe step up into vehicle

Set out equipment in vehicle

Check oxygen & suction equipment

Adequate light.

Casualty Room

Sign Posted

Clean as possible
— sweep and wipe down

Needs:

— Water for washing
— Lighting
— Tables
— Seating
— Blankets
— Stretchers away from entrance
— Rubbish bin or bags
— Communications

Set up Areas for:

May be same area on Small Duty

— Triage
— Admitting Patients
— Discharging Patients
— Sitting Patients
— Lying Patients
— Relatives
— Records
— Equipment
— Hand Washing for Personnel (away from treatment areas)

— Check oxygen and suction equipment in the room.

Let organisers know your Position.

Sign post it.

Organisation of Personnel in Room:

Have Roster

Members 1, 2, 3, 4, etc.

Work per numbers, one member to each casualty as they enter — unless it is obvious that more staff are necessary. Otherwise, wait to be asked by person attending casualty.

Know Capabilities

If asked to treat a casualty and it is beyond your ability, say so; ask if you can observe other member who will then treat, to learn yourself.

Supervision and Teaching at Duties

If a doctor is present, they are in charge of the treatment given in the First Aid Room. If no Doctor present, then an S.R.N. will take charge.

DR's, SRN's and AMBULANCE OFFICERS — should supervise and teach members of the Operations branch. (USE OF THE TRAINING PROGRAMME SHOULD BE ENCOURAGED).

Senior members should always supervise and teach new members and cadets.

New members and cadets should not learn or practice on people with very painful or serious injuries —
e.g. — large burns
— multiple fractures

These people need the most experienced treatment available.

Reception of Casualties:

TRIAGE ➤ done by a receiving person most senior medical, nursing or ambulance person available on duty. → N.B. Not done by duty officer. His/Her duty is administration.

OBSERVE ➤ Casualty on his approach

FIRSTLY ➤ Lie Down

➤ or Sit Down

THEN ➤ Ask Name

➤ Ask Complaint

KEEP ➤ People who deliver casualty to First Aid Room

TO GET ➤ History
➤ Where found
➤ What treatment already given
➤ Known medical history
➤ Assist with disposal of casualty
➤ Assist with calling for assistance

CASUALTY

LOOK AT → LIE DOWN or SIT DOWN

Ask name

Ask complaint

Take history

Ask symptoms

Check signs

Treat

Record

T.L.C.

ONGOING ADVICE

→ HISTORY

Take Record:-

— How it happened

— Where it happened

— When it happened

— Has it happened before

— Medical history

Note symptoms and signs

Seek help if necessary

Treat

Advice to casualty

Disposal: 1. Back to Function
2. To Home
3. To Hospital
4. To Local Doctor

FOR TEACHING

If patient not too ill, ask him if other Operations Branch members can observe his injuries.

ALLOW PATIENTS PRIVACY IF NECESSARY

Very elderly females may prefer a female treating them, or very young males may prefer a male treating them, if possible.

Very heavy, very drunk or very rude casualties. Male members can help here.

PATIENTS' VALUABLES AND BELONGINGS

Check all belongings are looked after and transferred with patient.
e.g. money — check with another member if necessary.
handbags
shoes
coats — old torn coat may be only coat patient has.

INFORMATION

Keep the casualty's relatives or friends informed on his condition (with patient's permission). Be polite to them at all times.

COMMON TREATMENTS:

HEADACHE

Ask Why ➤ — Out drinking last night.
— Sitting in the sun.
— Fell over and hit head.
— Has high B.P. etc.

Ask ➤ — Age.
— ? Allergy to paracetamol.
— ? When did he last have tablets.

NO to ? ➤ Give paracetamol tabs and record.

CARE OF WOUND

Ask History ➤ Look for foreign bodies. If loose, remove. → Check they are not allergic to sticky plaster
Control bleeding.
— if no bleeding, → Area dry
Clean and dry wound.
Apply dressing. → Keep plaster off hair, eyebrows etc. if possible.

ONGOING ADVICE TO CASUALTY:

WOUNDS ➤ — Keep dry.

— Change dressing in 24 hours.

— If it becomes red, sore, swollen or starts throbbing or red line running up the limb,

SEE OWN DOCTOR PROMPTLY — check TETANUS COVER.

WOUNDS FOR SUTURING ➤ — Do not paint with coloured dyes e.g. mercurochrome or Tinct Benz Co. (Can't see to suture.)

Tell casualty to go to own doctor or hospital as SOON as possible — check TETANUS COVER.

SPRAINS ➤ — Continue to apply ice or cold pack in wet towel for 15 minutes.

— Apply firm bandage — check circulation
— remove if becomes too tight.

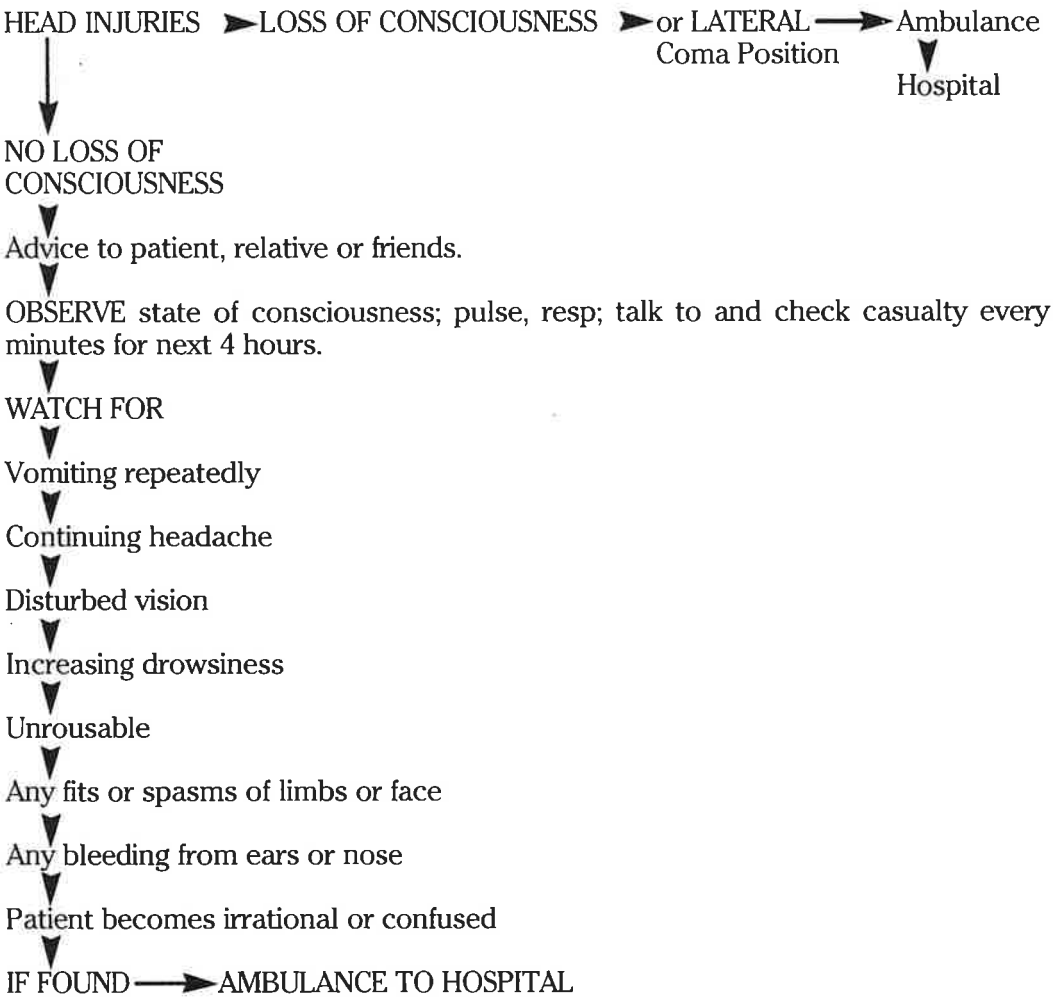
— Tell patient not to bear weight for next few hours.

— If pain or swelling persists or becomes worse or there is loss of function,

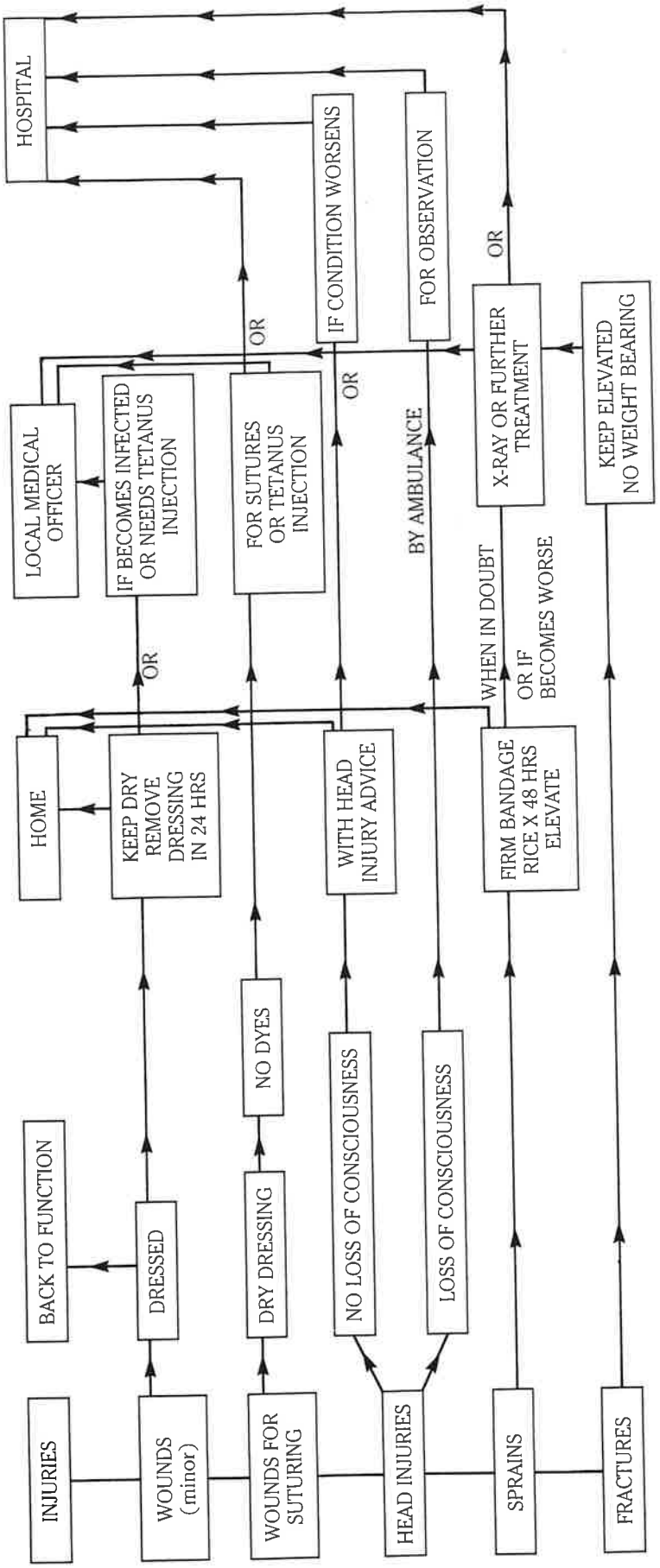
GO TO OWN DOCTOR.

— Instruct patient to apply ice (20 minutes on, 20 minutes off) over next four hours then 20 minutes on every four hours up to 48 hours.

ONGOING ADVICE TO CASUALTY:



DISPOSAL


INJURIES
WOUNDS (minor)
WOUNDS FOR SUTURING
HEAD INJURIES
SPRAINS
FRACTURES
BACK TO FUNCTION
DRESSED
DRY DRESSING
NO DYES
NO LOSS OF CONSCIOUSNESS
LOSS OF CONSCIOUSNESS
HOME
KEEP DRY REMOVE DRESSING IN 24 HRS
WITH HEAD INJURY ADVICE
FIRM BANDAGE RICE X 48 HRS ELEVATE
KEEP ELEVATED NO WEIGHT BEARING
OR
LOCAL MEDICAL OFFICER
IF BECOMES INFECTED OR NEEDS TETANUS INJECTION
FOR SUTURES OR TETANUS INJECTION
IF CONDITION WORSENS
FOR OBSERVATION
BY AMBULANCE
WHEN IN DOUBT
OR IF BECOMES WORSE
X-RAY OR FURTHER TREATMENT
HOSPITAL

RECORDS

Casualty record forms as laid down by the Operations Branch regulations must be filled in accurately:

White copy is to be given to casualty.
Blue copy is to be kept by member managing the casualty.
Pink copy is to be kept in Duty Records.

(Copy on following page).

OBSERVATION CHARTS

Please remember to hand on copy of observation and history taken on casualty when transferring him to his local Medical Officer or to hospital casualty section. (Give to Ambulance Officer.)

CALLING FOR AN AMBULANCE

Identify yourself.

▼

Location ► State address — nearest cross street, suburb.

▼

How many patients.

▼

State type of injuries or illness.

▼

Give call-back phone number — This assists Ambulance service to check location if necessary.

▼

If possible have person to guide in Ambulance.

▼

State if Police or Fire Brigade needed.

▼

Give history and observations to Ambulance Officer.

▼

Hand over belongings to Ambulance Officer.

IF HOSPITAL TREATMENT NEEDED FOR CASUALTY ARRANGE TRANSPORT AS SOON AS POSSIBLE **DO NOT DELAY.**

CHECK Arrangements for ordering of Ambulances. On large or combined duties usually done through duty officer only.

N.B. FOR OPERATIONS BRANCH RECORDS ⟶ Take Ambulance number also Ambulance Case number and Destination.

CASUALTY REPORT

St. John Ambulance Australia

LOCATION OF DUTY		TIME	DATE	
SURNAME OF CASUALTY	GIVEN NAMES	TITLE	D.O.B.	SEX
ADDRESS OF CASUALTY			POSTCODE	

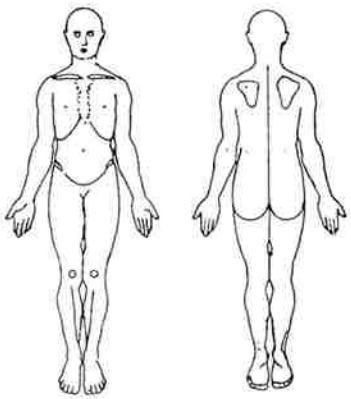
FIRST AID ASSESSMENT AND OBSERVATIONS

LEVEL OF CONSCIOUSNESS			
TIME	FULLY CONSCIOUS	CONFUSED DROWSY	UNCONSCIOUS

TIME	PULSE	RESP.	L PUPILS R	

KEY TO CODING

A—ABRASION
B—BURN
C—CONTUSION
D—DISCOLOURATION
F—FRACTURE
H—HAEMORRHAGE
L—LACERATION
P—PAIN
R—RIGIDITY
S—SWELLING
T—TENDERNESS



COMPLAINTS/SYMPTOMS/HISTORY

GENERAL OBSERVATIONS

FIRST AID MANAGEMENT

REFERRAL FOR MEDICAL ADVICE

HOSPITAL (BY AMBULANCE) ☐ HOSPITAL (BY CAR) ☐ OWN DOCTOR ☐

SIGNATURE OF ST. JOHN MEMBER	DIVISION	DISTRICT

White: to CASUALTY for DOCTOR **Pink: to DIVISION** **Blue: Retained by MEMBER**

CLEAN UP

Pack away all equipment not used.

▼

Clean up any equipment used and leave ready for further use.

▼

Empty rubbish containers.

▼

Clean area.

REPORTING OFF

To Duty Officer. ⟶ To Organisers of function.

▼

To Radio Control.

NOTIFYING HEADQUARTERS

It is not necessary for most incident reports to be notified to Headquarters. However, a copy of any incident reports about cardiac arrests, deaths and any occurrence where legal action is expected, should be forwarded to Headquarters so that appropriate records and legal advice can be assured.

TREATMENT FOLLOW UP

DISCUSS BACK IN YOUR OWN DIVISION

▼

Injuries or illness experienced — management carried out.

▼

If you have treated a patient but are not sure if your management was correct, check —

Divisional Surgeon
Divisional Nursing Officer
Divisional Ambulance Officer

OR

Through the chain of communication up to the District Surgeon.

Stress counselling, especially following care of seriously injured or ill, or in event of unsuccessful C.P.R.
— CRISIS INTERVENTION
— CARING for the CARER

REMEMBER

Casualty *care* at all times.
The casualty is entitled to the best first aid available.
Our job is to look after them.
OR to refer them.

QUESTIONS

	SATISFACTORY	
	TICK	DATE
1. List the information you would need to know in relation to requirements for a Pony Club Duty		
2. What extra equipment would you require if attending a bush fire.		
3. What ongoing advice should you give a patient who has had a head injury with no loss of consciousness		
4. Why should you not put mercurochrome on a wound that has to be sutured		
5. When sending a patient to hospital by ambulance, what infomation for recording purposes should be obtained		
6. Draw up a check list you could use to obtain information for a basketball duty		
7. Draw up a check list for the preparation of a First Aid Room		

MODULE 5

PATIENT CARE AND COMFORT

AIMS:

To prepare the member to give appropriate measures to ensure patient comfort, safety and well being.

OBJECTIVES:

At the conclusion of a period of instruction, the members will be able to:

1. REST AND SLEEP
   — list the basic needs of any sick person, and reasons for needing adequate rest and sleep and psychological support.

2. NUTRITION
   — list the daily nutritional needs of sick person and describe the preparation and serving of appropriate meals.

3. PROTECTION
   — demonstrate safe and effective patient care techniques including:
   - making an occupied bed in the home or first aid room.
   - changing the bed linen on an occupied bed.
   - lifting and moving a sick person up or down the bed, stretcher, trolley, etc., from bed to chair and back to bed.
   - care of pressure areas and preventive measures.
   - use of various aids for a sick person's comfort.

4. ELIMINATION
   — administration of bedpan.
   — administration of urinal.

PRESCRIBED REFERENCES:

In addition to the references listed throughout this section, members are referred to the new series of 22 pamphlets, *Family Care at Home*, which St John Ambulance Australia is currently publishing and which are expected to available by early 1990. These effectively replace *Care of the Sick in the Home* (1981).

PART 1 — REST AND SLEEP

PRESCRIBED REFERENCE:

Supplementary Training Material

SUPPLEMENTARY TRAINING MATERIAL

Adequate rest and sleep are essential for a person to awake feeling physically energetic and mentally refreshed. A sick person needs more rest than a healthy person, to restore energy that has been used fighting illness and infection. Rest, in itself, is restorative without sleep. It is necessary for a person to sleep but a person who has difficulty sleeping should be encouraged to rest as much as possible.

A person has most difficulty sleeping when his regular pattern is disturbed so it is necessary to examine his regular habits and keep them as close to normal as possible.

Other causes of wakefulness:

Environmental
- change of room
- temperature of room
- smells in room
- amount of light in room

Discomfort
- unfamiliar nightwear to sleep in
- wrinkled, or untucked sheets
- crumbs in bed
- bedclothes too heavy or too light
- full bladder, especially during night
- indigestion
- coughing

A lack of change in scene may heighten any discomfort.

Hunger and Thirst
- in the middle of the night
- stimulants e.g. tea, coffee last thing prior to settling
- due to fever

Noise
- made by the person caring for the sick
- in radiators or air conditioners
- doors shutting quickly
- absolute quiet can also be disturbing

Pain
- may be increased by any of the above

Alleviating these problems may be a simple matter that will allow the drowsy patient to relax and eventually fall asleep.

Emotional
- consideration should also be given to the patient's mental well being. There may be factors causing added restlessness which you may not be aware of and gentle questioning may be necessary to find the cause of this. Some factors are:
  - cultural differences
  - language difficulties
  - dietary problems
  - family worries — financial
    — job security
  - anxiety regarding illness
  - religious beliefs

Always be aware of the patient's emotional state and do whatever is possible to relieve anxieties.

PART 2 — FOOD FOR THE HEALTHY AND SICK

PRESCRIBED REFERENCES:

Care of the Sick in the Home, St John Ambulance Association Text, 5th Edition, 1981.
Supplementary Training Material

OBJECTIVES:

The Operations Branch member, having READ and DISCUSSED the topic with OTHERS, will be able to:

— Describe briefly the digestive process.
— State the five food groups.
— State five special nutrients and give two food examples from each group.
— State six preventive measures when handling and serving food.
— Define food poisoning.
— Define what is meant by:
  • liquid diet
  • soft diet
  • full diet
— State briefly what is meant by special diet.
— State one example of a special diet.
— State briefly how to feed and care for the sick at meal times.

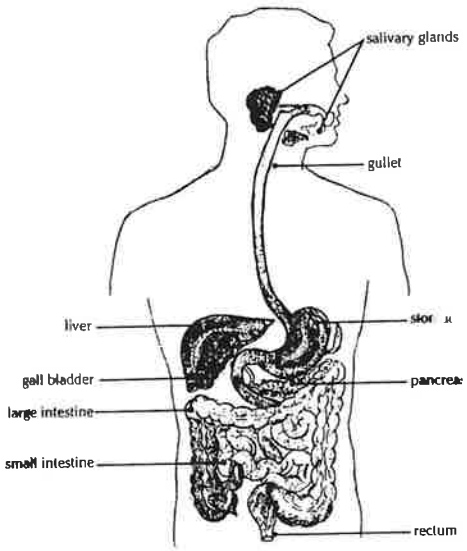
SUPPLEMENTARY TRAINING MATERIAL

INTRODUCTION:

This topic is on food and how we can best supply our body with the correct nutrients, whether it be for the healthy or the sick.

A basic knowledge of the digestive process will provide you with a better understanding of the various diets discussed.

DIGESTIVE PROCESS — ANATOMY — Figure 1



PHYSIOLOGY

Before food can be utilised by the body it must be broken down into simple units.

The simple units are carried in the blood stream to where they are needed or stored for later use.

The process of digestion starts in the mouth and progresses along the digestive tract:

(words marked * are defined later in the topic)

1. MOUTH — Particles of food are ground by a mechanical action with teeth and tongue, whilst at the same time being mixed and moistened with saliva.

   Saliva contains an *enzyme PTYALIN, this enzyme commences the break-down of any cooked starch.

2. OESOPHAGUS GULLET — After the food has been thoroughly chewed it passes down this long straight tube by gravitational forces and *peristaltic action.

3. STOMACH — Upon reaching this pouch-like structure, further mechanical action is undertaken by a churning movement of the stomach muscles, as well as excretion of gastric juices. Proteins are broken down by an enzyme — PEPSIN. When this mixture is a semi-fluid consistency it moves through an opening which is the lower end of the stomach and into the Small Intestine.

Note: 1. The enzyme — Ptyalin still continues to work in the stomach until the acid mixture inactivates it.

This can take several hours.

2. There is also some absorption of water, alcohol and certain drugs in the stomach.

SMALL INTESTINE (3 parts)

4. DUODENUM
5. JEJUNUM
6. ILEUM — The partly digested food is moved along the length of the small intestine by a series of rhythmic muscular contractions (peristalsis). During its progress it is modified further by excretions from the:

   a. Gall Bladder (Bile)
   b. Pancreas (Pancreatic Juice)
   c. Wall of the Small Intestine (Intestinal Juice)

Enzymes contained in the juices aid conversion of

1. STARCH to GLUCOSE.
2. PROTEINS (which have been partly digested in the stomach) to AMINO ACIDS.
3. FATS so they become water soluable.

Absorption of the end products of digestion occurs during the passage of food along the length of the Small Intestine. Any unabsorbed food, (*residue) passes in liquid form to the LARGE INTESTINE.

LARGE INTESTINE — (3 parts)

7. ASCENDING COLON
8. TRANSVERSE COLON
9. DESCENDING COLON & RECTUM — During the passage of the food residue (which generally takes 24 hours or more) most of the water and the remains of the digestive juices are absorbed.
10. ANUS — Controls when the *residue (faeces) is expelled from the body.

    Increase in fibre stimulates the colonic muscular contractions which help promote normal evacuation.

WHAT HAPPENS TO THE "SIMPLE UNITS"?

GLUCOSE	Energy for cellular activity is Stored in liver as GLYCOGEN. Excess glucose converted to fat and stored as *Adipose Tissue.
FATTY ACIDS	Stored as fat deposits or can be broken down by the liver, with glycogen, for energy.
AMINO ACIDS	Carried by blood stream to liver then sent off to the areas requiring repair and replacing e.g. skin.
MINERALS VITAMINS	Are absorbed from the gastro-intestinal tract during the passage of food. However, absorption may not be complete, and elimination is in the faeces and water soluble vitamins by the kidneys.

DEFINITIONS related to digestion.

ENZYME	A protein capable of accelerating or producing some change in a food substance.
PERISTALTIC ACTION	A wave of contraction passing along the gastro-intestinal tract for a variable distance.
RESIDUE	That which remains after all usable products have been absorbed by the body.
ADIPOSE TISSUE	Fatty tissues.

The person giving care:

Needs an understanding of BASIC FOOD REQUIREMENTS and what constitutes a WELL BALANCED DIET.

The Commonwealth Department of Community Services and Health provides a suitable dietary plan for people both sick or well.

The plan divides food into 5 groups:

1. Milk and Milk Products — e.g. cheese and yoghurt
2. Meat and Meat Equivalents — e.g. poultry, fish, eggs, nuts, seeds, lentils, beans, (lima, soya or kidney), peas.

3. Vegetables and Fruit — Both raw and cooked.

4. Bread, Flour and Cereals.

5. Butter, Cream and Table Margarines.

Food contains special nutrients for special purposes.

a) PROTEIN — There are two sources:

— Animal (1st Class Protein) meat of all kinds including poultry

— Vegetable (2nd Class Protein) peas, beans, bread, cereals, nuts. As proteins are a part of every living cell, a supply of this nutrient is vital in your diet for:

i) growth and repair of tissues
ii) replacement of body tissues
iii) formation of enzymes and hormones
iv) formation of antibodies (Immunity from Disease)

NOTE: Not all the amino acids (the simple units of protein) can be made by the body, so it is important we have a good balanced intake of various proteins.

e.g. cheese has an amino acid LYSINE in abundant supply, an "essential" amino acid which the body cannot manufacture.

b) FATS — Are a concentrated source of energy and heat.
These are:

i) Animal fats e.g. butter, cheese, cream, milk.
ii) Vegetable fats e.g. nuts and vegetable oils.

Fats are said to be saturated or unsaturated depending on the type of fatty acids. Also they are an important source of fat soluble vitamins "A" & "D" & "E".

c) CARBOHYDRATES Energy producing foods.

Two Groups:

Sugar — Honey, jam, fruit and other cane sugars.

Starch — Potatoes, flour and foods made from flour e.g. bread, cakes and pastry.

The above are broken down in the body to glucose then used or stored as glycogen in the liver or any excess as fat.

NOTE: The fibres which form the structural part of plants, skins of fruit and the coverings of seeds are made from forms of carbohydrates e.g. cellulose. Recent years have seen an increased awareness of the need for the diet to contain adequate amounts of fibre.

d) MINERALS

The body contains a large number of mineral elements all of which must be obtained in the diet.

They have FOUR main functions:

— constituents of bone and teeth.
— constituents of body cells of which muscle, blood corpuscles, liver and so on are composed.
— as soluble salts, present in a delicate balance in the body — electrolytes.
— as factors in chemical processes taking part in the body such as the release of energy

The main Minerals are:

i) CALCIUM — essential for healthy bones, teeth and blood.

Sources
— milk of all kinds
— milk products
— fish especially salmon and sardines
— some nuts and legumes

ii) IRON — essential for healthy red blood cells to enable them to carry oxygen to all parts of the body.

All cells require oxygen in order to live.

Sources
— meat, especially liver and kidneys dark green leafy vegetables, cereals, especially whole-grain.
— legumes
— dried apricots and prunes

iii) IODINE — essential for normal function of thyroid gland. (This structure is responsible for controlling the rate at which we burn our body fuel).

Source
— fish, some vegetables which are grown in iodine rich soil.

iv) FLUORIDE — works with calcium and phosphorus to assist in healthy development of teeth. Found in most water supplies.

d) VITAMINS

Are complex chemical substances found in a variety of foods. Some of the Vitamins A, D, E, K, are found mainly in fatty foods — FAT SOLUBLE. The other Vitamins, B and C, are WATER SOLUBLE.

Taken in excess of requirements, fat soluble vitamins are stored in the liver, while any excess of water soluble vitamins will usually be excreted in the urine.

i) VITAMIN A — for healthy development and function of the eyes. Gives a high resistance to infection by maintaining a healthy lining (mucous membrane) in the air passages.

Source
— liver and kidneys
— fish liver oils
— eggs
— whole milk and whole milk products
— butter and fortified margarine.

Certain fruits and vegetables also possess Vitamin A in the form of CAROTENE. This is a yellow pigment that is converted in the body into Vitamin A. It is found in yellow fruits and vegetables and green leafy vegetables.

The darker the leaf, the more carotene present.

e.g. apricots, pumpkin, mangoes, silverbeet, carrots, spinach, paw paw, rockmelon.

ii) VITAMIN B GROUP — responsible for healthy skin, nerves, blood and a healthy digestive system.

Sources
- wholemeal cereals
- eggs, liver, nuts and yeast extracts
- meat e.g. liver, kidney, pork and ham
- beans

iii) VITAMIN C — essential for the normal function of tissue, to maintain healthy gums and to aid the healing of wounds.

Sources — lemons, oranges, grapefruit, pineapple, strawberries, tomatoes, green vegetables, e.g. green peppers.

iv) VITAMIN D — Necessary for strong bones and teeth.

Sources
- cod liver or shark oil
- butter
- eggs

BUT: Sunlight falling on the skin causes the formation of Vitamin D in the body, and is our major source.

v) VITAMIN E — helps to protect cells from damage and degeneration.

Sources — wheatgerm, oil, cereals, egg yolk.

WATER

It is needed for every chemical process in the body.

NOTE: The diet should be a varied one as no food contains all of these ingredients. The amount of food we need depends on sex, age and occupation of the person.

As a general rule, men eat more than women, older persons eat less than the younger, heavy or manual workers eat more than persons who sit or carry out light duties.

HANDLING AND SERVICE OF FOOD

Anyone handling food has a *responsibility* to the receiver to maintain correct hygiene as well as proper housekeeping techniques.

Prevention of "disease".

Preventive Measures

- Wash hands before and after attending patients.
- Personal cleanliness — clean clothes, aprons, towels, dish cloths.
- Clean, short nails.
- Wash eating and cooking utensils thoroughly after each use in hot soapy water, and rinse in clean water.

— Don't let food stand at room temperature for long periods.
— Food is best stored in a refrigerator.
— Protect food from dust, flies, other insects and rodents.
— Handle dishes and utensils correctly.
— Store crockery in dust-proof cupboards.
— If possible, avoid preparing and serving food if you have sores on face or hands; otherwise wear gloves and cover wounds.
— No smoking.

NOTE: when serving food it should be nourishing and look attractive in colour and presentation.

Food must be clean and free from harmful substances. These harmful substances sometimes enter food during preparation. The substances may be bacteria or their poisons which produce disease.
Bacteria need suitable nourishment, moisture, the right temperature and time to become harmful.

What is Food Poisoning?

This is a condition which occurs when a person eats food which has been contaminated by bacteria. Contamination commonly occurs in food which has been allowed to cool and reheated but not recooked. Either the bacteria themselves or the toxins produced by them cause the sickness.

Foods which are most commonly affected by the bacteria (salmonella, staphylococci) are:

— pies, pasties, potted meats, poultry
— fish — shell e.g. oysters, prawns
— milk — alone, and in cream, custard
— duck eggs

FOOD FOR THE SICK

The person who is caring for the sick will be given orders by the doctor on the type of food he or she wishes the patient to have. Diets he or she may prescribe are as follows:

NOTE: In large hospitals and before the patient is sent home, the dietitian may give the advice required.

The Liquid or Fluid Diet

Often required for those persons who are acutely ill e.g. high temperature, severe nausea or vomiting, persistent diarrhoea.

Patients who are on a liquid diet are to have both intake and output of fluids measured and recorded.

It is vitally important that nourishing fluids are given to encourage the patient to drink, as well as maintain fluid balance in the body.

e.g.
— strained fruit juice and soups
— weak tea or coffee
— thin custards; cooked cereals can be thinned with milk.
— egg flips, jelly.

The addition of honey or glucose powder to fruit or vegetable juice gives additional energy value and the addition of salt maintains the mineral or electrolyte balance.

Concentrates of powdered protein or powdered milk can be added to fluids in high protein diets.

As the illness subsides the patient will progress to a soft, light, or full diet.

Soft Diet

Soft easily digested foods of high nutritional value are permitted.

e.g.
- softly cooked eggs
- cooked cereals
- chicken
- fish
- bread/butter

The usual family meals may be converted to a soft one by the use of a food processor or a sieve.

Light Diet

This is a modified full diet. The serves are usually smaller. Avoid — fried food, cabbage, onions, spices and condiments.

The Full or Regular Ordinary Diet

The patient may have any food desired. It is necessary to choose food from all groups previously discussed in order for nutritional requirements of the body to be met.

Special Diets

Modified or special diets are often needed by patients with such conditions as:

- Diabetes Mellitus
- Certain Heart conditions
- After certain operations on the bowel
- Terminal conditions
- Bowel disorders, e.g. Ulcerative Colitis
- Ulcer problems
- Gall bladder disorders.

People with any of the above disorders can get help either from their local doctor or dietitian or from the specific foundations, clubs or associations which have members with similar problems. e.g. Diabetic Association, Cystic Fibrosis Association, Ileostomy Association etc.

Special points to remember when preparing and serving food

The type of food permitted should be selected and prepared for cooking with care as to its quality and appearance.

Serve meals attractively and as punctually as possible.

See that hot foods are served hot, and cold meals cold.

How to care for the Sick at Meal Times

- Prepare the patient before the meal is served.
- Offer toilet facilities.
- See that the patient washes their hands (small disposable wash cloths in packs are available if expense is not a problem for the patient).
- Position the tray conveniently and safely for the patient to reach.
- Provide any eating aids required.
- Give assistance if necessary.

— Remove the tray promptly after patient has finished.
— Finally, note whether the patient has eaten the meal and write down the amount of liquid taken if this is required.

How to Feed a Patient

— Wash hands
— Give small amounts of food from tip of fork or spoon — use spoon if patient is restless.
— Feed slowly, never give the sick person a feeling of being rushed.
— Allow enough time between each mouthful for the food to be chewed and the patient to rest a little.
(Talk quietly to the patient at this time).
— If liquids cannot be taken directly from a cup or glass, use a drinking straw (preferably a plastic disposable one).
— Wipe their lips clean with serviette as necessary.
— Clean teeth as soon as possible after the meal.

NOTE: If the person is able to assist in any way, allow them to do so.

If the person is blind or unable to see the tray for any reason, explain what food is on the plate.

This usually stimulates interest and appetite.

Feeding the Aged

As a person advances in years, their appetite diminishes, as activity is decreased.

This is why it is vital for the aged to have a good balanced diet in the small amount of food they consume; otherwise tiredness, inability to sleep, anxiety and depression will be noticeable.

An organisation, "Meals on Wheels", is valuable to the aged who can't cope with cooking, as they are given one full meal per day at a minimal cost.

FEEDING CHILDREN

Sick children often reject food, so it is necessary to make sure their fluid intake is maintained as discussed in a previous section on diets.

Once their illness has passed, offer small amounts of food, gradually building up to their normal diet.

QUESTIONS

CHECKLIST	SATISFACTORY	
	TICK	DATE
1. Briefly describe the digestive process		
2. Name the five food groups		
3. Name five nutrients and give two examples from this group		
4. Give six preventive measures when handling and serving food		
5. What is Food Poisoning?		
6. Briefly explain — liquid diet — soft diet — full diet		
7. What is a Special Diet?		
8. Give six important points when feeding and caring for the sick at meal times.		

PART 3 — BED MAKING

PRESCRIBED REFERENCES:

Supplementary Training Material

INTRODUCTION:

This procedure is vital for the comfort of a patient.

OCCUPIED BED

— Allow good movement around bed by
  • removing bed tables, etc.
  • or pull bed away from wall.

— Provide a container for soiled linen.

— Instruct patient before procedure to gain maximum co-operation.

TO REMOVE TOP LINEN

— Remove bed spread — fold neatly place over back of chair.
— Loosen blankets and sheet from under mattress.
— Each item is removed separately and folded neatly into three or four sections, place over back of chair.

— Leave last blanket to cover patient.
— From under this, the top sheet is drawn downwards and folded if clean.
— Remove all but one pillow and place on the chair seat, note patient's respiration whilst lying with one pillow.
— Remove any other articles at this stage from bed, e.g. bed cradles, air/foam cushions.
— Check that mattress is up towards head of bed.
— Ask patient to roll to far side of bed with head supported on a pillow.
— Have a person support patient if warranted.

NOTE: Do not let linen touch floor.

TO REMOVE BOTTOM LINEN

— Remove crumbs.
— Untuck lower linen.
— Roll each piece in separately to centre of bed.
— Place bottom sheet in position, roll to centre. Mitre corners.
— Patient rolls over the bulk of folded linen in centre of bed and moves back towards the completed side; bring pillow for patient's head to rest upon.
— Make sure bottom sheet is taut.
— Roll patient back to centre of bed.
— Re-adjust pillows for comfort e.g. more than one if applicable.
— Note patient's items replaced e.g. foam cushions.
— Replace top sheet.
— Take blanket from beneath top sheet towards bottom of bed and then replace it over sheet to prevent chilling.
— Form 5cm pleat in top sheet, then tuck in.
— Replace remaining blankets and bed spread.
— Remove soiled linen in a container.
— Replace bed in right position if applicable, as well as articles moved prior to procedure.

PRACTICAL SKILLS MASTERED

SIGNED .....

DATED.....

UNOCCUPIED BED

Pre-requisite — knowledge of how to mitre a corner of a sheet/blanket.

Introduction — Mattress must have a firm base:

- improvise if necessary e.g. hard wooden slats.
- pull mattress to top of bed.

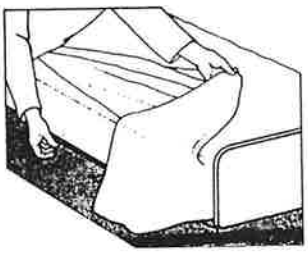
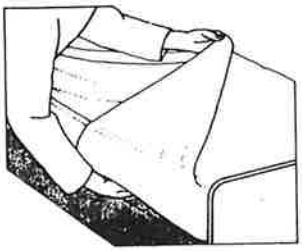
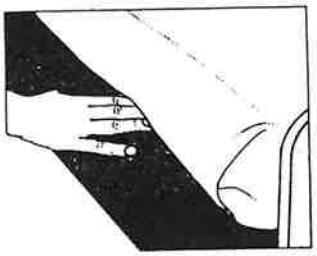
BOTTOM LINEN

— Apply mattress-cover over mattress securely.
— Place plastic protection in position.
— Place bottom sheet on bed, hem smooth side up, making sure equal amounts of sheet on each side of bed.
— Pull tightly — noting to allow sufficient sheet to hold securely over the head of mattress.

— Facing the head of bed, mitre the corner of the sheet to tuck in.
— Repeat for other side.
— Straighten sheet — making sure there are no wrinkles.
— Tuck the sheet under the mattress at the bottom.

NOTE: If drawsheet to be used, it is placed in position now, as well as any articles to be utilised for relieving pressure on patients legs e.g. sheep skin rugs, booties for heels, or lightly inflated wine cask bags.

Making mitred corners

TOP LINEN

— Place top sheet on bed, hem wrong side up, extend it about 15cm above the head of the mattress. (Later used to fold over the blankets as a protection).
— Grasp sheet in the centre, make a pleat 5cm (2 inches) deep.
— Tuck sheet under mattress at the bottom end and mitre corners.
— Tuck sides of the sheet under the mattress to halfway up the bed.
— Place blankets on singly, top edge just below top of mattress. At foot of bed they are turned under in the same way as for sheet.
— Fold top sheet over the blankets.
— Place pillows in position.
— Place bed-spread on the bed to cover pillows at the top; lower ends and sides hang free and evenly.

PRACTICAL SKILL MASTERED

SIGNED .....

DATE.....

PART 4 — LIFTING A PATIENT IN BED

PRESCRIBED REFERENCES:

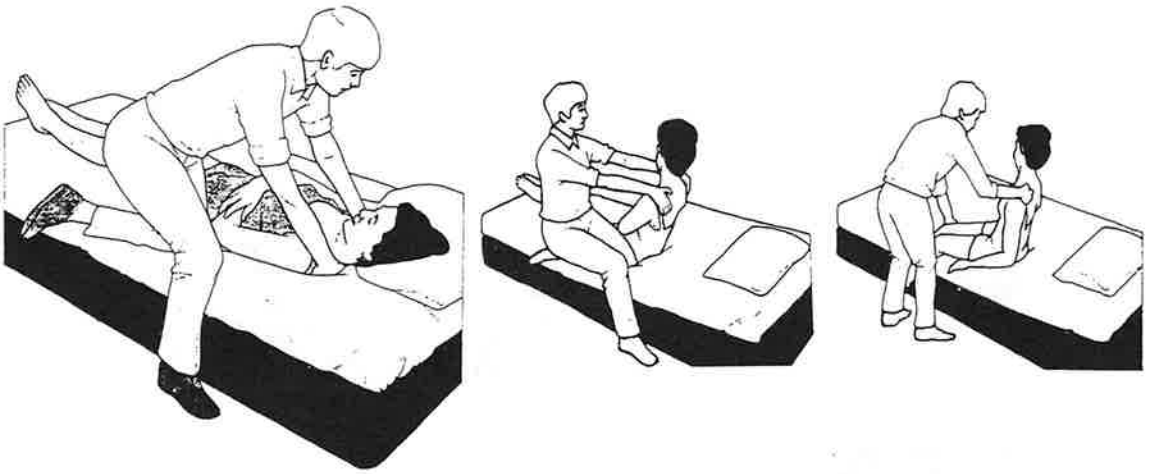
Supplementary Training Material

INTRODUCTION

A patient who is in bed for prolonged periods requires frequent position changes to alleviate pressure problems. In moving the patient it is necessary to avoid causing further problems by dragging the patient up or down the bed. Correct lifting procedures will ease a patient's discomfort, without endangering the health of the person doing the lifting.

SITTING A PATIENT UP IN BED

— Explain procedure to patient.
— Clear floor area around bed, especially any loose rugs.
— Place your inside knee on the bed near patient's hip and out-side foot firmly on floor with knee bent.
— Keeping arms straight, place both hands under patient's shoulder blades.
— Gently sit back on heels pulling the patient into a sitting position.
— Lift back against pillows and make comfortable.

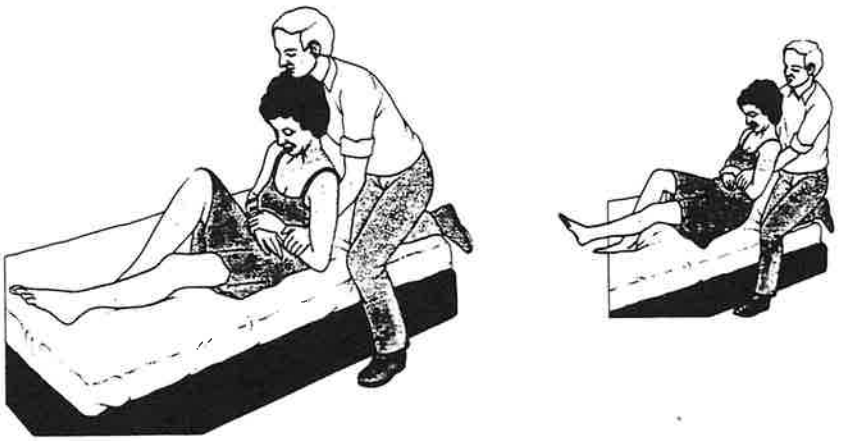


LIFTING PATIENT UP BED — BY YOURSELF

(if possible all lifting should be done in pairs)

— Sit patient up (as above).
— Position yourself at patient's back.
— Place one kneee on bed behind and beside patient.
— Other foot firmly on floor near bed.
— Patient grasps her own wrist with arms across waist.
— Slide your arms under patient's armpits and grasp patient's forearms.
— Patient bends one knee in preparation to push down as you lift.
— Sit back on heel, at the same time pushing down with foot that is on the floor and getting the patient to push with her bent leg, thereby lifting her back in the bed. She should end in a position near your knee that rests on the bed.

It may take several attempts to lift the patient high enough in the bed for comfort.



LIFTING PATIENT WITH TWO PEOPLE

— Sit patient up as above.
— It is necessary to have one person on each side of the bed.
— The lifters stand facing the head of the bed with their feet apart and knees bent, the back is kept strainght.
— Grasp helper's forearm under patient's thighs placing your shoulder in patient's armpit. Your helper is to do the same on the other side.
— Place outside hand on bed at position you will move patient to.
— Patient's arms rest down your backs.
— On count of "3" lift patient off bed taking some of patient's weight on outside hand and carry patient forward by pushing with your legs and carrying your body forward.

When lifting a person up a bed that is too high or too low or when the lifters are of unequal height then:

— each person places inside knee level with patient's hip on the bed, outside foot on the floor.
— sit back on heel then continue lift as above.

OBJECTIVE

After practising the practical skill below (to the satisfactory performance level as per the module skill sheets) the Operations member will be able to apply this skill to the Section's mock practical incident.

PRACTICAL SKILL

Transfer a Patient From Bed to Chair.

Stores Required: — Chair
— Bed
— Blanket
— Dressing Gown
— Slippers

TRANSFER A PATIENT FROM BED TO CHAIR

CHECKLIST	SATISFACTORY TICK
1. Assess patient's capabilities.	
2. Explain the procedure.	
3. Prepare patient e.g. offer bedpan, place slippers and gown nearby.	
4. Position chair next to bed.	
5. If one person assisting: — sit patient upright. — slide legs over side of bed. — put on dressing gown and slippers. — help patient slide from bed to standing position. — hold chair steady. — place patient's hand on far side arm of chair (if chair has arms). — pivot patient slightly on his/her feet into position to lower into chair. — place feet together. — cover patient's legs with blanket if necessary.	
6. If two persons assisting: — sit/lie patient along edge of bed. — one assistant stands behind the chair and grasps the upper body of the patient on the bed by placing his/her arms under the armpits and locking them across the chest of the patient on the bed. — one assistant stands in front of the chair and supports the thighs and legs of the patient on the bed. — together, gently LIFT patient off bed and lower into chair. — put on dressing gown and slippers. — place feet together. — cover patient's legs with blanket if necessary. NOTE: Always keep your back straight and lift with your legs.	
7. Don't leave patient in a draught.	

PRACTICAL SKILL MASTERED

SIGNED .....

DATE.....

PART 5 — PRESSURE SORES

PRESCRIBED REFERENCES:

Supplementary Training Material

OBJECTIVE:

To be able to recognise and manage the areas of the body which are subjected to unrelieved pressure, causing lack of blood supply to the tissue, leading to pressure sores.

INTRODUCTION

Areas most likely to be affected are:

i) Where the bone is near the surface of the body e.g.
- — head — back of skull.
- — upper back — shoulder blades.
- — lower back — over the spine,
  - — over sitting areas e.g. buttocks.
- — hips, knees.
- — ankles and heels.

ii) Where two skin surfaces are in contact e.g.
- — under breasts
- — in folds of buttocks
- — behind knees
- — in crevices formed in groin
- — in bend of elbows.

PREVENTION OF PRESSURE SORES

Relieving pressure:

- — know how and why to turn patient every 2 hours
- — positioning — on alternate sides then back every 2 hours
- — protection — of bony areas by
  - foam
  - pillows
  - cushions
  - sheepskins
  - foot boards
  - light, loose top bed clothing etc.

Remember:

Once pressure sores occur they are difficult to treat and can take a long time to heal.

NOTE: Rubbing the skin DOES NOT prevent pressure sores. Excessive rubbing can cause skin damage.

Eliminating Friction

- — Know technique of carefully positioning patient without dragging them e.g. correct lifting technique should be implemented.

Eliminating Moisture

— Ensure the bed linen and bed attire are not soiled or damp.
— Keep the skin clean and dry e.g. urine and faeces must always be washed off skin.

PREDISPOSING CAUSES

Certain patients are more likely to develop pressure sores in the following circumstances:

1. Poor circulation of the blood due to:
   — old age
   — heart disease
   — diseases of blood vessels

2. Malnutrition/poor nourishment due to:
   — insufficient or unsuitable foods (very thin or very fat patients).
   — body's inability to use food to best advantage e.g. diabetes
   — prolonged illness (malignant growths, TB)

3. Immobility due to:
   — the patient to ill to move without help
   — injury to nerves — loss of sensation
   — unconscious patient (but this condition is probably nursed in hospital).

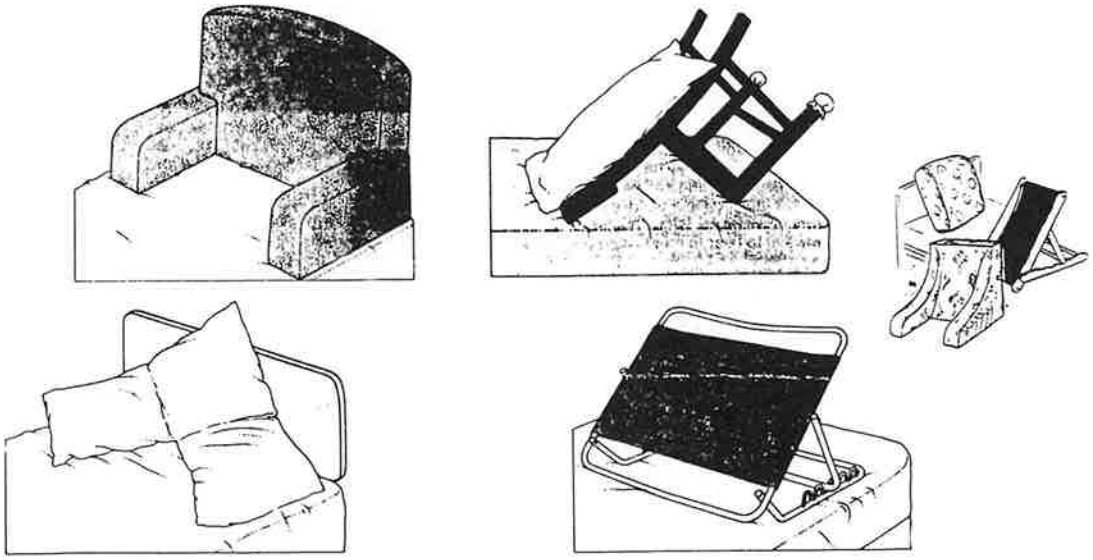
SYMPTOMS AND SIGNS

a. redness
b. tenderness
c. irritation and numbness
d. blistering and broken skin

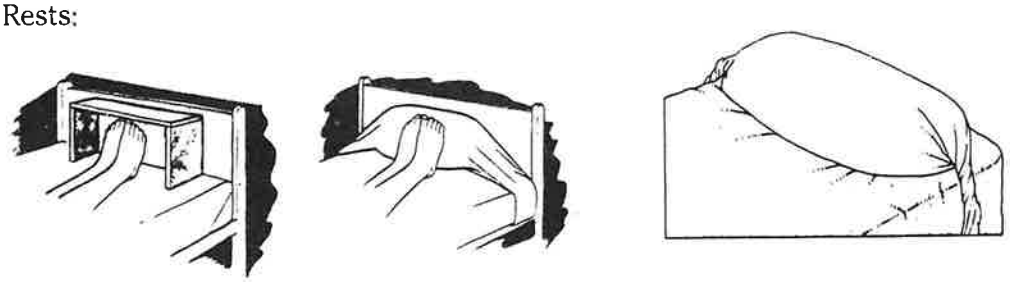
If any of these signs and symptoms are found use methods already described to relieve pressure. If there is no improvement notify visiting nurse or patient's own doctor.

AIDS TO PATIENT COMFORT

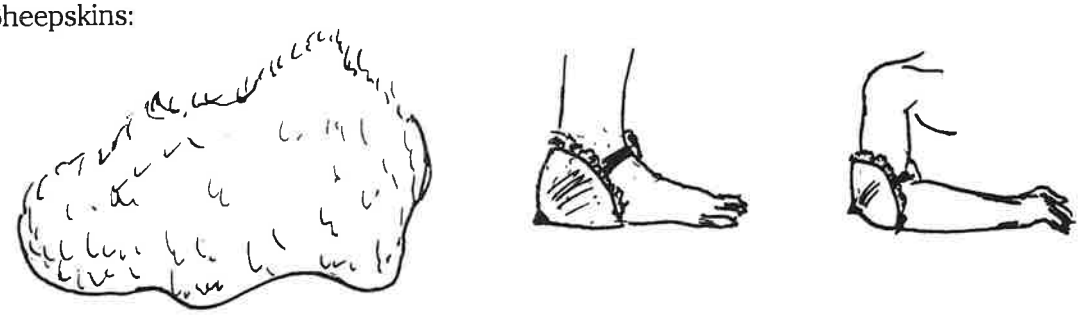
Back Rests:



Foot Rests:

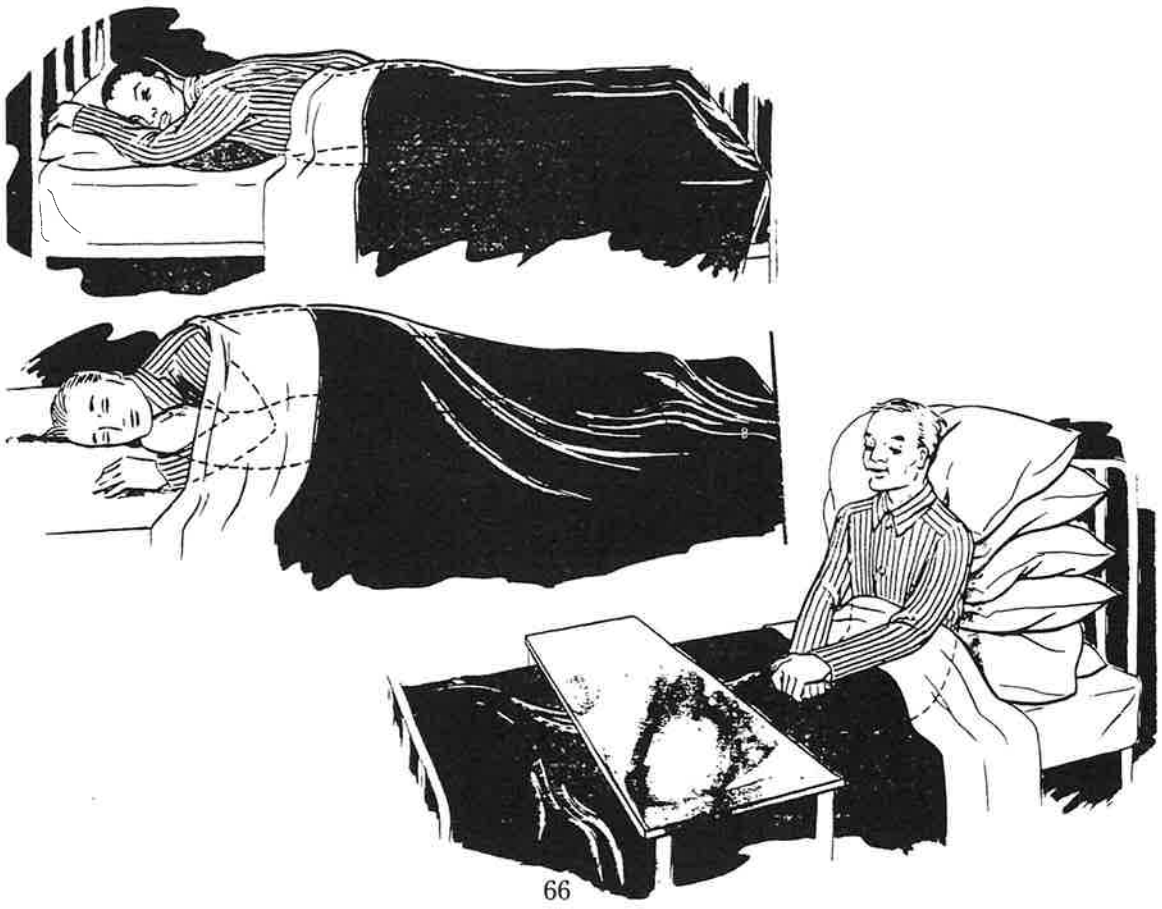


Sheepskins:



Bed Cradles:

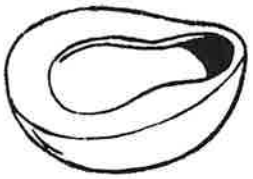
Pillows:



PART 6 — BEDPAN AND URINAL

PRESCRIBED REFERENCES:

GIVING A BEDPAN



CHECKLIST	SATISFACTORY
— Bedpan warm and dry with cover. — Roll of toilet paper at hand. — Ensure privacy. — Assist patient to lift nightgown/remove pyjama trousers — Assist patient to lift him/herself with one hand and slip bedpan in position with the other. — Support their back with pillows. — Once finished allow patient to use toilet paper (unless too ill; then you would assist). — Remove pan from under patient and cover immediately. — Rearrange night clothes and bed linen. — Ensure patient is comfortable. — Allow patient to wash hands. — Remove pan to toilet, empty and rinse well. — Wash own hands.	

GIVING A URINAL

CHECKLIST	SATISFACTORY
— Cover urinal with paper towel etc. — Hand urinal to patient to position. — If patient too ill, position for him. — After use, remove and cover. — Empty into toilet. — Rinse urinal well. — Males may have difficulty passing urine while lying, so if possible they should be assisted to stand beside bed.	

PRACTICAL INCIDENTS

1. Mrs Smith, who has burns to both feet, has been in bed for three hours and requests to sit out in a chair. She is unable to put weight on her feet. You are to shift her from the bed to a chair and change the bed linen while she is sitting out. After completion of changing the bed, Mrs Smith is to be put back into bed.

2. Prepare, and bring to next meeting, an attractive snack.

3. Indicate on a swimsuit-clad model the sites of possible pressure sores in the bedridden patient.

4. Research the community organisations and/or services that are available to you that will enable you to care for an elderly relative with a terminal illness at home. List any equipment you feel may aid this patient's comfort or mobility.

MODULE 6

ASPECTS OF PREVENTIVE FIRST AID

PRESCRIBED REFERENCE:

Australian First Aid Vol. 1 1989 pg. 17-28.

OBJECTIVES:

After completing this Section, the St. John member should recognise the need for a safe environment.

1. Each member should assess his meeting place for hazards. What preventive measures need to be taken?

2. Each member should assess their home for hazards. What preventive measures need to be taken?

List all the hazards in and around your meeting place.

PLACE	HAZARD	CORRECTIVE STEPS

List all the hazards in and around your home.

PLACE	HAZARD	CORRECTIVE STEPS

MODULE 7

PRESCRIBED REFERENCES:

Supplementary Training Material

OBJECTIVES:

After completing this section, the Operations Branch member will be able to recognise and give emergency care to persons affected by drugs and alcohol.

SUPPLEMENTARY TRAINING MATERIAL:

DEFINITION

A drug is a substance that affects the function of part or all of the body.

TYPES OF DRUGS

Many drugs are harmless or even beneficial to most people most of the time, if taken in small quantities, eg. alcohol, penicillin, paracetamol.

Most drugs are harmful if used in excess, and there are some drugs too dangerous to try even once e.g. L.S.D.

Drugs may be legal, like tobacco, alcohol, valium; or illegal, like heroin.

They may be obtained legally or illegally.

DRUG MISUSE

Accidental Drug Misuse can occur with children, or adults who forget how many tablets they have taken. Refer to Poisons and Poisoning.

Suicidal Drug Misuse

All people who attempt suicide **must** have expert help for their emotional problems. If one suicide attempt is ignored or unsuccessful, they will try again.

Drug Dependence

Some people cannot function physically or emotionally without the drugs they are used to. The drugs misused most in this way are caffeine, tobacco, alcohol, tranquilisers and heroin. A drug dependent person needs encouragement and support when they stop taking their favourite "poison".

SOME SPECIFIC DRUGS

1. Tobacco

Tobacco is the drug that causes the most health problems in Australia. It is not really a First Aid problem, but prevention is always better than lung cancer or a heart attack. Every time a smoker walks into a First Aid room, we have a great opportunity to educate him or her about their addition. (If cigarettes aren't addictive, why are they so hard to give up?) Recurrent respiratory problems are not only more frequent in smokers, but in the families, especially young children, forced to inhale the smoke — so called Passive Smokers. Cigarette smokers die earlier than non-smokers.

2. Alcohol

Alcohol is misused very widely in Australia, contributing to car accidents and violent crime. An overdose of alcohol in a short time may cause unconsciousness and death; overdose in the long term causes brain damage, liver disease and heart disease.

Alcohol **depresses** brain activity. Too much alcohol will depress the breathing centre of the brain, causing respiratory arrest and death.

Alcohol overdose is especially dangerous

— in teenagers
— in association with other drugs
— in association with a head injury

Signs of alcohol overdose

— vomiting
— slurred speech
— unconsciousness
— respiratory difficulties
— loss of co-ordination

Anyone who is unconscious due to alcohol, **must** be treated the same as **any** unconscious patient:

— DRABC
— stable side position
— urgent medical assistance

Too many people who are left to "sleep it off" never wake up.

3. Tranquilisers

Tranquilisers include barbiturates, sleeping tablets (Mogadon, Rohypnol, Noctec), Valium, Serapax, Ducene, Murelax. These drugs are used for people who want a sleeping tablet or something to "calm their nerves".

An overdose of these tablets is usually not fatal, unless taken with alcohol. Sleeping tablets washed down with spirits cause many accidental overdoses (e.g. Marilyn Monroe).

Management of Overdose

— identify tablets and amount taken
— give Syrup of Ipecac 20ml unless patient is drowsy or unconscious
— coma position
— medical aid

Withdrawal

People taking legally prescribed tranquilisers over a long time may become dependent on them. There may be a severe withdrawal effect if the tablets are stopped abruptly. Any patient who wishes to stop taking these tablets should contact their doctor.

4. Antidepressants

These drugs — including Tryptanol, Tofranil, Sinequan and Doxepin — are used to treat depression. If taken as an overdose, they can cause heart irregularities and cardiac arrest. The patient **must** receive hospital treatment urgently.

5. Aspirin

Aspirin overdose causes:
— vomiting, stomach cramps
— sweating, rapid pulse
— laboured breathing

Management

— induce vomiting with Syrup of Ipecac 20ml
— give plenty of fluids
— hospital treatment

6. Panadol

Panadol, or Paracetamol, is found in many bathroom cupboards. An overdose of only 20 tablets (less in children) can cause severe liver damage, but symptoms may not appear for several days. Medical treatment must be given within FOUR HOURS of overdose to be effective.

7. Asthma Drugs

Theophylline — also known as Nuelin, Theodur, Brondecon — is used in tablet form to treat asthma. A relatively small number of tablets taken as an overdose, can cause heart irregularities and death.

ALL THE ABOVE DRUGS ARE LEGAL. THE FOLLOWING DRUGS ARE ILLEGAL.

8. Marijuana

Marijuana has an effect similar to alcohol, but does not have the same severe overdose effects. It does affect the user's ability to drive safely. It may also trigger off severe psychiatric disturbance.

9. Hallucinogens

L.S.D., Acid and Magic Mushrooms cause hallucinations which may be pleasant or unpleasant. Unpleasant hallucinations — a "bad trip" — causes incredible panic in the mind of the sufferer who may attempt suicide to escape from the thoughts inside their head. The person should be kept calm and secure, with people they trust, until medical aid is available.

10. Heroin

Heroin is a drug from the same family as morphine. Addicts are usually thin, pale and unhealthy, with pinpoint pupils and easily recognised needle marks and bruises at their elbows.

Impurities mixed in with the heroin cause many health problems. Sharing syringes and needles with other heroin users greatly increases the chances of a user catching Hepatitis B or AIDS.

An overdose of heroin leads to rapid unconsciousness and respiratory arrest.

Management

— DRABC
— oxygen if available
— medical aid

11. Stimulants

Stimulants like cocaine (coke), amphetamines (speed) and crack make the user feel happy, energetic, "high", confused and violent. The user is hyperactive, and may injure themselves through trying to do the impossible. Approach them with tact and caution. Caffeine is found in tea, coffee & cola drinks. It is also addictive, and excess can cause tremor, agitation and confusion, whilst withdrawal is associated with headache, moodiness and depression.

12. Inhaled Drugs

Young teenagers who can't afford other drugs sniff the fumes of petrol, glue, paint-thinner and correction fluid. This causes a very exciting "high" — but overdose can lead to fits, unconsciousness and death. Long term abuse results in personality changes and incurable brain, liver and lung damage.

After an overdose, users often have a runny nose, red eyes and act strangely and aggressively.

Management

— DRABC
— oxygen if available
— medical aid

N.B. Additional Reading *Australian First Aid* Vol. 2 1989 pp 21-26.

TOPICS FOR DISCUSSION

1. What is the phone number of Alcoholics Anonymous in your State? Where is the nearest A.A. meeting place?

2. One of your cadets has had a bad year. His parents split up, he dropped out of school, hasn't got a job, has become unkempt and doesn't turn up much for duty. The other cadets believe that he is hanging around with known drug users. How do you, as a Division, deal with this?

3. How can you, as a Division, encourage your members and your casualties to become non-smokers?

4. You work on a car assembly line. A fellow worker confides in you that she was picked up for drunken driving on the weekend, with a reading of 0.15. This woman also drives the school bus to sports events. What do you do?

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Subject