Thank you for choosing St John Ambulance Australia (VIC) Inc. for your First Aid training.

As Australia’s leading First Aid provider, we have developed this self-directed Pre-course Review Pack to assist you to achieve the best possible First Aid training with St John. It is highly recommended that you do work through this Review Pack before attending the course even if you may have attended first aid course before.

This pack includes:

- Information about this course and how it will be conducted;
- *First Aid material to assist you acquire the essential skills and knowledge you require to meet the performance criteria of this unit of competency;
- Assessment criteria you are required to meet to be deemed competent and gain a Statement of Attainment.

How does this Pack work?

Simply work through the Pack. It would work best if you read through the whole pack first and then work your way through each section, answering the scenarios.

The scenarios are designed to assist you with assessing your understanding of the First Aid principles of the section you have just reviewed. The correct answers are provided at the end of this pack.

*This Pack is NOT a first aid text book. If you would like to refer to a reference book, you can purchase the St John Australian First Aid textbook. Call St John on 1300 360 455.
Things you should know

At the face-to-face session, the material covered in this pack will be assessed with:

- Assessments conducted throughout the session through “Question and Answers” and practical demonstrations methods.
- A 45 multiple choice questionnaire, at the end of the session. You must achieve an 80% score.

It is also important that you read the Terms and Conditions included on the First Aid Training Confirmation letter. We recommend that you familiarise yourself especially with the training sections highlighted below.

Training

The training offered by St John provides skills and knowledge in First Aid management but does NOT constitute a medical qualification. St John accepts no responsibility for the subsequent actions of participants. Training of this nature involves moderate physical activity, including kneeling and bending. St John does not accept any responsibility for any harm suffered by you as a result of your participation in your sessions.

If you have any special needs (including those in relation to language, literacy or numeracy), a relevant disability or condition or any other concerns, you should raise these at the time of booking. St John reserves the right to end your involvement in a course if you fail to follow the directions, policies or procedures communicated to you by the trainer.

To gain your competency, you must fulfil both the following criteria:

1. You must attend all sessions and complete all assessments to a standard deemed to be competent by your trainer. The assessment is based on interactive involvement in all aspects of your course;

2. You are required to complete a questionnaire for which you must achieve at least 80% accuracy.

*The information provided is accurate as of June 2014.

At St John, we’re about
Saving lives through First Aid

We aim for at least one person educated, equipped & prepared to provide First Aid in every home, workplace & public gathering.
WHAT IS FIRST AID?

First Aid skills are based on knowledge, training and experience. First Aid is the initial care of the ill or injured, and usually is given by someone who is on the spot when a person becomes ill or injured. The skills of First Aid are for all.

The aims of First Aid are to:

- Promote a safe environment
- Preserve life
- Prevent injury or illness from becoming worse
- Help promote recovery
- Provide comfort to the ill or injured

A First Aider should:

- Assess the situation quickly
- Identify the nature of the injury or illness as far as possible
- Arrange for emergency services to attend
- Manage the casualty promptly and appropriately
- Stay with the casualty until able to hand over to a health care professional
- Give further help if necessary

INFECTION CONTROL

Infection Control refers to a series of actions taken to minimise or control the spread of diseases. An infectious disease is transmitted only by a specific kind of contact. Examples are measles, chicken pox, and the common cold.

The following actions are collectively known as Standard Precautions:

- **Hand Washing**
  It is very important to wash your hands with soap and running water before commencing First Aid and when you finish. In the absence of those resources, a hand sanitiser may be used.

- **Personal Protection Equipment**
  Gloves and eye goggles should be worn.
  Resuscitation masks or face shields should be implemented when carrying out resuscitation.

- **Health**
  Consider being immunised.
  Needle stick injury - most misunderstood and often neglected as it is just a small wound.
  Most work places have a protocol for the management of this incidence.
  Baseline management include:
    - Wash the wound with soap and water, or if unavailable, wipe with an alcohol wipe or sanitiser gel;
    - Report the incident to the appropriate person; and
    - Immediate referral to a medical practitioner or health care worker with experience in infection control, or to the nearest hospital (with an A & E Dept.) for assessment and evaluation of potential disease transmission.

- **Waste Management**
  The waste contaminated with body fluid (blood, pus) produced during the First Aid scenario should be dealt with as soon as possible. They should be disposed into an infectious waste bin but if this is not possible, it should be double bagged before disposing of it in a lidded waste bin.

Good practice of Infection Control is even more important in a child care setting as children are very susceptible to infection.
LEGAL CONSIDERATION

Duty of Care

A Duty of Care exists wherever there is a relationship between two persons. For example, between partners; between a parent and their child; between the teacher and the student; between the coach and the team player; between the employed First Aider and other employees; between the employer and clients who come into the workplace.

If a person in your care becomes injured or ill, you must do something, within the scope of your training, to assist that person.

Negligence

An act of negligence may exist where it can be proven that:

- A duty of care exists;
- The First Aider breached their duty of care (i.e. did something that was outside the scope of their training); and
- The First Aider made the person worse as a result of their actions

A Duty of Care can be breached by either action or inaction (i.e. if you do nothing and the person in your care gets worse).

An employer is vicariously liable for its employees’ acts “in the course of employment”.

Consent to First Aid Treatment

As a general rule, intellectually competent adults have the right to refuse any treatment even if that treatment is necessary to save their lives. Treatment given without the person’s consent is an assault.

Consent may be implied or expressed. It is implied when a person attends a First Aid room for treatment and cooperates with the First Aider. For example, if a person attends the First Aid room, holds their arm out and lets the First Aider apply a bandage. Consent is expressed when, for example, the First Aider asks for permission to apply a dressing and the person verbally agrees to treatment.

In some situations a person cannot give consent to treatment, for example when the injury or illness has affected the ability to make an informed choice, or the person is unconscious, very young or obviously confused. In these cases consent is not required and a qualified person may administer any necessary treatment to save the person’s life or to prevent serious illness or injury.

If the casualty is a child, the parent/guardian should be asked for permission but if they are not present and the injury/illness is life threatening, immediate first aid should be given. Often in an organisation e.g. Child care centres, a pro forma consent is obtained on enrolment.

Treatment without consent will be justified when:

- There is a necessity to act when it is not practicable to communicate with the casualty, and
- The treatment is reasonable (i.e. what a reasonable person, given the level of training completed, would do in the circumstances)

In these cases the treatment may be given even though the person has not, and cannot, give consent.
Documentation

In a workplace there is requirement to document First Aid management of any casualty in the workplace regardless of perceived seriousness of the condition or injury.

The most common name for the document is CASUALTY REPORT. Some of the rules of filling in the form are:

- Ink
- Clearly:
  - Casualty details - spelling, legal name
  - Details of the scenario
  - Summary of signs and symptoms
  - Summary of management
  - Summary of outcome i.e. what happened to the casualty
  - Signed off - usually a copy is to be provided to the casualty
  - If there are errors put a line through it and initial it
- Storage

Confidentiality is a must when storing these reports. The only people who have access to this are the casualty, the First Aider and in a workplace and the designated HR personnel. For any other access, the casualty's permission must be sought in writing.

Compliance

There are compliance requirements in various sectors. To complicate matters there can be state to state variations as well to consider.

Under Section 183 of the Education Care Services National Regulations the following requirements for keeping records in an education and care setting apply:

For an approved provider and family day care educator:
- An incident, injury and illness record needs to be kept until the child turns 25.
- A medication record must be kept until 3 years after the child’s last attendance.

For an approved provider:
- A death of a child while being educated and cared for by the service until the end of 7 years after the death of the child.

Parents should be notified within 24 hours of an incident, injury or illness relating to their child.
- The regulatory authority must be notified of a serious incident in an education and care service within 24 hours.

A serious incident means:
- The death of a child while attending a service, or following an incident while attending a service.
- Any incident involving serious injury, trauma or illness of a child while being educated and cared for at an education and care service which a reasonable person would consider required urgent medical attention from a registered medical practitioner, or for which the child attended or ought reasonably to have attended a hospital. This might include, for example, whooping cough, a broken limb or an anaphylactic reaction.
- An incident at the service premises where the attendance of emergency services was sought, or should have been sought
- If a child:
  - Appears to be missing or cannot be accounted for
  - Appears to have been taken or removed from the service premises in a way that breaches the National Regulations, or
  - Is mistakenly locked in or locked out of any part of the service premises.
Note:
‘Medical attention’ includes a visit to a registered medical practitioner or attendance at a hospital. ‘Emergency services’ may include ambulance, fire brigade, police and state emergency services.

An approved service must have a policy for managing medical conditions which sets out practices in relation to the following:

- The management of medical conditions
- If a child enrolled has a specific health care need, allergy or relevant medical condition, procedures requiring parents to provide a medical management plan
- Requiring the development of a risk minimisation plan in consultation with the child’s parents
- Requiring the development of a communications plan for staff members and parents.

Medical conditions that must be outlined in the service policy include asthma, diabetes, or a diagnosis that a child is at risk of anaphylaxis.

Medication (including prescription, over-the-counter and homeopathic medications) must not be administered to a child at a service without authorisation by a parent or person with the authority to consent to administration of medical attention to the child.

In the case of an emergency, it is acceptable to obtain verbal consent from a parent, or a registered medical practitioner or medical emergency services if the child’s parent cannot be contacted. In the case of an anaphylaxis or asthma emergency, medication may be administered to a child without authorisation. In this circumstance, the child’s parent and emergency services must be contacted as soon as possible.

The medication must be administered:

- From its original container before the expiry or use-by date
- In accordance with any instructions attached to the medication or provided by a registered medical practitioner
- For prescribed medications, from a container that bears the original label with the name of the child to whom it is prescribed
- With a second person checking the dosage of the medication and witnessing its administration
- Details of the administration must be recorded in the medication record.

In the case of a family day care service, or a service that is permitted to have only one educator, a second person is not required to check the dosage and witness the administration of the medication.

FOR FURTHER INFORMATION VISIT THE AUSTRALIAN EDUCATION AND CARE QUALITY AUTHORITY
The following sections from the ‘Guide to the Education and Care Services National Law and the Education and Care Services National Regulations 2011’ cover the above topic:
Part 4.2: Children’s health and safety
Part 4.7: Leadership and service management
Sample of a Casualty Report

CASUALTY REPORT

CONFIDENTIAL

Date: 20/11/2013
Workplace/Location: STAFF ROOM, HQ
M F

Casualty Name: COLLINS ALEXIS

Casualty Address: 13/10 FORSTER ROAD, MT Waverley 3149
Post Code 3149

Witness Name: SMYTHE THOMAS

History

What happened? Alexis staggered and fell backwards. Thomas caught her.

When did it happen? Occurred during a staff presentation.

How did it happen? It was very hot and crowded in the staff room.

Past Medical History

- Not Known
- Cardiac
- Loss of Consciousness
- Medications: NIL
- Diabetes
- Asthma
- Epilepsy
- Allergies: NIL

Casualty Assessment

- Pulse: Slow
  - Breathing: Regular
  - Skin: Pal
  - Conscious Level: Alert
  - Other Signs & Symptoms: No actual loss of consciousness

- Rapid
  - Shallow
  - Flush
  - Confused

- Strong
  - Rapid
  - Most Clamy
  - Drowsy

- Weak
  - Wheeze
  - Dry
  - Unconscious

- Irregular
  - Gasping
  - Sweaty

- Regular
  - Absent
  - Cold
  - Not

Overall Assessment

Felt faint - reacted to environment

Referred to:

- Ambulance
- Hospital
- Own Doctor
- Refused
- x Return to Work
- Other

Advice if it occurred again:

Treatment

ACD Action Plan implemented - N A D

Cleared area, laid Alexis down. Almost as soon as she laid down Alexis was alert, breathing normally and no longer pale, cold and clammy. Laid for about 10 minutes then sat up and had a cup of tea and a slice of cake. As Alexis phleged she had had

Casualty Signature: 

Time Out: 10:30

White: Company Copy
Pink: Casualty Copy

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THE DRSABCD ACTION PLAN

The DRSABCD Action Plan assists you to prioritise your actions, including the primary assessment of the casualty for any life-threatening conditions and what management to put in place.

It should be where you start at any scenario and so it is very important that you are familiar with the Action Plan. Your trainer will review the DRSABCD Action Plan further with you.
THE DRSABCD ACTION PLAN IN DETAIL

DANGER
1. Check for danger using all your senses - look, listen, touch, smell and taste
2. If there are any dangers, can you remove or isolate it? Check for response
3. If you cannot manage the danger, go or send for help and ensure no one else places themselves in danger

RESPONSE
1. Check for response by talking to the casualty (“What’s your name?”).
2. Gently squeeze the casualty’s shoulders looking for signs e.g. are there any facial movements?
3. If there is no response to any of the above, the casualty is deemed as unconscious and you move on to sending for help and checking that the airway is clear.

If there is a response you move on to collecting history, signs and symptoms and managing the outcome of your investigations.

SEND FOR HELP
Send for help as soon as possible. Preferably ask another person to do so. Call Triple Zero (000) and cooperate with the operator to the best of your ability including answering the questions as accurately as you can.

AIRWAY
Check the airway. Gently put pressure on the jaw which will open the mouth so you can look inside:

- If it is clear and the casualty is lying on their back, tilt the head back (i.e.. lift the chin) and check for breathing
- If there is debris in the mouth and the casualty is lying on their back, roll the casualty into the recovery position (see page 8), open their mouth and sweep the debris out with two of your fingers. Then tilt the head to open the airway and check for breathing
How to turn a casualty into the Recovery Position

1. Kneel beside casualty
2. Place farther arm at right angle to the body
3. Place nearer arm across chest
4. Lift nearer leg at knee so it is fully bent upwards
5. Roll patient away from you onto side while supporting head and neck
6. Keep leg at right angle with knee touching ground to prevent patient rolling onto their face

BREATHING
Check for normal breathing using the “look, listen, feel” method for at least 10 seconds. Look for consistent rise and fall of the chest, and hear and feel consistent breaths.

Gasping or occasional gasps often referred to as agonal breathing are not normal breathing.

If the casualty is breathing but is unconscious:
- Roll the casualty into the recovery position
- Continually check the casualty’s condition until medical aid arrives (call for help if not already done)
- Be ready to turn the casualty onto their back and start CPR if breathing stops

If the casualty is unconscious and not breathing, commence CPR.

Note: The position of the body, particularly the neck, contributes to the ability to breathe.

For example, after a car accident and the driver, still in the seat, is slumped forward with their chin on their chest. This will compromise the airway and their ability to breath and result in positional asphyxia. The management is to open and clear their mouth. Then hold their chin in a “pistol” grip to raise their chin to tilt their head, or from behind with each of your hand holding their head firmly on both sides, tilt their head. This will open their airway.
CARDIOPULMONARY RESUSCITATION (CPR)
Cardiopulmonary Resuscitation (CPR) is the technique of compressions of the chest (pushing down on the lower half of the casualty’s breastbone) and inflation of the lungs (breathing into the casualty’s mouth). CPR is given to a casualty when they are not breathing, not responding and not moving.

1. Give 30 compressions
2. After 30 chest compressions, tilt head and lift chin
3. Give 2 breaths
4. Return your hands (fingers for infants) immediately to correct position on sternum.
5. Give a further 30 compressions
6. Continue compressions and breaths in a ratio of 30:2 at approximately 5 cycles in 2 minutes until medical aid arrives

**Note:** If a First Aider is unwilling or unable to perform rescue breathing, compression-only CPR will be better than not doing CPR at all.

**Giving Compressions**
Compressions should be performed with the casualty on a firm surface. In the case of an infant this is best done on a table or similar surface.

1. Kneel beside casualty, one knee level with head and the other with casualty’s chest.
2. Locate lower half of sternum (breastbone) in the centre of chest.

**Adult / Child (over 1 year)**
1. Place heel of hand on lower half of sternum (breastbone) and place heel of other hand on top of first
2. Interlock fingers of both hands and raise fingers to ensure that pressure is not applied over casualty’s ribs, upper abdomen or bottom part of sternum.

**Infant (under 1 year)**
1. Position yourself vertically above casualty’s chest.
2. Place two fingers (index and middle) over lower half of sternum (breastbone).
3. Press down on the sternum (breastbone) to depress about one third of chest and then release the pressure (compressions and release should take equal amounts of time).
4. Repeat to complete 30 compressions at a rate of approximately 100 per minute.

**Note:** During CPR (combining chest compressions with rescue breathing), you would expect to achieve 5 sets of 30 compressions and 2 breaths (30:2) in about 2 minutes

**Change over between First Aiders during CPR**
When two First Aiders are present or if a second person arrives to help:
- Ensure that an ambulance has been called
- One of the two First Aiders indicates readiness or a need to change
- The First Aiders must change over smoothly with minimal interference to the resuscitation procedure
- Change should be done frequently, approximately every two minutes, to minimise fatigue
How to carry out seamless changeover

- Two First Aiders A & B in position to provide CPR facing each other over the casualty
- When First Aider A, currently applying compressions, bends down to give the 2 breaths of the fifth (5th) cycle in their two minutes of CPR, First Aider B gets ready to commence compressions by placing their hands in the correct position on the casualty’s chest
- As soon as First Aider A completes the second breath, First Aider B begins their two minutes of CPR
- First Aider A removes their face shield or resuscitation mask from the casualty's face and replaces it with the face shield or resuscitation mask that First Aider B would be using.

When to stop CPR

- You can stop giving CPR when:
  - The casualty begins breathing and is responsive
  - More qualified help arrives
  - You are physically unable to continue
  - Danger returns

What to do when the casualty starts breathing

1. Turn the casualty to the recovery position
2. Call for an ambulance or medical aid as soon as possible (if not done already)
3. Assess casualty for bleeding and other injuries noting tenderness, swelling, wounds or deformity in the following order:
   - Head, face and neck
   - Shoulders, arms and hands
   - Chest
   - Abdomen
   - Pelvis and buttocks
   - Legs, ankles and feet.
4. Continue monitoring for DRSABCD

What to do if the casualty regurgitates / vomits during CPR

1. Turn the casualty into the Recovery Position
2. Clear the mouth
3. Check for breathing
   - If breathing is present, leave in the Recovery Position and monitor
   - If breathing is still absent, turn onto back and recommence CPR

THE RESPIRATORY SYSTEM

The primary function of the respiratory system is to supply the blood with oxygen in order for the blood to deliver oxygen to all parts of the body.

Breathing / respiration is achieved with the mouth/nose, trachea, lungs and diaphragm. Air enters through the nose or mouth down the trachea (windpipe) which branches into two called bronchi, into the lungs.

Each bronchus divides forming the bronchial tubes which in turn divide into many smaller tubes which connect to tiny sacs called alveoli. The average adult's lungs contain about 600 million of these spongy, air-filled sacs that are surrounded by capillaries. The inhaled oxygen passes into the alveoli and then diffuses through the capillaries into the arterial blood. Meanwhile, the waste-rich blood from the veins releases its carbon dioxide into the alveoli. This gaseous exchange is vital to life. The carbon dioxide follows the same path out of the lungs when you exhale.

The process of breathing (respiration) is divided into two distinct phases, inspiration (inhalation) and expiration (exhalation). During inspiration, the diaphragm contracts and pulls downward while the
muscles between the ribs contract and pull upward. This increases the size of the thoracic cavity and decreases the pressure inside. As a result, air rushes in and fills the lungs.

During expiration, the diaphragm relaxes, and the volume of the thoracic cavity decreases, while the pressure within it increases. As a result, the lungs contract and air is forced out.

The ambient air we breathe in consists of about 20.8% oxygen. The gaseous exchange uses up about 5%. Therefore the expired air has about 15% oxygen in it. This amount of oxygen breathed into the casualty’s lungs, combined with compressions during CPR will preserve the circulation of air and blood around the body while waiting for medical aid to arrive.

**Giving rescue breaths**

1. Leave or place casualty onto back
2. Open airway

**Adult/child (over 1 year)**
- Place your hand on the casualty’s forehead, tilt head backwards and pinch soft part of the nose closed with the index finger and thumb, or seal nose with your cheek
- Open the casualty’s mouth and maintain chin lift—place thumb over the chin below the lip, supporting the tip of jaw with the knuckle of middle finger
- Place your index finger along jaw line

**Infant (under 1 year)**
- Tilt head back very slightly and lift chin to bring tongue away from back of throat avoiding pressure under chin
- Take a breath and place your lips over the casualty’s mouth, ensuring a good seal. If it is a small child or infant, place your lips over mouth and nose. Blow steadily for about one second
- Watch for chest to rise
- Maintain head tilt and chin lift
- Turn your mouth away from the casualty’s mouth—watch for chest to fall, and listen and feel for signs of air being expelled
- Take another breath and repeat the sequence

*Note: If the chest does not rise, recheck the mouth and remove any obstructions, ensure adequate head tilt and chin lift and ensure there is an adequate seal around the mouth (or mouth/nose).*

**DEFIBRILLATION**

**What is a defibrillator?**
It is a machine that can analyse the heart rhythm and decide to deliver a jolt of biphasic electricity to stop the arrhythmia. This in turn will allow normal sinus rhythm to resume. A fully automated external defibrillator is known as an AED and a semi-automated as an SAED but the term AED is most commonly used.

**Defibrillating a casualty**
1. Follow DRSABCD
2. Establish that the casualty is unresponsive, not breathing and not moving
3. Call Triple Zero (000) for an ambulance — ask bystander if present
4. Commence CPR, and continue during following steps
5. Expose casualty’s chest

*Note: If casualty is wearing a bra, remove it before placing defibrillator pads.*
1. Remove any medication patches, check for pacemaker or defibrillator implant (look for scar between the collar bone and top of the breast (either left or right side of chest).
2. Wipe chest to ensure it is dry—if chest is excessively hairy, clip with shears.
3. Depending on the type of defibrillator either attach cables to defibrillator pads or pull handle on the device to access pads.
   - Attach pads to casualty’s chest: One pad to casualty’s right chest wall—below collarbone (ensure pad adheres to skin)
   - One pad to casualty’s left chest wall—below left nipple (ensure pad adheres to skin).

**Note:** If implant is identified, place pad at least 5 cm away from site—do not place pad on top of pacemaker or implant site.

**CHILDREN**

Non-cardiac arrest causes such as drowning or suffocation are more likely to occur in children and therefore defibrillation is unlikely to be of assistance as heart activity from such causes are unlikely. However in case it is feasible to defibrillate, there are a number of AEDs that can be used. The principles are the same. As almost all infants and young children who require resuscitation is in respiratory arrest and therefore CPR should not be interrupted during the preparation for defibrillation.

A standard AED may be used on a child eight years or older (weight over 25 kg approximately).

If the child is under 8 years old or weigh less than 25kg, use child / infant pads but do not delay to determine exact age or weight. These pads are placed front and back of chest.

You will be required to demonstrate implementing the DRSABCD Action Plan which includes:

- Management of an unconscious breathing casualty including:
  - The Recovery Position
- Management of an unconscious non-breathing casualty including:
  - Performing CPR at 30 compressions to 2 breaths at 5 cycles in 2 minutes for 4 minutes with seamless changeover on an adult and infant manikin.
  - Application of an AED

**CHAIN OF SURVIVAL**

The Chain of Survival is a series of interlinked actions which when followed is the key to improving the survival rate of casualties in cardiac and/or respiratory arrest.

It is a proven fact that the Chain of Survival can improve survival rate up to 80%.
DROWNING

A person gasping for air while struggling to stay afloat may inhale a small amount of water. This usually results in a little water being trapped in the lungs because the muscles of the larynx spasm, closing off the airway. Eventually a mucus plug forms and whilst this closure prevents water from entering, it also prevents air from entering. As a consequence, the person suffocates and become unconscious. If not resuscitated, death is the outcome.

The danger here is people jump in to rescue the drowning person and end up drowning themselves. Once the person is out of the water CPR would most likely need to be commenced.

Note:
- There is a better than 50% chance of saving an apparently drowned infant or child by giving CPR.
- Even in the case of a successful rescue the casualty still need to be assessed and monitored. Hence the need to call Triple Zero (000).

CHOKING

A person chokes when the airway is partly or completely blocked. The person usually has trouble breathing, but if the blockage is a complete blockage they cannot breathe at all.

The First Aid aim is therefore to dislodge the object obstructing the airway, because if this is not done the person could die.

Causes:
The most common causes of choking are:
- Eating or drinking too quickly or together
- Not chewing the food sufficiently
- Swallowing small bones
- Swallowing small objects

Signs and symptoms

- Clutching the throat
- Coughing, wheezing, gagging
- Having difficulty breathing, speaking or swallowing
- Trying to cry but making strange sounds or no sound at all
- Making a whistling or crowing noise
- Turning blue in the face, neck, lips, ears or fingernails
- Collapsing or being unconscious

The simplest way to assess the severity of an airway obstruction is to check whether a cough is effective or ineffective.

If an effective cough is present, the casualty is encouraged to keep coughing to expel the object. The casualty should be monitored until recovery but if deteriorating, call Triple Zero 000, ask for an ambulance and commence CPR if necessary.
You will be required to demonstrate the management of choking.

Scenario 1
You are supervising meal time. Suddenly one of the children is coughing, gagging and wheezing.

What actions should you take?
A. Make the casualty drink a glass of water very quickly;
B. Call Triple Zero (000) for an ambulance;
C. Make the casualty lie down with their legs raised;
D. Assist the casualty to relax and cough.
SHOCK

Shock is caused by lack of circulating blood volume. It is caused by the heart failing, bleeding, vomiting, diarrhoea, burns, pain, trauma, infections, or severe allergic reaction/anaphylaxis. The physical injuries may not appear to be severe but if the blood volume is too low to meet the body’s needs and to remove the waste products, then it may result in life threatening consequences.

Signs and symptoms

These may develop progressively depending on the severity of the injury, continuation of fluid loss or the lack of effective management. They can include:

- Cold, clammy skin
- Faintness or dizziness
- Nausea
- Anxiety

Increasing to:

- Restlessness
- Thirst
- Rapid shallow breathing
- Drowsiness, confusion or unconsciousness
- Cyanosis - extremities become a blue like colour - this is a late sign and the person is very ill.

Management

1. DRSABCD
2. Reassure the casualty
3. Call Triple Zero (000) for an ambulance
4. Raise the casualty’s legs (unless fractured or a snake bite) above the level of the heart - place head flat on the floor
5. Treat any wound or burn and immobilise any fractures
6. Loosen any tight clothing at neck, chest and waist
7. Maintain casualty’s body warmth with a blanket or similar
   (DO NOT use any source of direct heat)
8. Give small amounts of clear fluid (preferably water) frequently to the conscious casualty who does not have abdominal trauma and unlikely to require an operation in the immediate future. If in doubt, do not give fluid
9. Monitor and record breathing, pulse and skin colour at regular intervals
10. Place the casualty in the recovery position if there is breathing difficulty, the casualty becomes unconscious or is likely to vomit

You will be required to demonstrate the management of shock.

Scenario 2

The casualty you are managing has progressively become quieter and anxious. Their skin is now pale and feels cold and clammy. They are also complaining of “the room is spinning” / feeling dizzy.

What actions should you take?

A. Make the casualty move around to keep warm;
B. Call Triple Zero (000) for an ambulance;
C. Lie the casualty down, raise their legs and keep them warm with a blanket;
D. Ask the casualty to place their head between their knees.
WOUNDS & BLEEDING

A wound is a break in the continuity of the tissues of the body. It may bleed and it may become infected. Types of wounds are:

- Amputation
- Abrasion
- Laceration
- Puncture
- Incision

Regardless of the type of wound, the same management steps apply:
1. Control the bleeding
2. Clean the wound if possible and apply a non-adhesive dressing to prevent infection
3. Seek medical aid if necessary or if in doubt.

If a wound is not bleeding, clean the wound thoroughly with sterile gauze soaked in saline or cooled boiled water. Then apply a non-adhesive dressing.

Dirty penetrating or open wounds should be examined by a doctor as tetanus or other serious infections may result especially if there is dirt or foreign material in the wound.

External Bleeding

Management
1. DRSA
2. ABCD
3. Lay casualty down if the bleeding is severe
4. Remove or cut clothing to expose the wound
5. Apply firm direct pressure or instruct casualty to do so if possible
6. If casualty is unable to apply pressure, apply pressure using a pad or your hands (use gloves if available)
7. Raise and rest the injured part when possible
8. Apply a pad over the wound if not already in place and secure with bandage - ensure pad remains over the wound
9. If bleeding continues, leave initial pad in place and apply a second pad over the first and secure with a bandage
10. If bleeding continues replace second pad only
11. Seek medical aid

You will be required to demonstrate the management of a bleeding wound including that of uncontrolled bleeding following the initial bandaging.

Scenario 3
You have just stepped into the kitchen startling the person who was chopping onions at the kitchen sink. They cut the palm of their left hand, dropped the knife and the onions have gone everywhere.

How would you manage this situation?
A. Ask the casualty to wash their hands and call for help;
B. Call Triple Zero (000) for an ambulance and wait at the street corner;
C. Ask the casualty to grab a tea towel and tie it around their wrist;
D. Apply the DRSA Action Plan and take actions to stop the bleeding.
Constrictive bandage

Occasionally severe bleeding from major limb injuries such as partial amputation cannot be controlled by direct pressure. As a last resort and only when others methods have failed to control the bleeding, a Constrictive Bandage may be applied to the limb.

Applying a constrictive bandage:

1. Use a firm (non-stretch) cloth at least 5cm wide
2. Wrap the cloth firmly around the injured limb between elbow and shoulder or knee and pelvis until a pulse can no longer be felt beyond the constrictive bandage and bleeding has been controlled. If is applied too loosely, it defeats the purpose.
3. Note the time of application – write this on the casualty in pen as after 30 minutes, release the bandage and check for bleeding
   - If there is no bleeding, remove the bandage
   - If bleeding recommences, apply direct pressure
   - If direct pressure is unsuccessful, reapply the constrictive bandage and recheck in 30 minutes again
4. Call Triple Zero (000) for an ambulance

NOTE: The constrictive bandage must be visible at all times and must be mentioned in the handover.

Basic Wound Care

The aim of the basic wound care is to prevent infection in a minor wound. The casualty should be advised to keep the dressing dry and to change the dressing at least once a day or if the dressing is compromised in any way e.g. gets wet, dirty.

The casualty should also be advised of the signs and symptoms of infection including localised pain, redness, swelling, offensive discharge, not healing. In this case they should seek medical aid.

How to clean a minor wound e.g. a graze
Collect appropriate equipment from the First Aid kit:
- Normal Saline (Clean fresh water is a good substitute)
- Sterile gauze swabs
- Pair of gloves
- Bag for the waste

1. Create a clean area in which to work e.g. a clean paper towel
2. Wash your hands and put on gloves
3. Wet the gauze swabs with the normal saline and clean the wound
4. Apply a non-adherent dressing covering the whole wound
5. Discard gloves into rubbish bag
6. Tape dressing securely on all sides
7. Discard sealed rubbish bag appropriately
There are three separate actions in cleaning the wound:

1. With a wet gauze, wipe the furthest section of the wound from you from top to bottom once only and discard used gauze into rubbish bag.
2. With another wet gauze, clean the middle section using the same method.
3. Then with a third gauze swab, wipe the portion nearest to you, again, using the same method.

*You will be required to demonstrate basic care of a wound on the forearm.*

**Embedded Object**

Where there is a foreign object embedded in the wound *DO NOT* remove the object.

If you need to control the bleeding, you should apply pressure to the surrounding areas, but not actually on the foreign body.

You can do this by placing pads around the object, and securing the pads with a bandage taking care not to put pressure on the object.

**Amputations**

Managing the amputated part:

1. *DO NOT* wash or soak the amputated part in water or any other liquid
2. Wrap the part in gauze or material and place in a waterproof container such as a plastic bag
3. Place the sealed container in cold water, (add ice to the water if available)
4. *DO NOT* let the amputated part come into contact with the ice or water.
5. Ensure the amputated part is sent to the hospital with the casualty

**Internal Bleeding**

Severe internal bleeding usually results from injuries caused by a violent blunt force such as a car accident or falls from a height. It can also occur when an object, such as a knife, penetrates the skin and damages internal organs. Some conditions such as stomach ulcers can also result in internal bleeding.

**Signs and symptoms of internal bleeding**

- Pain
- Tenderness
- Rigidity of abdominal muscles
- Coughing up red, frothy material
- Shock - pale, cold, clammy skin

**Management**

1. Lay casualty down or if casualty is coughing up frothy blood half sitting will be more comfortable
2. Raise the legs or bend the knees
3. Loosen tight clothing
4. Call Triple Zero (000) for an ambulance
5. *DO NOT* give the casualty anything to eat or drink
6. Reassure the casualty, manage shock
CRUSH INJURIES

A crush injury results when something large and heavy strikes or falls on a person. The damages that these injuries may cause include internal bleeding, fractures, rupture of internal organs and impair blood supply and therefore are potentially life-threatening.

Management

1. Follow DRSABCD. Ensure your OWN safety. If safe and able to do so, remove the crushing object as soon as possible
2. Call Triple Zero (000) for an ambulance
3. Control bleeding then manage other injuries

Scenario 4

Your neighbour is calling out that their child has a nail in the palm of their hand.

How would you manage this situation?

A. Ignore it as you have no legal obligation to do anything
B. Apply the DRSABCD Action Plan, then pad around the nail
C. Ask the casualty if you can call someone for them
D. Call Triple Zero (000) for an ambulance and leave
**ASTHMA**

In an asthma episode the lining of the lungs and airway become inflamed and swollen. Excess mucus is produced, causing the person to have great difficulty in breathing which in turn creates great distress. Usually it is the expiration (breathing out) phase that is difficult and varying volume of wheeze is audible. The reduction in the volume of the wheeze or cessation does not necessarily mean that the casualty is recovering.

Factors triggering an asthma episode may include exercise, respiratory infections, allergies (to pollen, foods, bee stings etc.), exposure to sudden changes in weather conditions especially cold air, anxiety, smoke. Although asthma is treatable and usually can be managed, there is no known cure. There are two types of medication – relievers and preventers.

Relievers reduce the muscle spasm and open the narrowed airways. Common brands are Ventolin, Asmol, and Bricanyl. This is the medication First Aiders are likely to assist the casualty to self-administer in an asthma attack OR in Victoria; State regulation permits the administration of the reliever medication. It also permits the use of another person's reliever or one from the First Aid kit. Ventolin puffers can also be purchased without a prescription in Victoria. In an acute asthma attack, the reliever is best administered with a spacer.

Preventers reduce the inflammation in the airways and reduce symptoms and exacerbations. Examples are Pulmicort and Flixotide.

There are also combination medications like Seretide and Symbicort which is a preventer plus a symptom controller.

**Signs and symptoms**

The casualty may be:
- Unable to get enough air
- Progressively more anxious, short of breath, subdued or panicky
- Coughing, wheezing

**Management**

1. Follow DRSABCD
2. Assist the casualty, if conscious, into a comfortable position - usually sitting upright.
3. Be reassuring and ensure adequate fresh air
4. Assist with prompt administration of medication - give 4 puffs of a reliever inhaler (puffer) with breaths in between puffs. Stop for 4 minutes
5. If no improvement after 4 minutes, give another 4 puffs with 4 breaths in between puffs
6. If still no improvement, call Triple Zero (000) for an ambulance
7. Keep giving 4 puffs with 4 breaths in between puffs, and 4 minutes breaks until the ambulance arrives (For adults with severe asthma attack, you may give up to 6-8 puffs every 5 minutes)
8. If the casualty becomes unconscious, follow DRSABCD

**You will be required to demonstrate the administration of a reliever medication using a disposable spacer.**

**Scenario 5**

It is a hot, windy and dusty day. One of the children in the playground is wheezing and having breathing difficulties. The child is a known to have asthma.

**What First Aid action can you take?**

A. Ignore the situation as the child is only “playing up” to get attention;
B. Remove the child into the Centre and administer Ventolin following established protocol;
C. Move the other children away to make room and more air for the affected child;
D. Call Triple Zero (000) for an ambulance and wait for them at the front entrance.
ALLERGIC REACTIONS

An allergic reaction occurs when the person’s immune system reacts to something in the environment that usually does not bother anyone else. The triggers can be medication, insect stings, dust mite, pet's saliva, pollens, mould, foods and chemicals. Hay fever is the commonest from of allergic reaction. The reaction can be mild causing eczema or watery eyes to the extreme of causing breathing difficulty. This stage is known as anaphylaxis.

Anaphylaxis

Anaphylaxis is potentially life threatening and therefore needs urgent management and medical attention. The First Aid management is the administration of a bolus dose of adrenaline. This is usually given with an auto-adrenaline device which is a predosed, one use only device which can be administer by a lay person.

There are two brands of adrenaline auto injector (AAI) currently in Australia – EpiPen and Anapen. Each has two doses – an adult dose and a junior dose. The junior dose is usually prescribed for a child less than 20kg.

Signs & Symptoms
- Swelling and redness of the skin
- Itchy, raised rash (hives)
- Swelling of the throat
- Wheezing and/or coughing
- Breathing and/or speech difficulties
- Nausea and vomiting
- Dizziness or unconsciousness

Management
- Assess DRSABCD
- Ask casualty if they have an adrenaline auto injector
- Assist to administer the adrenaline auto injector or administer yourself
- Call Triple Zero (000) for an ambulance
- Keep the casualty in a lying position or sitting if it assists them to breathe; do not allow casualty to stand or move around as this may result in a sudden drop of blood pressure and a loss of consciousness
- If casualty is unconscious, follow DRSABCD

Scenario 6
During lunch a child’s eyes are puffy and a rash is appearing on their skin. Apparently the child had a taste of someone else’s sandwich. This child has an anaphylactic history with peanuts.

What should your First Aid management include?
A. Give the child a cup of tea with a lot of sugar in it twice over;
B. Help the child scratch their back as they cannot reach the itchy spot;
C. Wait until the child has breathing difficulties before doing anything;
D. Follow established procedures for anaphylactic management.
How to Administer an Adrenaline Auto injector:

1. ANAPEN

Training Device:  

Anapen Packaging:

Used/Fired Anapens:

How to Give an Anapen:

1. Pull off black needle shield.

2. Pull off grey safety cap from red button.

3. Place needle end firmly against outer mid-thigh at 90° angle (with or without clothing).

4. Press red button so it clicks and hold for 10 seconds. Remove Anapen® and DO NOT touch needle. Massage injection site for 10 seconds.
2. EPI PEN

Training Device:

EpiPen Containers:

Live EpiPens (Used/Fired):

How to Give an EpiPen:

1. Form fist around EpiPen© and pull off blue safety release.

2. Place orange end against outer mid-thigh (with or without clothing).

3. Push down hard until a click is heard or felt and hold it in place for 10 seconds.


*You will be required to demonstrate the administration of an AAI.*
HEART DISORDERS

The function of the heart is to pump blood around the body via the circulatory system. A heart attack occurs when there is a sudden complete blockage of an artery that supplies an area of the heart. This is a life threatening emergency.

The damaged heart muscle may initiate an uncontrolled disorganised rhythm that may stop the heart beating effectively. This is the most common cause of a Sudden Cardiac Arrest. This could occur within minutes of the first symptoms of a heart attack.

So, the First Aider must act quickly and call Triple Zero (000) for an ambulance immediately.

If the casualty has chest pain or discomfort similar to angina, but is not relieved by medication and rest, the First Aider should manage the casualty as having a heart attack.

**Common Heart Disorders**

<table>
<thead>
<tr>
<th>Angina</th>
<th>Heart Attack</th>
<th>Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs &amp; Symptoms</strong></td>
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</tr>
<tr>
<td>• Feeling of pressure or tightness in the centre of the chest</td>
<td>• Pain or discomfort is persistent</td>
<td>• General feeling of tiredness</td>
</tr>
<tr>
<td>• Pain or discomfort may spread to the neck, jaw, shoulders and arms</td>
<td>• Crushing sense of pressure or burning in the centre of the chest</td>
<td>• Breathlessness when exercising</td>
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<tr>
<td></td>
<td>• Sweating, shortness of breath and a sick feeling</td>
<td>• Swollen feet, ankles, legs, abdomen and veins</td>
</tr>
<tr>
<td></td>
<td>• Pain may spread to back, neck and arms</td>
<td>• Coughing and wheezing</td>
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<tr>
<td></td>
<td></td>
<td>• Blue lips and extremities</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td><strong>Management</strong></td>
<td><strong>Management</strong></td>
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<tr>
<td>• Follow DRSABCD</td>
<td>• Follow DRSABCD</td>
<td>• Follow DRSABCD</td>
</tr>
<tr>
<td>• Encourage the casualty to stop what they are doing and rest</td>
<td>• Call Triple Zero (000) for an ambulance</td>
<td>• Call triple zero for an ambulance</td>
</tr>
<tr>
<td>• Support casualty in sitting position or lay down. Ask them to describe their symptoms</td>
<td>If casualty is conscious, support in sitting position.</td>
<td>If casualty is conscious, place in a sitting position.</td>
</tr>
<tr>
<td>• Loosen tight clothing</td>
<td>• Loosen tight clothing</td>
<td>• Reassure casualty and loosen tight clothing</td>
</tr>
<tr>
<td>• Assist casualty to take their prescribed medication – Anginine tablet or Nitrolingual Spray. Repeat dose if symptoms not relayed in 5 minutes</td>
<td>• Give one tablet (300mg) of aspirin unless casualty is allergic to aspirin, or their doctor has warned them against taking aspirin</td>
<td>• Manage for shock</td>
</tr>
<tr>
<td></td>
<td>• Stay with the casualty until the ambulance arrives</td>
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</tr>
<tr>
<td>• If pain persists for longer than 10 minutes or the pain gets worse or is severe, call Triple Zero (000) for an ambulance</td>
<td>If the casualty is unconscious</td>
<td></td>
</tr>
<tr>
<td>• Stay with the casualty until the ambulance arrives</td>
<td>• Place the casualty in the recovery position</td>
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<tr>
<td>• Monitor breathing and be prepared to start CPR</td>
<td>• Monitor the breathing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Be prepared to commence CPR</td>
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</tbody>
</table>
Scenario 7
A fellow child care worker is observed to be rubbing their left arm and complaining of tightening in their chest. They look pale and tired.

What actions would you start with?
A. Nothing as you are not the designated First Aid officer;
B. Ask if you can help and for more details of the pain;
C. Let them rest in the First Aid room alone until it is time to go home;
D. Commence CPR and call Triple Zero (000) for an ambulance.
**DIABETES**

Diabetes is caused by a disorder of the pancreas. The pancreas produces insulin which converts the sugars absorbed into the bloodstream. The sugars are a result of the breakdown of foods by the digestive system. So if the insulin production and function are impaired, sugar builds up in the blood and the cells do not get the energy they require. Diabetes is managed by diet and medication in the form of tablets, or insulin injections. The injection of insulin is a specific skill. Most people living with diabetes have a glucometer – a machine that measures the blood glucose level from a drop of blood.

There are two types of diabetic emergencies – very high blood sugar and very low blood sugar. The more common and immediately dangerous emergency is hypoglycaemia. It can develop quickly and some people may not be aware of the early signs. Commonly caused by a missed or delayed meal after diabetic medication but could be due to too much medication and not enough food or incorrect type of food or unaccustomed exercise. Alcohol consumption increases the likelihood of a “hypo”.

**Signs and symptoms**

**Low blood sugar** - There will normally be a fast onset of symptoms. Any abnormal signs and symptoms in a person with diabetes should be considered as possibly caused by low blood sugar and sugar should be given.

- Feel dizzy, weak and hungry
- Profuse sweating
- Look pale and have a rapid pulse
- Aggressive behaviour
- Can appear as if drunk
- Mimic the symptoms of a stroke

**High blood sugar** - There will normally be a slow onset of symptoms.

- Excessive thirst
- Frequent need to urinate
- Acetone smell on breath
- Drowsiness
- Hot, dry skin

**Management**

1. **Low blood sugar**: Give sugar, glucose or a sweet drink (e.g. soft drink, but NOT ‘diet’ soft drinks). Continue giving sweet drinks every 15 minutes until the casualty recovers. Follow up with a sandwich or other food. If no improvement call Triple Zero (000) for an ambulance.

2. **High blood sugar**: The casualty may need assistance to check their sugar level and to self-administer insulin. DO NOT administer it yourself. Seek medical aid if required. If help is delayed, encourage the casualty to drink sugar-free clear fluids.

If unsure whether it is high or low blood sugar scenario, give the casualty a sugar drink.

**Note:** If the casualty is unconscious:
- Follow DRSABCD, GIVE NOTHING BY MOUTH
- Ensure Triple Zero (000) is called and an ambulance is on its way

**Scenario 8**

Just before Morning Tea time, bright, bubbly, chatty Betty was seen to be behaving very aggressively and seemed to be unco-ordinated, fighting with her best friend.

What First Aid action should you take?

A. Nothing as they are just acting out X-box scenes;  
B. Tell them to stop fighting and give them a game to play;  
C. Convince the Betty to have a sweet drink and then something to eat;  
D. Assume that Betty is just having “a bad start to the day”.
A stroke occurs when an artery taking blood to the brain becomes blocked or bursts. Brain cells are damaged and functions controlled by that part of the brain become paralysed.

Although many people make a good recovery, a stroke can be fatal. People most at risk of a stroke are those who are elderly, have high blood pressure, smoke, have heart disease or diabetes or have previously had a stroke. A stroke is a life threatening emergency.

**Signs & Symptoms**
- Sudden decrease in the level of consciousness
- Weakness or paralysis, usually on one side of the body
- Feeling of numbness in face, arm or leg
- Difficulty speaking or understanding
- Unexplained dizziness
- Disturbed vision
- Loss of balance
- Confusion

**Management**
1. Follow DRSABCD
2. Call Triple Zero (000) for an ambulance

**If casualty is conscious:**
1. Support head and shoulders on pillows
2. Loosen tight clothing
3. Maintain body temperature
4. Wipe away secretions from the mouth
5. Ensure airway is open and clear

**If casualty is unconscious:**
1. Place in recover position

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**Scenario 9**
You are at a meeting when you suddenly realise the speaker’s speech is slurring and not within the context of the meeting. The speaker also seems to be losing their balance and appears confused.

**What should your First Aid actions include?**
A. Stop the meeting, call an ambulance and make the speaker comfortable on the floor;
B. Help the speaker to the First Aid room to rest;
C. None as you are not in charge and it would look like you are interrupting;
D. Stop the meeting and let the speaker rest, then continue where you left off.
SEIZURES / CONVULSIONS

Seizures are the result of sudden, usually brief, excessive electrical discharges in a group of brain cells involving part or the whole brain. Therefore the signs and symptoms vary. Transient symptoms can occur, such as loss of awareness or consciousness and disturbances of movement, sensation (vision, hearing and taste), mood or mental function and behaviour.

Not all seizures are epilepsy. Some seizures can be caused by head injury, high fever, brain tumour, poisoning (including drug overdose), serious infections or severe impairment of oxygen or blood to the brain.

Epileptic seizures

Epileptic seizures are caused by a disturbance of the brain. They can be a result of chemical imbalance, a previous injury or an unknown cause. This section is concerned with convulsive type seizures caused by epilepsy, which can affect people of any age. These can last from 1 to 3 minutes.

Signs and symptoms
- A ‘cry’ as air is forced out through the vocal cords
- Casualty falls to the ground and lays rigid for some seconds
- Congested, blue face and neck
- Jerking, spasmodic muscle movement
- Froth from the mouth
- Possible loss of bladder and bowel movement

Management

During seizure
- DO NOT try to restrain the person
- DO NOT put anything in the mouth
- Protect person from obvious injury
- Place something under head and shoulders

After seizure
1. Follow DRSABCD
2. Place in the recovery position
3. Manage all injuries
4. DO NOT disturb if the casualty falls asleep but continue to check airway and breathing
5. Seek medical aid if the casualty does not recover

Seek medical aid if seizure continues for more than 5 minutes, another seizure quickly follows, the casualty has been injured, there is no history of epilepsy, there is a history of a head injury, or when in doubt.

Scenario 10
You are at a party where strobe lights are flashing. One of the dancers falls to the ground and is exhibiting jerky movements and frothing at the mouth.

What are some of the actions you can carry out to help the casualty?
A. Nothing as you do not know the casualty;
B. Make it safe for the casualty to have their seizure;
C. Call Triple Zero (000) for an ambulance immediately and leave;
D. Call the casualty’s family to come and manage the casualty.

You will be required to demonstrate the management of a seizure
Febrile convulsions

Convulsions, usually brief, lasting no more than 5 minutes, may occur in infants and young children between the ages of 6 months and 5 years old. This may be due to fever, infection, epilepsy or other conditions.

Even a small rapid rise can cause convulsions.

Often the seizure is the first sign of a fever so it is very difficult to prevent these convulsions.

Signs and symptoms

- Fever
- Twitching of face and limbs
- Stiffness of body with arched back
- Eyes rolling up
- Congestion of the face and neck
- Blue face and lips

Management

- **During the Convulsions**
  1. Place the child on their side for safety
  2. DO NOT restrain the child
- **After the Convulsions**
  1. Follow DRSABCD
  2. Seek medical aid

*Note: DO NOT cool the child by sponging or bathing but remove excess clothing or wrapping.*

Scenario 11

You are cuddling a toddler who has a fever. The child suddenly begins to convulse.

**What would you do?**

A. Place the child on their side for safety and time the seizure;
B. Cuddle the child closer to sustain the child;
C. Give the child a double dose of Paracetamol immediately;
D. Cool the child by sponging the body with icy cold water.

HYPERVENTILATION

Hyperventilation is a result of involuntary over-breathing due to excitement, hysteria, stress or other emotion.

Signs and symptoms

There are a number of signs and symptoms which help you to distinguish hyperventilation from other breathing disorders, such as asthma

- Shallow, rapid breathing
- Rapid pulse
- Feeling of choking or suffocation
- Dizziness
- Pins and needles in hands, feet and face

Management

1. Follow DRSABCD
2. Calm casualty - remove to a quiet, private place
3. Encourage slow, regular breathing - slowly count breaths aloud
4. Seek medical aid
FAINTING

Fainting is the result of a temporary reduction in blood flow (and therefore oxygen) to the brain.

A person experiencing this effect will feel dizzy and may lose consciousness for a brief period of time. People usually faint from a standing position and injuries may result.

Signs and symptoms

- Feeling light-headed, dizzy or nauseated
- Pale, cool, moist skin
- Numbness in the fingers and toes

Management

1. Lay the casualty down with legs raised, with the head and body flat
2. Ensure plenty of fresh air
3. Loosen tight clothing such as belts or ties
4. Check for injury or illness
5. After recovery, let the casualty rest for some minutes before moving

Note: DO NOT sit the casualty down on a chair with their head between their knees.

Scenario 12
A friend is complaining they are feeling dizzy and seeing stars.

What First Aid management can you put in place?

A. Make them sit down on a chair and push their head between their legs;
B. Ignore the situation as it will only embarrass them;
C. Give them a glass of water and tell them to take some deep breaths;
D. Request that they lie down and assist them to raise their legs.

FRACTURES

A fracture is a break in the continuity of bone and is defined according to the type and extent. Fractures can be caused by either direct or indirect force. Other indirect fractures can occur when a muscle pulls violently on a bone, separating a fragment.

Complications

Any fracture can be complicated by injury to adjoining muscles, blood vessels, nerves and organs. Fractures of large bones usually result in considerable blood loss and shock.
**Signs and symptoms**
- Pain at or near the site of injury
- Swelling
- Tenderness at or near site of fracture
- Redness
- Loss of function
- Deformity
- Casualty feels or hears the break occur
- A coarse grating sound is heard or felt as the bones rub against each other (crepitus)

Fractures are classified as closed, open or complicated.

**Aims of fracture management**
- Immobilise the injured part in order to lessen pain
- Reduce serious bleeding and shock
- Prevent further internal or external damage
- Prevent a closed fracture from becoming an open fracture

**Management**
1. Apply the DRSABCD action plan
2. Assist casualty to remain as still as possible
3. Control any bleeding and cover any wounds
4. Observe casualty carefully
5. Manage shock
6. Seek medical aid

*Note: NO attempt should be made to force the fracture back into place.*

A splint can be made from almost any material. It should be:
- Rigid and not too heavy
- Wide enough to support the arm width wise
- Long enough to support the arm length wise

So for example packaging cardboard, newspaper, magazines can be used. It should be neatly folded so that it does not unravel or catch anywhere. The procedure is usually finished off by supporting the splinted limb with a full arm sling.

**Method:**
1. Place the forearm length wise on the improvised splint with the fingers wrapped over the edge of the splint and so the splint protrudes slightly beyond the elbow
2. Firmly apply a narrow bandage before and beyond the fracture site, try not to pull or jerk
3. The procedure is usually finished off by supporting the splinted limb with a full arm sling

You will be required to demonstrate splinting of a forearm fracture and the application of a full arm sling.

**Scenario 13**
A young child has fallen off their bicycle. They landed on their right lower arm. It is now painful and has a slight swelling.

**What should you do?**
A. Apply a sling to the injured arm and send them back out to play;
B. Apply a sling to the injured arm and seek medical advice;
C. Apply a heat pack on the area and repeat every 15 minutes;
D. Apply an ice pack on the injury for an hour and repeat.
DISLOCATION

A dislocation occurs when one or more bones are displaced at a joint - most commonly at the shoulder and fingers. It always results in tearing of the ligaments which normally hold the joint in the connected position.

Signs and symptoms
- Pain at or near the site of the injury
- Difficult or impossible to move the joint
- Loss of power
- Deformity or abnormal mobility
- Tenderness
- Swelling
- Discoloration and bruising

Management
1. Follow DRSABCD
2. DO NOT attempt to reduce the dislocation
3. Call Triple Zero (000) for an ambulance
4. Rest and support the limb
5. Apply ice packs if possible directly on the injury/joint
6. IF IN DOUBT, manage as a fracture

SPRAINS AND STRAINS

A sprain occurs when the ligaments holding a joint together are stretched and torn. A strain is where the fibres of a muscle or tendon are stretched and torn.

Management
Follow DRSABCD and apply RICE:

1. Rest the casualty and the injured part
2. Apply Ice pack wrapped in a damp cloth or a cold compress for 15 minutes, every 2 hours for 24 hours, then for 15 minutes every 4 hours for 24 hours
3. Apply a Compression bandage firmly to extend well beyond the injury
4. Elevate the injured part

If the application of the ice pack does not help, seek medical aid.

Note: If in doubt about the injury, treat as a fracture.

You will be required to demonstrate the application of a compression bandage to a sprain.

Scenario 14
A group of children is playing football when one of them rolled their ankle.

What First Aid actions can you take?
A. Massage the ankle for 15 minutes;
B. Get the casualty to rotate their injured ankle a few times;
C. Apply the RICE management;
D. Get the casualty to rest and give them a sweet drink.
HEAD, NECK and SPINE

A casualty with a head or spinal injury including injury to the neck must receive medical aid urgently.

When a casualty has a serious head injury, the neck or spine may also be injured.

The skull gives the head its shape and protects the brain. The skull may be fractured by either a direct force (a blow to the head) or indirect force such as a fall from a height and landing heavily on their feet. Severe injuries may cause multiple cracking (an ‘eggshell’ fracture) which may extend to the base of the skull.

Concussion is an altered state of consciousness, usually caused by a blow to the head or neck. The casualty may become unconscious but this is often momentary.

Compression is excess pressure on part of the brain. It may be caused by a depressed skull fracture where the broken bones put pressure on or directly damage the brain, or by a build-up of blood inside the skull. If a blow to the head causes bleeding in the brain or on the surface of the brain and the blood cannot drain from the closed space, it builds up and puts pressure on the brain. This is life-threatening.

Assessment of Head Injuries

It is often very difficult to make an accurate assessment of the severity of a head injury. Therefore no head injury should be disregarded or treated lightly. The cause of the injury is often the best indication of its severity. Strong forces will usually cause severe injuries to head and spine.

Signs and Symptoms

If the casualty temporarily loses consciousness, but does not have any apparent injury of after effects, the First Aider should assume the potential for hidden injury and advise the casualty to seek medical aid promptly.

- Headache
- Loss of memory, particularly of the event
- Confusion
- Altered or abnormal responses to commands and touch
- Wounds to the scalp or to face
- Nausea or vomiting
- Dizziness

In more complicated injuries, signs include:

- Blood or clear fluid escaping from nose or ears. Depending on where the injury is, blood may appear from the ears or nose. If the base of the skull is fractured there may be no obvious sign or injury, but cerebrospinal fluid or blood may escape through the ears.
- Pupils becoming unequal in size
- Blurred vision

Management

1. Follow DRSABCD
2. If casualty is conscious:
   - Place casualty in a comfortable position with head and shoulders slightly raised
3. If casualty is unconscious:
   - Place in recovery position
   - Clear and open airway
   - Monitor breathing
4. Support casualty’s head and neck during any movement; avoid twisting movement
5. Keep casualty’s airway open with a chin lift
6. Control bleeding but do not apply direct pressure to the skull if you suspect a depressed fracture.
7. If blood or fluid comes from the ear, cover with a sterile dressing (lay casualty on injured side if possible to allow fluid to drain) DO NOT plug ear canal.
8. Call Triple Zero (000) for an ambulance. Note the casualty’s condition so that you can report it to the paramedics.

The spine is a flexible column with the spinal column housing the spinal cord. The spinal cord is encased entirely within the spine, surrounded by the cerebrospinal fluid which cushions the spinal cord against the stresses of movement. Injuries to the spine may impact on the spinal cord which can result in complete and permanent loss of feeling and paralysis below the point of injury. The casualty may become a paraplegic or a quadriplegic.

Causes of spinal injuries include falls from a height, a direct blow to the spine, diving or surfing accidents, high speed car/motorcycle accidents or sudden acceleration or deceleration (such as whiplash).

**Signs and Symptoms**
- Pain at or below site of injury
- Tenderness over the site of injury
- Absent or altered sensation e.g. tingling in hands or feet, below site of injury
- Loss of movement or impaired movement below site of injury

**Management**
1. Immobilising the spine is the priority for any casualty with a suspected spinal injury.
2. Support the head and neck in a neutral position by placing your hands on either side of the casualty’s head.
3. If the casualty is unconscious, the airway must be kept open.
4. Calling Triple Zero (000) is urgent.
5. **DO NOT** move the casualty unless you have to.

**Scenario 15**
At your child care centre, a child fell off the monkey bar and hit their head on the frame of the set - up 10 minutes ago. The child has a “lump and bump” on their forehead. There are no other visible injuries.

**What First Aid actions should you take?**
A. Let the child rest, apply a cold pack to the injury and monitor for concussion;
B. Place the child in the recovery position to rest for 30 minutes;
C. Give the child two tablets of Panadol and let the child rest in the shade;
D. As there are no visible injuries let the child continue to play somewhere else.
FACIAL INJURIES

Eye Injuries

The eye is one of the most sensitive and delicate organs in the body. It is easily injured and should be managed with great care. Causes of eye injuries run the gamut from fingernail scratches, grit, chemical burns, radiant heat and trauma from blunt or sharp objects.

Quick reference to managing eye injuries

General rules:
- Start with DRSABCD
- Do not put pressure on the eye i.e. if applying cover, it should be loose.
- Only cover the injured eye
- Advice the casualty not to rub their eye, try not to blink hard, move their eyeball. Ask casualty not to move eyes by e.g. focusing on an object directly in front of them

<table>
<thead>
<tr>
<th>Burns to the eye</th>
<th>Penetrating eye injury</th>
<th>Wounds to the eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open the eyelid gently if eye lid is not fused together and wash eye with cold flowing water for 20 mins</td>
<td>Lay casualty on back “Protect” the embedded object e.g. paper cup</td>
<td>Place light dressing over eye</td>
</tr>
<tr>
<td>Place eye pad(s) or light dressing over injured eye(s)</td>
<td>Call Triple Zero (000) for an ambulance ASAP</td>
<td>Lay casualty on back if only the eyeball is involved</td>
</tr>
<tr>
<td>Call Triple Zero (000) for an ambulance ASAP</td>
<td></td>
<td>Seel medical aid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Small foreign object in eye</th>
<th>Embedded foreign object in the eye</th>
<th>Smoke in the eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the casualty to look up</td>
<td>Cover eye and seek medical aid</td>
<td>Wash eyes with Normal Saline or clean water</td>
</tr>
<tr>
<td>Draw lower lid down. If object is visible, it could be removed with the corner of moist, clean cloth OR wash eye with Normal Saline or clean water</td>
<td></td>
<td>Seek medical aid if necessary</td>
</tr>
<tr>
<td>If unsuccessful, cover eye and seek medical aid.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nosebleeds

There are various causes of nosebleeds ranging from trauma to simple excessive blowing to no obvious causes.

Management
1. Ask the casualty to breathe through mouth and not to blow nose
2. Sit the casualty up, head slightly forward
3. Apply pressure by pinching the soft part of the nostril (below the bridge) together for at least 10 minutes
4. Loosen tight clothing around neck
5. Place cold wet towels around neck
6. If bleeding persists seek medical aid.
Foreign object in the ear

Foreign objects such as beads or even an insect can become lodged in the ear canal. An insect in the ear canal can be quite alarming and uncomfortable.

Management

1. Look in the ear to identify the object
2. Do not attempt to remove the object
3. See medical aid

If the object is a small insect in the ear:
1. Tilt the side, injured side up
2. Gently pour some (a tablespoon) warmed (to body temperature) vegetable oil (or water if oil not available) into the ear canal
3. Tilt head injured side down. If insect does not float out, seek medical aid.

PENETRATING CHEST INJURIES

A penetrating chest wound can cause severe internal damage within both the chest and upper abdomen. The lungs are particularly vulnerable to injury. If a puncture is deep enough, the rib cage may be penetrated allowing air to enter the chest through the wound. When air enters this space, called the pleural cavity, the lung on this injured side collapses. Pressure in the chest cavity may build up to such an extent that the heart is pushed to the side. The function of the uninjured lung on that side may also be affected.

Signs and symptoms

- Pain at site of wound
- Unconsciousness
- Difficult and painful breathing
- Bloodstained bubbles around wound when casualty exhales
- Sound of air being sucked into chest as the casualty inhales
- Check for an exit wound

Management

1. Follow DRSABCD
2. Place casualty in a sitting position with affected side down
3. Cover the wound – use the casualty’s or your own hand to stop air flowing in and out of chest cavity
4. Cover wound with a dressing such as plastic sheet or bag or aluminium foil. If not available, use a sterile dressing or pad
5. Seal with tape on three sides (not bottom)
6. Call Triple Zero (000) for an ambulance

Scenario 16

A child has had a sharp exposed branch puncture their chest when they fell hard into a bush. When the child exhales you can see blood stained bubbles around the wound and on inhalation a sound of air being sucked in is heard.

What is the priority in managing the injury?

A. Call Triple Zero (000) and ensure another colleague is waiting for them outside;
B. Seal the wound while allowing fluid and air to escape from the wound;
C. Lay the child down on their back and raise their legs upright;
D. Collect all the necessary equipment to do CPR and give oxygen with a mask;
ABDOMINAL INJURIES

Organs in the abdomen can easily sustain an injury because there are is no bone structure to protect them. The liver, spleen and stomach tend to bleed easily and profusely, so injuries to them can be life-threatening. Injury to the bowel may result in the contents being spilled into the abdominal cavity, causing infection.

An injury to the abdomen can be open or closed. Both are serious as even in a closed wound an organ can be ruptured, causing serious internal bleeding and shock. With an open injury, abdominal organs can protrude through the wound.

Signs and symptoms
- Severe pain
- Nausea or vomiting
- Bruising and tenderness around the wound
- Shock or unnatural paleness
- External bleeding
- Blood in the urine
- Distension/swelling, protrusion of intestines through an abdominal wound

Management
1. Follow DRSABCD
2. Place casualty on back with knees slightly raised and supported (a pillow may be used under the head to increase comfort)
3. Loosen clothing
4. Cover protruding organs with aluminium foil or plastic food wrap, or a large, non-stick sterile dressing, soaked in sterile saline (clean water if saline is not available)
5. Secure with broad bandage (not tightly)
6. Call Triple Zero (000) for an ambulance

DO NOT give anything to drink.
DO NOT try to push organs back into abdomen.
DO NOT apply direct pressure to the wound.

Scenario 17

A child has managed to eviscerate themselves and their intestine is protruding from their abdomen.

What First Aid action would you take in managing the injury?
A. Apply the DRSABCD Action Plan and decide it is too dangerous to approach so just wait for the arrival of an ambulance;
B. Immediately apply firm pressure with your bare hands to push the intestines back into the abdomen;
C. Apply the DRSABCD Action Plan and include covering the protruding organs with plastic food wrap soaked in clean water;
D. Leave the child where they are and after calling Triple Zero (000) get the other children out of the way.
BURNS

Burns are injuries to the skin and underlying tissues caused by heat, extreme cold, chemicals, corrosive substances, electricity, friction and radiation. Burn injuries are usually extremely painful and the risk of infection is high.

Although there is no bleeding, burn injuries result in fluid loss, loss of temperature control and damage of varying degrees of underlying layers of tissue and nerves. Damage may include the respiratory system and eyes. The probability of the casualty going into shock is very high. Besides the obvious physical damage, burns also cause psychological damage as they can disfigure and disable resulting in an altered body image.

Various causes of burns:

<table>
<thead>
<tr>
<th>Most common is</th>
<th>Fire (flame), steam, hot objects or liquids in direct contact with the body.</th>
<th>Heat generated when skin rubs on materials such as rope and carpet.</th>
<th>Electrical energy from the mains or lighting can produce very serious burns.</th>
<th>Most common chemicals in the home cause burns e.g. pool acid, caustic soda.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation</td>
<td>Thermal</td>
<td>Friction</td>
<td>Electrical</td>
<td></td>
</tr>
</tbody>
</table>

General Management

1. Follow DRSABCD
2. Remove the source of the burn
3. Cool the burnt area with cool running water
4. Cover burn for example with a non-adhesive burns dressing, or plastic food wrap
5. Manage shock

The purpose of the cool running water is to return the burnt area to normal temperature. It can take up to 20 minutes. With bitumen burns continue the cooling for 30 minutes but no longer.

Clothing, jewellery and rings may be removed unless stuck. If a person’s clothing is on fire, manage by applying the action of STOP-DROP-ROLL.

DO NOT apply lotions, ointments or oily dressings.  
DO NOT prick or break blisters.  
DO NOT give casualty alcohol.  
DO NOT over cool casualty.  
DO NOT use towels, cotton wool, blankets or adhesive dressings directly on burn.  
DO NOT remove clothing stuck to burnt area.

Seek medical aid if:

- Burn involves airway, hands, face, feet or genitals
- Burn is deep, even if casualty does not feel any pain
- A superficial burn is bigger than a 20 cent piece
- You are unsure of severity of burn

Scenario 18
A child had a hot cup of tea land on their bare, right lower arm. The area is now turning red and the child is upset.

What is your First Aid priority?

A. Put their injured arm under cool gently running water;  
B. Spread toothpaste evenly all over their injury;  
C. Pick up the child and give them a cuddle;  
D. Drive the child to the nearest hospital.

You will be required to demonstrate the management of a burn
POISONING and TOXIC SUBSTANCES

A poison is any substance which, when introduced into the body, interferes with one or more normal body functions. Poisons may be solid, liquid or gaseous. They may be found in food, medication, household substances and industrial products. Poisoning may be intentional or accidental.

Poison may enter the body by:
- Ingestion
- Inhalation
- Absorption
- Injection

Signs and symptoms

The signs and symptoms of poisoning depend on the nature of the substance and, in some cases, how it entered the body. Any of the following may occur:

- Abdominal pain
- Drowsiness
- Nausea or vomiting
- Burning pain from mouth through to stomach
- Difficulty breathing
- Tight feeling in chest
- Headache
- Ringing in ears
- Blurred vision
- Seizures
- Smell of fumes
- Odour on breath
- Bite or injection marks, with or without local swelling
- Contamination of skin
- Change of colour, blueness around lips
- Burns around and inside mouth or on tongue
- Sudden collapse

General management

1. DRSABCD
2. Call Triple Zero (000) for an ambulance
3. Call fire services if atmosphere is contaminated with smoke or gas
4. With a conscious casualty - listen to history and give reassurance
5. Call Poisons Information Centre 13 11 26

Note: DO NOT try to induce vomiting, but if the casualty does vomit, you should send as much of the vomit as possible to the hospital with them.

Note: DO NOT give the casualty anything to eat or drink.

- Wash corrosive substance off mouth and face with water or wipe it off
- With inhaled poisons - move casualty to fresh air if possible

Scenario 19
A child tells you that the lemonade in the kitchen tastes awful. The child is not showing any signs or symptoms of poisoning.

What First Aid steps should you take?
A. Make the child vomit by sticking your finger down their throat;
B. Give the child a glass of milk to drink every 10 minutes;
C. Drive the child to the local doctor as fast as you can;
D. Sit the child down and call the Poison Information Centre for advice.
BITES & STINGS

Bites and stings fall into four main categories: INSECTS - SPIDERS - SNAKES - MARINE.

Management

<table>
<thead>
<tr>
<th>Pressure Immobilisation</th>
<th>Apply ice pack or cold pack</th>
<th>Hot Fluid</th>
<th>Vinegar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snakes</td>
<td>Bee Wasp</td>
<td>Stonefish</td>
<td>Box Jellyfish</td>
</tr>
<tr>
<td>Funnel Web &amp; Mouse Spiders</td>
<td>Centipedes Scorpions Red-Back Spider Ant &amp; Tick</td>
<td>Bullrout Stingray Bluebottle</td>
<td>Irukandji Jellyfish</td>
</tr>
</tbody>
</table>

**Snakes**

The venom travels in the lymphatic system of the body. Applying a pressure immobilisation bandage reduces the speed of the circulation. Commence the application with a non-adhesive dressing to the site of the bite and bandage firmly with a crepe bandage (refer to how to apply a pressure immobilisation bandage below).

- **DO NOT** wash the venom off the skin, it can be used to identify the type of snake that bit the casualty
- **DO NOT** cut the bitten area
- **DO NOT** try to suck the venom out of the wound
- **DO NOT** use a constrictive bandage
- **DO NOT** try to catch the snake

**CALL** Triple Zero (000) for an ambulance.
How to apply a Pressure Immobilisation Bandage

Use heavy crepe or elasticised roller bandage (about 10-15cm wide). Only use other material if these items are not available.

1. If on a limb, apply a broad pressure bandage (crepe bandage preferred) over the bite as soon as possible
2. Apply a firm, heavy crepe or elasticised roller bandage just above the fingers or toes and moving upwards as far as can be reached up the limb (including the bite site)
3. Apply tightly without stopping blood supply to limb
4. Immobilise the limb using a splint and secure with second bandage
5. Check at fingers or toes for circulation (blood supply)
6. Keep casualty and the limb at rest
7. DO NOT remove splint or bandage once applied

Note: DO NOT allow casualty to move

Scenario 20
You are on a bush walking excursion with a group of children. One of the accompanying adults called out that they have been bitten by a snake.

What would your First Aid management include?
A. Ask the casualty to lie down and apply a pressure immobilisation bandage;
B. Find a knife to cut the bite site and suck on the wound three times;
C. Ask everyone to find and catch the snake for identification purposes;
D. Wash the bite site. Hurry back to the car and drive to the nearest hospital.

You will be required to demonstrate the application of a pressure immobilisation bandage
EXPOSURE TO HEAT

The body works efficiently only as long as it remains at a constant temperature between 36°C and 37°C. If the body temperature drops or raises more than a few degrees it cannot function properly.

**Heat cramps** - Result from losing too much water and salt through sweating causing painful muscle cramps, usually in legs and abdomen.

**Heat exhaustion** - Results from being physically active in a hot environment without taking the right precautions.

**Heat stroke** – A potentially life threatening condition. Water levels in the body become so low that sweating stops and body temperature rises because the body can no longer cool itself.

Management
The basic principle of managing exposure to heat is immediate cooling. However, you must take care to ensure that the casualty is not over cooled.

**General management**
- DRSABCD
- Move the casualty to a cool environment
- Give fluids to drink in small amounts

**For heat cramps**
1. Ask the casualty to stop the activity and rest in a cool environment
2. Gently stretch the affected muscle and massage gently if this assists in relieving pain
3. Place an ice pack on muscle area
4. Give cool water to drink.

**For heat exhaustion**
1. Move the casualty and lay down in a cool place with circulating air
2. Loosen tight clothing and remove unnecessary garments
3. Sponge with cold water
4. Give cool water to drink if conscious
5. Seek medical aid if casualty vomits or does not recover promptly

**For heat stroke**
In the case of heat stroke, you must cool the casualty more rapidly by:
1. Removing almost all clothing
2. Applying cold packs or ice to neck, groin and armpits
3. Cover body with a wet sheet and direct a fan onto sheet if possible to increase air circulation
4. Call Triple Zero (000) for an ambulance. This casualty needs urgent medical aid.
5. If the casualty is fully conscious and is able to swallow, give fluids
EXPOSURE TO COLD

To conserve body heat, blood vessels in the skin shut down to prevent the body’s core heat escaping. Wind and skin wetness increases the effects of cold air.

The body loses heat by radiation especially from the head, evaporation, breathing, conduction and convection. Certain groups of people are particularly prone to cold-induced conditions. These include the elderly, babies and young children, and anybody weakened by disease/illness, starvation, fatigue, injury etc.

Signs and Symptoms
When body temperature first drops, the signs are:
• Feeling cold
• Shivering
• Clumsiness and slurred speech
• Apathy and irrational behaviour

As the body temperature continues to drop:
• Shivering usually ceases
• Pulse may be difficult to find
• Heart rate may slow
• Level of consciousness continues to decline

Management
Hypothermia occurs when the body’s warming mechanisms fail, or is overwhelmed, and the body temperature drops below 35°C.

The aim is to stabilise core temperature rather than attempt rapid rewarming:
1. DRSABCD
2. Move the casualty to a warm, dry place
3. Protect casualty from wind, rain, sleet, cold and wet ground
4. Handle gently, avoid activity or movement
5. Remove wet clothing
6. Wrap casualty in blanket
7. Cover head to maintain body heat
8. Give casualty warm drinks if conscious
   Note: Add hot water bottles or heat packs to casualty’s neck, armpits and groin if managing hypothermia
9. Call Triple Zero (000) for an ambulance if hypothermia is severe and when in doubt

Scenario 21
You are acting as a marshal for a fun run when a runner arrives at your station and collapses. The casualty tells you they feel exhausted, dizzy, has a headache, and is nauseated. The casualty is breathing rapidly and has pale, cool and clammy skin.

Which of the following actions would you take in managing the casualty?
A. Call Triple Zero (000) for an ambulance and wait with the casualty;
B. Give the runner a bottle of water to drink and tell them to continue the run;
C. Lie the casualty down in the shade, give fluids and sponge with cold water;
D. Massage the casualty’s limbs for 15 minutes and make them drink 2 litres of water.
A space blanket reflects radiated heat back to the body, but it can also conduct heat away so some form of insulation such as blankets, a sleeping mat or even thick layers of newspaper should be provided either inside or outside of the space blanket.

FROSTBITE

Frostbite occurs when the skin and underlying tissues become frozen as a result of exposure to below zero temperatures.

In superficial frostbite, the skin is white, waxy-looking and firm to touch but the tissue underneath is soft. The casualty may feel pain at first, followed by numbness. In deep frostbite, the skin turns greyish-blue.

The skin feels cold and hard and there is no feeling.

Management

1. DRSABCD
2. Move the casualty to a warm, dry place and prevent further heat loss
3. Rewarm the frostbitten part with body heat (e.g. place frostbitten fingers in armpit)
4. Handle the frozen tissue very gently to prevent further tissue damage
5. Call Triple Zero (000) for an ambulance
6. If possible remove any jewellery

DO NOT rub or massage the frozen area.
DO NOT re-warm with fire or other direct heat.
DO NOT apply snow or cold water to area.
DO NOT give a casualty alcohol to consume.

Scenario 22

In a group of bushwalkers you notice that one of them does not have rain protection. The person is staggering, has slurred speech, is shivering and complains of feeling cold.

What would you do?
A. Place the casualty as near as possible to the camp fire;
B. Provide the casualty with an alcoholic drink;
C. Massage the casualty arms and legs briskly to warm them up;
D. Move the casualty to a warm place and warm them up slowly.
**FIRST AID TOOLS**

First Aid, like all other skills that are practical by nature, needs the necessary tools to be effective. In First Aid, the tools include:

1. You booking into a course! Training is the first stage in achieving the skills and knowledge
2. Having the right equipment i.e. a First Aid kit to suit your needs in the workplace, in your home and in your car. How about other aspects of your life e.g. your sports club?

A centre-based service must provide an appropriate number of suitable first aid kits that are easily recognisable and readily accessible to adults.

A family day care educator must provide a suitable first aid kit at the residence or family day care venue that is easily recognisable and readily accessible to adults.

First aid kits should also be taken when leaving the service premises for excursions, routine outings or emergency evacuations.

**Contents of a First Aid kit**

**Items that should be considered when selecting a First Aid kit:**

- Non-adhesive dressings
- Hypo-allergenic tape
- Disposable gloves
- Resuscitation face shield
- Ice pack
- Notepad & pencil
- Roller bandages
- Normal saline solution
- Scissors
- Thermal blanket
- Triangular bandage
- Tweezers
- Adhesive strips

**Improvising**

There may be occasions where you need to give First Aid but there is no First Aid kit available.

If a kit is not available, you will need to improvise First Aid equipment, by using whatever you can find but, sort out the pros and cons of using the item before applying it.

For example, using a plastic bag for gloves, and a folded face cloth wrapped in cling wrap as a non-adhesive pad are feasible and has positive outcomes. But using a plastic bag as a mask is not, as there is no substitute for a face mask.

However, you should not let the absence of a First Aid kit prevent you from offering First Aid to a casualty.
COMPLETING THIS REVIEW PACK

How did you do in the scenarios? Please check your answers against the answers provided below. If you did not achieve the correct answer initially, you should review the section again.

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<td>7. B</td>
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<td>8. C</td>
<td>16. B</td>
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</table>

CONGRATULATIONS

You have completed the self-directed pre-course learning pack.

Again, thank you for choosing St John. We look forward to seeing you at the course.

References:

Australian and New Zealand Resuscitation Council Guidelines

St John Australian First Aid Manual Edition 2012
ST JOHN FIRST AID READY PROGRAM

St John 5 steps to First Aid Readiness enable organisations and individuals to minimise their business risks by being better prepared to respond to First Aid emergencies.

Many businesses believe they are First Aid READY for a First Aid emergency BUT this is not necessarily the case.

First Aid compliance is a complex area.

St John 5 Steps to First Aid Readiness enables organisations to minimise their business risks by being better prepared.
How First Aid READY is your workplace?
If you cannot answer these questions confidently, contact St John for assistance to ensure your workplace is always safe and always First Aid Ready.

<table>
<thead>
<tr>
<th>R</th>
<th>First Aid Ready Assessment</th>
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<tbody>
<tr>
<td></td>
<td>• When did your workplace last undertake a First Aid Assessment?</td>
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<td></td>
<td>• Is your organisation a high or low risk workplace?</td>
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<td></td>
<td>• Do you have workplaces that are remote or where access to emergency services is limited?</td>
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</tbody>
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<thead>
<tr>
<th>E</th>
<th>Enough Trained First Aiders</th>
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<tbody>
<tr>
<td></td>
<td>• When your First Aiders are away from the workplace - sick, at lunch or on leave, who’s looking after you?</td>
</tr>
<tr>
<td></td>
<td>• Do all First Aiders in your workplace have current First Aid qualifications and up-to-date skills obtained in the last 12 months?</td>
</tr>
<tr>
<td></td>
<td>• Does everyone know who the First Aiders are in your workplace?</td>
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</table>

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<tr>
<th>A</th>
<th>Accessible, visible First Aid Equipment</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Does your workplace have visible First Aid Kits and Signage?</td>
</tr>
<tr>
<td></td>
<td>• How often is your First Aid Equipment checked so it is ready for a First Aid emergency?</td>
</tr>
<tr>
<td></td>
<td>• Does your workplace require a First Aid Room and/or Equipment?</td>
</tr>
</tbody>
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<tr>
<th>D</th>
<th>Drills and First Aid Procedures</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Does your workplace run First Aid Drills?</td>
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<td></td>
<td>• Do you need assistance to assess your First Aid Drills and Procedures?</td>
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<tr>
<td></td>
<td>• Are your workplaces First Aid Procedures visible and accessible?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Y</th>
<th>You and your unique Business Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Would you know if, and when, your business requires additional First Aid?</td>
</tr>
<tr>
<td></td>
<td>• Do some of your activities increase First Aid risk to employees, visitors and customers?</td>
</tr>
<tr>
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<td>• How do you cover First Aid beyond standard business hours?</td>
</tr>
</tbody>
</table>

Are you First Aid READY?

CALL 1300 360 455
www.firstaidready.com.au