CHINTHURST SCHOOL

TRADITIONAL VALUES | MODERN TEACHING

Chinthurst Preparatory School

First Aid Policy

Reviewed by TB/WB/SN - September 2016

Next review date – September 2017

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1.1 - Chinthurst School First Aid Policy Statement

The Governing Body is responsible for ensuring that there is adequate and appropriate first aid provision at all times when there are people on the school premises and during off-site visits and activities. (Health and Safety (First Aid) Regulations 1981)

Adequate first aid provision at Chinthurst means:

1. There are sufficient numbers of trained personnel together with appropriate equipment to ensure someone competent in basic first aid techniques can rapidly attend an incident at all times during normal school hours.
2. Appropriate first aid arrangements are made whenever staff and pupils are engaged in off-site activities and visits.

1.2 - Responsibilities under the policy

1.2.1 - **The School Health and Safety Committee:** Mr T. Button (*Headmaster*), Mrs A. Lothian (*Bursar*) and Mrs Maxine Hulme (*Designated Governor*), Mr W. Beadle (*Head of Policy and Procedure*), Mr J. Vetch Dip Grad (*Health and Safety Consultant*) and Mr M. Russell (*Fire Safety Advisor*) on behalf of the Governing Body, are responsible for:

- Inspecting the School's first aid provision each term.
- Reporting to the Governing Body their recommendations.
- Ensuring suitably qualified first aid staff are available and arranging appropriate staff training.
- Ensuring there is adequate provision of first aid services during school hours.
- Appropriate first aid cover is available for off-site school organized activities.
- Organizing the provision of first aid equipment
- Reviewing accident forms.

1.2.2 - **The Qualified First Aider – Miss J. Smith** (Qualified 'First Aid at Work' – August 2016; renewed every 3 years) is responsible for:

- Responding promptly to calls for assistance.
- Providing first aid support within level of competence.
- Summoning medical help as necessary.
- Recording details of treatment given.
- Maintaining accurate records of first aid treatments given.

1.2.3 - **Mrs Janice Russell** is 'Emergency First Aid at Work' trained (August 2016). Mrs Russell will act as the chief on-site first aider in the event of Miss Smith being off site.

1.2.4 - **The Qualified Paediatric First Aiders are:** Mrs. Fran Button (Aftercare), Mrs. Jackie Daley (EYFS) and Mrs. Carrie Smith (EYFS.

1.2.5 - **Appointed Persons** (all staff who have received First Aid training every 3 years) are responsible for:

- Giving assistance to the Qualified first aider.
- Taking charge when someone becomes ill.
- Ensuring that an ambulance or other professional medical help is summoned as appropriate.

1.2.6 - **Head of Sport** is responsible for:

- Ensuring appropriate first aid cover is available at all out of hour's sports activities.
- Ensuring appropriate first aid cover and equipment for all practice sessions and matches.

1.2.7 - **Parent/Guardian** is responsible for:

- Completion of the medical form issued by the school annually. Any changes to any new or existing medical condition must be notified to the school as soon as possible.
- Providing a signed consent form for administration of medication.
- Ensuring that a member of the family or other nominated person is easily contactable at all times in the event of an emergency or a child requiring to be sent home from school due to illness or injury.

2.1 - First Aid Risks

2.1.1 - The Health and Safety Committee carries out the following annual assessment of first aid needs at Chinthurst:

- Numbers of pupils, staff and visitors on site.
- Layout and location of buildings and grounds.
- Specific hazards- highlighting areas where incidents are most likely to occur; break/Games &PE//Science/DT & Art/Kitchen/Maintenance
- Special needs.
- Hours of work.
- Out of hours and off-site activities.
- How many first aiders are needed during the school day?
- Out of hours and off-site arrangements.
- Back-up arrangements to cover absence of first aiders.
- Which departments require a qualified first aider?
- What equipment is needed?
- Where equipment is to be located.
- Where notices and signs are displayed.
- Good practice in record keeping.

2.1.2 - **Hours of work**

The school office (first aid station) is open in school hours from 0830 to 1730 Monday to Friday during term time.

2.2 – First Aid Kits

2.2.1 - First aid kits are clearly labelled with a white cross on a green background in accordance with Health and Safety regulations. The contents of the first aid kits may vary depending on the particular needs in each location. . First aid kits are currently situated in:

- School office (including travel bags which must be taken on school trips and other off-site activities).
- PE Office
- Kitchen
- DT Prep Room
- Science Lab
- Swimming Pool
- Pre-Prep
- Nursery
- Maintenance Dept
- Minibuses

2.2.2 - These areas are clearly marked with a sign.

2.2.3 - The school secretary is responsible for the checking and restocking of first aid kits at the beginning of each half term. Staff must notify the school secretary when items have been used so they can be replaced without delay.

2.3 – Information

2.3.1 - This First Aid Policy is located on the school website and is available to parents and staff on request in the school office.

2.3.2 - New staff are briefed on the first aid policy and procedures. This briefing includes:
Location of the school office (first aid station)

- What to do in an emergency
- Names of first aiders and appointed persons
- Location of first aid kits

2.3.3 - **First aid notices** are posted in the staff room, school office, kitchen, upper corridor of Morris House, and changing rooms. Notices give the names of first aider and location of first aid boxes.

2.3.4 - There is a locked **medicine cupboard** in the school office where all medicines are to be stored. Keys are kept by the office staff.

2.4 - Training

2.4.1 - **Miss J. Smith (Year 2 Class Teacher)** is the qualified first aider.

2.4.2 - A **qualified first aider** is someone who holds a valid certificate of competence in First Aid at Work. The certificate must be issued by an organization approved by the Health and Safety Executive and must be renewed every three years.

2.4.3 - An **appointed person** is someone who has attended a minimum of 4 hours first aid training (renewable every three years).

2.4.3 - **All staff at Chinthurst have attended this training and are competent to give emergency aid until further help arrives.**

3.1 - Minor Incidents/Illness

3.1.1:

- Any child sustaining an injury or suffering illness whilst at school will be treated by the school staff who if necessary will inform the parent/carer of any treatment given either by telephone or email.
- All minor incidents should be treated in the school office (cuts and grazes). The wound should be cleaned with sterile water and covered with a dressing. Staff should send the casualty with an escort to the school office or accompany them themselves if the casualty is in distress.
- If a child needs to be sent home from school, he/she will remain in the school office with a member of staff until collected by a parent/carer. The parent/carer is to collect the child as promptly as possible.

3.1.2 - A mobile bed is available near to the Bursar's office and may be used for any person requiring to lie down. The Bursar (or another suitably qualified member of staff) will remain with the casualty at all times until they can be collected.

3.2 - Major Incidents

3.2.1 - In the case of severe bleeding, serious injury to legs or back, head injury, eye injuries and severe nose bleeds, the casualty must not be moved and a qualified first aider called to the scene as soon as possible. He/She will assess if the emergency services are to be called. Such serious incidents must be reported to the Local Child Protection Agency with 14 days of the incident occurring.

3.3 - Hospitalisation

3.3.1 - In the event of a child needing to be taken to Hospital, a member of staff will escort the child and remain with him/her until the parent/carer arrives.

3.4 - Medication

3.4.1 - Prescribed medication may be administered by the school office staff or if unavailable a S.M.T. member. If a child needs to take medication whilst at school, the parent/carer should hand

it in to the school office. Medication should be clearly labelled and a medication consent form signed giving clear instructions.

3.4.2 - No non-prescription medication will be administered by school office staff or if unavailable a S.M.T. member unless the parent/carer has provided written, signed consent which is sought from parents at the time of acceptance to the school and thereafter annually by completion of the medical consent form. Such administration of medication will be recorded in writing in the school office, available to the appropriate staff members ensuring a full record of, and hence understanding of any dosages given is available. Thus allowing accurate monitoring of recent activity whilst equally enabling a periodic analysis of any particular repetition of event.

3.4.3 - Staff Medicines must be stored in the Main School & Pre-Preparatory Office where appropriate in a locked cabinet.

3.5 - Asthma / Epipens

3.5.1 - Inhalers and epipens (or any other treatment) must be kept in the school office, suitably labelled. Parents/carers should ensure that they are not out of date and replace when necessary.

3.6 - Medical history of pupils

3.6.1 - The Headmaster must ensure that all staff are aware of any relevant medical history of the children they teach. It is also essential that staff are aware of any children suffering from potentially life-threatening conditions such as diabetes, asthma or allergies which could give rise to anaphylactic shock, and the action necessary to take in the vent of such as attack.

3.7 - Swimming pool

3.7.1 - Children with open wounds must not swim.

3.8 - Matches and off-site activities

3.8.1 - A first aid bag must be taken on all trips. First aid bags are kept in the school office and must be taken on all coach trips and to matches. It is the responsibility of the member of staff to carry a first aid bag.

3.9 - Bodily fluids

3.9.1 - Gloves should be worn at all times if in contact with body fluids and any spillages cleaned up immediately.

4.1 - Accidents

4.1.1 - The guidance and in turn procedure to follow is outlined below; cross-referenced from the school's *Health and Safety Environmental Policy*:

Health and Safety Environmental Policy; *6.1 – Accidents at school; pgs. 26-27.*

6.1.1 - Every accident that occurs in the school or whilst representing the school in the working day must be reported, however slight it may be.

6.1.2 – This policy supports and has been strictly cross-referenced with our "First Aid" policy to ensure continuity and security across policy and procedural boundaries.

Accidents at the school

6.1.3 - Staff are 'First –Aid' qualified, and regular 'emergency first aid' inset training is held for all staff every 3 years.

6.1.4 - **Qualified First Aiders**

Miss Jessica Smith is 'First Aid at Work' trained (August 2016)

Mrs Janice Russell is 'Emergency First Aid at Work' trained (August 2016).

Mrs Fran Button (Aftercare) & **Mrs Jackie Daley** (EYFS) and **Mrs Carrie Smith** (EYFS) all hold paediatric first aid qualifications.

6.1.5 - If an accident does occur in the classroom, a school building, or outside then the first teacher to the scene needs to quickly assess how serious the injury is. If the injury is minor (the school defines 'minor' in terms of anything that *can* be dealt with, within the capabilities of the school) eg a small graze or a bump in the playground, then the child should be taken to school office where the school secretary will administer any first aid treatment that may be needed. **A record of this 'minor' incident must be made in the school's "*Minor Incident Log",* which is kept securely in the Main School Office.**

6.1.6 - If the accident is more serious (the school defines 'serious' in terms of anything that *cannot* be dealt with, within the capabilities of the school) and needs treatment elsewhere, then *if* the pupil can comfortably make their way to the school office this is where they should be taken to wait. The school secretary will inform their parents and explain what has happened and what action is being taken, eg. taken to local clinic / hospital etc. **The details of this incident must be entered into the 'accident book' in the Main School Office.**

6.1.7 – ***All*** accidents that occur at school and require treatment will be recorded in the *Minor Incident Log* or in the *Accident Book* as per the above protocol and depending on the severity of the accident.

6.1.8 - Depending on the severity of the accident will determine whether or not it will be reportable under RIDDOR 2013.

6.1.9 - If the injured pupil is unable to move then the teacher should not leave them. He / she should send 2 pupils to inform the nearest member of staff (starting with the nearest available classroom). It is the responsibility of *this* staff member who has been informed of the incident by the two pupils to assume command of the situation and inform the school secretary in the office, if it is a serious accident and/or an ambulance is needed. The pupils must return to the source of the accident straight away to confirm that another staff member has been informed.

6.1.10 - All staff are expected take a responsible and sensible approach towards ensuring the safety of the pupils and themselves at all times.

6.1.11 – In dealing with slips and trips, staff will ensure that they analyse the situation carefully and take appropriate measures as listed above and/or within line with the school's First Aid policy and procedures. Staff should also report the slip or trip hazard to Tim Button, Alison Lothian or Will Beadle who will instruct an appropriate response to the situation (coning off area etc…). Staff to ensure that pupils and visitors are directed away from slip and trip hazard. Moreover, staff are informed to 'look out' for potential slip and trip hazards in the promotion of effective prevention scenarios. Indeed, if such potential hazards are identified, the person(s) should contact Tim Button, Alison Lothian or Will Beadle who will instruct an appropriate response.

6.1.12 – Golden Rules:

- Act swiftly and with authority
- It is better to be safe than sorry
- Keep everyone calm

4.1.2 - Any member of staff or visitor to the school who has an accident must also complete an accident form (in the school office) which should be passed to the Bursar for filing.

4.2 - Medication

4.2.1 - Any treatment or medication administered should be recorded in the Medicine Book kept in the school office and should include:

- Date and time of administration
- Name and amount of medication or treatment given
- Name of person receiving medication
- Signature of administrator

4.2.2 - The Medicine Book is reviewed by the Health & Safety Inspection Committee each term and records are kept for a minimum of five years.

4.2.3 - In accordance with Health and Safety law, some accidents and illnesses must be reported to the Health and Safety Executive. This is the responsibility of the Bursar.

Appendix 1: Guidelines for Staff

(St John's Ambulance First Aid Training)

1. FIRST AID KIT (H.S.E. recommended contents)

- Guidance leaflet
- 20 plasters (NB; casualty may be allergic)
- 6 medium dressings
- 2 large dressings
- 4 triangular bandages (these are very useful and have many uses)
- 2 medium support bandages / 2 large support bandages
- 6 safety pins
- 2 eye pads
- 1 pair of disposable non-latex gloves
- alcohol-free wipes

Decide on special requirements for your workplace.

Designated 'first aider' is responsible for maintaining First Aid Kit and restocking its contents regularly.

Other useful items you may decide to include:

- chemical icepack
- distilled water

NB: **No lotions / No potions / No pills.**

The only exception may be 'aspirins'

Useful items to keep next to First Aid Kit:

- Notebook and pen (to keep a record)
- Clingfilm (used for covering burns)

EMERGENCY PRIORITY

1. **Breathing**
   ↓
2. **Bleeding**
   ↓

2. REPORTING AND RECORDING (H.S.E. First Aid Regulations 1981)

The employer has a duty to make correct First Aid provision for the workplace

A.C.O.P. (Approved Code of Practice and Guidance notes) updated regularly.

Risk Assessment will help you to decide what provision you need. (see Risk Assessment form)

- **Accident Book:**

Everything is to be recorded.

Anyone may write it down, but the First Aider who attended to casualty must sign it.

It is a legal document to be stored safely. (locked away) Your responsibility.

For children, must be kept until they are 21yrs, and for adults, for 3 years after incident.

- R.I.D.D.O.R.

Reportable Injuries, Diseases, and Dangerous Occurrences Regulations.

Incident must be reported to H.S.E. if as a result casualty is kept off work for 3 days or more or has been in hospital for 24 hrs or more.

3. EMERGENCIES AT WORK

Effective - Safe - Prompt

- **Incident Management Plan**

1. Assess situation
2. Make safe
3. Emergency aid
4. Get help
5. Report

- 6 Positions for First Aid

1. Abdominal lateral cut
2. Fractured pelvis – (releases pressure on pelvis)
   Breathing problems
3. Severe blood loss / fainting / fractured foot
4. 'Recovery Position' – only someone unconscious
5. Excessive bleeding away from head / stroke / eye injury
6. Keep airways open recovery – slightly leaning forward / bleeding nose

- **'112'** - European emergency number

Example information need to provide by phone:

- Give your contact telephone number / name / location
- Explain incident
- How many casualties / age / names if possible
- Injuries / conscious or not etc

Emergency operator will repeat questions to confirm details.

4. MANAGING CASUALTY

- Diagnose

Recognition features: 3 categories

1	→	2	→	3
History and External Clues		**Signs**		**Symptoms**

- Monitor (every 10 mins)
  - level of response
  - Breathing (16 breaths / min average)
  - Pulse (take for 1min / use wrist if casualty is conscious and neck if unconscious)

Air contains 21% oxygen – we use only 5% and breathe out 16%

Average Pulse = 60-80 per min

- **Primary Survey**

- DANGER
- RESPONSE
- AIRWAY
- BREATHING
- CIRCULATION

1. **DANGER**? Is there any danger? – If so, make it safe

2. **RESPONSE** (from casualty) – approach casualty

-

Ask? →

Alert if responds – eg 'can you hear me?' / 'are you ok?'

-
Command → Voice – eg ‘open your eyes’ / ‘move your fingers’
- Gentle shoulder shake /
tap → Pain
- Unresponsive

4 levels of response:
Alert → Voice → Pain → Unresponsive

1. If Alert / Voice / Pain – continue checking and monitoring casualty and asking questions.

2. If unresponsive –

AIRWAY – onto back / tilt head and lift chin

↓

Normal - **BREATHING –** see chest rise + fall / feel / hear (10 sec)

↓

ACTION

- Tilt head with palm of one hand + lift chin with 2 fingers only
- Check breathing – ‘listen / feel / look at chest’
- Ask someone to call **112**, and return
- Check for obvious bleeding – support chin and feel with back of other hand around edge of body

TREATMENT PROCEDURES

5. MINOR SEIZURES

Sometimes casualty can appear alert but is unresponsive. Not serious itself but could be!

It is a momentary 'switching off' – and absence seizure.

- Recognition Features

  - Sudden switching off
  - Slight localized twitching or jerking movements
  - Odd 'automatic' movements

- Aims

  - To protect casualty until fully recovered

- Actions

  - Help to sit down only if in danger, otherwise leave alone
  - Remove any dangers eg; kettle..
  - Reassure them that it is ok
  - Chat and advise medical consultation (DO NOT mention 'epilepsy')

6. FAINTING

Lack of oxygen to the brain

- Causes

  - Pain / exhaustion / hunger / emotional stress / standing or sitting still / heat etc..

- Recognition features

  i. Brief loss of consciousness
  ii. Slow pulse
  iii. Pale cold skin and sweating

- Aims

iv. Improve blood flow to brain
v. Reassure casualty

- Action

vi. Lay down and raise legs
vii. When better, remain lying position legs flat
viii. If ok, sit up and perhaps offer drink of water

7. BLEEDING

MINOR BLEEDING

- **Small Cut**

CLEAN – hygiene / use gloves / clean cut with water or antiseptic wipes. (bleeding itself will clean wound). Cover with plaster. Minimize risk of infection.

Eg; Cut to finger – if bleeding does not stop, raise arm / elbow resting on desk (elevate)

Is casualty at risk from Tetanus?

- **Bruising** – 1st sign is red mark / swelling

- To reduce swelling apply: **cold compress → pressure → elevate**

Monitor for underlying injury / possible fracture

- **Nosebleed**

i. Sit / leaning slightly forward
ii. Pinch nose below bridge (10 mins)
iii. Repeat if needed up to x3 (max 30 mins)
iv. If bleeding persists send to hospital

SEVERE BLEEDING

*** **APPLY PRESSURE + ELEVATION** ***

- Use disposable gloves if available
- Apply pressure over wound with fingers or palm of hand
- Raise and support injured limb above level of heart
- (if in shock, raise and support legs)
- Cover wound with dressing bandage. Tight enough to maintain pressure
- If bleeding comes through dressing, apply 2nd dressing on top
- If continues to bleed, remove both dressings and reapply new one, slightly tighter
- If injury is to hand or forearm, support in elevation sling

OBJECT EMBEDDED IN WOUND

*****DO NOT REMOVE EMBEDDED OBJECT*****

Aim to cover wound without touching object. (tented bandage)

- Apply pressure either side of object
- If injury is on limb, raise limb above heart
- If in shock, raise and support legs
- If possible, build up padding either side of object and then apply dressing

or

- Apply dressing either side of object
- Support in raised position

ABDOMINAL BLEEDING

*****Cover wound and treat for shock*****

- cover with sterile dressing
- secure with 'broad' or 'narrow' fold bandage (use triangular bandage)
- horizontal cut – place in '**position 1'**
- vertical cut – **lie flat**
- any organs exposed – cover with clingfilm / plastic bag to keep moist

BODY PARTS

*****fingers / hands etc*****

- do not clean
- place in cling film / plastic bag
- wrap with triangular bandage to protect and cushion to avoid damage
- pack around with ice in another plastic bag / box..
- label with name of casualty and time of incident if possible

8. BURNS and SCALDS

CAUSES : hot surfaces / fire / sun / chemicals / steam / ice / electricity etc..

Types:

Dry - touching hot iron etc..

Scald - hot liquid / steam / something wet etc..

Electrical - normally entry + exit wound visible

DANGER to yourself → turn off contact

- May interfere with heart rhythm → **refer to hospital**

Cold -

Chemical - acid / bleach / chlorine (burn develops slowly)
Go to hospital to be checked

Radiation - sunburn: **1. Superficial** – top layer skin / redness

2. partial thickness – redness / blisters

3. Full thickness – tender / raw / blistered

(Skin is in layers – full thickness burns go to lowest layers of skin. May not 'feel' too much pain at first, as it will have damaged nerve endings.)

TREATMENT

i. cool with cold running water
ii. remove covering / clothing on area if possible, not if stuck
iii. remove jewellery / watches / rings etc..
iv. cover with clingfilm – reduces risk of infection and keeps out air.
(lay loosely over burnt area do not wrap around it as it may swell)
v. severe burns → shock → lay down with feet raised

1% of body surface burned = hand palm size

Guideline for HOSPITAL:

5% SUPERFICIAL = Hospital

1% PARTIAL = Hospital

all FULL THICKNESS = Hospital

all CHILDREN = Hospital

10. SPRAINS and STRAINS

SPRAINS affect joints STRAINS affect muscles

Apply the '**R.I.C.E**' method

REST
ICE
COMPRESS
ELEVATE

- Sit or lie casualty down
- Support injured part in elevated comfortable position
- If injury just happened, apply cold compress / ice pack for at least 10 mins
- Apply even pressure – surround area with thick soft padding (cotton wool/plastic foam) and secure with bandage
- Elevate injured part
- Check circulation every 10 mins
- If serious refer to hospital

11. DISLOCATION

If accompanied by sickening pain and joint looks peculiar, could be dislocation.

Action - immobilize and support joint. Do not move until this is done

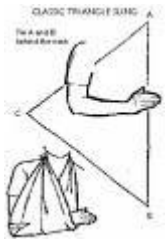
- send to hospital

- do not give drink or food as may need anaesthetic

DISLOCATED SHOULDER
Will feel heavy and painful – support with sling

TYPES OF SLINGS

- **ARM SLING 'S.A.D'**



Use for: -**S**IMPLE rib fracture

-ARM injury + wrist

-DISLOCATED shoulder

Supports forearm horizontally or slightly raised across body

- keep injured part supported
- always work from infront of casualty and from injured side, if possible
- 'point to joint + base to toes'
- Slide under arm and tie around neck
- Check hand for circulation

- **ELEVATION SLING**

Use for: -Cuts in hand or forearm

-Injuries and fractures to hand

-Burns – to minimise swelling

-Support chest and complicated rib fractures

Supports forearm and hand in raised position across chest with fingers touching shoulder.

- Casualty support injured arm up across chest
- Place triangular bandage over injured arm (point to joint)
- Casualty hold bandage in fingers on shoulder
- Tuck bandage under forearm and around elbow
- Twist bandage securely around elbow
- Bring end diagonally across back and tie at shoulder
- Check sling is securely supporting elbow and arm

BANDAGES

Principles of Applying Bandages:

- Keep injured part supported
- Keep casualty comfortable – sitting or lying if possible
- Apply firmly but not too tightly
- Leave fingers and toes exposed where possible – to check circulation

NB: Be careful with crepe bandages as they will get tighter as injury swells

APPLYING BANDAGE

Support bandage should extend well beyond injury to provide pressure over whole area:

1. ARM and LEG

- Place tail of bandage under injury
- Work from inside limb outwards – make 2 turns to secure
- Make series of spiralling overlapping turns up limb
- Finish with straight turn and secure bandage

2. HAND and FOOT

HAND

- Place tail of bandage inside wrist, make 2 straight turns by base of thumb around wrist
- Pass bandage diagonally across back of hand to nail of little finger
- Take bandage under, across fingers to base of index finger. Leave thumb free.
- Pass bandage diagonally across back of hand to outer side of wrist
- Wrap around wrist and over hand again.
- Repeat
- Finish with 2 straight turns around wrist, and secure.
- Check circulation in fingers

FOOT

- Same as for hand

- Begin bandaging at base of big toe + leave heel unbandaged
- Apply 'figure of eight' around ankle and foot
- Secure bandage at ankle
- Elevate foot
- Check circulation in toes

12. CRUSH INJURY

Crush Injury Syndrome**

If area of muscle is crushed for long can create kidney failure.

15 mins time limit from start of crushing to release. Kidneys are only able to cope with toxins for 15 mins.

- Do primary survey

If can not be released inside 15 mins or unsure how long been crushed

- Call ambulance and fire brigade immediately. **Do not release.**
- Monitor **'abc'** and treat other obvious injuries

13. EYE INJURY

- **Irrigation**
- Tilt head back → pull lower lid down → /upper lid up → sterile saline capsules
- If can not clear, cover eye with eye pad.
- Place in position 5
- Call ambulance

14. HEAD INJURIES

RECOGNITION

- Change in level of response **(A**lert → **V**oice → **P**ain → **U**nresponsive **)**
- Wound?
- Headache?
- Loss of memory?
- Confusion?
- Nausea?

TREATMENT (general)

- A B C
- Maintain airway

- Monitor level of response – getting better or worse
- Get help if necessary

ACTION

- Change in level of response
- Mechanism of injury (what has happened?)
  will help to decide how serious injury might be
- Position – if suspected skull fracture could also have injured neck
  DO NOT MOVE
- Medical aid if judged necessary
- Monitor condition

15. LOW BLOOD SUGAR

Most prone are diabetics but anyone can suffer from 'LBS'. (1 IN 400 are diabetic)

RECOGNITION

-irritable / miserable	- faint
-tired / lethargic	- blurred vision
-feel cold	- hunger
-light headed	- poor concentration
- feel sick	- weak / dizzy
- sweaty	- forgetful

* Alcohol lowers blood sugar level *

AIMS:

- Raise blood sugar level quickly
- Get help if necessary

ACTION:

- Sit casualty down / rest
- Give sugar (chocolate / biscuits / fizzy drinks with sugar)
- If no recovery send for help

Caution :

- if consciousness is impaired, **DO NOT** give anything to eat or drink
- if unconscious, perform 'primary survey

16. SEIZURES

1 in 200 people have seizure / epilepsy

CAUSES:

vi. epilepsy
vii. head injury
viii. disease eg; brain tumour
ix. shortage of oxygen to brain
x. shortage of glucose to brain
xi. poisoning

RECOGNITION:

xii. lips quiver
xiii. loud cry
xiv. muscles tense
xv. shaking
xvi. 'foam' at mouth
xvii. fall to floor
xviii. eyes fixed
xix. incontinent
xx. possibly vomit (no control)

May get an 'AURA', sensing a seizure

8X normal strength

AIMS:

- protect casualty from injury
- give care when regains consciousness
- arrange removal of casualty to hospital if necessary

ACTION:

- try to ease any fall if safe to yourself / remove dangers
- protect casualty / keep people away
- when over, perform primary survey
- put in recovery position

Caution:

- **do not move** casualty unless in immediate danger
- **do not put** anything in mouth
- **do not use** force to restrain casualty

WARNING:

Call 999 / 112 if…

- unconscious for 10 mins +
- seizure continues for 5 mins +
- seizure repeats

(If not careful, casualty can get into state of 'continual seizures' until they die)

17. BONE INJURIES

FRACTURES:

*** A fractured thigh can lose up to 3 pints of blood ***

Cause:

- direct or indirect force
- twisting or wrenching

RECOGNITION:

- pain
- loss of movement
- shortening / bending / twisting of limb
- deformity
- bruises and swelling
- wound
- shock
- 'crepitus' – ends of bones rubbing together

AIMS:

- prevent movement
- get help

ACTION:

- steady and support in position found – immobilize joint above break
  (hold above and below fracture and keep still)
- cover any open wound for risk of infection
- lower limb fractures → steady and support:
  use rolled up blanket like blanket either side
- fractured jaw → sit down / lean forward (fallen teeth place in milk)
- upper limb fracture + rib fracture → SLING

(ARM SLING → arm fracture + dislocated shoulder **)**

ARM =	Shoulder Upper arm Elbow	**+** Simple rib fracture	**+**	Dislocated shoulder

Complicated rib fracture

↓

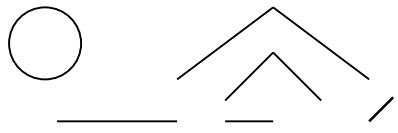
elevated sling

Caution:

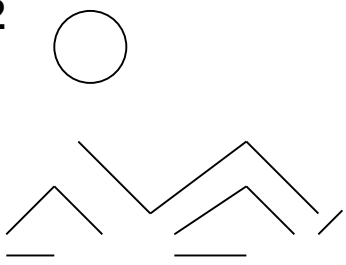
- **DO NOT MOVE** until injured part is supported
- **Nil by mouth**

6 FIRST AID POSITIONS

1



2

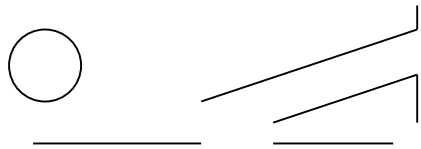


ABDOMINAL LATERAL CUT

FRACTURED PELVIS

BREATHING PROBLEMS

3

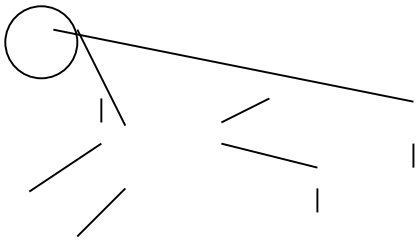


SEVERE BLOOD LOSS

FAINTING

FRACTURED FEET

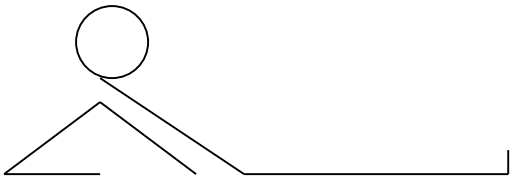
4



‘RECOVERY POSITION’

(unconscious)

5



STROKE

EXCESSIVE BLEEDING FROM HEAD

EYE INJURY

6

NOSE BLEED

ASTHMA