



Pre-course  
information

# HLTAID004

## Provide an emergency first aid response in an education and care setting

Student name \_\_\_\_\_

Student number \_\_\_\_\_

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# Introduction

The information contained in this booklet will assist you in completing the pre-course assessment for the following unit:

- HLTAID004 – Provide an Emergency First aid Response in an Education and Care Setting

This booklet contains the same content as seen in the online presentation.

This information is based on the guidelines of the Australian Resuscitation Council 2013.

# Section A – Principles of first aid, Safety and Manual handling

## What is first aid?

First aid is the emergency care provided for injury or illness before medical care is available

## The principles of first aid:

### The 4 P's

- Preserve life
- Protect casualty from further harm
- Prevent casualty's condition from worsening
- Promote recovery

## Multiple Casualties

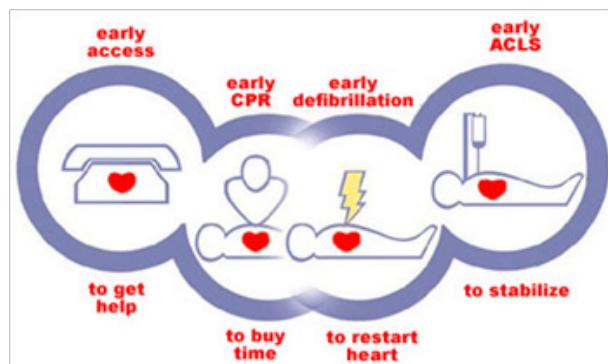
If there is more than one casualty, care of the unconscious person has priority. People that are conscious have an open airway and are breathing.

## Managing an emergency

In an emergency, early recognition is a key step to initiating early management.

In ALL emergency situations you should follow the 'Chain of Survival'

- Early Access
- Early CPR
- Early Defibrillation
- Early Advanced Care Life Saving



# Section A – Principles of first aid, Safety and Manual handling

## Handling a casualty

A collapsed or injured casualty should not be moved unless necessary:

- To ensure safety for yourself or the casualty
- In extreme weather conditions
- To make possible the care of airway, breathing or perform CPR
- To control severe bleeding

When moving a casualty ensure you follow appropriate manual handling techniques

- Bend your knees
- Use your leg and abdominal muscles
- Know your own limitation
- Ask for help
- Plan the move

If you are required to move a casualty, move them from one point to another in the most direct way possible.

## Infection control

Infection control is about taking steps to minimise the transmission of infectious agents from person to person or person to environment

Standard precautions apply in all first aid situations regardless of the casualty's presumed infectious status. Treat all casualties the same by wearing gloves, using barrier masks and eye protection each and every time you provide first aid.

To minimise the chance of cross infection:

- Avoid contact with blood and bodily fluids
- Use protective devices
- Be aware of sharp objects
- Wash your hands before and after each first aid situation

# Section B – Duty of Care, Consent, own skills and limitations

## Duty of Care in the workplace

- In the workplace staff have a duty of care to all people that come onto the premises
- You are required by law to help anyone on the premises that becomes ill or injured and to conduct yourself in a certain way
- Failure to do so can result in the company being sued for negligence

## Working in early childhood education and care

- When working in early childhood education and care, the first aid officer has a duty of care to provide first aid (if necessary) to all staff, children and visitors

## Duty of care in the wider community

- In the wider community you have a choice to help a casualty. There is no law regarding duty of care in the wider community, so therefore no obligation to provide first aid
- If you decide to help a casualty and provide first aid, you cannot walk away. You are obliged to provide first aid to the best of your ability until medical help arrives
- If you are involved in a road accident, you have a legal requirement to stay at the scene of the accident and provide assistance to any injured people. This must then be reported to the police.

You must ensure that you provide the standard of care appropriate to your level of training and understanding

## Negligence

In the unlikely event that a first aider is sued for negligence for providing first aid there will need to be a number of things proven before they are successful. The questions that will be asked are:

- Did a duty of care exist between the first aider and the casualty?
- Did the first aider exercise appropriate care and skill in providing first aid and was this conducted to the level of first aid training of the first aider
- Did the first aider breach the relevant standard of care and
- Did the casualty sustain any damage as a direct result of the first aider's actions

The first aiders training and knowledge will also be taken into account and they will look at what a reasonable person would do in the same circumstances with the same amount of training.

# Section B – Duty of Care, Consent, own skills and limitations

## Consent

- Before you provide first aid to a casualty, you must receive consent
- Ask the person if you can provide them with first aid and if they refuse you must respect their decision
- If they are unresponsive and unable to speak or nod their head, you may assume they would give consent and proceed with first aid
- If the casualty is a minor (Under 18 years) you should seek consent from the parents or guardians. If the parents or guardians are not immediately available and the situation is life threatening, immediately provide first aid.

## Confidentiality

- During a first aid situation, you may receive information about the casualty that is private. You need to ensure that you take steps to maintain the privacy of the person at all times.
- Exceptions to this would be sharing information with emergency services but should get the consent of the casualty first

## Own skills and limitations

- It is important to know and understand your own limitations when providing first aid.
- You need to ensure that you are working within the bounds of your training and not providing first aid above your qualification
- Be confident in your ability to provide first aid. This is achieved by completing first aid training sessions and constantly updating your skills.

## Respectful behaviour

- When providing first aid, it is important to remember that the traditions and values of the casualty may vary from your own.
- Different cultures may react differently to first aid principles
- You need to be respectful, sensitive and aware of specific needs relating to age, culture, religion and background
- Don't judge people as you may not know or fully understand decisions a person may make

# Section C - Cultural awareness and psychological impact on self and others

## Psychological impact on self and others

People respond differently to each emergency and first aid situation depending on a variety of factors. These factors include: experience of the emergency, health, personal history and available supports.

Some people may be at a higher risk of negative consequences so it is important to recognise the signs and symptoms of psychological impact and seek or provide support as soon as possible.

You may be psychologically affected immediately, within days or even months after the emergency or first aid situation.

### Signs and symptoms of psychological impact

1. Physical effects	<ul style="list-style-type: none"><li>• Headaches/Migraines</li><li>• Tense and/or aching muscles</li><li>• Rapid, shallow breathing and/or difficulty breathing</li><li>• Tiredness/lethargy/lack of energy/physically worn out</li></ul>
2. Mental effects	<ul style="list-style-type: none"><li>• Poor concentration</li><li>• Forgetfulness</li><li>• Racing thoughts</li><li>• Thoughts of being trapped/cornered/ seeing no way out</li><li>• General pessimistic thinking</li><li>• Low mental energy</li></ul>
3. Emotional effects	<ul style="list-style-type: none"><li>• Persisting moodiness/changeable moods</li><li>• Crying easily</li><li>• Sense of not coping or of not feeling in control</li><li>• Low self confidence</li><li>• Worry/anxiety/inner agitation/restlessness</li><li>• Panic attacks or increased fears</li><li>• Depression</li></ul>
4. Behavioural effects	<ul style="list-style-type: none"><li>• Difficulty getting to sleep/ waking early</li><li>• Nightmares</li><li>• Loss of appetite or eating excessively</li><li>• Increased alcohol/smoking/drug use</li><li>• Withdrawing socially</li><li>• Increased absenteeism or workaholic</li></ul>

These signs and symptoms will vary from person to person and age groups.

# Section C - Cultural awareness and psychological impact on self and others

## Children and young people

When working with children and young people who may have experienced or witnessed an emergency or first aid situation, you should consider the following points:

- Listen, talk and play
- Be calm, talk softly and be kind.
- Listen to children's views on their situation.
- Protect them from hearing upsetting stories about the event.
- Don't push for information, allow the child to use their own words and inform parents of the conversations in a non-alarming manner
- Try to involve them in play activities or simple conversation about their interests, according to their age.

## Seeking feedback

It is important to seek feedback about your performance after an emergency or first aid situation.

You can seek feedback from:

- First aid officers
- Paramedics/ambulance officers
- Medical practitioners/medical staff

## Debriefing

Debriefing is the process undertaken after an emergency situation. It allows all participants to discuss their version of events with each other.

Debriefing is useful in a first aid situation as it allows participants to understand:

- what happened
- what went right and what went wrong
- what could be done differently if this situation arises again

It will also help with the thought process if you are not coping mentally and are experiencing negative physical or mental symptoms as described in psychological impact.

# Section D – DRSABCD

## DRSABCD

DRSABCD is the acronym used in all first aid situations.

Remember not to rush into an emergency situation, take a breath and follow 'DRSABCD'

		NO	YES
DANGER	Is there any danger to yourself or others	Move onto the next step	Remove any dangers if possible and safe to do so
RESPONSE	Is there a response	Move onto the next step	Assess the need for an ambulance or first aid
SEND FOR HELP	Call 000 or 112 for emergency assistance		
AIRWAY	Is there anything blocking the airway	Move onto the next step	Roll the casualty into the recovery position and finger sweep obstruction
BREATHING	Is the casualty breathing/ are they breathing normally	Move onto next step	Roll the casualty into the recovery position and monitor until medical aid arrives
COMPRESSION		30 compressions and 2 breaths	
DEFIBRILLATOR		Attach as soon as possible if available and follow the prompts	

# Section D – DRSABCD

## D – Danger

Always ensure that you check for danger before you enter into an emergency situation. Check for any danger to yourself, the bystanders or the casualty

You need to ensure your safety above all else

If possible, remove any dangers to ensure the scene is safe to provide first aid

If you cannot remove the danger you may need to move the casualty. Do this very carefully to avoid further injury to the casualty

Dangers may include:

- Fire
- Electricity
- Chemicals
- Aggressive behaviour
- Intoxication
- Machinery
- Chemical fumes
- Bodily fluids (blood, vomit, saliva, urine or faeces)
- Oncoming traffic
- Weather



# Section D – DRSABCD

## R – Response

‘Talk and Touch’

Talk to the casualty and carefully approach.

If the person does not respond to you by either speaking to you or opening their eyes and looking at you, you can try gently squeezing their shoulders while speaking to them to obtain a response.

NOTE: Never shake a baby or an infant as this can cause irreversible and permanent brain damage

### Consciousness

If the casualty is conscious (awake and able to speak to you) you will need to carry out a ‘no touch’ examination beginning at the head and asking questions while observing them.

There are 4 levels of consciousness that a casualty will respond to in descending order.

- Voice
- Touch
- Pain
- Nothing. If there is no response, the person can be assumed to be unconscious.

### Unconsciousness

Unconsciousness is a state of unresponsiveness where the victim is unaware of their surroundings and no purposeful response can be obtained.

Unconsciousness can be caused by:

- Low brain oxygen levels
- Heart and circulation problems (fainting, abnormal heart rhythms)
- Metabolic problems (overdose, intoxication, low blood sugar)
- Brain problems (head injury, stroke, tumour, epilepsy)



In an unconscious casualty, care of the airway has priority over all other injuries

Where there is more than one casualty, care of the unconscious casualty always has priority.

# Section D – DRSABCD

## S – Send for help

At this stage whether the person is responding or not, you may need to call for help.

If the casualty is unconscious, always call for help

This can be done by calling 000 or 112 for mobile phones or yelling out to another person to come and assist you.



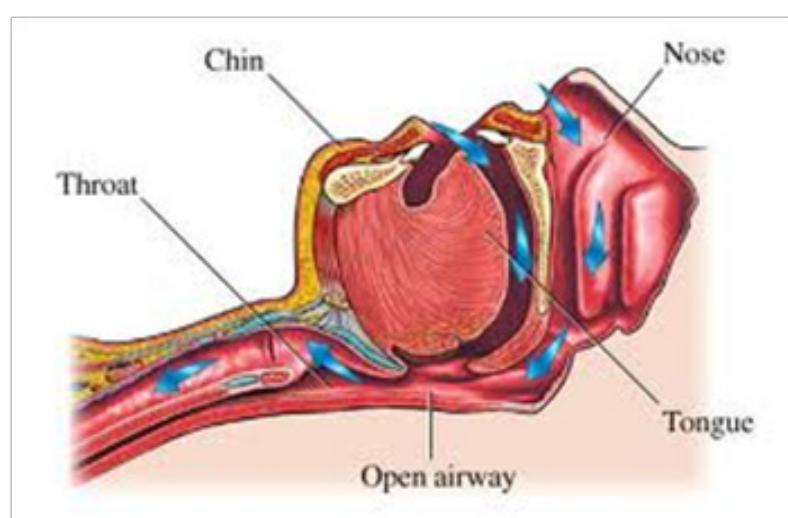
## A – Airway

- Open the casualty's mouth and have a look inside. You are looking for anything that may block the airway and stop the casualty from breathing:
  - Blood
  - Vomit
  - Broken dentures/teeth
  - Food
  - Tongue
- If not clear, roll the casualty onto their side (recovery position) and clear using your fingers (finger sweep)
- Roll casualty onto their back, lift up their chin and backward head tilt to open the airway

The tongue is the most likely object to block an unconscious person's airway.

This can happen if the person is:

- Lying on their back
- Lying on their stomach
- Sitting with their head drooping down



# Section D – DRSABCD

## B – Breathing

LOOK, LISTEN and FEEL for normal breathing.

The average person takes approximately 2.5 breaths every 10 seconds and when you check to see if a person is breathing you will also check if their breathing is normal. To do this you need to:

- LOOK for the rise and fall of the chest
- LISTEN for breath sounds coming out of the casualty's nose and mouth
- FEEL the breath coming out of the casualty's nose and mouth and the rise and fall of the chest

When checking breathing, it is important to take 10 seconds to fully assess if the casualty is breathing normally. This must be completed with the head fully tilted for everyone over the age of 12 months and in the neutral position for all infants (under 12 months of age)



Is the person breathing normally?

YES - If the person is breathing normally, place the person in the lateral (recovery) position



NO – Victims that are not breathing or not breathing normally (gasping) and are unresponsive require CPR

# Section D – DRSABCD

## C – Compression

**30:2**

- The purpose of CPR (Cardiopulmonary Resuscitation) is to temporarily maintain circulation to preserve brain function until more specialised medical treatment is available
- Compressions need to be applied firmly in the centre of the chest on the sternum (chest bone)
- 30 compressions: 2 breaths is applied for all ages regardless of the amount of rescuers available
- CPR is extremely tiring. It is advised you encourage as much help as possible and multiple rescuers can be very beneficial for both the casualty and the rescuers. It is designed to reduce fatigue.

When providing 30 compressions (at approximately 100/min) and giving 2 breaths you should achieve the delivery of approximately 5 cycles every 2 minutes. This is the recommended universal standard required for CPR



### Giving compressions

- Place casualty on a firm flat surface
- Ensure your arms are straight and your shoulders are over the top of the casualty
- Place hands on the lower part of the sternum (Centre of the chest in line with the arm pits)
- Deliver compression with the heel of hand (no pressure on ribs) with your second hand on top or bracing the wrist
- Deliver 30 quick compressions, compressing 1/3 the depth of the chest
- Compressions should be rhythmic with equal time for compression and relaxation



# Section D – DRSABCD

## CPR – Infants (0 – 12 months)

- Locate the lower part of the sternum (in line with the armpits)
- Use 2 fingers only at a right angle to the chest
- Ensure the head is in the neutral (flat) position



## CPR – Children (1 – 8 Years)

- You can use one or two hands depending on your own strength and what is comfortable



# Section D – DRSABCD

## Giving breaths mouth to mouth

- Pinch the casualty's nose and tilt the head right back for casualty's over the age of 12 months
- Fully seal the casualty's mouth with your mouth
- Breath into the casualty's lungs for approximately 1 second
- Turn your head to the side and watch the chest rise and fall
- Repeat
- Compressions must be paused to allow for ventilation

**NOTE:** If the chest does not rise, this could indicate that there is an airway blockage, a bad seal whilst administering breaths or that an insufficient amount of air has been expelled into the lungs by the rescuer.



## Giving breaths mouth to nose

- The mouth to nose method can be used if the casualty's jaw is tightly clenched or when resuscitating infants or small children.
- Close the casualty's mouth while supporting the jaw and push the lips together with the thumb
- •Tilt the head right back (neutral position for children under 12 months)
- Take a breath and blow through the casualty's nose to inflate the lungs
- For infants or small children, you may need to place your mouth over the child's nose and mouth
- For infants, you need to ensure the head is kept in the neutral position as the trachea is very soft and tilting the head back can close the airway



# Section D – DRSABCD

## Giving breaths mouth to mask

- Position yourself at the casualty's head and use both hands to maintain an open airway and to hold the mask in place to maximise the seal. Maintain head tilt. Place the narrow end of the mask on the bridge of the nose and apply the mask firmly to the face.
- Using a face mask avoids mouth to mouth contact.
- Tilt the head right back (neutral position for children under 12 months)
- Inflate the lungs by blowing through the mouthpiece of the mask with sufficient volume and force to achieve chest movement
- Remove your mouth from the mask to allow exhalation. Turn your head to listen and feel for the escape of air. If the chest does not rise, recheck head tilt, chin lift and mask seal
- Failure to maintain head tilt and chin lift is the most common cause of obstruction during resuscitation

## Chest compressions only

- If rescuers are unable or unwilling to perform rescue breaths they should do chest compressions only
- If chest compressions only are given, they should be continuous at a rate of approximately 100 compressions per minute

## Multiple rescuers

When there is more than one rescuer available ensure:

- An ambulance has been called
- All available equipment has been obtained (e.g. Automated External Defibrillator)

This is to be completed prior to rotating rescuers during CPR

It is highly recommended to change rescuers during CPR every two minutes to reduce fatigue and enable the CPR to be continued for a longer period of time.

## Duration of CPR

It is important that interruptions to chest compressions are kept to a minimum and that CPR is not interrupted to check for a response of breathing. Interruption of chest compressions is associated with lower survival rates.

CPR should be continued until:

- The casualty responds or begins to breathe normally
- It is impossible for the rescuer to continue (e.g. exhaustion)
- A health care professional arrives to take over CPR
- A health care professional directs that CPR be ceased

**Note:** Sounds of a casualty gurgling, sighing or coughing does not indicate normal breathing

# Section D – DRSABCD

## Risks

- The risk of disease transmission during training and actual CPR performance is very low
- If available, the use of a barrier device during rescue breathing is encouraged
- After resuscitation, all casualties should be reassessed and re-evaluated for resuscitation-related injuries.

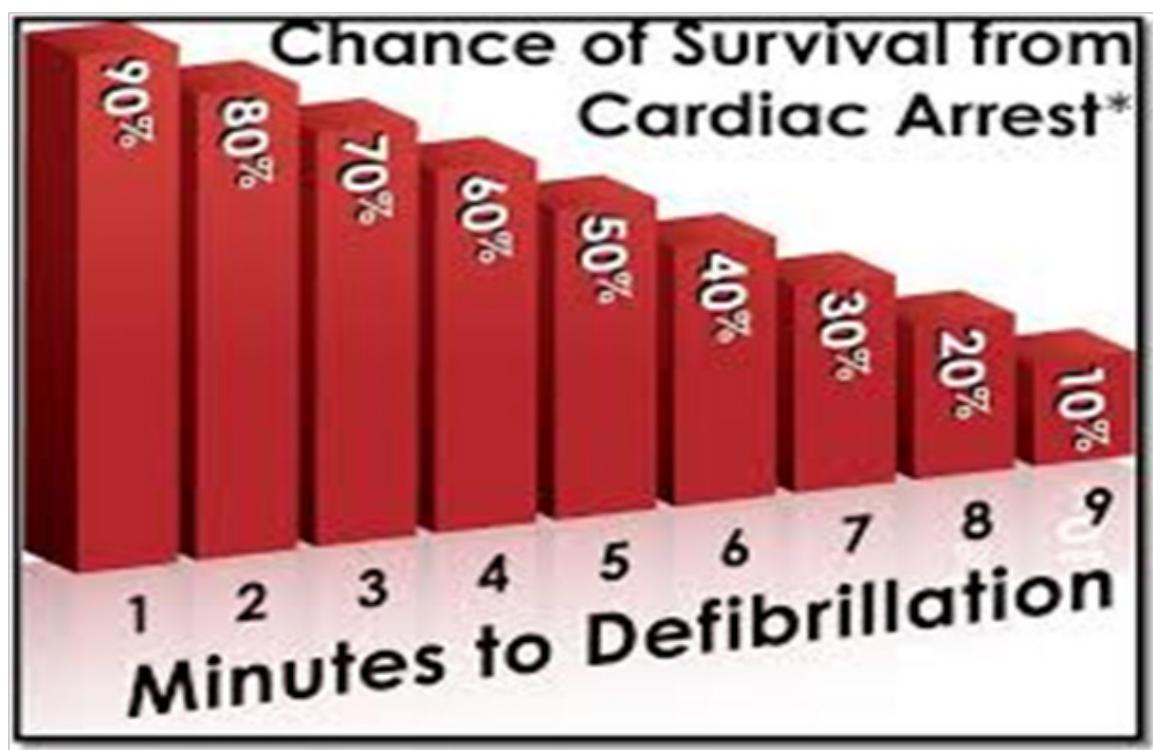
## D – Defibrillation

- In cardiac arrest situations when the casualty is not responsive and not breathing normally, the use of an Automated External Defibrillator (AED) is highly recommended
- AED's can accurately identify the cardiac rhythm as 'shockable' or 'non-shockable'
- There are many different brands of AED available but they all operate in the same manner



# Section D – DRSABCD

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# Section D – DRSABCD

## Steps to use a defibrillator

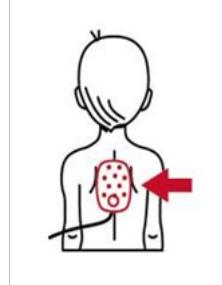
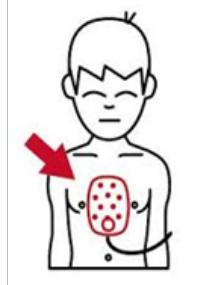
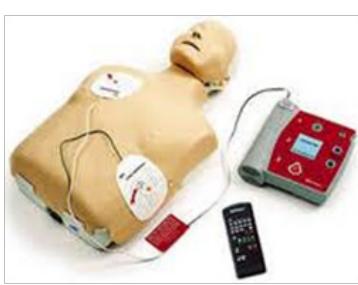
1. Retrieve and unpack the defibrillator
2. Ensure nobody is touching the casualty
3. Expose the chest and place pads as shown (pictures show pad placement on the pads)
4. Follow the voice prompts as instructed



- Do not let anyone touch the casualty whilst the AED is analysing the heart rhythm or when the AED is providing a shock to the casualty
- If the AED suggests that no shock is needed, recommence CPR and continue to follow the prompts of the AED
- If the casualty responds to the AED, follow DRSABCD but do not remove the pads (even if the casualty is conscious)
- Do not apply a defibrillator to a child under the age of 12 months
- Ideally for children aged between 1 – 8 years, apply paediatric pads with an AED with paediatric mode however if this is not available, use the adult pads.

## Placement of Pads

- Placement of pads for an adult should be in an anterior – lateral position (upper right torso and left side below the breast)
- Placement of pads for a child aged between 1-8 years should be in the anterior-posterior position (in the centre of the chest and middle of the back between the shoulder blades)



An AED should be attached as soon as possible to all casualties requiring CPR.

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Anaphylaxis

- Anaphylaxis is the most severe form of allergic reaction and is potentially life threatening
- Must be treated as a medical emergency, requiring immediate treatment and urgent medical attention
- Allergic reactions range from mild to moderate to severe (anaphylaxis)
- Most cases of anaphylaxis occur after a person with a severe allergy is exposed to the allergen they are allergic to. This is usually a food, insect or medication
- Severe reactions usually occur rapidly (seconds – minutes) but can be delayed for anywhere up to 2 hours
- Mild to moderate reactions can occur rapidly but can be delayed for anywhere up to 72 hours.
- A mild allergic reaction can escalate to anaphylaxis within 1-2 minutes

## Allergens/Triggers – Food

The most common foods that may cause allergic reactions are:

- Peanuts
- Eggs
- Milk
- Seafood
- Shellfish
- Tree nuts
- Wheat
- Soy
- Sesame

Even though these foods are the most common and cause 90% of allergic reactions to food, any food can cause an allergic reaction. At present, there are over 160 food that are known to possibly cause an allergic reaction.



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Allergens/Triggers – Medication

Any medication can cause an allergic reaction. These include:

- Conventional
- Herbal/natural medicine
- Bush medicine

An allergic reaction to medication is usually lifelong.



## Allergens/Triggers – Insects

Insect allergies can be caused by the venom from:

Bees



Wasps



Jumping Jack ant



Ticks



Allergies to insect venom is usually life long.

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Recognition

The following signs and symptoms will vary from person to person:

Mild – Moderate - Skin	Mild – Moderate - Gut	Severe - Respiratory	Severe – Cardio Vascular
<ul style="list-style-type: none"><li>• Hives/rash</li><li>• Swelling of the lips</li><li>• Swelling of the eyes</li><li>• Tingling mouth</li></ul>	<ul style="list-style-type: none"><li>• Vomiting</li><li>• Abdominal pain</li><li>• Diarrhoea</li></ul>	<ul style="list-style-type: none"><li>• Difficulty or noisy breathing</li><li>• Difficulty talking/ Hoarse voice</li><li>• Swelling of the tongue</li><li>• Swelling/tightness of the throat</li><li>• Wheeze or persistent cough</li></ul>	<ul style="list-style-type: none"><li>• Persistent dizziness or collapse</li><li>• Pale and floppy (young children)</li><li>• Low blood Pressure</li></ul>

Mild to moderate allergic reaction can involve the skin and the gut (Gastrointestinal).

**Vomiting, abdominal pain and diarrhoea are signs of a severe allergic reaction (anaphylaxis) to an insect sting or bite.**



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Administering an Epipen



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Administering an Anapen



# **Section E – Anaphylaxis, Asthma, Seizures and Diabetes**

## **Management of a mild to moderate reaction**

The management of a mild to moderate allergic reaction is:

- Stay with person and call for help
- Locate Epipen/Anapen
- Give other medications (if prescribed)
- Phone the family/emergency contact
- For insect allergy, flick out sting if visible. Do not remove ticks

Ensure that you stay with the person at all time and watch for signs and symptoms of Anaphylaxis

## **Management of a severe allergic reaction**

- Lay the person flat. Do not allow them to stand or walk. If breathing is difficult, allow them to sit
- Give EpiPen/AnaPen
- Phone the ambulance on 000
- Phone the family emergency contact
- Further adrenaline doses may be given if no response after 5 minutes

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Anaphylaxis Action plans

**ACTION PLAN FOR Anaphylaxis**

For use with Anaphylaxis or Anaphylactic asthma in educational environments

**How to give Anaphylaxis**

1. Standing upright, hold nose.  
2. Take breath.  
3. Inhale deeply.  
4. Exhale slowly, breathing through nose.

**What to do if Moderate allergic reaction**

- Difficulty of breathing, hives, or swelling of mouth, eyes, nose, or throat.
- Itching, rash, or hives.
- Abdominal pain, vomiting, diarrhea are signs of a severe allergic reaction in adults.

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Watch for any one of the following signs of Anaphylaxis**

**SERIOUSLY SEVERE ALLERGIC REACTIONS**

- Difficult breathing or swelling.
- Swelling of tongue.
- Swelling of lips, eyes, nose, or throat.
- Wheezing or difficulty breathing.
- Abdominal pain or diarrhea.
- Pale and floppy (young children).

**How to give Anaphylax® or EpiPen®**

1. Lay person flat, do not stand or walk. If breathing is difficult, sit upright or sit.
2. Remove EpiPen® or Anaphylax® from case.
3. Press antistrike™ (blue) onto EpiPen® or Anaphylax®.
4. Extend firmly, emergency contact.

**Further adrenaline doses may be given if no response after 5 minutes, give Anaphylax® or EpiPen® again.**

**Additional information:**

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**How to give Anaphylax® or EpiPen®**

1. Lay person flat, do not stand or walk. If breathing is difficult, sit upright or sit.
2. Remove EpiPen® or Anaphylax® from case.
3. Press antistrike™ (blue) onto EpiPen® or Anaphylax®.
4. Extend firmly, emergency contact.

**Further adrenaline doses may be given if no response after 5 minutes, give Anaphylax® or EpiPen® again.**

**Additional information:**

**ACTION PLAN FOR Allergic Reactions**

For use with Moderate allergic reactions

**How to give Anaphylax® or EpiPen®**

1. Standing upright, hold nose, sit.  
2. Take breath.  
3. Inhale deeply.  
4. Exhale slowly, breathing through nose.

**What to do if Moderate allergic reaction**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Watch for any one of the following signs of Anaphylaxis**

**SERIOUSLY SEVERE ALLERGIC REACTIONS**

- Difficult breathing or swelling.
- Swelling of tongue.
- Swelling of lips, eyes, nose, or throat.
- Wheezing or difficulty breathing.
- Abdominal pain or diarrhea.
- Pale and floppy (young children).

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Additional information:**

**ACTION PLAN FOR Anaphylaxis**

For use with Anaphylaxis or Anaphylactic asthma in educational environments

**How to give Anaphylax®**

1. Standing upright, hold nose.
2. Inhale deeply.
3. Exhale slowly, breathing through nose.
4. Repeat steps 1-3.

**What to do if Moderate allergic reaction**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Watch for any one of the following signs of Anaphylaxis**

**SERIOUSLY SEVERE ALLERGIC REACTIONS**

- Difficult breathing or swelling.
- Swelling of tongue.
- Swelling of lips, eyes, nose, or throat.
- Wheezing or difficulty breathing.
- Abdominal pain or diarrhea.
- Pale and floppy (young children).

**How to give Anaphylax®**

1. Standing upright, hold nose.
2. Take breath.
3. Inhale deeply.
4. Exhale slowly, breathing through nose.

**What to do if Moderate allergic reaction**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Additional information:**

**ACTION PLAN FOR Anaphylaxis**

For use with Anaphylaxis or Anaphylactic asthma in educational environments

**How to give Anaphylax®**

1. Standing upright, hold nose.
2. Take breath.
3. Inhale deeply.
4. Exhale slowly, breathing through nose.

**What to do if Moderate allergic reaction**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Watch for any one of the following signs of Anaphylaxis**

**SERIOUSLY SEVERE ALLERGIC REACTIONS**

- Difficult breathing or swelling.
- Swelling of tongue.
- Swelling of lips, eyes, nose, or throat.
- Wheezing or difficulty breathing.
- Abdominal pain or diarrhea.
- Pale and floppy (young children).

**How to give Anaphylax®**

1. Standing upright, hold nose.
2. Take breath.
3. Inhale deeply.
4. Exhale slowly, breathing through nose.

**What to do if Moderate allergic reaction**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Action**

- For insect sting, tick, not sting, & insect bite, do not remove stings.
- Take oral antihistamine as soon as possible.
- If severe, give Anaphylax® or EpiPen® as instructed by emergency contact.

**Additional information:**

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

There are 3 different action plans.

- Red is for people that have been prescribed an EpiPen or AnaPen.
- Green is for allergic reactions but the person has not been prescribed an EpiPen or AnaPen
- Orange is a generic action plan

Action plans provide the following information:

- Mild to moderate signs and symptoms
- Action for a mild to moderate allergic reaction
- Medications (other than the EpiPen or AnaPen) that may need to be given
- Anaphylaxis (Severe) signs and symptoms
- Action for a severe allergic reaction
- Instructions on how to administer the EpiPen or AnaPen

Individual action plans (Red) include:

- Person's name, date of birth and current photo
- What they are allergic to (allergens)
- If they also have asthma
- Family/Emergency contact details
- Doctor Details

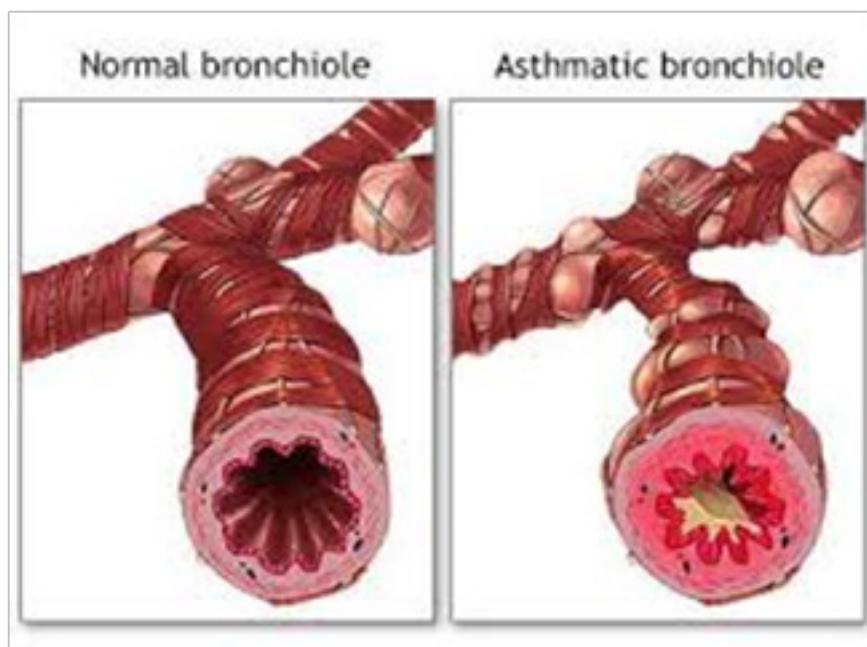
# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Asthma

Asthma is an allergic reaction which causes narrowing of the small airways of the lungs. People with asthma have sensitive airways which can narrow when exposed to certain 'triggers' or 'allergens'. This can lead to difficulty breathing.

Three main factors cause the airways to narrow:

- The muscle around the airway tightens (bronchoconstriction)
- The lining of the airways become swollen (inflammation)
- Extra mucus (sticky fluid) may be produced



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Triggers of asthma

In asthma, symptoms are made worse by ‘triggers’. Every person’s asthma is different and not all people will have the same triggers. Triggers can include:

- Colds and flu
- Cigarette smoke
- Exercise
- Inhaled allergens (e.g. pollens, moulds, animal dander, and dust mites)
- Environmental factors (e.g. dust, pollution, wood smoke, bush fires)
- Changes in temperature and weather
- Certain medications (e.g. aspirin)
- Chemicals and strong smells (e.g. Perfumes, cleaning products)
- Emotional factors (e.g. laughter, stress)
- Some foods and food preservatives, flavourings and colourings (uncommon)

## Signs and symptoms of asthma

**Mild to moderate asthma can be recognised by the following signs and symptoms:**

- A dry, irritating, persistent cough, particularly at night, early morning, with exercise or activity
- Chest tightness
- Shortness of breath
- Wheeze (High pitched whistling sound during breathing)

**Severe asthma can be recognised by the following signs and symptoms:**

- Gasping of breath (may have little or no wheeze due to little movement of air)
- Severe chest tightness
- Inability to speak more than one or two words per breath
- Feeling distressed or anxious
- Little or no improvement after using ‘reliever medication’
- ‘Sucking in’ of the throat and rib muscles, use of shoulder muscles or bracing with arms to help breathing (Muscle exertion)Blue discolouration around the lips (can be hard to see if skin colour also changes)
- Pale and sweaty skin
- Symptoms rapidly getting worse or using reliever more than every two hours

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Signs and symptoms of asthma in young children

As well as the symptoms above, young children may also display the following:

- Restlessness
- Unable to settle or become drowsy
- Sucking in of the muscles around the ribs
- Problems eating or drinking due to shortness of breath
- Severe coughing and vomiting

An asthma attack can take anywhere from a few minutes to a few days to develop.

## Reliever medication

Reliever medication is designed to quickly help a person having an asthma attack. It helps to relax the muscles around the airways. Reliever medication is available in a blue/grey puffer device.



Reliever puffer



Reliever Auto haler

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Spacers

Spacers greatly increase the chances of the medication reaching the airways. Any person using a puffer device should be using a spacer. For a child aged 1-5 years, a face mask should be used.



## Administering asthma medication

### Administration with a spacer:



Shake the reliever inhaler and place mouthpiece into the spacer. Place the spacer mouthpiece into the victim's mouth. Administer one puff of reliever medication into the spacer and ask the victim to breathe in and out normally for four breaths. Repeat this promptly until four puffs have been given.

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Administration without a spacer:



When a spacer is not available, shake the inhaler and place the mouthpiece into the victim's mouth. Administer one puff as the victim inhales slowly and steadily. Ask the victim to hold their breath for four seconds and then take four normal breaths. Repeat this promptly until four puffs have been delivered

## Asthma Action Plans

Some individuals will have their own emergency asthma action plan. Asthma action plans will include the following information:

- What to do for a mild, moderate and severe asthma attack
- What the person's symptoms are when they are well
- What the person's symptoms are when they are not well
- Parent/emergency contact details
- Doctor details

If a person has a personal asthma action plan, then that needs to be followed.

If a victim has any signs of a severe asthma attack, call an ambulance straight away and follow the Asthma first aid plan while waiting for the ambulance to arrive.

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Management of asthma

If you believe that a person is suffering from a mild to moderate asthma attack and there is no asthma action first aid plan, follow the asthma first aid plan below:

- Sit the person upright in a comfortable position. (Do not lay the person down) Be calm and reassuring. Do not leave the person alone
- Without delay give four separate puffs of a blue/grey reliever. The medication is best given one puff at a time via a spacer device
- Ask the person to take four breaths from the spacer device after each puff of medication. Use the victim's own inhaler if possible. If not, use one from the first aid box or borrow one from another person.
- Wait four minutes. If there is little or no improvement give another four puffs
- If there is still no improvement after the second round of reliever medication, call an ambulance immediately. Keep giving four puffs, four breaths per puff wait four minutes until the ambulance arrives.

No harm is likely to result from giving a 'reliever' puffer to someone without asthma.

## Seizures/Epilepsy

### What is a seizure?

- Our every thought, feeling or action is controlled by brain cells that communicate with each other through regular electrical impulses
- A seizure or convulsion is the result of uncontrolled, uncoordinated electrical activity occurring in the brain
- Communication between our cells becomes scrambled and our thoughts or movements become confused and uncontrolled



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

There are many reasons a person may suffer a seizure. These include:

- Epilepsy
- Febrile convulsions (In children under 5 years, in association with fever)
- Head trauma (head injury, stroke, meningitis, brain tumour, hypoxia)
- Withdrawal from alcohol or drugs of dependence
- In association with some poisons and drugs

On average, around 3% of all children aged 0 - 5 years will suffer a febrile convolution. This is caused when the core body temperature rises. This is usually caused by illness or a virus.

## Signs and symptoms of a seizure

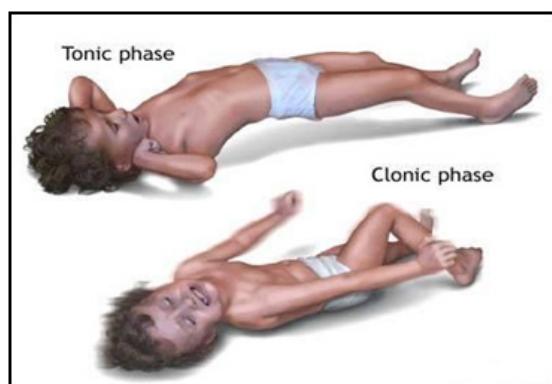
### Minor seizures (Absence and complex partial):

- A person experiencing an absence seizure may appear to suddenly start daydreaming. This may only last a few seconds before the victim starts to recover. The person may not even realise what has happened.
- A complex partial seizure may start like an absence seizure but is usually accompanied with strange movements such as twitching of the face, jerking of an individual limb or lip smacking or making a noise such as letting out a cry.

### Major Seizures:

The phases of a major seizure:

- Tonic phase – There is a sudden spasm of muscles producing rigidity and the victim will fall down. The back may arch and the lips may turn blue (cyanosis). This stage typically only lasts approximately 20 seconds
- Clonic phase – Jerking movements of the head, arms and legs may occur, the victim's eyes may roll back, the jaw may clench shut, saliva may drool out of the mouth and breathing may be loud. The patient may lose control of their bowel or bladder.
- This phase can last from 30 seconds to hours, although most seizures will stop within a few minutes. Call an ambulance for any seizure lasting longer than 5 minutes.
- Recovery phase – This starts from the first sign of normal consciousness. Recovery will be quite quick (around 20 minutes), although most people will want to sleep it off.



# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Management of seizures/epilepsy

### The management of an absence or complex partial seizure:

- Remove any dangers from around the casualty or guide them around objects to a safe place
- Help the casualty to sit down in a quiet place and reassure them
- Stay with the casualty until they are fully alert
- Note the duration of the seizure and pass this onto ambulance officers if needed
- If the casualty is unaware of their condition, encourage them to see a medical practitioner

### The management of a major seizure:

- Help the casualty to the floor if possible
- Remove any objects from around the person that they may injure themselves on
- Protect the casualty's head by cushioning the head with your hands or a coat
- Loosen any tight clothing from around the casualty's neck
- Take note of the exact time the seizure started
- Once the seizure has finished follow DRSABCD

Call an ambulance:

- If you do not know the casualty
- There is no history of epilepsy
- Seizure lasts longer than 5 minutes
- A second seizure occurs
- The victim is pregnant
- The victim has other medical condition/s
- Injury has occurred during the seizure
- Recovery appears to be slow

DO NOT

- Restrain the casualty
- Place objects in their mouth

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Diabetes

Diabetes is a chronic condition suffered by a person that does not produce enough of a hormone called insulin.

Insulin breaks down the food that we eat so that it can be used by the cells of the body or stored for later use. Insulin reduces the amount of sugar in the blood.

If diabetes goes untreated, the blood sugar levels in the body will steadily climb to very dangerous levels over 1 to 2 days

For people with diabetes, insulin is either overproduced or under produced. This creates an imbalance between glucose/insulin resulting in either hypoglycaemia (low blood sugar) or hyperglycaemia (high blood sugar)

As the brain cells can only use glucose (sugar) as its source of energy, if the blood sugar levels become too low you are literally starving the brain.

## Hypoglycaemia

Hypoglycaemia is the most common type of diabetic emergency. This is caused by the blood sugar levels being too low

This may happen if the casualty:

- Takes too much medication (insulin)
- Does not eat enough food
- Over exercises
- Becomes ill (viral infection – vomiting or diarrhoea)
- Experiences great emotional stress

## Signs and symptoms of hypoglycaemia

The casualty may display some of the following signs and symptoms:

- Pale, agitated and sweaty
- Rapid breathing/pulse
- Slurred speech
- Unco-operative or violent behaviour
- May appear to be drunk (dizzy, confused, altered level of consciousness)
- Seizures
- Unconsciousness within 1 hour

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Management of hypoglycaemia

The management of hypoglycaemia:

- Sit the casualty down
- Give the casualty a sugary drink (isotonic drinks), sugar lumps, glucose tablets, chocolate or other sweet foods

If the casualty responds to treatment quickly, give more food or drink such as a sandwich. Stay with the casualty until fully recovered

If the casualty does not respond to treatment, call an ambulance immediately.

If the casualty is unconscious, call 000 immediately and follow DRSABCD

**DO NOT administer insulin as this could be fatal**

## Hyperglycaemia

- This is a less common form of diabetic emergency
- This is caused by the blood sugar levels being too high
- This has a slow onset and therefore gives the casualty more time to take corrective action

## Signs and symptoms of hyperglycaemia

The casualty may display some of the following signs and symptoms:

- Dry warm skin
- Rapid pulse/breathing
- Excessive urination
- Hunger or thirst
- Lethargy
- Fruity odour on the breath
- Drowsy lethargic behaviour
- Unconsciousness if the condition is left untreated

# Section E – Anaphylaxis, Asthma, Seizures and Diabetes

## Management of hyperglycaemia

The management of Hyperglycaemia:

The casualty should be able to bring their own blood sugar levels down on their own. If not, call an ambulance immediately on 000.

**DO NOT administer or assist a casualty to take their own insulin.**

# Section F – Choking, Drowning, Heart Attack and Angina

## Choking – Mild Obstruction

Signs and symptoms:

- Effective cough
- Laboured breathing
- Breathing may be noisy

Management:

- Encourage coughing
- Continue to check victim until recovery or deterioration
- Call Ambulance (000)



## Severe Obstruction

Signs and symptoms:

- Clutching of the throat
- Anxious and agitated
- Unable to speak or cough.
- Cyanosed (blue skin and lips).
- May quickly become unconscious

Management:

Unconscious casualty:

- Call Ambulance Immediately on 000 and
- Commence CPR

Conscious casualty:

- Call 000
- Give up to 5 back blows
- If not effective give up to 5 chest thrusts

# Section F – Choking, Drowning, Heart Attack and Angina

## Drowning

- Drowning is the process of experiencing respiratory impairment from immersion in liquid
- The most important consequence of drowning is the interruption of the oxygen supply to the brain.
- Early rescue and resuscitation are major factors in survival.



## Management – Drowning

- DRSABCD
- Remove from the water
- Place into the recovery position
- Call 000
- Assess airways and breathing in the recovery position. (This is done to reduce the risk of regurgitation and inhalation of liquid)
- Commence CPR if the casualty is not breathing

Administration of oxygen is very beneficial but resuscitation should not be delayed while waiting for oxygen.

### DO NOT

- Attempt in water resuscitation
- Put pressure on the abdomen to empty the stomach of water
- Always ensure that you continuously observe the victim even if they appear well as late deterioration is common. An immersion victim should be assessed at the hospital.

# Section F – Choking, Drowning, Heart Attack and Angina

## Angina

Angina is caused by a narrowing of the coronary artery usually during exercise or excitement. Signs and symptoms may include:

- Development of pain/tightness of chest
- Pain radiating to neck, arms, shoulders or jaw
- Shortness of breath
- Pale, cold, sweaty skin
- May be gradual or sudden in onset



**If this is the casualty's first episode of chest pain, assume a heart attack & seek urgent medical assistance**

## Angina Management

Rest & reassure the victim

Assist victim to take their own medication if available

If no relief after 10 minutes following medication & rest, seek urgent medical assistance

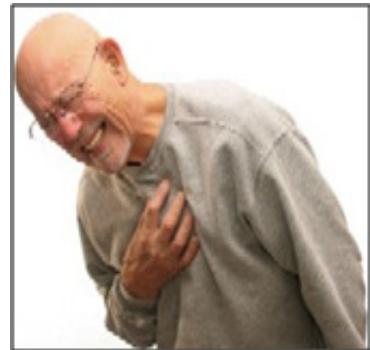
**Anginine tablets, which are placed under the tongue & nitrolingual sprays, which are sprayed into the mouth are common medications used to manage angina**

# Section F – Choking, Drowning, Heart Attack and Angina

## Heart Attack

Blood flow to the heart muscle is interrupted, initially depriving it of oxygen due to reduced blood flow. If blood flow is not restored the heart muscle will die. The casualty may display the following signs and symptoms:

- Pain or discomfort in the centre of the chest, behind the breastbone, which lasts for more than 10 minutes
- Shortness of breath
- Pale, cold & sweaty skin
- Nausea &/or vomiting
- Pain may radiate to shoulder, arm, neck or jaw



**Early treatment may be able to reverse the damage of a heart attack**

## Heart Attack Management

- Call an ambulance immediately
- Assist the victim to rest in the position of greatest comfort
- Discourage physical activity
- Assist victim to take their own medication if available

**If casualty is unconscious and not breathing or not breathing normally, start CPR.**

**Gurgling, sighing or coughing in an unconscious person following a cardiac arrest indicates that the casualty is not breathing normally and CPR should be commenced.**

# Section G – Poisons, Needle stick injury, Envenomation



**131126**

A poison is any substance that, if it enters the body, accidentally or deliberately can impair function or be harmful.

It may be:

- Injected
- Ingested
- Inhaled
- Absorbed

The effect will vary according to the substance and how much is absorbed.

The first aid response to a suspected poisoning is DRSABCD, establish type, quantity and time of poisoning, call poisons information line (131126)



# Section G – Poisons, Needle stick injury, Envenomation

## Injected

- Commonly occur as a result of drug overdose or envenomation.
- Management depends on type/amount of poison and casualty condition.
- Ingested
- When ingested some substances act within minutes, some over a long time.

### Management:

- DRSABCD
- DO NOT induce vomiting
- Try to identify type/quantity & time of poisoning
- Refer to MSDS if available
- Contact Poisons Information 131126 & act on advice given
- Medical aid as required



## Ingested

When ingested some substances act within minutes, some over a long time.

### Management:

- DRSABCD
- DO NOT induce vomiting
- Try to identify type/quantity & time of poisoning
- Refer to MSDS if available
- Contact Poisons Information 131126 & act on advice given
- Medical aid as required

# Section G – Poisons, Needle stick injury, Envenomation

## Inhaled

Consider your safety first:

- Do not place yourself at risk!
- If possible isolate source
- Call the fire brigade and ambulance as required
- DO NOT attempt confined space rescue

### Management:

- DRSABCD
- Refer to MSDS if available
- Contact Poisons Information 131126 & act on advice given
- Medical aid as required



## Absorbed

**Includes Plants / Fertilisers / Pesticides. Think DANGER!!!!**

### Management:

- DRSABCD
- Urgent medical aid
- Irrigate affected area with large amounts of water



# Section G – Poisons, Needle stick injury, Envenomation

## Needle Stick Injury

### Management:

- Wash wound in clean running water &/or clean with sterile saline/water
- Dry using sterile gauze
- Cover with clean, sterile dressing

Medical attention should be sought if:

- Wound may require stitches
- Wound is very dirty
- Risk of infection is present
- Tetanus immunisation may be necessary
- Severity is unclear
- ALL puncture wounds



## Envenomation (Snake bite)

Facts:

- There are 75 different species of snake in Australia, 55 of them are venomous
- Vision 2-3 metres, respond predominately to shadows/movement and deaf
- Good swimmers
- Visual identification is extremely difficult (75%+ error rate)
- 90% of snake bites contain very little venom
- The Brown Snake is Australia's 'most deadly'
- The Taipan is Australia's most venomous

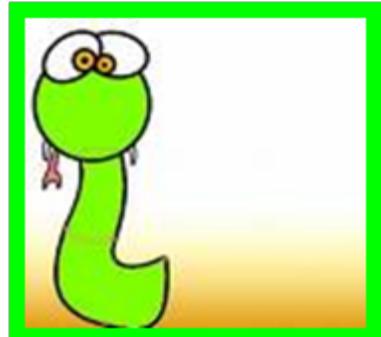
### Snake identification

Identification of venomous snakes can be made from the venom present on clothing or skin using a venom detection kit. For this reason do not wash or suck the bite or discard the clothing. It is not recommended to kill the snake for purposes of identification, because medical services do not rely on visual identification for the snake species.

# Section G – Poisons, Needle stick injury, Envenomation

**Signs and symptoms of a snake bite include:**

- Puncture Marks
- Headache
- Blurred vision
- Nausea
- Vomiting
- Rapid/weak pulse
- Difficulty breathing



**Treatment includes:**

- DRSABCD
- Apply a pressure immobilisation bandage
- Keep the casualty at rest, reassured and under constant supervision
- Commence CPR if needed
- Transport the casualty to a medical facility, preferably by ambulance

**DO NOT:**

- ‘Cut & Suck’
- Use tourniquet
- Wash the bitten area

# Section G – Poisons, Needle stick injury, Envenomation

## Spider Bites – Funnel Web Spider

**Signs and symptoms of a Funnel Web Spider bite are:**

- Tingling or numbness around the mouth or lips
- Difficulty breathing, swallowing and speaking
- Profuse salivation and tears
- Puncture marks
- Sweating/pale cool skin
- Anxiety
- Blurred vision
- Nausea/ vomiting, abdominal pain
- Headache and confusion
- Seizure may occur
- Unconsciousness

**Treatment includes:**

- DRSABCD
- Pressure Immobilisation Technique
- Keep the casualty still and monitor
- Urgent medical aid



# Section G – Poisons, Needle stick injury, Envenomation

## Spider Bites – Red Back Spider

**Signs and symptoms of a Red Back Spider bite include:**

- Immediate pain at the bite site which becomes hot, red and swollen
- Intense local pain which increases and spreads
- Nausea, vomiting, abdominal pain
- Profuse sweating, especially at the bite site
- Swollen, tender glands in the groin or armpit of the bitten limb

Local pain occurs rapidly after the bite, but the venom acts slowly, so serious illness unlikely to occur in less than 3 hours.

**Treatment includes:**

- Keep the casualty under constant supervision
- Apply an ice pack or cold compress to the bite site to lessen pain (no longer than 20 minutes at a time)
- Transport the casualty to a medical facility

Transport by ambulance if:

- The casualty is a child
- The casualty has collapsed
- The pain is severe

**The pressure immobilisation technique is not used because the venom acts slowly and the bandage tends to increase the pain.**



# Section G – Poisons, Needle stick injury, Envenomation

## White Tail Spider

**Signs and symptoms of a White Tail Spider bite includes:**

- Local Pain
- Mild to moderate swelling and redness

**Management:**

- Ice pack for pain relief
- Medical assessment is required
- Pressure immobilisation is NOT to be used



## Bees, Wasps, Scorpion and Ant stings

**Signs and symptoms:**

- Local intense pain
- Swelling & redness
- Possible signs & symptoms of anaphylaxis



**Treatment:**

- DRSABCD
- Remove bee sting sideways
- Ice pack for pain relief
- Pain Relief
- Urgent medical aid & Pressure Immobilisation for anaphylaxis



# Section G – Poisons, Needle stick injury, Envenomation

## Marine bites and stings



Cone Shell



Sea snake



Blue ringed octopus

### Signs and symptoms:

Severe

- May not be painful
- Maybe paralysed
- Unable to respond
- Numbness
- Fixed dilated pupils
- Respiratory arrest.

Less severe

- Tingling around mouth
- Mild weakness

### Treatment:

- DRSABCD
- Pressure Immobilisation Technique
- Ambulance required urgently.
- CPR if required

# Section G – Poisons, Needle stick injury, Envenomation

## Marine bites and stings - Box Jellyfish and Irukandji

The Box Jelly

### Signs and symptoms:

- Severe red welts
- Severe Pain
- Difficulty or cessation of breathing
- Restless or irrational behaviour
- Nausea and vomiting, headache
- Possible Cardiac arrest

### Treatment:

- DRSABCD
- Remove casualty from water
- Pour vinegar liberally over area for 30 seconds
- Remove any tentacles with tweezers
- Pain relief
- PIB after vinegar
- CPR if required



# **Section H – Heat exposure (Hyperthermia), Hypothermia and Frostbite**

## **Dehydration, Heat Exhaustion and Heat Stroke**

Heat induced illness may be caused by:

- Excessive heat absorption from a hot environment
- Excessive heat production from metabolic activity
- Failure of the body's cooling mechanisms
- An alteration in the body's set temperature

Factors that may contribute to heat induced illness include:

- Excessive physical exertion
- Hot climatic conditions with high humidity
- Inadequate fluid intake
- Infection (particularly a viral illness)
- Inappropriate environments (e.g. unventilated hot buildings)
- Wearing inappropriate heavy, hot and dark clothing on hot days
- Drugs which affect heat regulations

The very young and very old are more prone to heat induced illness.

### **Hyperthermia (Dehydration or heat exhaustion)**

#### **Recognition**

- Profuse sweating
- Nausea, vomiting, diarrhoea
- Headache, dizziness
- Pale or flushed skin
- Thirst
- Muscle cramps
- Weak, rapid pulse

#### **Management**

- DRSABCD
- Lay victim down & protect from environment
- Sips of cool water
- Cool victim's body
- Seek medical advice

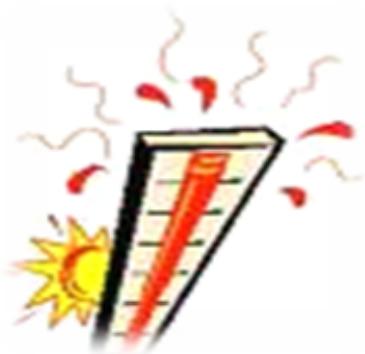
# Section H – Heat exposure (Hyperthermia), Hypothermia and Frostbite

## Heat Stroke

Heat stroke is the most severe form of heat induced illness which may lead to unconsciousness and death. All body organs may be affected.

### Recognition

- Dry, red, hot skin
- No sweating
- Seizures
- Decreased conscious state



### Management

- Urgent medical aid
- Lay victim down
- DRSABCD
- Cool victim's body rapidly
- Sips of water if the casualty is responsive & can swallow

# Section H – Heat exposure (Hyperthermia), Hypothermia and Frostbite

## Hypothermia

Hypothermia is when the body's temperature is below 35°C. As the body's temperature falls, systems and organs progressively start to fail until death occurs, usually from cardiac arrest. Infants and the elderly are at a greater risk. Hypothermia may develop quickly (e.g. falling into icy water) or slowly over a number of hours (e.g. working in cold, wet, rainy weather).

Hypothermia may be caused by:

- ENVIRONMENTAL – Exposure to cold, wet or windy conditions; cold water immersion/submersion; exhaustion
- TRAUMA – Trauma, immobility and burns
- DRUGS – Alcohol and/or sedatives
- NEUROLOGICAL – Stroke and altered consciousness
- ENDOCRINE – Impaired metabolism
- SYSTEMATIC ILLNESS – Severe infections, malnutrition
- 
- 

	Mild	Moderate	Severe
<b>Recognition</b>	<ul style="list-style-type: none"><li>• Maximum shivering</li><li>• Pale, cool skin</li><li>• Poor coordination</li><li>• Slurred speech</li><li>• Apathetic, slow thinking</li></ul>	<ul style="list-style-type: none"><li>• Little shivering only</li><li>• Muscle rigidity</li><li>• Clouded consciousness</li><li>• Pulse &amp; breathing slow</li></ul>	<ul style="list-style-type: none"><li>• Progressive L.O.C.</li><li>• Irregular pulse</li><li>• Fixed &amp; dilated pupils</li><li>• May appear dead</li></ul>
<b>Management</b>	<ul style="list-style-type: none"><li>• Change wet clothing</li><li>• Protect from elements</li><li>• Warm, sweet drinks</li><li>• No alcohol / caffeine</li><li>• Medical advice as necessary</li></ul>	<ul style="list-style-type: none"><li>• Urgent medical aid</li><li>• Gentle handling</li><li>• Lay victim flat</li><li>• Wrap with blankets</li><li>• No massage / rubbing</li><li>• No excessive heat</li></ul>	<ul style="list-style-type: none"><li>• DRSABCD</li><li>• CPR if indicated</li></ul>

# Section H – Heat exposure (Hyperthermia), Hypothermia and Frostbite

## Frostbite

Frostbite is caused when an extremity (fingers, toes, ears, nose) has been exposed to cold conditions. The cells of the limb start to freeze. This then causes these cells to rupture and die.



### Recognition

- Pins and needles in the affected area
- Hardening of the skin
- Colour changes in the skin – first white, then blue tinges and then starts to turn black



### Management

- Gently remove any jewellery
- Elevate the affected area
- Prevent further exposure (placing the hand under the armpits or moving the casualty inside)
- Slowly rewarm the limb if there is no risk of refreezing. (Warm water or skin to skin contact)
- Medical aid is required

### DO NOT

- Rub or massage the affected limb
- Break blisters

# Section I – Bleeding, Burns and Shock

## Bleeding

Bleeding can be external and obvious or internal and often not seen!

### External bleeding

#### Direct pressure

- Examine wound for embedded foreign object
- Apply direct/indirect pressure
- Elevate & rest
- Check circulation and that the bleeding is controlled
- If Bleeding continues, apply a further pad and bandage over the first
- DO NOT remove the first pad and bandage



To assist in the control of bleeding once direct pressure has been applied:

- Elevate the bleeding part
- Restrict movement
- Immobilise the part
- Advise the casualty to remain at total rest
- DO NOT remove a foreign object
- DO NOT bandage over a foreign object



Direct pressure



Indirect pressure

**Note: If bleeding cannot be controlled using direct pressure, elevation and restricting movement, you may need to apply pressure above the wound using a compression bandage. (Do not use a tourniquet)**

# Section I – Bleeding, Burns and Shock

## Internal Bleeding

Internal bleeding may be difficult to recognise.

### Recognition

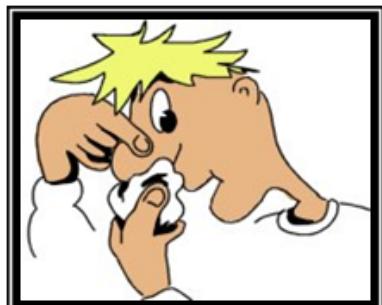
- History of the incident
- Pain, tenderness or swelling over or around the affected area
- The appearance of blood from a body opening. E.g. – Bright red and/or frothy blood coughed up from the lungs
- Vomited blood which may be bright red or dark brown
- Blood stained urine
- Vaginal bleeding
- Rectal bleeding which may be bright red or black and ‘tarry’

### Management

- Urgent medical treatment is required as this may be life threatening
- Call 000
- DRSABCD

## Blood Nose

- Head upright & slightly forward
- Firmly squeeze nostrils together
- Instruct the casualty to breathe through their mouth
- Try not to swallow blood



**If bleeding has not been controlled after 20 minutes of applying pressure, seek medical aid**

# Section I – Bleeding, Burns and Shock

## Amputation

- Control bleeding with direct pressure and elevation
- Place body part in sealed plastic bag or container
- Place this in container of icy water
- Do not allow body part to come into contact with ice or water

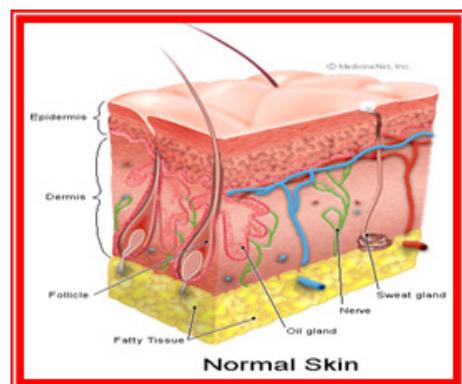


**Manage both the bleeding & the body part**

## Burns

A burn is an injury caused by heat, cold, electricity, chemicals, gases, friction and radiation (including sunlight)

The aim of first aid treatment of burns should be to stop the burning process, cool the burn (thereby providing pain relief) and cover the burn.



### Superficial

- Redness
- Pain



### Partial Thickness

- Severe pain
- Redness
- Weeping
- Blistering



### Full Thickness

- Painless
- Cracked & dry
- White or charred colour



# Section I – Bleeding, Burns and Shock

## Management

- Ensure safety for the rescuer, bystanders and casualty
- In the case of a chemical burn, ask the casualty to remove any contaminated clothing
- Move the casualty to a safe environment as soon as possible
- Stop the burning process:
  - Stop, Drop, Cover and Roll
  - Flood the affected area with water for a chemical burn
  - Smother any flames with a blanket
  - Move away from the burn source
- Assess the casualty's airway and breathing
- Check for other injuries
- Call 000

To stop the burning process:

- Cool with running water for as long as is necessary, usually 20 minutes
- Remove any restrictive jewellery or clothing (If not stuck to the casualty)
- Elevate affected limbs (where possible)
- Once cooled, cover with a non-stick dressing (e.g. cling film)

## DO NOT:

- Remove any clothing or jewellery that is stuck
- Use ice or ice water
- Break blisters
- Apply lotions, ointments, creams or powders other than Hydrogel

Medical assistance is required for:

- A flame or scald burn the size of the victim's palm or larger
- Any flame or scald burn involving the hands, face or genitals
- Any chemical burns
- Any electrical burns
- Any burns with suspected respiratory tract involvement
- Any child or infant with burns



# Section I – Bleeding, Burns and Shock

## Shock

Shock is an inadequate oxygen supply to the tissues due to the loss of an effective circulation.

Shock can be caused by:

- Loss of blood volume
  - Severe bleeding
  - Major or multiple fractures
  - Severe burns or scalds
  - Severe diarrhoea and vomiting
  - Severe sweating and dehydration
- Heart attack
- Allergic reactions/infection/severe spinal or brain injuries

### Recognition:

- Pale, cold clammy skin
- Rapid, weak pulse
- Rapid, shallow breathing
- Thirst
- Dizziness, nausea, vomiting
- Altered responsiveness (reduced level of consciousness)
- Weakness, collapse



### Management:

- DRSABCD
- Lay victim flat with legs elevated if conscious
- Treat any injuries
- Keep victim warm / maintain body temperature
- Reassure casualty
- Seek medical assistance



# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

## Head injury

**Concussion** – Caused by ‘shaking’ of the brain.

The brain is protected by a layer of ‘cerebro-spinal fluid’ so that if the head receives a blow, the brain will bounce from side to side. This can cause widespread damage and interrupt the normal function of the brain.

### Recognition

- Possible loss of consciousness (may be brief)
- Dizziness
- Nausea, vomiting
- Headache
- Blurred vision
- Confusion, loss of short term memory

### Management

- Assess for an underlying skull fracture
- Consider the possibility of a spinal injury
- Observe for deterioration
- Medical aid as required

**Compression** – Caused by bleeding or swelling in the cranial cavity.

Swelling of the brain can be caused by a skull fracture, head injury, illness (stroke), a brain tumour or infection (meningitis). This puts a large amount of pressure on the brain and should be treated as a medical emergency.

# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

**Fractured skull** – Caused by a blow to the head, fracturing the bone around the brain.

A fractured skull is a serious condition and concussion or compression should also be considered. Urgent medical aid is required.

## Recognition

- Possible altered conscious state
- Headache
- Nausea, vomiting
- Altered vision
- Numbness, tingling
- Paralysis
- Seizures
- Fluid discharge ears/nose/mouth
- Bruising around eyes (raccoon eyes)
- Bruising behind ears (battle's sign)
- Altered pupils
- Altered/absent breathing



# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

## Management

If Conscious:

- Keep the victim still by supporting their head
- Reassure the casualty
- Seek urgent medical aid
- If discharge from ear – allow to drain



If Unconscious:

- Primary Survey
- Log Roll to maintain airway
- Provide resuscitation if required
- Urgent medical aid



# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

## Spinal injury

### Recognition

- History of the incident
- Pain / discomfort neck or back
- Altered sensation / movement / strength
- Incontinence
- Slow pulse
- Diaphragmatic breathing
- Priapism

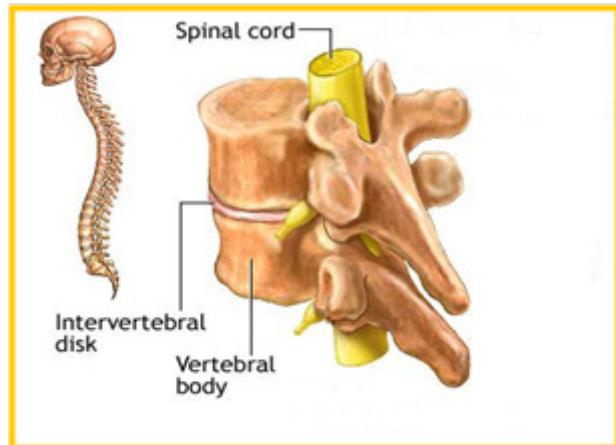
### Management

If Conscious:

- Keep the victim still to protect the airway and minimise spinal movement
- Immobilise head / back
- Maintain normal body temperature
- Seek urgent medical aid

If Unconscious:

- Primary Survey
- Log Roll to maintain airway
- Provide resuscitation if required
- Maintain normal body temperature
- Urgent medical aid



# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

## Crush Injury

Crush injuries can be caused by:

- Vehicle entrapment
- Falling debris
- Industrial accident
- Prolonged pressure to a part of the body

Crush injury syndrome should be considered if:

- A large muscle mass has been crushed
- There has been prolonged compression on any part of the body
- There has been compromised blood circulation to any part of the body

### Management

- If safe & physically possible, remove all crushing forces as soon as possible
- Seek urgent medical aid
- Monitor victim in position of comfort

DO NOT use tourniquet

DO NOT leave the casualty alone

**Although a crush victim may appear alert & not unduly distressed, severe and irreversible damage may have been sustained and the victim's condition may deteriorate**

# Section J – Head injury, Spinal injury, Crush injury and Abdominal injuries

## Abdominal Injuries

Abdominal injuries are usually caused by blunt force trauma to the abdomen. This may affect internal organs such as the spleen, the pancreas, the liver, the kidneys and/or the bowel.

### Recognition

- History of the incident
- Visible wounds
- Weak, rapid pulse
- Cool, pale and clammy skin
- Pain in the abdominal area
- Tight abdomen
- Shallow breathing
- Signs of shock

### Management

- DRSABCD
- Control bleeding with direct/indirect pressure
- If loops of intestine are visible, cover using a wet pad or wet non-stick dressing such as cling film.
- Place casualty in a position of comfort (usually with knees bent if possible)
- Keep casualty warm
- Monitor for signs of shock

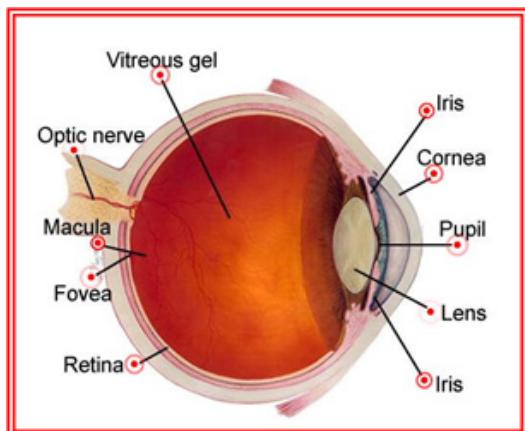
### DO NOT

- Try to place organs back into the abdomen
- Remove any protruding objects
- Give anything to eat or drink

# Section K – Eye Injuries and Ear Injuries

## Eye Injuries

- Foreign object
- Embedded object
- Chemical injury



### Small foreign body

- Encourage victim to blink
- Flush with clean water (sterile saline if available)
- Seek medical aid if required



### Embedded object

- Do not try to remove
- Do not put pressure on object
- Cover both eyes
- Urgent medical aid



### Chemical injury

- Rinse affected eye for at least 20 minutes with cool running water with injured eye down
- Cover both eyes
- Urgent medical aid

# Section K – Eye Injuries and Ear Injuries

## Ear Injuries

Pain, hearing loss, dizziness, ringing in the ear and ruptured ear drum may be caused by:

- Inserting cotton swabs, toothpicks, pens, pencils into the ear
- Ear infections
- Head injuries
- Loud percussions, such as a gun going off
- Sudden changes in pressure such as:
  - Flying,
  - Scuba diving
  - Explosions
  - Blow to the head
  - Being slapped on the ear

### Recognition

- Bleeding from the ear
- Bruising or redness
- Fluid discharge
- Earache
- Loss of hearing
- Nausea and vomiting
- Noises in the ear
- Swelling
- Visible objects in the ear

## Objects in the ear

### Management:

- Calm and reassure the casualty
- If the object is sticking out and easy to remove, gently remove it. Seek medical aid to ensure no inner ear damage has occurred
- If you think a small object has lodged inside the ear but you cannot see it, DO NOT reach into the ear with your fingers or tweezers as this may cause more damage
- Tip the person's head to the side, injured side down and try to use gravity to dislodge the object. If the object does not come out, seek medical help

# Section K – Eye Injuries and Ear Injuries

## Insect in the ear

### Management:

- DO NOT let the person place their finger in the ear as this may cause the insect to sting
- Turn the persons head to the side, injured side up to encourage the insect to crawl or fly out.
- If this does not work, pour some mineral oil, baby oil or olive oil into the ear. As you are pouring the oil gently pull the earlobe. This should suffocate the insect and it may float out. Use oil for insects only as the oil may cause other objects to swell.
- Seek medical attention, as small parts of the insect may irritate the sensitive inside of the ear.

## Drainage from inside the ear

### Management:

- Cover the outside of the ear with a sterile dressing
- Lie the person down with the affected ear facing down
- Get medical help immediately
- DO NOT wipe the fluid away



## Ruptured ear drum

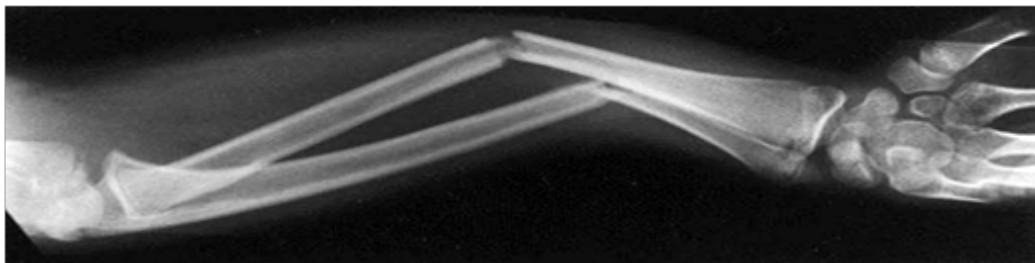
### Management:

- Place a sterile cotton wool ball gently in the outer ear
- Seek medical help

# Section L – Fractures, Dislocations and Soft Tissue Injuries

## Fractures

A fracture is a broken bone



**Fractures are usually defined as open, closed or complicated**

Fractures can be caused by:

- Direct force
- Indirect force
- Abnormal muscle movement
- Disease



## Recognition

- Pain
- Loss of movement
- Loss of function
- Swelling
- Deformity
- Crepitus
- Tenderness
- Possible shock



# Section L – Fractures, Dislocations and Soft Tissue Injuries

## Management

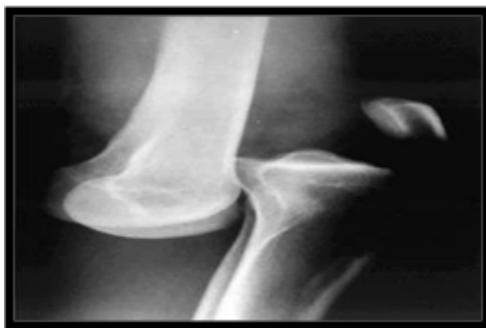
- Prevent movement
  - Support
  - Immobilise
  - Medical assistance
  - Manage for shock
  - Splinting should usually only be considered if ambulance transport is unavailable / unnecessary
- DO NOT attempt to realign a deformed limb



## Dislocations

A dislocation is:

- Displacement of bone at a joint
- Ligaments & tendons may also be damaged
- Fracture may also be present
- Sensation & circulation may be impaired



# Section L – Fractures, Dislocations and Soft Tissue Injuries

## Recognition

- Deformity
- Pain
- Loss of movement

## Management

- Immobilise in position found
- Support
- Medical aid as required
- Ambulance may be required for larger dislocations

## Soft Tissue Injuries (Sprain, strain or bruise)

Soft tissue injuries are usually caused by a sudden wrenching movement resulting in the over stretching or tearing of a muscle or ligament.



# Section L – Fractures, Dislocations and Soft Tissue Injuries

## Management

Soft tissue injuries are usually painful and will swell very quickly.

The treatment for all soft tissue injuries is: RICE

**R**est

**I**ce

**C**ompression

**E**levation



# Section M – Reporting Incidents and Updating of Information

## First aid reporting

- If time permits and if the casualty no longer requires first aid, make a report while waiting for the ambulance/ medical help
- This will help with patient management at the hospital and will reduce time spent by ambulance paramedics at the scene of the incident
- All incidents that occur at a workplace are to be fully documented using appropriate documentation. This is a legal requirement
- It is the responsibility of the staff member that witnessed the incident to record it according to company policy and procedure.
- Ensure that you record only what happened without embellishment or subjective observation
- Keep all first aid reports confidential and locked away
- The first aid officer must ensure they fully document all incidents and personnel who seek advice or treatment relating to first aid.

## Updating your first aid qualification

- Your first aid qualification requires updating every three years.
- Some companies and organisations require the CPR component to be updated every year
- The Education and Care Services National Regulations for children's services state that at least one staff member immediately available at all times with current and approved first aid, asthma and anaphylaxis training.
- This may differ if you fall under Children's Services Regulations 2009. (Please check with your employer)

## ARC Guidelines

- The Australian Resuscitation Council (ARC) produces Guidelines to meet its objectives in fostering uniformity and simplicity in resuscitation techniques and terminology
- Guidelines are produced after consideration of all available scientific and published material and are only issued after acceptance by all member organisations
- First aid classes run by RTO's issuing nationally recognised first aid certificates must comply with ARC guidelines relevant to the provision of CPR and first aid.

For more information, please visit the ARC website: [www.resus.org.au](http://www.resus.org.au)





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