First Aid
and
Individual First Aid Kit (IFAK)
Use

References:

1. FM 4-25.11 (FM 21-11): First Aid
2. National Registry of Emergency Medical Technicians Psychomotor Examination
3. Tactical Combat Casualty Care (TC3) Manual
4. U.S. Army Combat Lifesaver Course Manual: Subcourse IS0871

IFAK Contents:

- Emergency Trauma Dressing (Field Dressing or Israeli Pressure Dressing)
- CAT, SOF-T or SWAT-T Tourniquet
- Compressed Gauze
- Quik-Clot Hemostatic Gauze
- Chest Seal (2)
- Nasopharyngeal Airway (NPA)
- 14ga Chest Decompression Needle
- 1.5" Fabric Tape Roll
- Nitrile Gloves
- Trauma Shears
- Blue or Black Sharpie
- IFAK Pouch

* Mark IFAK with obvious cross

* Recommend Blood Type and Allergy Warnings on gear

Evaluating the Casualty

***Secure the scene, don't become a casualty yourself!**

- Observe the casualty and try to recognize the mechanism of injury.
- Your job is to stabilize the casualty so that they can be transported to a higher level of care (hospital, doctor, etc)
- Check casualty for responsiveness (AVPU scale)
    - **Alert**: the casualty is aware of situation and surroundings
    - **Voice**: the casualty responds to your voice.
        - Ask "Are you ok?" in a loud voice
- If there is no response at this point, if the casualty is on his stomach, roll him towards you by raising the casualty's arm closest to you above his head, place one of your hands under the casualty's head and neck for support and use the other hand to reach across the casualty and grasp his waistband or armpit and roll him steadily and evenly towards you. Lay both arms at casualty's side once he's on his back. Continue assessment.
    - **Pain**: perform a Sternal Rub/Hand Pinch
    - **Unresponsive**: if the casualty has not responded to pain stimulus, he is considered unresponsive

Airway

- If casualty is unconscious or choking, open the airway using either the Head Tilt/Chin Lift method or the Jaw Thrust method (if neck/cervical spine injury is suspected)
    - **Head Tilt/Chin Lift method:** kneeling at the casualty's shoulder, place one hand on the casualty's forehead, and two fingers from the other hand on the upper bony prominence on the chin, NOT the soft fleshy part of the chin, as this will push the casualty's tongue into the airway and hinder his breathing. Apply enough pressure on the forehead and chin to tilt the head backwards so as to open the casualty's airway. You need not try to open the casualty's mouth as this will interfere with the airway.
    - **Jaw Thrust:** kneel at the top of the casualty's head, rest elbows on ground, and place one hand on each side of casualty's head and stabilize the casualty's head with forearms. Place hands at the angles of the casualty's lower jaw and push the jaw forward using your index fingers.

Breathing

- **Look**, **Listen**, and **Feel** for the rise and fall of the chest and breathing.
    - Keeping your hands in place maintaining the casualty's airway, bend over and place your ear a few inches from the casualty's nose and mouth and look down the casualty's body at his chest.
        - Look for the rise and fall of the casualty's chest
        - Listen for breath sounds
        - Feel for air passing from the casualty's airway onto your ear and cheek
- Count the casualty's respirations for 15 seconds. If less than two respirations during 15 seconds, a nasopharyngeal airway (NPA) may be required.
- Insert the NPA to maintain a patent airway and breathing UNLESS:
    - A head injury is suspected
- If indicated, lubricate the NPA using either a water-based lubricant or if one is not available, use spit. Insert the NPA into the right nostril first, bevel towards the septum. If unsuccessful, re-lubricate and try the left nostril. If still unsuccessful then stop, this casualty will not get an NPA.
    - Always be sure the curvature of the NPA matches that of the casualty's airway (nose to sinus to throat).

Blood Sweep

- Perform blood sweep in a "*Head to Toe, Treat as you Go*" manner.
- Starting at the head and neck, slide your hands underneath the casualty, touching your fingers together and bringing them out to check for blood. Continue down the torso and then sweep the legs starting at the pelvis and working your way to the feet, being sure to check your hands for blood along the way. Last, sweep the arms starting from the armpits and working towards the hands, checking your hands for blood along the way.
    - If bleeding is found, control as indicated.
    - Do NOT remove penetrating objects, bandage around them.

Chest

- **Expose, Examine, Evaluate** casualty's chest and check for **Exit wounds.**
- **Expose** the casualty's chest by undoing his blouse. Next visually **examine** the chest for any possible wounds/penetrations and **evaluate.** Bubbling, frothing blood would indicate a sucking chest wound. Before treating, perform a Blood Sweep on the torso to check for any possible **Exit wounds** by starting at the shoulders and working your way down to the buttocks, slide your hands under opposite sides of the casualty's torso, touching your fingers underneath the casualty and bring your hands back out to check for any signs of blood indicating a possible exit wound.
    - Occlude and dress as indicated. Use a commercial chest seal (Hyfin) by opening the package and applying the occlusive dressing covering the hole in the casualty's chest.
    - If a commercial chest seal is not available, one can be made using a strong piece of plastic. Shape an occlusive dressing that will extend two inches in all directions from the edges of the wound. Apply the occlusive dressing upon the casualty's exhale. Tape all four sides down with 1.5" fabric tape.
        - Place occlusive dressings on any exit wounds, as well.
- Look for signs of Tension Pneumothorax.
    - The only two indications needed to perform a chest needle decompression are a sucking chest wound and respiratory distress. Other signs and symptoms include cyanosis, jugular vein distention, and tracheal deviation.
    - Using a 14-gauge needle/catheter, find the third rib on the affected side of the chest and just above that rib is the second intercostal space. In this space at the mid-clavicular line (nipple line) is where the needle should be inserted. Insert the needle at a 90° angle sliding along the top of the third rib, you should hear a pop and a hiss. This means that the decompression was successful. Remove the needle but leave the catheter in place and secure with tape.

Extremities

- Expose the wound and check for an exit wound.

* Apply manual pressure to the proximal (armpit or groin) pressure point to help control bleeding

- If there is an amputation, heavy arterial bleeding (spurts of bright red blood with each heart beat), or large amounts of pooling venous blood, apply a tourniquet to the limb.
    - A tourniquet should be applied at least two inches above the wound. Do not apply a tourniquet to a joint, place it two inches above the joint.
    - Tighten tourniquet until the bleeding stops, secure the windlass and any excess strapping.
    - Mark on the casualty's forehead a "T" with the time and date.

- If there is no arterial or heavy venous bleeding, apply manual pressure to the wound and apply a trauma dressing or Israeli pressure dressing to the wound.
    - Large, gaping wounds should be packed with gauze before applying a dressing to provide adequate pressure throughout the wound to stop bleeding.
    - Elevate the wound above the casualty's heart, if possible.

Head Wounds

- Bleeding from a head injury usually comes from blood vessels in the scalp and can be very heavy. Bleeding can also develop inside the skull or within the brain. In most instances visible bleeding from the head can be controlled by application of a trauma dressing.
- Do NOT attempt to put unnecessary pressure on the wound or attempt to push any brain matter back into the head (skull). Do NOT apply a pressure dressing.
- In severe head injuries where brain tissue is protruding, leave the wound alone and carefully place a loose moistened dressing over the wound.
- Do NOT remove or disturb any foreign matter that may be in the wound.

* Position the casualty so that his head is higher than his body.

Junctional Wounds

- Penetrating wounds to the shoulders and pelvis should be packed with gauze, applying pressure within the wound with your finger as you shove gauze into the hole. A pressure dressing can be applied to the wound once it is filled with gauze.
    - These types of wounds are excellent candidates for the use of Quik-Clot hemostatic gauze in controlling heavy bleeding.
- Wounds on the neck should be treated with manual pressure taking care not to occlude the airway or essential blood flow to the brain.

Abdominal Wounds

- The most serious abdominal wound is one in which an object penetrates the abdominal wall and pierces internal organs or large blood vessels. In these instances, bleeding may be severe and death can occur rapidly.
- Position the casualty on his back with his knees in an upright (flexed) position. This position helps relieve pain and allows the abdominal muscles to relax.
- When treating an eviscerating abdominal wound, gently pick up any organs that may be on the ground with a clean, dry dressing and place on top of the casualty's abdomen.
    - Do NOT probe, clean, or try to remove any foreign object from the abdomen.
    - Do NOT touch any exposed organs with bare hands.
    - Do NOT push organs back into the body.
- Place a clean trauma dressing over the wound. If a trauma dressing is not large enough to cover the wound, use the cleanest material possible to cover the wound and contain the viscera.
    - Do NOT apply pressure on the wound or any exposed parts as this can cause further injury (vomiting, ruptured intestines, damaged organs, etc.)
    - Do NOT give the casualty that has an abdominal wound food or water.