

Occupational First Aid

Level 2 Training Guide - August 2018



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Course Overview

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1. Introduction to the Course

The Occupational First Aid (OFA) Level 2 course is for intermediate first aid training and certification. It requires 35 hours of instruction. Upon successful completion of the course, learners earn an OFA Level 2 certificate.

This 2018 revision moves away from the traditional instructor-centred approach to a learner-centred approach. The new course follows best practices in adult learning, such as:

- Adults need to know why they should learn specific things.
- Adults learn better by doing than memorizing.
- Adults come from a wide range of backgrounds and effective instruction draws from all of the experience in the classroom.
- Adults are self-directed. They learn by discovering how to do things for themselves with guidance when they make mistakes.

With this model, the learners are central to the learning process. They are responsible for their own decisions and play an active role in all aspects of the instructional process. They keep track of what they need to learn, how well they are doing, and what they should do to improve.

Shifting the emphasis from instructor control to self-motivation is an important step towards ensuring that first aid training will continue to develop and improve. Although adult learning is relatively new as a field of study, it is just as substantial as traditional education and carries potential for greater success.

2. About the Course

The course includes 16 modules. Each module is broken down into lessons. The course is spread over 35 hours (5 days) excluding breaks. Each day includes 7 hours of instruction. Additional time must be added to each day to accommodate any breaks.

The maximum course load is 12 learners. This is a change from the traditional course load, which was 18 learners. The rationale for the change is to allow the instructor to give each learner formative and summative evaluations.

To ensure that the certification decision is equitable, summative evaluations of practical skills must be conducted one-on-one between each individual learner and the instructor.

3. Course Content

There are two types of content: theory and skills practice. A lot of the theory is covered in required reading and homework. Learners also gain knowledge from lectures, class discussion and exercises. A lecture is not meant to be a passive experience. To engage the learners, instructors use visual aids such as the whiteboard or flip charts. They also encourage questions and discussion.

Skills practice takes the learners through a series of activities. Each step deepens their skill and gives them more opportunity to improve their competency:

1. **Instructor Demo:** The instructor demonstrates the skill at the speed it would normally take to complete the task. The learners are encouraged to ask questions afterwards.
2. **Class-Guided Practice:** The class performs the skill while the instructor demonstrates the skill and gives step-by-step guidance. Depending on the needs of the learners, the class may work through the skill at the same pace, or they may set their own pace in smaller groups. The goal is to set a strong foundation for further progress. The learners practise completing the steps. The instructor pays close attention to each learner's progress and offers coaching as needed.

3. **Peer-Assessment:** Working in pairs or small groups, learners take turns performing the skill and giving each other feedback based on a Skill Sheet checklist. This gives the learners an opportunity to practise not only the skill, but the learner-generated assessment that leads to improving that skill.
4. **Self-Assessment:** Each learner assesses their performance using the Skill Sheet introduced earlier and targets areas needing improvement. They do this when they first practise a skill and later after additional Deliberate Practice. This places the onus for performance on the learner. The instructor provides coaching and mentoring in support. As part of this, the instructor debriefs each self-assessment by asking random learners to share what they noted about their performance.
5. **Deliberate Practice:** Working in pairs or small groups, learners continue to practice the skill using the Skill Sheet. They work on areas they have identified as needing improvement. They also assess their overall performance of each skill. If they have concerns, they ask the instructor for help. The instructor roams the classroom, observing the learners and offering coaching as needed. After the practice, the instructor debriefs, emphasizing any areas that were of concern and getting the learners to contribute to the discussion. For learners who have completed the required Deliberate Practice scenarios and believe they are competent in those skills, there are optional Deliberate Practice scenarios they can work on. Remind the learners that skill development is an ongoing activity and encourage them to take ownership.

4. Instructional Methods

As the instructor, you are encouraged to adjust delivery of the theory and skills practice based on the needs of the learners and time restraints. Although you must cover all of the theory and skills, you may adjust how much time you spend. If the learners show a high level of competency, you may spend less time. If they need more feedback, you may spend more.

You can also adjust when you give the learners quizzes and formative

assessments based on progress. But make sure you leave part of day 4 and all of day 5 open for formative and summative evaluation.

Most of the skills are taught based on a specific scenario. While the learners are acquiring a new skill, it's best to concentrate on the steps as written. But as the learners progress through the course, encourage them to use critical thinking skills. You can do this by mentioning a slightly different scenario and asking them what they would do.

Throughout the course, instructors use questioning, open discussion and role play to involve the learners. As an instructor, it is your job to encourage self-evaluation through discussion and reflection. Get the learners to talk about their knowledge, share their reasoning, and solve problems out loud. In this way, the learners will gradually reason their way closer to expert performance.

The course includes activities based on the following instructional methods.

- **Independent learning** – With this method, the learners work independently. The pre-reading and homework assignments use this method.
- **Pair-and-share** – With this method, the learners work in groups of two, exchanging ideas and offering feedback to one another. To increase the effectiveness of this method, use a timer to ensure that each person gets equal time.
- **Role-play** – Most of the skill practice relies on this method. One learner pretends to be the patient and the other learners are OFA attendants and helpers. This method fosters empathy and encourages co-operation.
- **Group-based learning** – With this method, the learners work in groups. One member of the group takes notes and another member presents the group's findings to the class. This method is good for bringing together a range of experience and ideas. As an instructor, you can help by encouraging all members of the group to contribute. If you notice that some people are not contributing, interject a question to help involve them in the group.

- **Classroom-based learning** – With this method, the learners respond when asked to contribute by the instructor. This method brings together the widest range of ideas and requires less time to deliver. To make the most of this method, ask a variety of learners to contribute.
- **Self-reflection** – With this method, each learner works independently, examining their performance and goals. Based on self-reflection, they target areas that need to be improved and make a plan for how they will get better. This method is a really good way to incite action and make learners accountable for their own competency. To increase the effectiveness of this method, you may want to role model it for the class, particularly the first few times it is used.

Regardless of the instructional method used, all activities must be debriefed. This involves more than going over the correct answers. In an effective debriefing, the instructor asks the learners what they discovered and encourages class discussion. This allows everyone to benefit from the range of experience in the classroom and keeps learners motivated.

5. Assessing Learner Progress

Throughout the course, written questions about theory and practical skill evaluations are used to assess learner progress. These assessments are mapped to the competencies in the CSA Standard Z1210-17. Assessment happens at two stages:

- **Formative Assessment** – During the course, learners complete quizzes and practical skill assessments to determine how well they're doing. The sole purpose of these assessments is to help people learn. Learners are not given a grade for formative assessments. Instead, they are given constructive feedback intended to help them improve their performance.

- **Summative Assessment** – After they've had several opportunities to learn the theory and skills, the learners complete a written exam and the final skill evaluations used to assess their competency. If they pass the written exam and final skill evaluations, they will be issued a certificate. Some of these assessments are given partway through the course, but most are given at the end.

The assessment tools are mapped to the competencies required for intermediate first aid in *CSA Standard Z1210-17*. They evaluate the learner's ability to demonstrate that they are able to meet the course learning objectives. This ensures that the assessment tools are valid, reliable and defensible. The grading criteria is based on the legacy program *Standard Grading Criteria* and the standards of performance are outlined in the *OFA 2 Reference and Training Manual* and the *OFA 2 Training Guide*.

During a simulation the learners are required to demonstrate intermediate first aid skills that, if not executed promptly and correctly by the attendant, could have devastating real-life consequences to an injured or ill worker. Failure to demonstrate any skill considered life-saving is graded as a fail. Failure to demonstrate a skill that would result in real-life injury aggravation, or non-devastating consequences if not executed promptly and correctly, is graded as a shortcoming but not necessarily a fail.

Learners will be given two opportunities to demonstrate competency. To receive a passing grade and achieve certification, learners must not make any devastating errors during the summative evaluations and must not make more than two non-devastating errors.

Module 1

Introduction

1. Introduction

- 1.1 Welcome to the Course
- 1.2 How the Course Works
- 1.3 Your Commitment to Learning
- 1.4 Certification
- 1.5 Course Agenda
- 1.6 Required Reading

1.1: Welcome to the Course

You Can Help Save Lives

As an OFA attendant, you provide an essential and important service in the workplace. You alleviate suffering. Sometimes your skills may help save lives. Also, by providing effective injury care, you can help shorten the time it takes workers to heal, allowing them to resume normal activities sooner.

Let's take a look at the affect a well-trained OFA attendant can have on the people in their workplace.

Class-Based Discussion

Present each of the following scenarios to the class and discuss the associated questions:

1. As his trailer was being loaded, a commercial truck driver walked around the trailer to remove loose debris. It was dark and he was in a poorly lit area. As he walked around the corner of the trailer, a forklift carrying a loaded pallet hit him in the chest. When the OFA attendant arrived, the driver was unconscious and he was not breathing. The OFA attendant gave the driver CPR. The driver began to breathe.

What might have happened if the OFA attendant did not give the driver CPR?

If you were the truck driver, would you want the OFA attendant to be well trained in CPR?

2. A worker was cutting lumber on a radial saw when she caught her index finger in the blade. The tip of her finger was cut off. When the OFA attendant arrived, she was lying supine and red blood was spurting out of the wound. The OFA attendant got help from a nearby worker. Together they stopped the bleeding by applying direct pressure. They cleaned and dressed the amputated fingertip. They put the amputated fingertip in a bag with ice and labelled the bag. At the hospital, the doctors were able to reattach the fingertip. The worker has retained full use of her finger.

How did the actions of the OFA attendant affect the life of the worker after her injury?

What might have happened if an OFA attendant wasn't there?

3. A middle-aged worker had been unloading boxes from a truck when he began to feel nauseous and asked for an OFA attendant. The worker was short of breath, very sweaty and pale, and experiencing chest pain. The OFA attendant recognized the signs and symptoms of a heart attack, called an ambulance and gave the worker two 80-mg chewable tablets of ASA. After medical care, the worker made a full recovery.

What might have happened if the OFA attendant had not recognized the signs of a possible heart attack?

1.2: How the Course Works

Skills Practice

During this course, you will work through a series of activities. These activities do more than let you practise the skill. They help you see how well you performed the skill and what you can do to improve.

For each skill, we take you through a series of activities:

1. **Instructor Demo:** The instructor demonstrates the skill at the speed it would normally take to complete the task.
2. **Class-Guided Practice:** The class performs the skill while the instructor does a break-down demo and gives step-by-step guidance.
3. **Peer-Assessment:** Working in pairs or small groups, learners take turns performing the skill and giving each other feedback based on a checklist.
4. **Self-Assessment:** Each learner assesses their performance and targets areas they need to improve.
5. **Deliberate Practice:** Working in pairs or small groups, learners continue to practise the skill. The instructor is available to answer questions.

Theory

A lot of the theory you need will be covered in the Required Reading from the textbook, *Occupational First Aid Level 2: A Reference and Training Manual*. You will also gain knowledge from homework assignments, lectures and exercises.

Assessments

Our goal is to help you develop effective skills and an understanding of essential concepts. To do that, we use two levels of assessment:

- **Formative assessments** are given during the course to help you track your progress and identify areas that need improvement. The sole purpose of these assessments is to help you learn. You will not be given a mark, but you will be given constructive feedback intended to help you improve your performance. You will complete quizzes and skill assessments during this stage.
- **Summative assessments** are given after you've had an opportunity to build your skills and understanding. Some of these assessments will be given partway through the course. Others will be given at the end of the course. You will be marked on summative assessments. There will be a written exam as well as skill assessments.

The Learning Environment

In this learning environment, you are free to ask questions and learn from mistakes. You can monitor your progress at every stage. Before the final assessment, you will have several opportunities to work on areas that need improvement. When you return to your job, you will have the tools to continue practising, monitoring your performance, and improving your skills.

1.3: Your Commitment to Learning

Course Schedule

There will be 35 hours of class time covered over 5 days. There are 16 modules. Each module is divided into lessons. We will start each day at _____ and finish at _____. A ___ min coffee break will be given in the morning and afternoon. A ___ min lunch break will also be provided.

Point out the washroom and exits. Explain the evacuation and emergency response procedures. Tell the learners to let you know right away if anyone feels ill while on the premises.

Learner Involvement

This is a hands-on course. For most of the course, you will be actively practising skills. To be successful, you need to be committed to your learning. This involves being on time, participating fully in class activities, completing required reading beforehand, and doing 1 to 3 hours of homework each night.

Being an OFA attendant is a potentially life-saving role. It takes effort to acquire the necessary knowledge and skills.

Keys to Success

To be successful in this course, you need to:

- Complete the Required Reading for each day in advance.
- Participate fully in Class-Guided Practices and other activities.
- Give one another useful feedback during Peer-Assessments.
- Honestly evaluate your competence during Self-Assessments and make a genuine commitment to further developing your skills.
- Use Deliberate Practice and Formative Assessments to develop your skills and address areas of weakness.
- Use your class time for maximum value. If you believe you are competent in the required Deliberate Practice skills and want more challenge, work on the optional Deliberate Practice scenarios.
- Complete a Homework Assignment every night.

Safety and Personal Protection

This course is physically demanding. You will have to kneel for long periods of time, move other learners who are pretending to be patients, and perform various manual tasks. Knee pads and closed-toe footwear are recommended.

If you have physical concerns that could limit your participation in an activity, talk to your instructor. We will try to make accommodations.

As an OFA attendant, you should wear waterproof gloves whenever there is a possibility of direct contact with blood and other bodily fluids. We are going to practise that now.

1.4: Certification

Certification Requirements

To qualify for an OFA 2 certificate, you must successfully complete this OFA 2 training course. You must also achieve a grade of at least 70% on the final written test and each part of the summative skills assessment.

The course must be taught and evaluated by a person authorized by WorkSafe BC. If you fail to complete any part of the course, you will have to complete the components you missed before you can be tested. This must be done without undue delay, within 30 days and at the discretion of the approved training agency.

Recertification

To renew an OFA Level 2 or equivalent certificate, a Candidate must successfully retake the full course of instruction and evaluation, or successfully challenge the OFA Level 2 evaluation.

To challenge the evaluation, the student must attend the final 14 hours of the OFA Level 2 course and successfully complete the practical and written evaluation. The evaluation challenge candidate must possess a current (unexpired) OFA Level 2 or equivalent certificate, and a CPR/AED certificate that included adult resuscitation.

The CPR/AED certificate must have been issued within the previous 6 months by a recognized basic life support curriculum provider such as Canadian Red Cross, Heart and Stroke Foundation, Lifesaving Society, or St. John Ambulance. Candidates challenging the OFA Level 2 evaluation are advised that, depending on the nature of the equivalent first aid course they completed, OFA Level 2 may involve unfamiliar equipment, protocol, and procedures (for example, the patient record). This could impact assessment results.

Remediation

If you fail any part of the written test or summative skill assessments, you may be allowed a second attempt, subject to approval from the training agency. If you do not pass on your second attempt, you will have to repeat the entire course before becoming eligible for another assessment.

On the second attempt, you must retake the failed portions of the assessment in their entirety. Passing grades that were obtained on other parts of the assessment during your first attempt will be carried forward to the second assessment.

Your second attempt can be no sooner than 24 hours after the first failed assessment. If you don't make a second attempt within 30 days of the first examination, you will have to repeat the entire course before being assessed again.

1.5: Course Agenda

DAY 1	8:30 – 9:10	1. Introduction
	9:10 – 9:35	2. Scene Assessment
	9:35 – 9:50	3. Effective Communication
	9:50 – 11:55	4. Primary Survey & Transport Decision
	11:55 – 12:25	Lunch
	12:25 – 2:40	5. Secondary Survey
	2:40 – 3:30	6. Patient Positioning
	3:30 – 4:30	Deliberate Practice Homework Assignment (Shock)
DAY 2	8:30 – 8:45	Quiz 1
	8:45 – 9:35	7. Basic Skills
	9:35 – 10:40	8. Airway & Breathing Conscious Patient
	10:40 – 11:30	Deliberate Practice
	11:30 – 12:00	Lunch
	12:00 – 1:45	9. Airway & Breathing Unresponsive Patient
	1:45 – 2:15	Deliberate Practice
	2:15 – 4:00	Formative Assessment
	4:00 – 4:30	10. Exposure to Heat and Cold Injuries Homework Assignment (Medication, First Aid Record)
	DAY 3	8:30 – 11:10
11:10 – 12:00		12. Minor Injuries
12:00 – 12:30		Lunch
12:30 – 2:00		12. Minor Injuries continued
2:00 – 4:30		13. Major Injuries Homework (Role of OFA Attendant and OFA Safety)

DAY 4	8:30 – 9:20	Deliberate Practice
	9:20 – 10:20	Formative Assessment
	10:20 – 12:15	14. Medical Emergencies
	12:15 – 12:45	Lunch
	12:45 – 1:45	15. Head and Nervous System
	1:45 – 2:00	16. Multiple Patients
	2:00 – 2:25	Deliberate Practice
	2:25 – 3:10	Quiz 2
	3:10 – 4:30	Formative Skills Assessment
DAY 5	8:30 – 10:00	Formative Skills Assessment
	10:15 – 12:00	Summative Skills Assessment
	12:00 – 12:30	Lunch
	12:30 – 2:45	Summative Skills Assessment
	3:00 – 4:30	Final Written Exam and Assessment Results

1.6: Required Reading

To be successful in this course, you must do some reading on your own. Complete the reading listed below before you come to class each day.

	Module	OFA2 Reference & Training Manual
Before Day 1	2. Scene Assessment	Chapter 3, page 17 - 22
	3. Effective Communication	Chapter 49, page 282 – 284
	4. Primary Survey & Transport Decision	Chapter 3, page 23 - 33
	5. Secondary Survey	Included above
	6. Patient Positioning	Chapter 16, page 110 - 115
Before Day 2	Homework: Shock	Chapter 8, page 66 – 73
	7. Basic Skills	Chapter 12, page 85 - 87
	8. Airway & Breathing Conscious Patient	Chapter 4, page 37 – 50 Chapter 5, page 41 – 44 Chapter 6, page 47 - 60
	9. Airway & Breathing Unresponsive Patient	Chapter 5, page 45 - 46
	10. Exposure Heat and Cold Injuries	Chapter 36, page 217 - 223
Before Day 3	Homework: Medication, First Aid Record	Chapter 25, page 153 - 154
	11. Bleeding	Chapter 9, page 74 – 77 Chapter 28, page 165 and 175 – 176
	12. Minor Injuries	Chapter 18, page 118 - 121 Chapter 19, page 122 – 129 Chapter 21, page 131 – 132 Chapter 24, page 147 – 149 Chapter 28, page 163 – 177 Chapter 30, page 182- 186 Chapter 32, page 196- 199 Chapter 37, page 224 - 229
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	Module	OFA2 Reference & Training Manual
	13. Major Injuries	Chapter 26, page 155 – 159 Chapter 31, page 189 – 195 Chapter 33, page 200 – 201 Chapter 34, page 202 – 208 Chapter 35, page 209 - 214
Before Day 4	Homework: Role of OFA Attendant, OFA Safety	Chapter 25, page 150- 153
	14. Medical Emergencies	Chapter 11, page 80 - 84 Chapter 41, page 243 - 248 Chapter 44, page 261 - 264 Chapter 45, page 267
	15. Head and Nervous System	Chapter 14, page 95 - 96 Chapter 15, page 101 - 106 Chapter 16, page 107 – 113 Chapter 17, page 114 – 115
	16. Multiple Patients	Chapter 48, page 278 – 281

Module 2

Scene Assessment

2. Scene Assessment

2.1 The Priority Action Approach

2.2 Scene Assessment

Lesson 2.1: The Priority Action Approach

Learning Outcomes

1. Describe the four stages of the Priority Action Approach and the purpose of each.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, pages 17 – 20

Theory

Why It's Important

The Priority Action Approach helps ensure that you:

- Recognize a seriously injured worker quickly.
- Perform life-saving first aid interventions quickly.
- Activate transportation and Emergency Management System resources.
- Get patients in need of medical care to the hospital without delay.

It's a step-by-step approach that helps you make a thorough yet rapid assessment and determine what needs to be done to care for the patient.

How thoroughly each step is conducted depends on the circumstances. For example, if the patient is not responsive and not breathing normally, you will move through the primary survey rapidly and begin CPR and AED immediately.

The Four Stages

The Priority Action Approach includes four stages:

1. Scene Assessment
2. Primary Survey with Critical Interventions
3. Transport Decision
4. Secondary Survey

This lesson provides an overview of the stages. Later lessons will cover each stage in detail.

Scene Assessment

The scene assessment helps ensure that the site is safe for you and the patient. As you approach:

- Assess the scene for hazards.
- Determine the mechanism of injury.
- Count the number of patients.

Primary Survey with Critical Interventions

The primary survey is a rapid patient assessment to determine if there are any immediately life-threatening injuries or conditions, and to provide critical interventions. In most cases, it shouldn't take more than 2 min.

Transport Decision

There are three options for transport:

- **Rapid Transport:** The patient is transported as quickly as possible to medical aid. The patient may be transported by ambulance, helicopter or an employer's Emergency Transport Vehicle (ETV).
- **Medical Aid:** The patient requires medical aid, but does not need to be transported as quickly. The patient may be transported by a company vehicle, taxi, ETV or ambulance.
- **Return to Work:** After assessment and treatment, the patient can return to work.

Secondary Survey

The secondary survey is similar to the primary survey, except it's more detailed and takes longer. A secondary survey is a more thorough assessment of the patient. The purpose is to determine the full extent of the developing injury or illness, and to identify any other injuries or illnesses that may not have been discovered during the primary survey.

Summary

1. What is the purpose of the scene assessment?
2. What is the purpose of the primary survey?
3. What is the purpose of the secondary survey?

Lesson 2.2: Scene Assessment

Learning Outcomes

1. Assess the scene for hazards.
2. Discover what happened and how many people are ill or injured.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 21 – 22

Theory

As you approach the patient:

1. Assess the hazards.
Are there hazards to you, your helpers or the patient? Can the hazard be removed or controlled? Does the patient need to be moved? Are emergency personnel, specialized equipment or specially trained personnel required?
2. Determine the mechanism of the injury.
What happened? How much force was applied? To which part of the body and in what direction?
3. Determine how many people are injured or ill.
Are there more people who are injured or ill?

Pair and Share Scenario Exercise

Learners work in pairs. They take turns being the patient and the OFA attendant. The patient reads the scenario out loud. The OFA attendant identifies the hazards, mechanism of injury, and number of people injured. Using the Answer Key, the patient tells the OFA attendant what happened. Allow 1 min for each turn.

Scenarios

1. Two workers were thrown off the forks of a forklift when the boom hit the ceiling.
2. An orchard worker hit the overhead powerlines with an irrigation pipe.
3. A ranch hand got his arm caught in the gears of the mill.
4. A glazier has been burned.
5. A carpenter fell from the first floor.
6. Three firefighters could not evacuate an area fast enough when the wind changed direction and they were overcome by smoke.

Answer Key		
1	Hazards	The area has been blocked off to prevent further traffic. The forklift has been stabilized. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	Workers were riding on the forks approx. 3.5 m (11 ft) in the air when the boom hit the ceiling. The forklift was travelling at 15 kph.
	People Injured	2
2	Hazards	The irrigation pipe is now on the ground. There is no longer an electrical hazard. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	An orchard worker was electrocuted. She was carrying a metal irrigation pipe and it touched an overhead power line. She's not moving.
	People Injured	1
3	Hazards	The mill has been shut down. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	A ranch hand was adjusting the motor with the transmission engaged. The sleeve of his jacket got snagged in the chain drive and it pulled his arm into the gears.
	People Injured	1
4	Hazards	Co-workers soaked her with water to put out the fire. Fire has been extinguished. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	She was cleaning the glass with chemicals and her arm caught fire. She has burns on her hand, arms and face. She seems to be in a lot of pain.
	People Injured	1

5	Hazards	The area has been blocked off to prevent further traffic. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	A carpenter was working on an unguarded sundeck and fell 3.5 m (11 ft). He hit his head when he landed.
	People Injured	1
6	Hazards	The wind is blowing away from the injured worker. She is away from the active fire. Other firefighters are not at risk. No other environmental, biological, physical, or chemical hazards.
	Mechanism of Injury (What happened?)	Three firefighters were exposed to smoke. They were laying out fire hose on a steep hill when the wind blew across the fire break, setting the adjacent gully on fire. The area where the firefighters were working filled with smoke.
	People Injured	3

Summary

1. What is the goal of scene assessment?
2. What types of things should you consider when looking for hazards?
3. What questions should you ask to identify the mechanism of injury?

Module 3

Effective Communication

3. Effective Communication

3.1 Your Communication Role

3.2 Communication Strategies

Lesson 3.1: Your Communication Role

Learning Outcomes

1. Describe when BC EHS should be called.
2. Describe the information that should be provided to EHS when you transfer patient responsibility.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 49: Transportation, page 282 – 284

Theory

Calling BC Emergency Health Services

Call BC EHS as soon as you think they may be needed. This may happen during scene assessment based on the mechanism of injury, or later based on patient assessments during the primary or secondary survey.

If the patient's condition changes or you discover more information during assessment, give BC EHS an update.

What You Should Tell Them

Tell the next level of care:

- the patient's name, age and gender
- chief complaints
- what happened (history of chief complaints)
- brief mention of injuries or treatments
- vitals
- medical history
- medications
- allergies
- changes in patient's condition, findings of physical examination and any other relevant comments

Summary

1. When should you call BC EHS?
2. What should you tell BC EHS?

Lesson 3.2: Communication Strategies

Learning Outcomes

1. Describe strategies for effective communication with patients and other workers.
2. Describe barriers to effective communication with patients and other workers.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 19 – 20

Theory

Effective Communication Strategies

When talking to patients and other workers:

- Be calm and reassuring.
- Tell them you're prepared and have practised for this type of situation.
- Use the patient's name and make eye contact.
- Explain what you're going to do and reassure the patient even if the patient is confused or comatose.
- Listen attentively and paraphrase what you've heard.
- Tell the truth or you may destroy the patient's trust in you.
- Use appropriate body language such as a pat on the shoulder.
- Avoid being coldly detached, angry or irritated with a patient.

Class Discussion

Barrier to Effective Communication

Discuss solutions to the following communication barriers:

1. The patient speaks a different language than you or has hearing challenges.
2. In the heat of the moment, you miss something important the patient says.
3. The scene of the accident is next to a noisy work area.
4. The patient seems to be confused by your question.

Answers

Summary

1. How can you reassure a patient who is feeling anxious?
2. What is just as important as talking?
3. What should you do if the patient does not speak your language?

Module 4

Primary Survey and Transport Decision

4. Primary Survey and Transport Decision

4.1 Manually Stabilizing Head and Neck

4.2 Primary Survey

4.3 Transport Decision

Lesson 4.1: Manually Stabilizing Head and Neck

Learning Outcomes

1. Restrict head and neck movement if there is a possible spinal injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 17-33

Skill Practice

Goal
Restrict the head and neck movement of a patient with a possible spinal injury. This is also referred to as c-spine control.
Scenario
A traffic control person was struck by an oncoming vehicle travelling at about 50 km/hr through a construction zone. When you arrive, she is lying supine on the ground with her head at an angle. You conduct a scene assessment. Based on the mechanism of injury, you determine that spinal motion restriction is required.
Steps
1. Approach the patient from their line of sight if possible. Explain that you're there to help them.
2. Tell patient to lie still while you kneel at the top of their head.
3. Tell the patient what you're going to do before you do it. Ask them to tell you if they experience any pain.
4. Brace your elbows on the ground if possible. Firmly place your hands on either side of the patient's head, over their ears. Don't completely cover the patient's ears.
5. Activate workplace emergency response procedure.
6. Gently support the patient's head in the position found.
7. If possible, train a helper to take over manual stabilization: "Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."

Summary

1. What is the purpose of supporting the head and neck?

Lesson 4.2: Primary Survey

Learning Outcomes

1. Assess a patient's level of consciousness using the AVPU system.
2. Assess a patient's airway.
3. Assess a patient's breathing.
4. Assess a patient's circulation.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 17-33

Theory

Purpose

The purpose of the primary survey is to quickly identify life-threatening conditions. It's a rapid examination of the patient to discover any immediate life-threatening conditions.

Level of Consciousness

Assessing the patient's level of consciousness is an important part of the primary survey. To assess level of consciousness, use AVPU:

- **A:** Patient is alert and responds appropriately.
- **V:** Patient responds to your voice.
- **P:** Patient responds to a pain stimulus.
- **U:** Patient does not respond at all.

The patient's level of consciousness will determine your actions in the primary survey. It will also determine the information that should be provided to the ambulance when they're called.

Airway, Breathing and Circulation

The primary survey is based on the ABCs:

- **Airway assessment:** Quickly identify whether the patient's airway is open and clear. Use spinal motion restriction if the mechanism of injury suggests spinal trauma.
- **Breathing assessment:** Quickly identify whether the patient is breathing normally.
- **Circulation assessment:** Quickly look at the person from head to toe for signs of shock and feel for any massive bleeding.

Modified Primary Survey

The attendant can modify the primary survey in some cases. For example, some patients who walk into the first aid room may be assessed visually as they approach. If the patient is alert, talking and breathing normally, has normal skin colour and is obviously not bleeding severely; you can consider that an assessment of the ABCs. You can see as the patient approaches that there are no immediate and obvious life-threatening conditions.

PRIMARY SURVEY RESPONSIVE

Skill Practice

Goal	
Rapid assessment of a responsive patient to: <ul style="list-style-type: none"> • Determine whether spinal motion restriction is required • Discover immediately life-threatening conditions • Identify critical interventions required 	
Scenario	
A worker fell 3 m (9.8 ft) from a stepladder. He was lying supine when you arrived, complaining about severe pain in his right knee.	
Steps	
1. Complete a scene assessment.	Based on the mechanism of injury, spinal motion restriction is required.
2. Assess the patient's level of consciousness. Approach patient from front. Identify yourself and advise the patient not to move. Ask what happened. Alert: Patient is aware of surroundings. Verbal: Patient responds when spoken to. Pain: Patient doesn't respond to questions, but responds to painful stimulus. Unresponsive: Patient doesn't respond to any stimuli.	He's alert and responds to you appropriately.
3. Manually stabilize head and neck. <ol style="list-style-type: none"> Brace elbows. Hands on either side of head. Don't cover the patient's ears. Gently support in the position found. 	

<p>4. If possible, train a helper to take over manual stabilization:</p> <p>"Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise by asking the patient to lie still and by using readily available materials to maintain head support until help arrives.</p>	
<p>5. Activate the workplace emergency response procedures.</p> <p>If patient is unable or unwilling to walk, ask someone to call an ambulance.</p> <p>If calling an ambulance, say there's a responsive adult who has fallen and has severe knee pain, and report back.</p>	Patient can't walk.
<p>6. Assess the patient's airway.</p> <p>Can patient speak clearly? If not, look, listen and feel.</p>	<p>He speaks clearly.</p> <p>The airway is clear.</p>
<p>7. Assess the patient's breathing.</p> <p>Is patient breathing? Look, listen and feel.</p>	Patient is breathing normally.
<p>8. Assess the patient's circulation.</p> <p>Signs of Shock: Cool, pale, clammy skin</p> <p>Rapid Body Survey: Massive bleeding</p>	<p>Skin is normal, warm and dry.</p> <p>No blood visible.</p> <p>No injury other than severe knee pain. Provide support for the injured leg. <i>Minor Fractures to be covered in Lesson 10.2.</i></p>
<p>9. Determine if critical interventions are required.</p>	The patient appears to be stable.
<p>10. Transport decision.</p> <p>Rapid transport, medical aid or return to work?</p>	The patient can't walk and can't return to work. An ambulance has been called.
<p>11. Secondary Survey</p>	<i>To be covered in Lesson 12.3.</i>

PRIMARY SURVEY UNRESPONSIVE

Skill Practice

Goal	
Rapid assessment of an unresponsive patient to: <ul style="list-style-type: none"> Determine whether spinal motion restriction is required Discover immediately life-threatening conditions Identify critical interventions required 	
Scenario	
A worker fell 3 m (9.8 ft) from a stepladder. He was lying supine when you arrived, he is not moving or making any sounds.	
Steps	
1. Complete a scene assessment.	Based on the mechanism of injury, spinal motion restriction is required.
2. Assess the patient's level of consciousness. Approach patient from front. Identify yourself and advise the patient not to move. Ask what happened. Alert: Patient is aware of surroundings. Verbal: Patient responds when spoken to. Pain: Patient doesn't respond to questions, but responds to painful stimulus. Unresponsive: Patient doesn't respond to any stimuli.	He's not responding to your voice. You apply a pain stimulus to his finger and still no response. Patient is unresponsive.
3. Activate the workplace emergency response procedures. Patient is unresponsive, ask someone to call an ambulance. Say there's an unresponsive adult who has fallen, and report back.	
4. Perform a head-tilt/chin-lift to open the airway. <ol style="list-style-type: none"> Place one hand on the forehead. Place other hand under the chin on the side closest to you. Gently push back on the forehead and lift the chin. 	
5. Assess the airway. Look, listen and feel for 5 - 10 seconds.	Airway is clear.

6. Assess the patient's breathing. Look, listen and feel.	Quiet breathing his heard. Patient is breathing normally.
7. If possible, train a helper to take over the head-tilt/chin-lift: "Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help." If there is no help available, you may have to improvise using readily available materials to maintain the head-tilt/chin-lift until help arrives.	
8. Assess the patient's circulation. Signs of Shock: Cool, pale, clammy skin Rapid Body Survey: Massive bleeding	Skin is normal, warm and dry. No blood visible. No injury other than deformity at the knee. Provide support for the injured leg in the position found.
9. Determine if critical interventions are required.	Maintain the patient in the position found and the head-tilt/chin-lift to protect the patient's airway.
10. Transport decision. Rapid transport, medical aid or return to work?	Rapid transport. The patient is unresponsive. An ambulance has been called.
11. Secondary Survey	<i>To be covered in Lesson 5.1.</i>

SAFELY REMOVING GLOVES

Skill Practice

Goal
Safely remove gloves.
Steps
1. With both of your hands gloved: <ol style="list-style-type: none"> a. Grasp the outside of one glove near the top of the wrist. b. As you peel off the glove, turn it inside out and pull it away from yourself. c. Hold the removed glove in your gloved hand.
2. With your ungloved hand: <ol style="list-style-type: none"> a. Grasp the second glove near the top of the wrist. b. As you peel off the glove, turn it inside out and pull it away from yourself. Leave the first glove inside the second glove.
3. Immediately dispose of both gloves in a waterproof garbage bag.
4. Wash your hands thoroughly with soap and water.

Summary

1. How do you assess the patient's airway?
2. How do you assess the patient's breathing?
3. How do you assess the patient's circulation?

Lesson 4.3: Transport Decision

Learning Outcomes

1. Describe the three options involved in the transport decision.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 17-33

Theory

Overview

The transport decision is usually made in the first few minutes. Often this decision is confirmed after the primary survey and the severity of the injury or illness has been assessed. But the decision can be changed at any time.

Ask three questions:

- Should the patient be transported?
- If so, when should the patient be transported?
- How should the patient be transported?

Transportation Options

There are three options:

- **Rapid Transport:** The patient is transported for medical aid as quickly as possible. The patient is unstable.
- **Medical Aid:** The patient requires medical aid, but does not need to be transported rapidly. The patient is stable.
- **Return to Work:** After assessment and treatment, the patient is able to return to work. The patient is stable, and can resume normal or modified work activities.

The workplace first aid attendant must know and follow the workplace emergency response procedures. Every worksite is required to have emergency response procedures. These are often referred to as the workplace ERP (or WERP). These procedures explain how patients who are not able to return to work should be transported. When deciding whether a patient should be transported by ambulance, helicopter, ETV or another means; refer to these written workplace emergency response procedures.

Rapid Transport

Use the *Rapid Transport Criteria* in your textbook to determine whether a patient requires rapid transport.

If an ambulance is required, call the BC Emergency Health Services (EHS). Give them as full a description of the event and the patient's condition as possible. If you discover new information that you think is important after your first call to BC EHS, call them again with an update.

Medical Aid

The decision about whether to refer a patient for medical aid is based on the severity of the illness or injury. A patient who needs medical aid, but is stable and able to walk, does not always need to be transported by ambulance. Ambulatory patients can often be transported for medical aid by a company vehicle or taxi.

Return to Work

Minor injuries, such as cuts and scrapes and musculoskeletal injuries (MSI), can often be managed by the attendant at the workplace.

MSIs result from work activities that include risk factors such as repetitive activity, awkward or static posture, twisting, bending, pushing or pulling. The following signs and symptoms indicate that the patient with an MSI may be managed at the workplace:

- The onset of symptoms is gradual.
- The patient is able to walk and does not have any weakness, numbness or tingling in the extremities.
- The patient can conduct a range of motion without experiencing a significant increase in pain.

Summary

1. How do you decide if a patient requires rapid transport?
2. How do you decide if a patient requires medical aid?

Module 5

Secondary Survey

5. Secondary Survey

5.1 Secondary Survey

5.2 Ongoing Assessment and After the Call

Lesson 5.1: Secondary Survey

Learning Outcomes

1. Take the patient's vital signs.
2. Obtain a medical history of the patient.
3. Assess the patient's level of consciousness using AVPU.
4. Complete a head-to-toe assessment.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 17 – 33

Theory

Purpose

The secondary survey is similar to the primary survey except this assessment is more detailed and takes longer. The purpose is to determine the full extent of the developing injury or illness, and to identify any other injuries or illnesses that may not have been discovered during the primary survey.

What It Includes

The secondary survey includes the following areas of assessment:

- Vital signs
- History taking
- Head-to-toe examination

Vital Signs

The patient's vital signs help you identify life-threatening conditions that may develop while the patient is in your care. Always record the time the vital signs were taken so that changes in the patient's condition can be evaluated over time.

Vital signs must be reassessed:

- Every 10 min for all patients transported by BC EHS
- Every 30 min for patients who do not require transport to medical aid by BC EHS

Vital signs include an assessment of the patient's:

- Breathing rate and quality
- Level of consciousness using AVPU
- Heart rate and quality (count for 15 sec and multiply by 4)
- Skin temperature, skin colour, and whether the skin is moist or dry

History Taking

History taking is a verbal assessment of what the patient feels and the patient's past medical history. The four components of history taking are:

- Chief complaint: Where does it hurt? What happened?
- Allergies: Drugs/medications, chemicals, foods, pollens, animal fur or dust
- Medications: Name of drug, dose, frequency, purpose and compliance
- Past medical history: Anything related to current problem or illness history including any recent hospitalizations

Head-to-Toe Examination

Carefully check the patient from head-to-toe looking for injuries that were not identified during the primary survey.

SECONDARY SURVEY RESPONSIVE

Skill Practice

Goal	
Complete a more thorough assessment of a responsive patient to determine the full extent of the developing injury or illness, and identify any other injuries or illnesses.	
Scenario	
A worker fell 3 m (9.8 ft) from a stepladder. He was lying supine when you arrived, complaining about severe pain in his right knee. The patient is unwilling to move his knee because it hurts much more when moved. You've decided to call for an ambulance or the workplace ETV. While waiting, complete a primary and secondary survey in the position found.	
Steps	
1. Complete a scene assessment.	Based on the mechanism of injury, spinal motion restriction is required.
2. Assess the patient's level of consciousness. Approach patient from front. Identify yourself and advise the patient not to move. Ask what happened. Alert: Patient is aware of surrounding. Verbal: Patient responds when spoken to. Pain: Patient doesn't respond to questions, but responds to painful stimulus. Unresponsive: Patient doesn't respond to any stimuli.	He's alert and verbal.

<p>3. Manually stabilize head and neck:</p> <ul style="list-style-type: none"> a. Brace elbows. b. Hands on either side of head. c. Don't cover the patient's ears. d. Gently support in position found. 	<p>Patient allows you to support the head.</p>
<p>4. If possible, train a helper to take over manual stabilization:</p> <p>"Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise by asking the patient to lie still and by using readily available materials to maintain head support until help arrives.</p>	<p>Use sandbags as helper.</p>
<p>5. Activate the workplace emergency response procedures.</p> <p>If patient is unable or unwilling to walk, ask someone to call an ambulance.</p> <p>If calling an ambulance, say there's a responsive adult who has fallen and has knee pain, and report back.</p>	<p>Patient can't walk. Send for an ambulance patient is non-ambulatory.</p>
<p>6. Assess the patient's airway.</p> <p>Can patient speak clearly? If not, look, listen and feel.</p>	<p>He speaks clearly. The airway is clear.</p>
<p>7. Assess the patient's breathing.</p> <p>Is patient breathing? Look, listen and feel.</p>	<p>Patient is breathing normally.</p>
<p>8. Assess the patient's circulation.</p> <p>Signs of Shock: Cool, pale, clammy skin Rapid Body Survey: Massive bleeding</p>	<p>No signs of shock. No blood visible. No injury other than severe knee pain. Provide support for the injured leg in the position found. <i>Minor Fractures to be covered in Lesson 12.3.</i></p>
<p>9. Determine if critical interventions are required.</p>	<p>The patient appears to be stable.</p>
<p>10. Transport decision.</p> <p>Rapid transport, medical aid or return to work?</p>	<p>The patient can't walk and can't return to work. An ambulance has been called.</p>

<p>11. Start the secondary survey.</p> <p>Record the patient's name, date, time, and all of the following secondary survey findings.</p>	<p>As provided</p>
<p>12. Assess breathing rate and quality.</p> <p>Rate: Count chest wall movements (in and out is 1 breath). Multiply 15-sec interval by 4. Normal is 12/min to 20/min.</p> <p>Quality: Effective, even, deep, shallow, distressed, laboured, gasping</p>	<p>His breathing rate is 12/min.</p> <p>His breathing is effective and even.</p> <p>Both sides expand equally.</p>
<p>13. Assess level of consciousness.</p> <p>Approach patient from front. Identify yourself and advise the patient not to move. Ask what happened.</p> <p>Alert: Patient is aware of surroundings.</p> <p>Verbal: Patient responds when spoken to.</p> <p>Pain: Patient doesn't respond to questions, but responds to painful stimulus.</p> <p>Unresponsive: Patient doesn't respond to any stimuli.</p>	<p>Patient answers all your questions appropriately.</p> <p>Patient is alert.</p>
<p>14. Assess heart rate and quality.</p> <p>Rate: Count pulse. Multiply 15-sec interval by 4. Normal is 60/min to 80/min.</p> <p>Quality: weak, strong, regular, irregular</p>	<p>His heart rate is 88/min.</p> <p>His pulse quality is regular and easy felt.</p>
<p>15. Assess skin colour, temperature and condition.</p> <p>Pale = Blood loss and possible shock</p> <p>Blue = Cyanosis (low oxygen), possible cardiorespiratory emergency</p> <p>Cold, sweating = Possible shock</p>	<p>Skin is normal, dry and warm.</p> <p>No signs of shock.</p>
<p>16. Record patient's medical history.</p> <p>Where does it hurt? What happened?</p> <p>Allergies? Medical alert devices?</p> <p>Medications: name, dose, frequency, purpose, compliance</p> <p>Past medical history related to current problem</p>	<p>Fell off stepladder. Sharp pain in right knee. Hurts when moved.</p> <p>No allergies. No medical alerts.</p> <p>No medications.</p> <p>No relevant past medical history.</p>

<p>17. Complete head-to-toe check.</p> <p>Look for injuries not identified earlier.</p> <p>Check circulation: skin temperature and colour</p> <p>Check motor and sensory function: range of motion</p> <p>Check sensory function: more toes and feet</p>	<p>There is redness and slight swelling distal to the patella on the anterior side. Patient refuses to move the injured leg due to a significant increase in pain when it's moved. No other injuries found. Circulation, motor function and sensory function is equal on all extremities.</p>
<p>18. Reassess the ABC's at 5-minute intervals</p>	<p>ABC's same as vitals. No change.</p>

SECONDARY SURVEY UNRESPONSIVE

Skill Practice

<p>Goal</p>	
<p>Complete a more thorough assessment of an unresponsive patient to determine the full extent of the developing injury or illness, and identify any other injuries or illnesses.</p>	
<p>Scenario</p>	
<p>A worker fell 3 m (9.8 ft) from a stepladder. He was lying supine when you arrived. He is not moving or making any sounds. You've called for an ambulance or the workplace ETV. While waiting, complete a primary and secondary survey.</p>	
<p>Steps</p>	
<p>1. Complete a scene assessment.</p>	<p>Based on the mechanism of injury, spinal motion restriction is required.</p>
<p>2. Assess the patient's level of consciousness.</p> <p>Approach patient from front. Identify yourself and advise the patient not to move. Ask what happened.</p> <p>Alert: Patient is aware of surroundings.</p> <p>Verbal: Patient responds when spoken to.</p> <p>Pain: Patient doesn't respond to questions, but responds to painful stimulus.</p> <p>Unresponsive: Patient doesn't respond to any stimuli.</p>	<p>He's not responding to your voice. You apply a pain stimulus to his finger and still no response. He is unresponsive.</p>

<p>3. Activate the workplace emergency response procedures.</p> <p>Patient is unresponsive. Ask someone to call an ambulance. Say there's an unresponsive adult who has fallen, and report back.</p>	
<p>4. Perform a head-tilt/chin-lift to open the airway.</p> <ol style="list-style-type: none"> Place one hand on the forehead. Place other hand under the chin on the side closest to you. Gently push back on the forehead and lift the chin. 	
<p>5. Assess the airway. Look, listen and feel for 5-10 seconds.</p>	Airway is clear.
<p>6. Assess the patient's breathing. Look, listen and feel.</p>	<p>Quiet breathing is heard.</p> <p>Patient is breathing normally.</p>
<p>7. If possible, train a helper to take over the head-tilt/chin-lift:</p> <p>"Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise using readily available materials to maintain the head-tilt/chin-lift until help arrives.</p>	
<p>8. Assess the patient's circulation.</p> <p>Signs of Shock: Cool, pale, clammy skin</p> <p>Rapid Body Survey: Massive bleeding</p>	<p>Skin is normal, warm and dry.</p> <p>No blood visible.</p> <p>No injury other than slight deformity at the knee (possible fracture). Provide support for the injured leg.</p> <p><i>Fractures to be covered in Lesson 12.3.</i></p>
<p>9. Determine if critical interventions are required.</p>	The head-tilt/chin-lift needs to be maintained to protect the patient's airway.
<p>10. Transport decision.</p> <p>Rapid transport, medical aid or return to work?</p>	Rapid transport. The patient is unresponsive. An ambulance has been called.
<p>11. Cover the patient with a blanket.</p>	

<p>12. Start the secondary survey.</p> <p>Record the patient's name, date, time, and all of the following secondary survey findings.</p>	<p>As provided</p>
<p>13. Assess breathing rate and quality.</p> <p>Rate: Count chest wall movements (in and out is 1 breath). Multiply 15-sec interval by 4. Normal is 12/min to 20/min.</p> <p>Quality: Effective, even, deep, shallow, distressed, laboured, gasping</p>	<p>His breathing rate is 12/min.</p> <p>His breathing is effective and even.</p> <p>Both sides expand equally.</p>
<p>14. Assess level of consciousness.</p> <p>Ask the patient what happened.</p> <p>Alert: Patient is aware of surroundings.</p> <p>Verbal: Patient responds when spoken to.</p> <p>Pain: Patient doesn't respond to questions, but responds to painful stimulus.</p> <p>Unresponsive: Patient doesn't respond to any stimuli.</p>	<p>Patient does not respond to your voice.</p> <p>Patient now withdraws to pain. Patient responds to painful stimulus.</p>
<p>15. Assess heart rate and quality.</p> <p>Rate: Count pulse. Multiply 15-sec interval by 4. Normal is 60/min to 80/min.</p> <p>Quality: weak, strong, regular, irregular</p>	<p>His heart rate is 88/min.</p> <p>His pulse quality is regular and easy felt.</p>
<p>16. Assess skin colour, temperature and condition.</p> <p>Pale = Blood loss and possible shock</p> <p>Blue = Cyanosis (low oxygen), possible cardiorespiratory emergency</p> <p>Cold, sweating = Possible shock</p>	<p>Skin is normal, dry and warm.</p> <p>No signs of shock.</p>
<p>17. Record patient's medical history.</p> <p>Where does it hurt? What happened?</p> <p>Allergies? Medical alert devices?</p> <p>Medications: name, dose, frequency, purpose, compliance</p> <p>Past medical history related to current problem</p>	<p>Fell off stepladder.</p> <p>Unknown allergies.</p> <p>No medical alerts.</p> <p>Unknown medications.</p> <p>Unknown relevant past medical history.</p>

<p>18. Complete head-to-toe check.</p> <p>Look for injuries not identified earlier.</p> <p>Check circulation: skin temperature and colour</p> <p>Check motor and sensory function: range of motion</p> <p>Check sensory function: more toes and feet</p>	<p>There is redness and slight swelling distal to the patella on the anterior side. Patient winces to pain on palpation of right knee. Possible fractured tibia. No other injuries found. Circulation, motor function and sensory function is equal on all extremities.</p>
<p>19. Reassess the ABC's at 5-minute intervals</p>	<p>ABC's same as vitals. No change.</p>

Summary

1. How should you assess level of consciousness?
2. What should the medical history include?

Lesson 5.2: Ongoing Assessment and After the Call

Learning Outcomes

1. Identify the appropriate interval for reassessing the patient.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 26 and 29

Theory

Airway, Breathing and Circulation

The airway, breathing and circulation (ABCs) assessments as explained in the primary survey are repeated:

- Every 5 min for patients who require transport by BC EHS
- Every 10 min on other patients

If critical interventions were required, check the ongoing effectiveness.

Vital Signs

After completing the secondary survey, the vital signs should be reassessed:

- Every 10 min for patients who require transport by BC EHS
- Every 30 min on other patients

Summary

1. How often should the ABCs be reassessed?
2. How often should vital signs be reassessed?

Module 6

Patient Positioning

6. Patient Positioning

6.1 Determining Safest Position

6.2 Standing and Sitting to Supine

6.3 Prone to Supine

6.4 Supine to 3/4 Prone

Lesson 6.1: Determining Safest Position

Learning Outcomes

1. Determine the safest patient position.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 16: Spinal Injuries, pages 110 – 113

Theory

Deciding Whether to Move a Patient

To determine whether the patient needs to be moved, ask yourself:

- Can I assess the patient in the position found?
- If the patient is alert or responsive to voice, can critical interventions be provided in the position found?

If the answer to either question is No, move the patient to the supine position.

Spinal Motion Restriction

If the mechanism of injury suggests spinal injury, manually stabilize the head and neck. Try not to move the patient's head and neck. If the patient must be moved, stabilize the spine and move the patient's body as a unit. This is best accomplished with help.

Summary

1. How do you decide whether to move a patient?
2. What should you do if you're unsure whether spinal motion restriction is required?

Lesson 6.2: Standing and Sitting to Supine

Learning Outcomes

1. Guide a patient from a standing or sitting position to the supine position with spinal motion restriction.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 17: Spinal Injury Management, page 115

Skill Practice

Goal
Guide a patient with suspected head or spinal injuries from standing or sitting to supine with spinal motion restriction.
Scenario
A driver slipped on ice when getting out of his vehicle in the shipping bay. His head struck the floor on impact. When you arrive, he's standing, leaning on the vehicle, and holding his head. You can see that the driver is unsteady on his feet. He's in pain and has a large lump on his head. You're concerned that he may collapse and you would prefer having him supine while you continue the assessment. You can see he is not fully alert. He is talking and you determine that he has an open airway, he is breathing normally, and his skin looks normal. You know he has a head injury.
Steps
1. Approach the patient from the front. Tell the patient to continue looking straight ahead.
2. If the patient is standing, ask the patient to keep their head and neck as still as possible while you help them to sit down. Ask the patient to move slowly and carefully to a sitting position. They may need support while they're doing this.
3. Once seated, ask the patient to continue keeping their head and neck as still as possible. Move to the patient's side.
4. Instruct a helper to kneel beside the patient on the opposite side of you to help support the patient's weight as the patient lies back.
5. Support the patient's head and instruct the patient to lie back. Explain that you and the helper will support them as they do so.
6. While assisting the patient into the supine position, gently help the patient maintain their head in position. Move your hands so that the patient will not be lying on your hands once supine.
7. Once the patient is supine, move around to the top of the patient's head and carefully maintain the patient's head in a position of comfort.

8. If possible, train the helper to take over manual stabilization.
"Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."
If there is no help available, you may have to improvise using readily available materials to maintain head support until help arrives.

Summary

1. What is the first step in guiding a patient with a possible spinal injury from standing to the supine position?
2. What are the key principles to keep in mind when moving a patient with a possible spinal injury?

Lesson 6.3: Prone to Supine

Learning Outcomes

1. Maintaining c-spine, roll a patient from the prone position into the supine position with help.

Required Reading

Occupational First Aid: A Reference and Training Manual, 2018 edition
Chapter 17: Spinal Injury Management, page 114 - 115

Skill Practice

Goal
Move a patient from prone to supine with spinal motion restriction.
Scenario
A brick layer was building a wall when a large piece of lumber fell from above and struck her in the head and chest. She fell to the ground and is lying prone on the ground when you arrive. You complete a scene assessment and can see she is responsive. Her airway is clear, but her breathing is distressed. She is trying to get up. You decide that she needs help, but you can't assess her breathing or help her in the position found. That is why she needs to be moved into the supine position. With a helper, you move her into the supine position.
Steps
1. Kneel at the patient's back and side. Tell them you're going to help them roll over onto their back.
2. Grasp the back of the patient's head with the hand closest to their head. Grasp the patient's waist or belt with the other hand.
3. Tell a helper to: <ol style="list-style-type: none"> a. Firmly grasp the patient's shoulder, and waist or belt. If other helpers are available, have them support the patient's legs and/or injured areas. b. Pull the patient towards them when you give the go ahead. c. Roll the patient as a unit to the lateral position and stop to ensure the airway is still clear.
4. Complete the roll to supine: <ol style="list-style-type: none"> a. Tell the helpers to keep their hands on the patient's shoulder and waist, and coordinate the roll from lateral to supine.
5. Maintain support of the patient's head and neck in the new position.

Summary

1. What are the key principles to keep in mind when moving a patient with a possible spinal injury?

Lesson 6.4: Supine to 3/4 Prone

Learning Outcomes

1. Roll a patient from supine to 3/4 prone.

Theory

It is particularly important to reposition an unresponsive patient in the 3/4 prone position. Unless it interferes with providing care or could worsen the patient's condition, the 3/4 prone position is the best position for recovery.

Do not leave an unresponsive patient unattended in the supine position. If left in that position without constant monitoring, their tongue or bodily fluids could block the airway.

Skill Practice

Goal
Maintain an unresponsive patient's airway by placing them 3/4 prone.
Scenario
An unresponsive patient with fluid in the airway needs to be placed in the lateral or 3/4 prone position. This will help keep the airway open and allow fluid to drain.
Steps
1. Kneel beside the supine patient's abdomen and chest.
2. Place the patient's arm that is closest to you straight out (at 90 degrees).
3. Place the patient's other arm across their chest.
4. Using your hand closest to their head, support the patient's head and neck.
5. Using your hand closest to the patient's feet, reach across the patient and grasp the patient's clothing just below the waist.
6. In one smooth movement, roll the patient against your thighs while supporting the patient's head and neck during the roll.
7. Place the patient's hand that was on their chest, under their head to prevent their face from making direct contact with the ground. Alternatively, you can use a folded blanket, coat or something similar to support their head.
8. Position the patient's leg to prevent the patient from rolling fully prone.
9. Ensure the patient's head and neck are positioned to ensure an open airway and to allow fluid to drain away by gravity.

Summary

1. What type of patient should be maintained 3/4 prone?
2. What is the purpose of using the 3/4 prone position?
3. How can you prevent a patient in the 3/4 prone position from rolling fully prone?

Day 1: Homework

Shock

During the evening, learners read the following:

- Chapter 8, Shock, page 66 - 73

They take notes on the following content that will later be included in the written test.

1. What are the signs and symptoms of hypovolemic shock?
2. What are the signs and symptoms of anaphylactic shock?

Module 7

Basic Skills

7. Basic Skills

7.1 CPR / AED

Lesson 7.1: CPR / AED

Learning Outcomes

1. Describe when CPR is needed.
2. Provide CPR to an adult.
3. Describe the signs and symptoms of cardiac arrest.
4. Describe what defibrillation is.
5. Describe the importance of workplace policy and procedures for AED use.
6. Explain how to inspect AED equipment.
7. Apply and use an AED on an adult.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 12: Cardiopulmonary Resuscitation (CPR): page 85 – 87

CPR

Theory

When CPR Is Needed

CPR is provided whenever a patient:

- Is unresponsive, and
- Is not breathing normally or not breathing at all.

Cardiac Arrest

Sudden cardiac arrest is an abrupt, unexpected loss of heart pump function. A patient who is unresponsive and not breathing is assumed to be in cardiac arrest. A patient who is in cardiac arrest should be given CPR/AED immediately.

Skill Practice

Goal
Provide CPR. This CPR demo requires at least 5 cycles of 30:2.
Steps
<ol style="list-style-type: none"> 1. Perform 30 chest compressions: <ol style="list-style-type: none"> a. Ensure patient is on hard surface and expose chest. b. Kneel beside the patient with your knees apart. c. Place the heel of your hands on the centre of the patient's chest. d. Interlock your fingers and straighten your arms until your elbows lock. Ensure your shoulders, arms and hands are directly over the centre of the patient's chest. e. Press straight down. f. Push hard; push fast. Compress at least 5 cm (2 inches) at a rate of 100/min to 120/min. Allow chest to recoil.
<ol style="list-style-type: none"> 2. After 30 compressions, if the patient remains unresponsive: Ventilate the patient with 2 breaths using a pocket mask.

AED

Theory

Using an AED

The heart contains an electrical system that sends out impulses that tell it when to contract to pump blood. The leader of this electrical system is the sinoatrial (SA) node. The SA node is the heart's pacemaker and is part of the autonomic nervous system.

With defibrillation, you use an AED to send a shock through the heart. This shock stops all electrical activity and allows the SA node to regain its role in providing effective electrical impulses.

Ventricular fibrillation (VF) and ventricular tachycardia (VT) are abnormal heart rhythms that need to be defibrillated immediately.

Inspecting an AED

Inspection requirements vary depending on the manufacturer. Typically, inspection includes the following:

1. Check that all of the components are in the kit.
2. Check that the pads and batteries are within their expiration dates. If the manufacturer recommends it, put the AED through a self-check to make sure it's working properly.
3. If any faults are discovered, contact your AED supplier immediately.

Skill Practice

Goal
Use an AED on an adult patient.
Steps
1. Prepare the patient and attach AED: <ol style="list-style-type: none">Turn on AED and follow voice prompts.Bare the chest if not already bare.Shave hair, remove medication patches, and make sure the chest is dry.Apply pads according to the instructions on the pads. They should be at least 1 inch from any implanted medical devices.
2. Analyze the heart rhythm: <ol style="list-style-type: none">When the pads are attached, tell the 1st Attendant, "Stop compressions and don't touch the patient."Make sure no one is touching the patient and look around to make sure everyone is standing clear.Follow AED voice prompts or press the Analyze button.
3. Deliver a shock: <ol style="list-style-type: none">Ensure nobody is touching the patient.Say, "I'm clear. Everyone is clear. Do not touch the patient."If prompted to do so, press the Shock button.
4. If patient remains unresponsive after the shock or you get a "No Shock" prompt: <ol style="list-style-type: none">Continue administering CPR for 2 min or 5 cycles of 30:2.After 2 minutes, the AED will reanalyze the heart rhythm.

CARDIAC ARREST

Skill Practice

Goal	
Perform CPR and use an AED on an adult patient in cardiac arrest.	
Scenario	
A worker was found slumped over in a chair and was carefully positioned on the floor by co-workers. You recognize the signs of cardiac arrest and ask a helper to retrieve an AED while you put on gloves and get your pocket mask ready.	
Steps	
1. Complete a scene assessment.	Based on the mechanism of injury, spinal motion restriction is not required.
2. Assess level of consciousness.	He is unresponsive to voice and pain.
3. Activate workplace emergency response procedure.	
4. Perform a head-tilt/chin-lift to open the airway.	
5. Assess airway. Look, listen and feel.	Patient is not speaking, but airway is clear.
6. Assess breathing. Look, listen and feel.	You see only occasional gasps. He is not breathing normally. Patient shows signs of cardiac arrest: unresponsive and not breathing normally.
7. Ask a helper to get an AED.	
8. If possible, train a helper to take over the head-tilt/chin-lift. "Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help." If there is no help available, proceed with CPR until help arrives.	

<p>9. Perform 30 chest compressions:</p> <ol style="list-style-type: none"> Ensure patient is on hard surface and expose chest. Kneel beside the patient with your knees apart. Place the heel of your hands on the centre of the patient's chest. Interlock your fingers and straighten your arms until your elbows lock. Ensure your shoulders, arms and hands are directly over the centre of the patient's chest. Press straight down. Push hard; push fast. Compress at least 5 cm (2 inches) at a rate of 100/min to 120/min. Allow chest to recoil. 	
<p>10. After 30 compressions, if the patient remains unresponsive:</p> <p>Ventilate the patient with 2 breaths using a pocket mask and repeat step 9.</p>	Patient is still unresponsive.
<p>11. Prepare the patient and attach AED:</p> <ol style="list-style-type: none"> Turn on AED and follow voice prompts. Bare the chest if not already bare. Shave hair, remove medication patches, and make sure the chest is dry. Apply pads according to the instructions on the pads. They should be at least 1 inch from any implanted medical devices. 	The helper arrives with the AED, but is too frightened to help with using it.
<p>12. Analyze the heart rhythm:</p> <ol style="list-style-type: none"> When the pads are attached, say, "Don't touch the patient." Make sure no one is touching the patient and look around to make sure everyone is standing clear. Follow AED voice prompts or press the Analyze button. 	

<p>13. Deliver a shock:</p> <ul style="list-style-type: none"> a. Ensure nobody is touching the patient. b. Say, "I'm clear. Everyone is clear. Do not touch the patient." c. If prompted to do so, press the Shock button. 	Patient is still unresponsive.
<p>14. If patient remains unresponsive after the shock or you get a "No Shock" prompt:</p> <ul style="list-style-type: none"> a. Continue administering CPR for 2 min or 5 cycles of 30:2. b. After 2 min, the AED will reanalyze the heart rhythm. 	Patient is still unresponsive.
<p>15. Switch roles every 2 min if possible.</p>	

Summary

1. When is CPR needed?
2. To what depth should chest compressions be given?
3. At what rate should chest compressions be given?
4. What should happen to the patient's chest in between chest compressions?
5. What happens when you use an AED?

Module 8

Airway and Breathing Conscious Patient

8. Airway and Breathing Conscious Patient

8.1 Signs of Airway Obstruction

8.2 Partial Airway Obstruction

8.3 Complete Airway Obstruction

8.4 Respiratory Distress

Lesson 8.1: Signs of Airway Obstruction

Learning Outcomes

1. Describe the signs and symptoms of airway obstruction.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 41 – 43

Theory

Signs of Airway Obstruction

As you approach, ask what happened. If the patient is unable to speak clearly, you should suspect airway obstruction. Look and listen for signs of airway obstruction.

Signs of partial obstruction include:

- Noisy, congested, or gurgling breathing
- Hoarseness
- High-pitched noise on inspiration or expiration (stridor)
- Possible blue lips and face (cyanosis)

Signs of complete obstruction include:

- Being unable to speak or cough, if conscious
- Blue lips and face (cyanosis)
- No movement of air in or out of the mouth
- Chest wall doesn't rise with ventilation

Indications of a Clear Airway

With a conscious patient, a clear airway is indicated by:

- Clear speech (even if the patient is confused)
- Effortless and quiet breathing

With an unresponsive patient, a clear airway is indicated by:

- The easy flow of air moving in and out of the mouth and nose
- The chest and abdomen rising on inspiration
- Quiet and effortless breathing

Summary

1. What are the signs of a partial airway obstruction?
2. What are the signs of a complete airway obstruction?

Lesson 8.2: Partial Airway Obstruction

Learning Outcomes

1. Manage a conscious patient with a partial airway obstruction.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 44

Skill Practice

Goal	
Clear and maintain the airway of a conscious patient with a partial airway obstruction.	
Scenario	
A worker stood up and began to cough forcefully immediately after taking a bite of food.	
Steps	
1. Conduct a scene assessment.	No hazards. One person injured. Based on mechanism of injury, spinal motion restriction not required.
2. Assess the patient's level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate.	The patient's eyes are open and he's coughing forcefully. Based on AVPU, he's alert.
3. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there is a responsive adult with a partial airway obstruction (who is choking).	
4. Assess airway for 5 to 10 sec.	The patient is talking, coughing forcefully, and saying, "I'm choking. Help me." Airway is partially obstructed.
5. Encourage coughing and position the patient to maximize his efforts to cough.	He continues to cough effectively. If he didn't, you would perform back blows and abdominal thrusts to clear the obstruction.

6. Assess breathing.	He inhales adequately before each cough. He is able to speak in short 3 to 4 word sentences between coughs. Breathing is effective at this time.
7. Assess circulation: <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Modified rapid body survey (massive bleeding) 	Skin colour is warm and the face is flushed red. There are no injuries.
8. Apply a blanket for warmth if necessary.	
9. Transport decision: rapid transport. Update BC EHS dispatch. Tell them patient has a persistent partial airway obstruction that is not relieving. He is showing signs of respiratory distress and becoming more agitated.	
10. Complete a secondary survey while waiting.	Watch for signs of a severe or complete airway obstruction.
11. Reassess ABCs every 5 min.	
12. Reassess vital signs every 10 min.	
13. Complete a First Aid Record and a Patient Assessment chart.	

Summary

1. How can you tell if a conscious patient has a partial airway obstruction?
2. What position should the patient be placed in?

Lesson 8.3: Complete Airway Obstruction

Learning Outcomes

1. Manage a conscious patient with a complete airway obstruction.
2. Perform back blows and abdominal thrusts.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 44

Skill Practice

Goal	
Clear and maintain the airway of a conscious patient with a complete airway obstruction.	
Scenario	
While eating a doughnut during a tailgate safety meeting, a worker starts to choke and stands up, clutching his throat with a look of panic in his eyes.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Based on mechanism of injury, spinal motion restriction not required.
2. Assess the level of consciousness: Approach the patient from the front, identify yourself, and attempt to communicate.	Eyes are open, but he is unable to speak. Based on AVPU, he is alert.
3. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there is a responsive adult with a complete airway obstruction (who is choking).	
4. Assess the airway for 5 to 10 sec. Ask, "Are you choking?"	Patient's eyes follow you, but he's unable to speak. He nods confirming that he's choking. This is a complete airway obstruction.

<p>5. Perform back blows:</p> <ol style="list-style-type: none"> Tell the patient what you will be doing. Place your arm across the patient's upper body as support and brace yourself. Give up to 5 forceful back blows. 	
<p>6. If back blows don't dislodge the object, and the patient is not too large to manage or obviously pregnant, perform abdominal thrusts:</p> <ol style="list-style-type: none"> Stand behind the patient and place one of your legs between their legs and brace yourself, locate the top of the patient's hips with your forearms and wrap both of your arms around the patient's waist. If you can't get your arms around the patient, use chest thrusts. Make a fist with one hand and hold your fist with your thumb against the patient's abdomen in the midline just above the navel. With your other hand, grasp your fist and press it into the patient's abdomen with a quick, forceful thrust directed inward and upward. Give up to 5 abdominal thrusts. 	The patient is not too large to manage or obviously pregnant.
<p>7. Repeat back blows and abdominal thrusts until the object clears, the patient starts to cough, or the patient becomes unresponsive.</p>	The airway clears after several cycles. The patient gasps and starts coughing forcefully.
<p>8. Position the patient for comfort and assess the breathing.</p>	Patient is coughing and taking deep breaths.
<p>9. Assess circulation:</p> <ul style="list-style-type: none"> Signs of shock (cool, pale, clammy skin) Modified rapid body survey (bleeding) 	<p>Skin is normal, warm and dry.</p> <p>Patient is complaining of abdominal pain where you performed abdominal thrusts.</p>
<p>10. Apply a blanket for warmth if necessary.</p>	

<p>11. Transport decision: medical aid.</p> <p>Update BC EHS dispatch. Tell them the patient has had a complete airway obstruction cleared. He is conscious and breathing normally and you will update them again after you complete the secondary survey.</p>	
<p>12. Complete a secondary survey before referring. If the secondary survey shows that the patient is now stable, the patient may be referred to medical aid by company vehicle or taxi.</p>	
<p>13. Reassess ABCs every 5 min.</p>	
<p>14. Reassess vital signs every 10 min.</p>	
<p>15. Complete a First Aid Record and a Patient Assessment chart.</p>	

Summary

1. How can you tell when a conscious patient has a complete airway obstruction?
2. When should back blows and abdominal thrusts be used?
3. What should you do if you can't get your arms around the patient's waist?

Lesson 8.4: Respiratory Distress

Learning Outcomes

1. Describe the major parts of the respiratory system and how they work.
2. Describe the signs and symptoms of respiratory distress and chest injury.
3. Manage a conscious patient with respiratory distress.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 4: Anatomy and Function of the Airway and Respiratory System,
page 37 – 40

Chapter 6: Respiratory Emergencies, page 47 – 60

Theory

Respiratory System

The major components of the respiratory system are:

- Airway: nose, mouth, pharynx, trachea and bronchi
- Lungs: bronchioles, alveoli and pleura
- Thorax: muscles and bones involved in breathing

Breathing

During inhalation, the respiration muscles contract, pulling down the diaphragm and lifting the ribs. This enlarges the thoracic cavity. When the thoracic cavity enlarges, pressure decreases, causing a negative pressure within the chest. This causes lung tissue to expand. Provided the airway is clear, air rushes in to fill the air sacs.

During exhalation, the respiration muscles relax, which decreases the size of the thoracic cavity. As the pressure in the chest increases, air is pushed out through the trachea.

Respiratory Distress

General signs and symptoms of respiratory distress include:

- Shortness of breath (dyspnea)
- Gasping
- Blue lips, fingernails or earlobes (cyanosis)
- A history of chest trauma or respiratory illness
- Pain at the injury site
- Pain when taking a deep breath

Chest Injuries

With a chest injury, you won't be able to tell the magnitude of the injury from looking at the patient. There may be few external signs of injury, yet there could be extensive internal damage. Unless treated, these injuries can be rapidly fatal.

Signs and symptoms of a chest injury include:

- Pain at the injury site
- Pain when breathing
- Shortness of breath or difficulty breathing
- Coughing up blood
- Cool or moist skin
- Blue lips, ear lobes or nail beds

Skill Practice

Goal	
Manage a conscious patient with respiratory distress.	
Scenario	
A worker was exposed to unknown lung irritants when he entered a shipping container used for storing landscaping supplies. He's having trouble breathing and coughing a lot.	
Steps	
1. Conduct a scene assessment.	There are no hazards. One person injured. Based on the mechanism of injury, spinal motion restriction is not needed.
2. Assess level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate.	Patient's eyes are open. Based on AVPU, he is alert.
3. Activate workplace emergency response procedure. Ask someone to call an ambulance and tell them there is a responsive adult with respiratory distress due to inhalation of unknown irritants.	
4. Assess airway for 5 to 10 sec.	He's coughing and short of breath, but able to talk. Airway is clear.
5. Position patient for ease of breathing.	Patient prefers to sit up.
6. Assess breathing.	He's coughing and short of breath, but able to speak in 4 to 5 word sentences between coughs.

<p>7. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Modified rapid body survey (massive bleeding) 	<p>No signs of shock.</p> <p>Patient has excessive tearing and is nauseated.</p>
<p>8. Apply a blanket for warmth.</p>	
<p>9. Transport decision: rapid transport.</p>	
<p>10. Complete a secondary survey while waiting.</p>	
<p>11. Reassess ABCs every 5 min.</p>	
<p>12. Reassess vital signs every 10 min.</p>	
<p>13. Complete a First Aid Record and a Patient Assessment chart.</p>	

Summary

1. What are the major components of the respiratory system?
2. What are the signs and symptoms of a chest injury?

Module 9

Airway and Breathing Unresponsive Patient

9. Airway and Breathing Unresponsive Patient

9.1 Partial Airway Obstruction (Fluids)

9.2 Pocket Mask

9.3 Complete Airway Obstruction

9.4 Respiratory Distress

Lesson 9.1: Partial Airway Obstruction (Fluids)

Learning Outcomes

1. Manage an unresponsive patient with a partial airway obstruction due to fluids.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 45

Skill Practice

Goal	
Clear and maintain the airway of an unresponsive patient with a partial airway obstruction due to fluids.	
Scenario	
A worker was struck in the face by the moving hook of an overhead warehouse crane. She was knocked to the ground. When you arrive, she is lying supine not moving with blood on her face.	
Steps	
1. Conduct a scene assessment.	The crane hook is secure and the crane has been deactivated. There are no hazards. One person injured. Based on mechanism of injury, spinal motion restriction is required.
2. Assess the patient's level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate. Do not attempt painful stimulus due to urgent need to manage the airway.	Patient doesn't respond to verbal stimulus. There is blood in and around the patient's mouth. You hear gurgling.
3. Activate the workplace emergency response procedure. Ask someone to call an ambulance and tell them there is an unconscious adult with facial trauma.	

Lesson 9.2: Pocket Mask

Learning Outcomes

1. Perform ventilation using a pocket mask.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 46

Skill Practice

Goal
Use a pocket mask to ventilate a patient who is not breathing normally.
Steps
1. Place a mask on the patient's face.
2. Perform a head-tilt/chin-lift to open the airway.
3. Using both hands, place the mask over the mannequin's nose and mouth: <ol style="list-style-type: none"> a. Put your thumbs over the mask on the patient's cheekbones. b. Put your fingers under the bony structure of the patient's jaw. With your fingers and thumbs, squeeze the mask to the patient's face to create a good seal. c. Lift the patient's jaw with your fingers. d. While sealing the mask to the patient's face, hold the patient's head in the head tilt-chin lift position.
4. Ventilate the patient for about 1 second with enough force to cause the chest wall to expand. Watch for the chest to rise. <p>If the patient's abdomen starts to distend, ensure the airway is open by slightly adjusting the angle of the jaw or extending the patient's neck.</p> <p>If the abdomen is still distending, ventilate with less force.</p>

Summary

1. How should you hold the pocket mask against the patient's face?
2. What should you do if the patient's abdomen starts to distend?
3. How should you time the breaths?

Lesson 9.3: Complete Airway Obstruction

Learning Outcomes

1. Manage an unresponsive patient with a complete airway obstruction.
2. Open a patient's airway using a head-tilt/chin-lift.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 5: Airway Management, page 45

Skill Practice

Goal	
Clear and maintain the airway of an unresponsive patient with a complete airway obstruction.	
Scenario	
A worker is found unconscious in a chair. As you approach, co-workers gently lay the worker supine. Use a mannequin.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Based on mechanism of injury, spinal motion restriction not required.
2. Assess the patient's level of consciousness. <ol style="list-style-type: none"> a. Approach the patient from the front, identify yourself, and attempt to communicate. b. Apply a painful stimulus by squeezing the nail bed on the patient's hand or another appropriate means. 	Patient does not respond to verbal stimulus. Patient does not respond to pain. Based on AVPU, he is unresponsive.
3. Activate workplace emergency response procedure. Ask someone to call an ambulance and tell them there is an unconscious adult who was found in a chair.	
4. Perform a head-tilt/chin-lift to open the airway.	
5. Assess airway.	Airway is not clear.

6. Assess breathing.	Patient is not breathing.
<p>7. If possible, train a helper to take over the head-tilt/chin-lift:</p> <p>"Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain the head-tilt/chin-lift until help arrives.</p>	
<p>8. Apply CPR:</p> <ol style="list-style-type: none"> Perform 30 chest compressions. Attempt to ventilate the patient using a pocket mask. Reposition the head-tilt/chin-lift and try to ventilate again. Perform 30 chest compressions. After 30 compressions, look in mouth and remove any object seen. Attempt to ventilate the patient using a pocket mask. If the chest does not rise when attempting to ventilate patient, repeat steps until able to ventilate. 	<p>The chest does not rise when you attempt to ventilate.</p> <p>The airway is obstructed.</p> <p>At first, nothing is seen in the mouth. But after a few cycles, a candy is seen and removed.</p> <p>Two breaths go in and the patient starts to breathe again.</p>
9. Reassess breathing.	You can hear and feel regular, quiet breathing.
<p>10. Assess circulation:</p> <ul style="list-style-type: none"> Signs of shock (cool, pale, clammy skin) Modified rapid body survey (massive bleeding) 	<p>Pale, cool, dry skin. No cyanosis.</p> <p>No injuries.</p>
11. Apply a blanket for warmth.	
12. Place the patient 3/4 prone.	
<p>13. Transport decision: rapid transport.</p> <p>Update BC EHS dispatch. Tell them the patient had an airway obstruction, but the obstruction is now relieved. The patient is breathing normally, but is still unresponsive.</p>	

14. Reassess ABCs every 5 min.	
15. Reassess vital signs every 10 min.	
16. Complete a secondary survey while waiting for transport.	
17. Complete a First Aid Record and a Patient Assessment chart.	

Summary

1. How can you tell if an unconscious patient has a complete airway obstruction?
2. What should you do to manage the obstruction?
3. How can you prevent a patient in the 3/4 prone position from rolling?

Lesson 9.4: Respiratory Distress

Learning Outcomes

1. Manage an unresponsive patient in respiratory distress.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 6: Respiratory Emergencies, page 47 – 60

Skill Practice

Goal	
Manage an unresponsive patient with respiratory distress.	
Scenario	
A worker assigned to clean the suites following a sporting event at an arena is found unresponsive by the event staff. He is on the couch in one of the venue guest suites. There is drug paraphernalia on the coffee table.	
Steps	
1. Conduct a scene assessment.	There are no hazards. One person injured. Based on the mechanism of injury, spinal motion restriction is not needed.
2. Assess level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate. Apply a painful stimulus by squeezing the nail bed on the patient's hand.	Patient doesn't respond to what you say, but curses at you. His eyes open when a painful stimulus is applied. After that, he wants to go back to sleep. Based on AVPU, he is responsive to pain.
3. Activate workplace emergency response procedure. Ask someone to call an ambulance and tell them there is an unconscious adult who was found on a couch and has possibly overdosed.	
4. Carefully reposition the patient onto the floor.	
5. Perform a head-tilt/chin-lift to open the airway.	
6. Assess airway.	Airway is clear.

7. Assess breathing.	Breathing is slow and shallow. NOTE: If the patient had been unresponsive and not breathing normally, you would have started CPR.
8. If possible, train a helper to take over the head-tilt/chin-lift: "Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help." If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain the head-tilt/chin-lift until you complete the primary survey.	
9. Assess circulation: <ul style="list-style-type: none">• Signs of shock (cool, pale, clammy skin)• Modified rapid body survey (bleeding)	Cold, dry, pale skin (no cyanosis) Track marks on patient's left elbow area
10. Other critical interventions: <ul style="list-style-type: none">a. Administer naloxone if available. Giving naloxone can prevent death or brain damage from lack of oxygen during an opioid overdose.b. Place patient 3/4 prone.c. Apply a blanket for warmth.	A Naloxone kit is not available at the arena.
11. Transport decision: rapid transport	
12. Complete a secondary survey while waiting for transport.	
13. Reassess the patient's ABCs every 5 min.	
14. Reassess vital signs every 10 min.	
15. Complete a First Aid Record and Patient Assessment chart.	

Summary

1. Why should you administer naloxone to a patient with a suspected opioid overdose?

Module 10

Exposure to Heat and Cold

10. Exposure to Heat and Cold

10.1 Cold Injuries

10.2 Heat Injuries

Lesson 10.1: Cold Injuries

Learning Outcomes

1. Describe the signs and symptoms of frostbite and hypothermia.
2. Manage a patient with frostbite.
3. Manage a patient experiencing hypothermia.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 36: Exposure to Heat and Cold, page 219 – 223

Theory

Frostbite

The signs and symptoms of frostbite include:

- Pain and redness in the affected area
- Pale skin, tingling and numbness as the frostbite worsens
- White, or blue and white skin
- Skin feels frozen solid to the touch

To treat frostbite, lightly dress the area with sterile dressing and wrap it in roller gauze. Patients with frostbite do not require rapid transport, but will need medical attention.

Hypothermia

The signs and symptoms of hypothermia include:

- Mild: shivering, body temperature 33 to 35°C
- Moderate: confusion, decreased level of consciousness, slowed breathing, body temperature 29 to 32°C
- Severe: slowed respiratory rate, unresponsive, frothy sputum, body temperature below 28°C, cardiac arrest, coma

Patients with moderate to severe hypothermia require rapid transport.

Skill Practice

Goal	
Manage a patient with moderate to severe hypothermia.	
Scenario	
A worker has been outdoors for several hours in the cold. His co-workers notice that he is acting confused and sluggish. They tell you that he decided to just lie down right where he was because he was very tired. When you arrive, he is lying supine and co-workers tell you that he just won't get up.	
Steps	
1. Conduct a scene assessment.	Ask a helper to check on other workers and caution them about the dangers of hypothermia.
2. Assess the patient's level of consciousness. <ol style="list-style-type: none"> Approach the patient, identify yourself, and attempt to communicate. Apply a painful stimulus by squeezing the nail bed on the patient's hand or another appropriate means. 	No response to your voice. Patient does not respond to verbal or pain stimulus. Based on AVPU, he is unresponsive.
3. Activate workplace emergency response procedure. Ask someone to call an ambulance, and tell them there is an unresponsive adult and to report back.	
4. Perform a head-tilt/chin-lift.	
5. Assess the airway.	
6. Assess the breathing.	Patient is not breathing.
7. If possible, train a helper to take over the head-tilt/chin-lift: "Kneel on the opposite side of the patient. Place your hands over mine: one on the forehead and the other under the chin. Maintain the head-tilt/chin-lift. Let me know if you have to move so I can help." If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain the head-tilt/chin-lift until the patient is resuscitated.	

<p>8. Perform 30 chest compressions:</p> <ol style="list-style-type: none"> Send another helper to bring the AED. Ensure patient is on hard surface and expose the chest. Place your hands on the chest between the nipples. Interlock your fingers and straighten your arms until your elbows lock. Press straight down. Push hard; push fast. Compress at least 5 cm (2 inches) at a rate of at least 100/min. Allow chest to recoil. After the helper returns with the AED, train them to take over chest compressions. Do not stop compressions while doing this. You can switch roles every 2 min or 5 cycles of 30:2. 	
<p>9. If the patient remains unresponsive, using a pocket mask, ventilate the patient with 2 breaths.</p>	
<p>10. Prepare patient and attach the AED:</p> <ol style="list-style-type: none"> Turn on AED and follow voice prompts. Bare the chest. Shave hair, remove patches and make sure the chest is dry. Apply pads at least 1 inch from implanted devices. 	<p>Chest is dry.</p> <p>No chest hair, medication patches or medical devices.</p>
<p>11. Analyze the heart rhythm:</p> <ol style="list-style-type: none"> Follow voice prompts or press the Analyze button. Tell helper to stop compressions and "Do not touch the patient." Make sure no one is touching the patient and everyone is standing clear. 	

<p>12. Deliver 1 shock only:</p> <ul style="list-style-type: none"> a. Ensure nobody is touching the patient. b. Say, "I'm clear. Everyone is clear. Do not touch the patient." c. If prompted to do so, press the Shock button. d. If normal breathing and circulation are not restored after 1 shock, resume CPR until medical help arrives. 	<p>Spontaneous circulation and normal breathing are restored.</p>
<p>13. Reassess airway and breathing.</p>	<p>Breathing is shallow and effective.</p>
<p>14. Assess circulation.</p>	<p>Skin is cold and pale. General cyanosis (bluish skin).</p>
<p>15. Other critical interventions:</p> <ul style="list-style-type: none"> a. Move patient to warm environment as soon as possible. Handle the patient gently. Do not suppress shivering. It helps the patient generate heat. b. Remove all wet clothes, cover patient with blankets, and turn up the heat if possible. c. Do not give the patient anything by mouth. 	
<p>16. Transport decision: rapid transport. Update BC EHS as needed.</p>	
<p>17. Complete a secondary survey while waiting for transport.</p>	
<p>18. Reassess ABCs every 5 min.</p>	
<p>19. Reassess vital signs every 10 min.</p>	
<p>20. Complete a First Aid Record and Patient Assessment chart.</p>	

Summary

1. What are the signs and symptoms of frostbite?
2. What is the difference between moderate and severe hypothermia?
3. Besides CPR and AED if the patient is in cardiac arrest, what else can you do to help a patient with moderate to severe hypothermia?

Lesson 10.2: Heat Injuries

Learning Outcomes

1. Describe the signs and symptoms of heat exhaustion and heat stroke.
2. Manage a patient experiencing heat stroke.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 36: Exposure to Heat and Cold, page 217 – 219

Theory

Heat Exhaustion

The signs and symptoms of heat exhaustion include:

- Shallow respiration
- Increased respiratory rate
- Cool, pale and clammy skin
- Sweating
- Weakness, fatigue or dizziness
- Headache and nausea
- Fainting
- Muscle cramps

The presence of sweating is an important finding because it is often the only way to differentiate heat exhaustion from the life-threatening emergency of heat stroke.

Heat Stroke

The signs and symptoms of heat stroke include:

- Hot, dry, flushed skin
- Absence of sweating
- Agitation and confusion
- Decreased level of consciousness
- Headache
- Nausea and vomiting
- Seizures
- Increased respiratory rate
- Shock
- Cardiac arrest

All patients with heat stroke require rapid transport.

To treat a patient with heat stroke:

1. Move the patient to the coolest spot available.
2. Have a biohazard bucket ready in case the patient vomits.
3. Remove all outer clothing.
4. Sponge/soak the patient with cool water and use a fan.
5. Give the conscious patient fluids to drink. Juice, non-caffeinated soft drinks, or a sports drink is best. If that's not available, mix 1 teaspoon of salt in 1 pint of water.

Summary

1. How do the symptoms of heat exhaustion differ from the symptoms of heat stroke?
2. How should you treat a patient with heat stroke?

Day 2 Homework

During the evening, the learners read the following:

- Chapter 25, First Aid Room Procedures, page 153 – 154

They take notes on the following content that will later be included in the written test.

Medication

1. What should you do before giving non-prescription medication to a patient?
2. What are your responsibilities when helping a patient with a prescription medication?

First Aid Record

During the evening, learners complete the following exercise. The correct answer will be debriefed in class the next day.

3. Complete the First Aid Record Exercise.

First Aid Record Exercise

Complete a First Aid Record based on the following scenario:

On April 1, 2018 at 2:40 PM, a millwright named Anna Prentice came into the first aid room to report an injury. She reached into a motor on power unit 16 to tighten the exhaust manifold. As she pulled her arm out, she cut her arm on a sharp piece of metal. The injury happened at 2:35 PM.

Chester Fields was working with Anna Prentice when it happened and is available as a witness.

Her ABCs are normal. She has a 2 cm (1 inch) laceration just through the skin on the upper-inside of her left forearm. There is minimal bleeding and pain, and no swelling. The wound appears clean. Circulation and nerve function are normal.

Supporting her arm on a large sterile dressing, you cover the wound with sterile gauze. You examine the arm from shoulder to fingertips and find no unusual symptoms or other injuries. With the wound covered, you cleanse around the wound with wound-cleansing towelettes. Then you walk over to the sink and remove the gauze to clean inside the wound with running tap water or sterile saline. Because this wound gapes slightly, you apply skin closures to close the wound. You dress the wound with four layers of sterile gauze and an absorbent dressing, which you bandage with a roller bandage.

Before Anna returns to work, you advise her to get a Tetanus booster within the next 36 hours and discuss the minor wound handout sheet on taking care of the wound. You tell her to keep the dressing clean and dry, and return immediately if the dressing gets wet or dirty, or starts to come off. You also tell her to return to first aid at the start of the next shift for reassessment.

Module 11

Bleeding

11. Bleeding

11.1 Signs of Bleeding

11.2 Hypovolemic Shock

11.3 Massive Bleeding

11.4 Amputation

Lesson 11.1: Signs of Bleeding

Learning Outcomes

1. Describe the signs and symptoms of external bleeding.
2. Describe the signs and symptoms of internal bleeding.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 9: Bleeding and its Management, page 74 – 75

Theory

External Bleeding

The signs and symptoms of external bleeding depend on which vessel is mostly involved:

- Arterial bleeding: The blood spurts or pulses out, and is usually bright red.
- Venous bleeding: The blood comes in a steady flow and is usually darker than arterial blood.
- Capillary bleeding: There is a continuous, steady ooze.

External bleeding can usually be controlled by applying pinpoint direct pressure on the wound. Although this may cause pain, it is necessary to control the bleeding. If bleeding is not controlled by direct pressure, a tourniquet should be applied proximal to the wound site.

Internal Bleeding

Signs and symptoms of internal bleeding include:

- Cool, pale and clammy skin
- Shortness of breath or air hunger
- Faintness and dizziness
- Thirst, anxiety and restlessness
- Nausea and vomiting

Summary

1. What are the signs and symptoms of external bleeding?
2. What are the signs and symptoms of internal bleeding?

Lesson 11.2: Hypovolemic Shock

Learning Outcomes

1. Manage a patient who is in hypovolemic shock.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 8: Shock, page 70 – 73

Skill Practice

Goal	
Manage a patient who is in hypovolemic shock.	
Scenario	
A stack of roof trusses being unloaded from a trailer struck a worker in the lower-right ribs. The worker was knocked 5.5 m (18 ft) off the roof. When you arrive, she is lying supine on the ground.	
Steps	
1. Conduct a scene assessment.	No hazards. One worker injured. Based on mechanism of injury, spinal motion restriction is required.
2. Assess the level of consciousness: Approach the patient from the patient's line of sight, identify yourself, and attempt to communicate. Tell the patient to lie still.	Her eyes are open, she appears anxious, and she responds with clear speech. Based on AVPU, she is alert.
3. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there is a responsive adult who has taken a significant fall.	
4. Manually stabilize the head and neck.	

<p>5. If available, train a helper to take over manual stabilization.</p> <p>"Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain head support until help arrives.</p>	
<p>6. Assess the airway.</p>	<p>Patient is talking normally. Airway is clear.</p>
<p>7. Assess the breathing.</p>	<p>Breathing is slightly rapid and shallow, but patient can speak in full sentences.</p>
<p>8. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Expose and examine the chest • Rapid body survey (bleeding) 	<p>Skin is cool, pale and clammy. Patient is in shock.</p> <p>There is redness and bruising in the lower-right rib area. Possible internal bleeding of liver. No external bleeding.</p>
<p>9. Transport decision: rapid transport.</p> <p>Update BC EHS dispatch. Tell them the patient is showing signs of shock from suspected internal injuries.</p>	
<p>10. Other critical interventions:</p> <ol style="list-style-type: none"> a. Leave patient supine and keep still. b. Provide a blanket for warmth. . 	
<p>11. Complete a secondary survey while waiting for transport.</p>	
<p>12. Reassess ABCs every 5 min.</p>	
<p>13. Reassess vital signs every 10 min.</p>	
<p>14. Complete a First Aid Record and Patient Assessment chart.</p>	

Summary

1. How can you tell if a patient is in hypovolemic shock?
2. What critical interventions can be provided for a patient in hypovolemic shock?

Lesson 11.3: Massive Bleeding

Learning Outcomes

1. Manage a conscious patient with massive bleeding.
2. Apply pressure to help control external bleeding.
3. Dress and bandage the injury as needed.
4. Apply a tourniquet if needed.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 9: Bleeding and its Management, page 75 – 77

Skill Practice

Goal	
Manage a patient with massive external bleeding.	
Scenario	
A worker was struck in the left leg by a chainsaw that kicked back. When you arrive, the chainsaw has been turned off and the patient is lying supine on the ground.	
Steps	
1. Conduct a scene assessment.	No hazards. One person injured. Left thigh is bleeding. Pool of blood underneath the leg. Patient confirms that he did not fall or hit his head. Spinal motion restriction is not required.
2. Assess the level of consciousness: Approach the patient from the front, identify yourself, and attempt to communicate. Put on gloves and glasses.	Patient's eyes are open, but he is extremely anxious. He responds with clear speech. Based on AVPU, he is alert.
3. If a helper is available, give them gloves and glasses, and ask them to put them on.	
4. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there is a responsive adult who has severe bleeding from a cut on the leg.	

<p>5. Assess the airway and breathing on approach.</p>	<p>Patient is speaking in full sentences. Airway is clear.</p> <p>Patient is breathing normally.</p>
<p>6. Apply direct pressure:</p> <ol style="list-style-type: none"> Open first aid kit, find scissors and expose the site of bleeding. Using absorbent dressings, apply direct pinpoint pressure on the wound site and maintain pressure. Apply more dressings. Ensure you're directly on top of the wound site. If available, ask helper to take over maintaining direct pressure. 	<p>Moderate flow of dark blood (venous).</p> <p>Bleeding is not controlled by direct pinpoint pressure.</p> <p>Bleeding is still not controlled. A tourniquet is needed.</p>
<p>7. Apply a tourniquet:</p> <ol style="list-style-type: none"> Apply a windlass-style tourniquet several inches proximal to the wound site on the thigh. Secure the tourniquet strap firmly around the limb. Explain that you would tighten the windlass until the bleeding stops. DO NOT ACTUALLY DO THIS IN CLASS. Anchor the windlass. Attach a tag to the tourniquet that indicates when it was applied. 	<p>Bleeding stops with correct application of the tourniquet.</p>
<p>8. Assess circulation:</p> <ul style="list-style-type: none"> Signs of shock (cool, pale, clammy skin) Rapid body survey (bleeding) 	<p>Skin is pale, cool and dry.</p> <p>No other injuries.</p>
<p>9. Other critical interventions:</p> <ol style="list-style-type: none"> Apply more dressings over the ones already applied, and one or more fracture straps over all of the dressings on the wound. If fracture straps are not available, use a crepe bandage. Do not cover the tourniquet. The patient should remain supine. Apply a blanket for warmth. 	
<p>10. Transport decision: rapid transport.</p> <p>Update EHS. Tell them a tourniquet was necessary to stop the bleeding.</p>	

11. Complete a secondary survey while waiting for transport.	
12. Reassess ABCs every 5 min.	
13. Reassess vital signs every 10 min.	
14. Complete a First Aid Record and Patient Assessment chart.	

Summary

1. When should direct pressure be applied to a massive bleed?
2. If the source of massive bleeding is obvious, do you need to do a rapid body survey?

Lesson 11.4: Amputation

Learning Outcomes

1. Manage a patient with an amputation.
2. Apply a tourniquet if needed.
3. Prepare the amputated part for transport.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 28: Soft-Tissue Injuries, page 165 and 175 – 176

Theory

Amputation

The OFA attendant should be primarily concerned with the ABC's of patient care. The OFA attendant should also take steps to keep the severed part viable in case it can be reattached. A well-preserved part may be attached up to 24 hours after injury. The following steps apply to amputations and detached pieces of skin and tissue

1. Find the detached part.
2. Clean off gross contaminants.
3. Package the part in moist dressings.
4. Place the part in a plastic bag.
5. Place that bag in a bag of ice.
6. Transport the part with the patient.

Skill Practice

Goal	
Manage a patient with an amputation.	
Scenario	
A worker was cutting lumber on a radial saw when he caught his hand in the blade. The hand was fully amputated above the wrist. When you arrive, he is on his knees clutching the stump.	
Steps	
1. Conduct a scene assessment.	<p>No hazards. One person injured.</p> <p>A significant amount of blood has soaked into the patient's sleeve and is pooling on the ground.</p> <p>Based on mechanism of injury, spinal motion restriction is not required.</p>

<p>2. Assess the level of consciousness: Approach the patient from the front, identify yourself, and attempt to communicate.</p>	<p>Patient's eyes are open. He is extremely anxious, but responds with clear speech. He confirms that he did not fall. Based on AVPU, he is alert.</p>
<p>3. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there is a responsive adult who has amputated his hand. Put on gloves and glasses.</p>	
<p>4. If a helper is available, give them gloves and ask them to put them on.</p>	
<p>5. Assess the airway and breathing on approach.</p>	<p>Patient is able to call out for help; airway is clear. Patient is breathing normally.</p>
<p>6. Control bleeding:</p> <ol style="list-style-type: none"> Apply direct pressure over the wound and position patient supine. Cut away sleeve to expose the whole limb. Keep the patient's upper arm in contact with the ground. Do not fully elevate the arm. Apply additional dressings if needed. Apply more direct pressure if needed. If available, ask a helper to take over applying direct pressure. 	<p>Bright red blood is spurting out of the wound. This is arterial bleeding. The bandage soaks through rapidly and the patient continues to bleed.</p> <p>Apply additional dressings over the initial dressing and apply more pressure. The bleeding rapidly soaks through all dressings. A tourniquet is needed.</p>

<p>7. Apply a tourniquet:</p> <ol style="list-style-type: none"> a. Apply a commercially prepared tourniquet several inches proximal to the stump. b. Secure the tourniquet strap firmly around the limb. c. Explain that you would tighten the windlass until the bleeding stops. DO NOT ACTUALLY DO THIS IN CLASS. d. Anchor the windlass. e. Attach a tag to the tourniquet that indicates when it was applied. 	<p>Bleeding stops with correct application of the tourniquet.</p>
<p>8. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey 	<p>Skin is cold, pale and dry. No other injuries are found.</p>
<p>9. Bandage the bleed using a crepe roller bandage. Cover the dressings completely with the crepe roller bandage. Do not cover the tourniquet with the crepe bandages.</p>	
<p>10. Other critical interventions:</p> <ol style="list-style-type: none"> a. The patient should remain supine. b. Apply a blanket for warmth. 	
<p>11. Prepare the amputated part for transport:</p> <ol style="list-style-type: none"> a. As carefully as possible, clean off any gross foreign matter. b. Dress the part in sterile, moist gauze. c. Place the dressed part in a waterproof bag with seal. d. Place the bag inside another filled with ice. e. Label the bag with the date and time of the amputation. f. Transport the part with the patient. 	
<p>12. Transport decision: rapid transport.</p>	

13. Complete a secondary survey while waiting for transport.	
14. Reassess ABCs every 5 min.	
15. Reassess vital signs every 10 min.	
16. Complete a First Aid Record and Patient Assessment chart.	

Summary

1. What should you do if the dressing becomes soaked in blood?
2. How should you clean an amputated part?
3. How should you store an amputated part?

Module 12

Minor Injuries

12. Minor Injuries

12.1 Minor Wounds

12.2 First Aid Record

12.3 Minor Sprains, Dislocations and Fractures

12.4 Activity-Related Soft-Tissue Disorders

12.5 Minor Ear, Nose and Eye Injuries

12.6 Assessing Burns

12.7 Minor Burns

12.8 Ongoing Management

Lesson 12.1: Minor Wounds

Learning Outcomes

1. Assess a minor wound.
2. Clean, dress and bandage a minor wound.
3. Provide follow-up care for a minor wound.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 24: The Priority Action Approach to the Walk-In Patient, page 147 – 149
Chapter 28: Soft-Tissue Injuries, page 163 – 177

Theory

Medical Aid

The following soft-tissue injuries must be referred for medical aid:

- Wounds longer than 3 cm (1 inch) through the full skin thickness
- Wounds to hands in areas of joints or tendons
- Wounds that require stitches
- Wounds that are very dirty, including human or animal bites
- Wounds with embedded materials
- Wounds that have any sign of infection

Signs of Infection

Signs of a wound becoming infected include:

- Pain and local tenderness around the wound
- Heat and increased redness around the affected area
- Pus beneath the skin or draining from the wound
- Swelling of the infected part or lymph nodes
- Red streaks extending from the wound area

Tetanus Prevention

Tetanus can be very dangerous. All minor wounds must be thoroughly cleaned. If medical attention is necessary but will be delayed beyond 36 hours, it is even more essential that the wound be properly cleaned and dressed. For major wounds with gross contamination, once hemorrhage has been controlled, there may be justification for some wound cleansing. Patients with a wound should receive a tetanus booster shot as soon as possible, preferably within 36 hours. The tetanus vaccine is approved by Health Canada and is provided for free.

Bandaging Guidelines

Use clean, sterile dressings. Before and after applying a bandage, check circulation. If circulation is reduced, loosen the bandage. If blood soaks through, leave the bandage and apply another one on top.

If the wound is caused by an impaled object, leave the object in place. Stabilize the object without putting direct pressure on it and secure the dressings in place.

Skill Practice

Goal	
Assess and treat a minor wound.	
Scenario	
A worker comes into the first aid room with a cut on her arm. While working on a motor, she was cut on the arm by a piece of metal.	
Steps	
1. Conduct a scene assessment: Is anyone else hurt? Are there any hazards at the scene that need to be addressed?	No hazards. One injured. Spinal motion restriction not required.
2. Modified primary survey: a. Look at patient to assess the airway. b. Assess breathing. c. Assess circulation. Look for signs of shock (cool, pale, clammy skin). Do a verbal rapid body survey. Ask, " <i>Did you hurt yourself anywhere else?</i> "	Patient is talking clearly. Airway is clear. Breathing is normal. Skin colour is normal. When asked, patient says, "Only my arm hurts."
3. Position: a. Position the patient based on the findings of the modified primary survey. If the patient is reacting to the injury (pale, anxious), position supine. If patient 's colour is normal (not showing anxiety), position sitting. b. Support arm on a sterile abdominal pad and cover the injury with a sterile dressing/gauze pad.	Patient can be treated in the sitting position.
4. Wash your hands and put on gloves.	

<p>5. Look at injury to make initial transport decision: return to work after treatment.</p>	<p>Laceration is only 2 cm (3/4 inch) and does not require stitches. Minimal bleeding. No swelling. Laceration appears clean.</p>
<p>6. Modified secondary survey:</p> <ol style="list-style-type: none"> a. Question patient about medical history. b. Ask if tetanus is up-to-date. c. Thoroughly examine injured area, and compare to uninjured arm and hand. 	<p>Patient has no allergies and is not on any medications.</p> <p>Tetanus was updated within the last 5 years.</p> <p>No discolouration, swelling, deformity, or excessive pain.</p>
<p>7. Injury care:</p> <ol style="list-style-type: none"> a. Keep the wound covered with sterile gauze while you cleanse the surrounding skin with mild antibacterial soap or warm water. b. Flush inside of wound with warm running water. c. If patient is returning to work and the wound is open, use skin closures to hold the wound closed. d. Apply a dressing large enough to cover the entire wound site. e. Wrap it with a bandage large enough to cover the entire dressing. 	<p>Skin closures should remain in place for 7-10 days.</p> <p>A gauze roller bandage is well suited for treating this injury.</p>
<p>8. Tell patient how to care for the wound and provide an at-home and return-to-work minor wound care sheet:</p> <ul style="list-style-type: none"> • Keep dressings clean and dry. • Skin closures should remain in place for 7-10 days. • Watch for signs of infection. • Make sure tetanus is up-to-date. • Return for reassessment. 	
<p>9. Complete a First Aid Record.</p>	

Summary

1. What parts of the secondary survey need to be completed for a patient that is otherwise healthy but has a minor wound that does not require medical treatment?
2. How do you cleanse a minor wound?
3. How do you dress a minor wound?

Lesson 12.2: First Aid Record

Learning Outcomes

1. Explain the purpose of the First Aid Record and when it should be completed.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 25: First Aid Room Procedures, page 153 – 154

Theory

Purpose of the First Aid Record

You must complete a First Aid Record for every patient you see. This includes the initial visit as well as any follow-up visits.

The First Aid Record:

- Gives the attendant a history of how the injury occurred
- Helps ensure that proper follow-up is provided
- Provides evidence of work relatedness for compensation claims
- Identifies trends so action can be taken by the employer
- Identifies work areas, and procedures or practices that may be causing injuries or illnesses

First Aid Records are confidential. Ensure they are stored securely. First Aid Records must be retained by the employer for a minimum of 3 years.

Only people who need to see the First Aid Records should be allowed access, such as:

- The worker named on the record
- The worker's direct supervisor
- Personnel who manage health and safety, compensation claims or return-to-work programs at the workplace
- A WorkSafeBC officer

For some reviewers, first aid records may need to be redacted to protect the identity of the worker. For example, the joint health and safety committee may review First Aid Records as part of the regular committee meetings. Their interest would primarily be the mechanism of injury (what happened) and the specifics of where the worker was injured. The committee does not need the name or other identifiable information about the worker in order to do committee work.

First Aid Record Answer Key

This record must be kept by the employer for 3 years

First Aid Record

Sequence number 20180016

Name Anna Prentice	Occupation Millwright
Date of injury or illness April 1, 2018	Time of injury or illness 2:35 PM
Initial reporting date & time April 1, 2018 2:40 PM	<input type="checkbox"/> Follow-up report date & time
Initial report sequence #	Subsequent report sequence number(s)

A description of how the injury, exposure, or illness occurred (What happened?)

Worker was reaching down into the motor on power unit 16, tightening the exhaust manifold. She cut her left arm on a sharp piece of metal when she pulled her arms out of the power unit.

A description of the nature of the injury, exposure, or illness (What you see - signs & symptoms)

ABC's all normal; no allergies; 2 cm. long laceration to the upper inside area of the left forearm. Laceration is just through the thickness of the skin. Minimal bleeding and pain; no swelling; wound appears clean; normal circulation and nerve function beyond the injury.

A description of the treatment given (What did you do?)

Assessed ABC's; supported arm and covered wound with sterile gauze. Examined arm from shoulder to fingertips. Cleansed around wound with wound-cleansing towelettes; cleaned inside wound with warm tap water. Applied skin closures. Dressed with 4 layers of sterile gauze and absorbent dressing; bandaged with gauze roller. Advised to get a Tetanus update.

Name of witnesses

1. Chester Fields was working with Anna Prentice	2.
---	----

Arrangements made relating to the worker (return to work / medical aid / ambulance / follow-up)

Return to work. Advised to get a Tetanus update within 36 hours. Discussed worker handout sheet. Advised to keep dressing clean and dry and to return to first aid immediately if it gets wet or dirty or pain increases. Must return at start of next shift (April 2, 2018) for redressing.

Provided worker handout	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Alternate duty options were discussed	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
A form to assist in return to work and follow-up was sent with the worker to medical aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
First aid attendant's name (please print) Sarah Bellum	First aid attendant's signature <i>Sarah Bellum</i>	
Patient's signature <i>Anna Prentice</i>		

Answer Key for Follow-Up Report (as an example time permitting)

This record must be kept by the employer for 3 years

First Aid Record

Sequence number 20180018

Name Anna Prentice	Occupation Millwright
Date of injury or illness April 1, 2018	Time of injury or illness 2:35 PM
Initial reporting date & time April 1, 2018 2:40 PM	<input checked="" type="checkbox"/> Follow-up report date & time April 2, 2018 8:10 AM
Initial report sequence # 20180016	Subsequent report sequence number(s)

A description of how the injury, exposure, or illness occurred (What happened?)

See initial report on Sequence #20180016

A description of the nature of the injury, exposure, or illness (What you see - signs & symptoms)

ABC's all normal; 2 cm. long laceration to the upper inside area of the left forearm. Laceration is beginning to heal. Skin closures still in place. Minimal redness and pain; no swelling or pus; normal circulation and nerve function beyond the injury.

A description of the treatment given (What did you do?)

Assessed ABC's; supported arm and removed old bandage and dressing. Examined arm from elbow to fingertips. Cleansed around wound with wound-cleansing towelettes; cleaned over wound with sterile saline. Left skin closures in place. Dressed with 4 layers of sterile gauze and absorbent dressing; bandaged with crepe roller.

Name of witnesses

1.	2.
----	----

Arrangements made relating to the worker (return to work / medical aid / ambulance / follow-up)

Return to work. Tetanus booster was administered after work on April 1st. Discussed patient handout sheet. Advised to keep dressing clean and dry and to return to first aid immediately if gets wet or dirty or pain increases. Must return at start of next shift in two days (April 4, 2018) for redressing.

Provided worker handout	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Alternate duty options were discussed	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
A form to assist in return to work and follow-up was sent with the worker to medical aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
First aid attendant's name (please print) Sarah Bellum	First aid attendant's signature <i>Sarah Bellum</i>	
Patient's signature <i>Anna Prentice</i>		

This form must be kept at the employer's workplace and is not to be submitted to WorkSafe BC.

Summary

1. Why is it important to complete the First Aid Record accurately?
2. What could happen if you don't complete the First Aid Record accurately?

Lesson 12.3: Minor Sprains, Dislocations and Fractures

Learning Outcomes

1. Manage a patient with a minor sprain.
2. Manage a patient with a minor fracture.
3. Manage a patient with a minor dislocation.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 32: Sprains, Dislocations and Fractures, page 196 – 199

Theory

Minor Sprains

To treat a minor sprain:

1. Ice the injured area.
2. Keep the injured area as still as possible.
3. Apply a Spica bandage using a crepe roller bandage.
4. Check the patient's circulation.

Minor Fractures

To treat a minor fracture:

1. Ice the injured area.
2. Keep the injured area as still as possible.

Minor Dislocations

To treat a minor dislocation:

1. Apply ice to the injured area.
2. Apply a large arm sling.
3. Place a pad under the patient's elbow to fill the gaps between body and position of arm.
4. Apply a wide transverse bandage around the elbow and torso. Tie it on the uninjured side.
5. Check the patient's circulation.

Immobilizing Injuries

With upper-limb injuries, use a sprint and/or sling:

- Follow the principles of immobilization outlined on page 200 of the OFA 2 Reference and Training Manual.
- Steady and support the injured limb at all times.
- Check circulation, and compare to the uninjured limb before and after immobilization.
- Remove jewellery below the site of the injury.
- Pad splints and slings wherever they rest against a limb.
- Make sure the splint is long enough to extend above and below the injury.

With lower-limb injuries, hold the limb steady with your hands.

MINOR SPRAINS

Skill Practice

Goal	
Assess and treat a minor sprain.	
Scenario	
A worker limps into the first aid room, complaining about pain in her ankle. While walking down the stairs, she twisted her ankle. She says she did not fall down the stairs.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Spinal motion restriction not required.
2. Modified primary survey: a. Ask what happened to assess the airway. b. Assess breathing. c. Assess circulation. Look for signs of shock (cool, pale, clammy skin). Do a verbal rapid body survey. Did you hurt yourself anywhere else?	Patient is talking clearly. Airway is clear. Breathing is normal. Skin colour is normal. When asked, patient says, "Only my ankle hurts."
3. Position the patient based on the findings of the modified primary survey. If the patient is reacting to the injury (pale, anxious), position supine. If patient 's colour is normal (not showing anxiety), position sitting.	Position sitting.

4. Support the injury. Ask the patient to remove both shoes and socks.	
5. Wash your hands and put on gloves.	
6. Look at injury to make initial transport decision: Return to work after treatment	No obvious deformity; minimal swelling; patient was bearing weight when she came into the first aid area. Give patient a chair on which to rest her foot.
7. Modified secondary survey: a. Question patient about medical history. b. Thoroughly examine injured area and compare to uninjured ankle.	Patient has no allergies and is not on any medications. She has slight pain when you touch her lateral ankle. Range of motion is reduced. Slight increase in pain when moved to the medial side. Circulation equal to the uninjured foot.
8. Injury care: a. Apply ice pack for 20 min with a protective barrier against the skin. b. Keep the injured area as still as possible. c. Apply a Spica using a crepe roller bandage and elevate. d. Check circulation before and after wrapping. Compare to uninjured ankle.	No swelling or increased pain after ice. No obvious impaired circulation after wrap. Patient is able to walk. Nothing to indicate the need for medical aid.
9. Tell patient how to care for injury and provide at-home and return-to-work wound care sheet: <ul style="list-style-type: none"> • Elevate, ice, and remove bandage at night. • Carry on activities within the limitations of pain. Complete rest extends recovery time. • Return for reassessment and re-wrapping. 	
10. Complete a First Aid Record.	

Theory

Arm Slings

When applying an arm sling:

- Place padding between the elbow and torso.
- Place padding under the knots.

MINOR FRACTURES

Skill Practice

Goal	
Assess and treat a minor fracture.	
Scenario	
A worker walks into the first aid room, supporting his right forearm. He was struck on the forearm by a drive shaft while working on a vehicle. He says he did not fall or hit his head.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Spinal motion restriction not required.
2. Modified primary survey: a. Ask what happened to assess the airway. b. Assess breathing. c. Assess circulation. Look for signs of shock (cool, pale, clammy skin). Do a verbal rapid body survey. Did you hurt yourself anywhere else?	Patient is talking clearly. Airway is clear. Breathing is normal. Skin colour is normal. When asked, patient says, "Only my arm hurts."
3. Position the patient based on the findings of the modified primary survey. If the patient is reacting to the injury (pale, anxious), position supine. If patient 's colour is normal (not showing anxiety), position sitting.	Position sitting.
4. Support the injury.	
5. Wash your hands and put on gloves.	

<p>6. Look at injury to make initial transport decision:</p> <p>Refer to Medical Aid – possible fractured forearm.</p>	<p>There is swelling, redness, bruising, pain and angulation at the mid-third section of his forearm.</p>
<p>7. Modified secondary survey:</p> <p>a. Question patient about medical history.</p> <p>b. Thoroughly examine injured area and compare to uninjured arm.</p>	<p>Vitals are all normal.</p> <p>Patient has no allergies and is not on any medications.</p> <p>Point tenderness when injured area touched. Swelling.</p> <p>Patient can feel and move areas distal to wound, but reluctant due to increase in pain. The circulation distal to the injury is equal to the uninjured arm.</p>
<p>8. Injury care:</p> <p>a. Apply ice pack for 20 min with a protective barrier against the skin.</p> <p>b. Immobilize the limb with a padded splint secured by crepe roller bandages.</p> <p>Keep the joints above and below the injured area from moving.</p> <p>c. Recheck circulation.</p> <p>d. Reapply ice.</p> <p>e. Apply a sling and transverse bandage.</p>	<p>No swelling or increased pain after ice.</p> <p>No obvious impaired circulation after immobilization.</p>
<p>9. Transport patient to Medical Aid.</p>	
<p>10. Complete a First Aid Record.</p>	

Summary

1. How should you treat a sprain?
2. How should you treat a fracture?
3. How should you treat a dislocation?
4. What should you keep in mind when applying a splint or sling for an upper-limb injury?

Lesson 12.4: Activity-Related Soft-Tissue Disorders

Learning Outcomes

1. Describe how you would manage a patient with an activity-related soft-tissue disorder (ASTD).

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 30: Activity-Related Soft-Tissue Disorders, page 182 – 186

Class-Based Discussion

Manage the patient described in the following scenario.

A man comes into the first aid room, complaining of a sore wrist. He has been painting guard rails for several days. Painting is not his usual job. His wrist was sore after work yesterday. Although it felt better in the morning, it's getting sore again today. He experiences some pain when he flexes and extends his wrist. There is no swelling, but there is some tenderness along the tendon sheath that increases when extending and flexing.

Answers

Summary

1. What are the signs and symptoms of ASTD?
2. What can you do to treat an ASTD?

Lesson 12.5: Minor Ear, Nose and Eye Injuries

Learning Outcomes

1. Manage a patient with a minor eye, nose or ear injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 18: Facial Injuries and Their Management, page 118 - 121
Chapter 19: Eye Injuries, page 122 – 129
Chapter 21: Ear Injuries, page 131 – 132

Theory

Minor Ear Injuries

The most common minor ear injury is an infection of the middle ear. The main symptoms are ear pain and hearing impairment at the time of an upper respiratory infection.

A patient with an ear injury may appear very ill. In addition to ear pain, they may have dizziness, nausea and vomiting.

Inner ear trouble may be a sign of a more serious condition, such as meningitis. Refer the patient to a physician.

Minor Nose Injuries

To treat a minor nose bleed:

1. Ask the patient to lean forward and pinch the nose for 15 to 20 min.
2. Ice the bridge of the nose for 10 min.
3. Stop for 5 min.
4. Repeat the above steps until the bleeding stops.

Minor Eye Injuries

The most common minor eye injury is a foreign body in the eye. Most foreign bodies in the eye are superficial and can be removed without any complications.

To treat a patient with a foreign body in their eye:

1. Tell the patient to:
 - a. Remove the contact lens in the affected eye if applicable.
 - b. Remove any cosmetics from around the eye or eye lashes if applicable.
 - c. Wash their hands.
 - d. Rinse their eye using an eye cup filled with sterile saline or potable, tepid, room-temperature water.
 - e. Pull the upper eye lashes down over the lower lashes and then blink.

2. Examine the eye more closely while separating the eyelids.
3. If needed, remove the dust with a moistened swab or gauze pad.

Summary

1. How should you treat a patient with dust in their eye?
2. Do you need to complete a First Aid Record for a simple treatment like getting the worker to flush their own eye?

Lesson 12.6: Assessing Burns

Learning Outcomes

1. Describe the types of burns.
2. Describe the difference between first-degree, second-degree and third-degree burns.
3. Describe the signs and symptoms of burn injuries.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 37: Burns, page 224 – 226

Theory

First-Degree Burns

First-degree burns affect only the outer layer of skin. The skin is red and the patient experiences mild pain, such as with a mild sunburn or a minor scald. This type of burn usually heals in about a week.

Second-Degree Burns

Second-degree burns can be partial or full-thickness. Partial-thickness second-degree burns affect the outer layer of the skin. Full-thickness second-degree burns affect the outer layer of skin and part of the second layer of skin.

Signs and symptoms include:

- Blisters
- Reddening of the skin
- Pain
- Fluid loss

A patient with a significant second-degree burn to less than 10% of the body surface should be referred for medical aid. If the burn is worse than that, the patient requires rapid transport.

Third-Degree Burns

Third-degree burns involve damage to the layers of skin and underlying structures. Muscles, bones and deeper structures may be damaged.

Signs and symptoms include:

- Charred, dry or pale skin
- Fluid loss

A patient with a third-degree burn to less than 2% of the body surface should be referred for medical aid. If the burn is worse than that, the patient requires rapid transport.

Rule of Nines

A first-degree burn may not have blisters when you first encounter the patient. In order to determine the extent of the burns, you need to consider more than the signs and symptoms.

The fastest and easiest way to estimate the extent of burns is to estimate the percentage of the body that has been burned. This is done using the Rule of Nines:

- Each upper extremity counts 9%.
- The head and neck together count 9%.
- Each lower extremity counts 18%.
- The anterior and posterior surfaces of the trunk each count 18%.
- The perineum and genitalia together count 1%.
- An area the size of the patient's hand can be assumed to be 1%.

Mechanism of Injury

Another important consideration is the mechanism of injury. A worker involved with a sudden flash or scalding liquid, is likely to have first-degree, second-degree burns, or both. If the worker's clothing caught fire, there may be third-degree burns. If the worker was burned in an enclosed space, there may be respiratory burns or smoke inhalation. If there was an explosion, there may be other associated injuries. The attendant should try to cool burns as soon as possible during the primary survey.

Rapid Transport

A patient with the following burns requires rapid transport:

- Any burn with associated smoke inhalation injury
- Second-degree burns to more than 10% of the body surface
- Third-degree burns to more than 2% of the body surface
- Significant burns involving the face
- Burns encircling a limb
- Major burns to the hands, feet or genitalia
- All electrical burns
- All chemical burns

Summary

1. What are the signs and symptoms of a first-degree burn?
2. What are the signs and symptoms of a second-degree burn?
3. What are the signs and symptoms of a third-degree burn?
4. Which burns required rapid transport?

Lesson 12.7: Minor Burns

Learning Outcomes

1. Manage a patient with a minor burn.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 37: Burns, page 226 - 229

Theory

Treating a Minor Burn

To treat a minor burn:

1. Cool the burn as soon as possible.
2. Remove any jewelry if possible.
3. Cover the area with moist sterile gauze.
4. Cover the gauze with drainage dressing.
5. Lightly secure the dressings with a roller bandage.

Tell the patient how to care for the injury:

- Keep the bandage clean and dry.
- Report back immediately to first aid if the bandage gets wet or dirty, or starts to come off.
- Come back the next day for reassessment.
- Give the patient a handout on care for minor burns.

Minor burns typically heal within a week.

Summary

1. How should you treat a first-degree burn?
2. How long do first-degree burns take to heal?

Lesson 12.8: Ongoing Management

Learning Outcomes

1. Describe the ongoing management of an injured worker who remains at the workplace.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 3: Initial Evaluation of the Trauma Patient, page 27

Theory

Return to Work Program

In cases involving more serious injuries and illnesses, the worker may need to take time off for treatment and therapy. This is managed through a return to work program. This program provides a systematic, progressive, individualized, and time-limited process for helping injured workers get back into their normal routine at home and at the workplace as quickly and safely as possible.

The first aid program and return to work program focus on:

- Compliance with regulation
- First aid best practice that meets or surpasses set guidelines
- Early intervention to prevent further damage
- Stay-at-work options that allow workers to remain at work on modified duties while they heal

Summary

1. How does a return to work program help workers and the organization as a whole?

Module 13

Major Injuries

13. Major Injuries

13.1 Musculoskeletal System

13.2 Major Sprains, Dislocations and Fractures

13.3 Major Eye Injuries

13.4 Major Nose Injuries

13.5 Major Ear Injuries

13.6 Major Burns

Lesson 13.1: Musculoskeletal System

Learning Outcomes

1. Describe the major parts of the musculoskeletal system and how they work.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition

Chapter 26: Anatomy and Function of the Skin and Soft Tissues, page 155 – 159

Chapter 31: Anatomy and Function of the Skeletal System, page 189 – 195

Theory

The Musculoskeletal System

The skeleton is the bony framework of the body. It gives the body shape, strength and rigidity. It also protects the organs and acts as a movable framework so that muscular contractions can move the body.

Bones are connected by joints. Ball and socket joints, such as the hip and shoulder, are the most mobile. Hinge joints, such as the knee and elbow, permit free movement in a single plane.

Muscles and their tendons pass around and across joints. A tendon is a band of strong, white, fibrous tissue that connects a muscle to a bone. When a muscle contracts, it pulls on the tendon, which moves the bone. When everything is working as it was intended, the body will become mobile. Tendons are so tough they are seldom torn. Ligaments are fibrous tissue bands that connect one bone to another at a joint.

Most skeletal muscles exist in groups or pairs, which have equal but opposite functions. Voluntary contraction of one group of muscles is accompanied by an automatic relaxation of the opposing group.

Summary

1. How are bones connected to other bones at a joint?
2. How does a muscle contribute to body mobility?

Lesson 13.2: Major Sprains, Dislocations and Fractures

Learning Outcomes

1. Manage a patient with a major sprain, dislocation or fracture.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition

Chapter 33: Immobilization, page 200 – 201

Chapter 34: Management of Upper Limb Injuries, page 202 – 208

Chapter 35: Management of Lower Limb Injuries, page 209 – 214

Theory

Signs and Symptoms

The signs and symptoms of a major sprain, dislocation or fracture are:

- Severe pain
- Obvious gross deformity and irregularity
- A complete or near-complete inability to move the injured limb
- A complete or near-complete inability to put weight on the injured limb
- Swelling and point tenderness
- A grating sound or feeling (fracture only)

Rapid Transport

A patient with any of the following major sprains, dislocations or fractures requires rapid transport:

- Severe crush injury
- Two or more proximal long-bone fractures
- Pelvic fracture
- Hip or knee dislocation

Medical Aid

A patient with a sprain, dislocation or fracture who has difficulty walking should be referred for medical aid.

Skill Practice

Goal	
Manage a patient with a major sprain, dislocation or fracture.	
Scenario	
A worker was struck on the right leg by a moving forklift. When you arrive, he is in the lateral position with his right side down. He is holding onto his right thigh.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Based on the mechanism of injury, spinal motion restriction is required.
2. Manually stabilize head and neck and maintain in the position found.	
3. Assess the level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate.	Based on AVPU, he is alert. He is yelling about extreme pain in his right thigh.
4. Activate the workplace emergency response procedure.	
5. Assess the airway.	Patient is talking clearly. Airway is clear.
6. Assess breathing.	Patient is breathing normally.
7. If available, train a helper to take over manual stabilization: "Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help." If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain head support until help arrives.	
8. Assess circulation: <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey (bleeding) 	Skin is normal, warm and dry. Small amount of blood soaked through pant leg. Baseball sized deformity is felt right mid-thigh region. No pain anywhere else.

<p>9. Immobilize the injury:</p> <ol style="list-style-type: none"> Support the injured leg in the position found using your hands. If available, ask a helper to take over support of the leg. Expose the injury, cover the open wound with a dressing and apply pressure to control any bleeding. If the injury site is not accessible due to the patient's position, roll them to the supine position with support. 	<p>The injury site is accessible in the position found.</p>
<p>10. Transport decision: medical aid.</p> <p>Call BC EHS (911) and ask for an ambulance.</p>	<p>Patient is conscious and has a suspected femur fracture.</p>
<p>11. Conduct a secondary survey:</p> <ol style="list-style-type: none"> Assess vitals. Record the patient's medical history. Thoroughly examine injured area. Complete head-to-toe check: Injuries, circulation, motor function and sensory function 	<p>Patient is alert, vitals are within normal range.</p> <p>Patient has no relevant medical history.</p> <p>Compound mid-1/3 femur fracture with minimal bleeding, slight deformity mid-thigh. Circulation, motor function and sensory function is equal on all extremities.</p>
<p>12. Provide injury care:</p> <ol style="list-style-type: none"> Cover dressings with a bandage if not already done. Apply ice pack for 20 min on and 5 min off with a protective barrier. Re-check circulation. Continue to manually immobilize the injured leg. 	<p>Circulation is normal. No change.</p>
<p>13. Reassess ABCs every 5 min.</p>	<p>No changes</p>
<p>14. Reassess vitals every 10 min.</p>	<p>No changes</p>
<p>15. Complete First Aid Record and Patient Assessment chart.</p>	

Summary

1. What is the difference in treatment between a stable patient with an upper-limb and stable patient with a lower-limb injury?
2. What should you keep in mind when applying a splint or sling for an upper-limb injury?

Lesson 13.3: Major Eye Injuries

Learning Outcomes

1. Describe the signs and symptoms of major eye injuries.
2. Manage a patient with a major eye injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 19: Eye Injuries, page 122 – 129

Theory

Types of Eye Injuries

Eye injuries are common in the workplace. They can result from a variety of workplace activities including:

- Working with or near chemicals, laser and UV light
- Flying particles from bursts of compressed air or other compressed gases
- Windblown debris

The main types of eye injuries are:

- Direct blows from sharp or blunt objects (lacerations, contusions, extruded eyeball)
- Burns (chemical, thermal, radiation)
- Foreign bodies (penetrating, superficial)

Skill Practice

Goal	
Manage a patient with a major eye injury.	
Scenario	
During a tree trimming procedure, a worker slipped from a ladder, fell face-first into a tree, and then dropped 2 m (6.5 ft) to the ground. When you arrive, she is lying supine on the ground. There is a small twig protruding from her eye.	
Steps	
1. Conduct a scene assessment.	No hazards. One injured. Based on the mechanism of injury, spinal motion restriction is required.
2. Manual stabilize the patient's head and neck.	

<p>3. If available train a helper to take over manual stabilization:</p> <p>"Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help."</p> <p>If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain head support until help arrives.</p>	
<p>4. Assess level of consciousness.</p> <p>Identify yourself and attempt to communicate.</p> <p>Ask patient to keep their head still, close both eyes if possible, and keep their hands away from injured eye.</p>	<p>Patient responds with clear speech, but is very anxious.</p> <p>She complains about pain in her eye.</p>
<p>5. Activate workplace emergency response procedure. Call 911.</p>	
<p>6. Assess airway.</p>	<p>Patient talks clearly.</p> <p>Airway is clear.</p>
<p>7. Assess breathing.</p>	<p>Patient is breathing.</p>
<p>8. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey (bleeding) 	<p>Skin is cool, pale and dry.</p> <p>No major bleeding or other gross deformity.</p>
<p>9. Cover the patient with a blanket for shock.</p>	
<p>10. Provide injury care:</p> <ol style="list-style-type: none"> a. Tell the patient what you're doing. b. Ask a helper to put on gloves. If it's a large object, ask the helper to support the twig to ensure no movement occurs. <p>The method of supporting the object will depend on several factors such as object size, shape and available supplies.</p> <ol style="list-style-type: none"> c. If a helper is not available, you may have to use bulky dressing or supportive bandages to maintain the position of the twig. d. Cover both eyes with sterile dressings. 	
<p>11. Transport decision: rapid transport.</p>	

12. Complete a secondary survey while waiting for transport.	
13. Reassess ABCs every 5 min.	No changes
14. Reassess vitals every 10 min.	No changes
15. Complete a First Aid Record and Patient Assessment chart.	

Summary

1. How should you treat a patient with a penetrating eye injury?

Lesson 13.4: Major Nose Injuries

Learning Outcomes

1. Describe the signs and symptoms of major nose injuries.
2. Manage a patient with a major nose injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 18: Facial Injuries and their Management, page 119 - 121

Theory

Nose Injuries

The signs and symptoms of nose injuries are obvious. They include pain and bleeding.

By itself, a nosebleed or a nasal fracture is not a medical emergency. Yet if it's the result of blunt trauma, there may be a brain and/or spinal injury. Also, due to the bleeding, there is the possibility of airway obstruction. To tell if the patient has an airway obstruction due to fluids, look for blood or other fluids around the nose or mouth. You may also hear gurgling.

Even a simple nosebleed may require medical aid if:

- The nosebleed lasts longer than 30 minutes
- The patient has a history of frequent recurrent nosebleeds
- The patient is on blood thinning medication that may complicate the first aid treatment

Summary

1. How can you tell if a patient with a nose injury has an airway obstruction due to fluids?

Lesson 13.5: Major Ear Injuries

Learning Outcomes

1. Describe the signs and symptoms of major ear injuries.
2. Manage a patient with a major ear injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 21: Ear Injuries, page 131 – 132

Theory

Treating an Ear Injury

The ear is a commonly injured sensory organ. The most common injury to the external ear is a laceration. The external ear is primarily made up of cartilage and skin. External ear lacerations don't heal well and should be referred to medical aid for sutures.

To treat an external ear laceration:

1. Stop the bleeding with direct pressure.
2. Cleanse the surrounding area.
3. Cover both sides of the outer ear with a sterile dressing.
4. Wrap roller gauze around the ear and head.
5. Secure the gauze with tape.
6. Refer the patient to medical aid.

Summary

1. What should you do to treat an outer-ear laceration?

Lesson 13.6: Major Burns

Learning Outcomes

1. Manage a patient with major burns.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 37: Burns, page 224 – 229

Skill Practice

Goal	
Manage a patient with a major burn to both hands.	
Scenario	
A painter was working at height applying labels to the plant flow piping near the top of a 4-metre step ladder when he lost his footing. As he reached out to prevent himself from falling, he grabbed an active steam pipe with both hands. When you arrive, he is at the industrial sink cooling his burned hands.	
Steps	
1. Conduct a scene assessment. Confirm mechanism.	There are no hazards. One person injured. Based on the mechanism of injury, spinal motion restriction is not needed. He did not fall.
2. Assess level of consciousness. Identify yourself and attempt to communicate.	Patient's eyes are open. He is anxious. Based on AVPU, he is alert.
3. Initiate or continue flushing his hands with cool water.	He is at the industrial sink cooling his burned hands.
4. Activate workplace emergency response procedure. Ask someone to call an ambulance and tell them there is a responsive adult with a serious burn on his hands.	Major burns to the hands, feet or genitalia require rapid transport.
5. Assess airway.	He's able to talk. Airway is clear.
6. Assess breathing.	He is breathing normally.

<p>7. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey (bleeding) 	<p>No signs of shock.</p> <p>Major second-degree full-thickness burns to the palms and fingers of both hands. No other injuries.</p>
<p>8. Continue cooling and remove any rings, watches or jewelry.</p>	
<p>9. Transport decision: rapid transport.</p>	
<p>10. Complete secondary survey while waiting for transport.</p>	
<p>11. Treat wound if still waiting for ambulance:</p> <ol style="list-style-type: none"> a. Cover the area with moist sterile gauze. b. Lightly secure the dressing with a roller bandage. c. Keep hands elevated if possible. 	
<p>12. Reassess ABCs every 5 min.</p>	
<p>13. Reassess vital signs every 10 min.</p>	
<p>14. Complete a First Aid Record and Patient Assessment chart.</p>	

Summary

1. What is the first thing you should do for a patient with a major thermal burn?
2. What critical interventions should you provide for a patient with a major thermal or chemical burn?

Day 3 Homework

During the evening, learners read the following:

- Chapter 3, Initial Evaluation of the Trauma Patient, page 17 – 19
- Chapter 25, First Aid Room Procedures, page 150-153

They take notes on the following content that will later be included in the written test.

Role of Occupational First Aid Attendant

1. What is occupational first aid (OFA)?
2. Describe your role and responsibilities as an OFA attendant.

Occupational First Aid Safety

3. What are the legislation requirements for first aid kits and equipment used by OFA attendants?
4. How can you keep first aid equipment clean and disinfected?

Module 14

Medical Emergencies

14. Medical Emergencies

14.1 Critical Incident Stress

14.2 Chest Pain

14.3 Diabetic Emergencies

14.4 Poison Management

Lesson 14.1: Critical Incident Stress

Learning Outcomes

1. Describe the signs and symptoms of critical incident stress.
2. Describe strategies for managing critical incident stress.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 45: Critical Incident Stress, page 267

Theory

Physical Effects

The physical effects of critical incident stress include:

- Nausea, weight loss and diarrhea
- Dizziness, shakiness, a weak feeling in the legs, and sweating
- Pounding heart, hyperventilation and a feeling of fatigue
- Headaches, general aches and pains, and chest pains

Cognitive Effects

The cognitive effects of critical incident stress include:

- Difficulty concentrating, absent-mindedness
- Confusion and difficulty making decisions
- Difficulty performing tasks

Emotional Effects

The emotional effects of critical incident stress include:

- Feeling anxious, jumpy and irritable
- Feeling guilt, anger, fear and grief
- Feeling depressed, having mood swings, nightmares and flashbacks
- Feeling lost, helpless and abandoned

Behavioural Effects

The behavioural effects of critical incident stress include:

- Increased use of drugs and/or alcohol
- Difficulty going certain places, or withdrawal from family, friends and colleagues
- Difficulty being alone

Class-Based Discussion

1. What are some strategies for self-care that can help you manage critical incident stress?
2. What other resources are helpful?

Answers

Summary

1. What are the possible physical effects of critical incident stress?
2. What are the possible behavioural effects of critical incident stress?
3. How will you take care of yourself?

Lesson 14.2: Chest Pain

Learning Outcomes

1. Manage a patient who is having a heart attack.
2. Manage a patient who is having an angina attack.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 11: Non-Traumatic Cardiac Emergencies, page 80 – 84

Theory

Heart Attack

If part of the heart is deprived of oxygen for long enough, the heart muscle cells in that area will die. This is called a heart attack.

Signs and symptoms of a heart attack are:

- Chest pain
- Apprehension and denial
- Marked weakness, especially in the arms
- Shortness of breath or difficulty breathing
- Sweating
- Pallor
- Nausea or vomiting and the desire to defecate

The pain may occur suddenly or build gradually. The pain is usually located beneath the sternum in the anterior chest and may radiate across the anterior chest. It may also be felt in the back, arms, neck or jaw. It may be described as choking, squeezing, vice-like, burning or intense indigestion. Patients who are having a heart attack often experience a feeling of pressure.

Before giving a patient who is having a heart attack ASA, make sure that they are:

- Not allergic to ASA
- Not having a heart attack due to a stroke
- Not under 19 years of age

Angina

With angina, there is a reduction of oxygen supply to the heart muscle due to narrowing of the heart's arteries. The lack of oxygen may cause pain that is similar to the pain of a heart attack, which is referred to as angina pectoris. A patient who has angina chest pain for more than 30 minutes is managed as though they are having a heart attack, and are in the rapid transport category.

Signs and symptoms of angina are:

- Pain (usually eases with rest and nitroglycerin; lasts less than 15 min)
- Nausea
- Apprehension or uneasiness
- Pallor
- Shortness of breath

Angina pain may occur suddenly or build gradually. The pain is usually preceded by physical activity and is located beneath the sternum in the anterior chest. The pain may radiate across the anterior chest. It may also be felt in the arms, neck and/or jaw, and/or through the back.

Before helping a patient take their angina medication, ask if they've taken their angina medication recently and when. Also ask if they've taken any other medications. Patients who have taken an erectile dysfunction medication within the last 24 to 48 hours cannot take nitroglycerin.

Skill Practice

Goal	
Manage a patient who is having chest pain.	
Scenario	
A worker walks into the first aid room and sits down. She tells you that she has pain in her chest that started when she was shovelling. She looks pale and sweaty, and says she is very tired.	
Steps	
1. Conduct a scene assessment.	There are no hazards. One patient. Spinal motion restriction is not required.
2. Assess level of consciousness. Identify yourself and attempt to communicate.	Patient is very anxious, but able to speak clearly. Based on AVPU, she is alert.
3. Position the patient in the position of most comfort, preferably supine if willing.	She prefers to sit and lean back in a chair or the cot.
4. Assess airway.	Patient is speaking clearly. Airway is clear.
5. Assess breathing.	Patient is breathing normally.

<p>6. Assess circulation:</p> <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey (bleeding) 	<p>Skin is cool, pale and clammy. No pain anywhere else.</p>
<p>7. Offer the patient a blanket if they are cold.</p>	<p>The patient feels cold, is tired and is very sweaty and welcomes the blanket.</p>
<p>8. Determine if patient is on medication or has a history of previous chest pain.</p>	<p>She is on medication for high blood pressure. No previous history of chest pain.</p>
<p>9. Because there is no history of trauma, assess the pain using PPQRRST.</p> <p>P = Position P = Provoke Q = Quality R = Radiation R = Relief S = Severity (1 to 10) T = Timing</p>	<p>P- Pain is behind the breastbone P- Heavy lifting/working hard Q- Feels vice-like/squeezing R- Radiates down left arm and jaw R- Pain gets worse when she's working hard or lifting S- 7:10 T- Pain has lasted 40 minutes with no relief</p>
<p>10. Activate workplace emergency response procedure:</p> <p>Ask someone to call an ambulance and tell them there's a responsive woman with chest pain that started 40 plus mins ago. No previous history of chest pain.</p>	
<p>11. Critical interventions:</p> <p>a. Check that patient isn't allergic to ASA, having a heart attack because of a stroke, or under 19 years of age.</p> <p>b. If NO to all of the above, offer the patient two 80-mg chewable tablets of ASA or one regular strength 325 ASA tablet to chew.</p> <p>It must be ASA, not acetaminophen or ibuprofen.</p>	<p>No allergies to ASA. Not having a heart attack because of a stroke. Over 19.</p>
<p>12. Transport decision: rapid transport.</p>	
<p>13. Complete a secondary survey while waiting for transport. Update BC EHS if any changes are noted.</p>	
<p>14. Reassess ABCs every 5 min.</p>	

15. Reassess vital signs every 10 min.	
16. Complete a First Aid Record and a Patient Assessment chart.	

Summary

1. Where is the pain associated with a heart attack, and what does it feel like?
2. What should you offer to a patient who is having a heart attack?
3. If the patient has angina, what should you ask them before helping them take their nitroglycerin?

Lesson 14.3: Diabetic Emergencies

Learning Outcomes

1. Describe what diabetes is.
2. Describe the signs and symptoms of a diabetic emergency.
3. Manage a patient who is having a diabetic emergency.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 44: Diabetes, page 261 – 264

Theory

Types of Diabetes

With patients who have diabetes, the body's ability to regulate blood glucose is impaired.

There are two types:

- Type I diabetes is caused by a total lack of insulin production. Patients who have this type of diabetes must take insulin to control their disease.
- Type II diabetes is caused by insufficient insulin production (insulin resistance). Many patients with this type of diabetes can control it by diet alone; others need oral medication.

Hypoglycemia (Low Blood Sugar)

Early signs of hypoglycemia include:

- Hunger
- Pale and clammy skin
- Dizziness, trembling and weakness
- Confusion, restlessness and irrational behaviour

As the condition progresses, these signs may also appear:

- Becoming unresponsive
- Slurred speech
- Seizures
- Profound sweating

Hyperglycemia (High Blood Sugar)

Early signs of hyperglycemia include:

- Thirst
- Excessive urination
- Loss of appetite
- Weakness and dizziness

As the condition progresses, these signs may also appear:

- Nausea and vomiting
- Deep, rapid breathing
- Dry mouth
- A fruity sweet odour to the breath
- Weak and rapid pulse
- Warm, dry skin
- Decreased level of consciousness

Managing a Diabetic Emergency

To treat a conscious patient who is having a diabetic emergency:

1. Give them as much sweetened fruit juice or non-diet soda as they can take, or a full candy bar or a similar sugary snack.

To treat a patient with an altered or decreased level of consciousness who is having a diabetic emergency:

1. Place them in the 3/4 prone position. Ensure the airway drains effectively.
2. If the patient is hypoglycemic, place sugar or glucose in the pocket of the cheek that's closest to the ground.
3. Monitor the airway closely.

Skill Practice

Goal	
Manage a patient who is having a diabetic emergency.	
Scenario	
A site manager who is known to be type I diabetic suddenly feels faint and starts to collapse. A co-worker standing nearby catches him and gently lowers him to a supine position on the floor. When you arrive, the site manager's eyes are closed and his skin is pale.	
Steps	
1. Conduct a scene assessment.	There are no hazards. One patient. Spinal motion restriction is not required.
2. Assess level of consciousness. Approach the patient from the front, identify yourself, and attempt to communicate.	Patient is unresponsive.
3. Activate workplace emergency response procedure: Ask someone to call an ambulance and tell them there's an unresponsive man who is known to have diabetes.	
4. Perform a head-tilt/chin-lift.	
5. Assess airway.	Airway is clear.
6. Assess breathing.	Patient is breathing normally.
7. If available, get a helper to take over head-tilt/chin-lift. If there is no help available, you may have to improvise using readily available materials to maintain the head-tilt/chin-lift. Or, you may immediately position the patient 3/4 prone and continue your assessments in that position until help arrives.	
8. Assess circulation: <ul style="list-style-type: none"> • Signs of shock (cool, pale, clammy skin) • Rapid body survey (bleeding) 	Skin is pale, cool and clammy. Medical alert device on wrist is discovered: Type 1 Diabetic.
9. Place patient in 3/4 prone position.	
10. Offer the patient a blanket if they are cold.	

11. Place sugar or glucose in the pocket of the patient's cheek that is closest to the ground.	
12. Monitor airway closely.	
13. Transport decision: Rapid Transport.	
14. Complete a secondary survey while waiting for transport. Update BC EHS if any changes are noted.	
15. Reassess ABCs every 5 min.	
16. Reassess vital signs every 10 min.	
17. Complete a First Aid Record and Patient Assessment chart.	

Summary

1. What are the two types of diabetes?
2. What are the signs and symptoms of hypoglycemia?
3. What are the signs and symptoms of hyperglycemia?
4. What should you do for a patient with an altered or decreased level of consciousness who is having a diabetic emergency?

Lesson 14.4: Poison Management

Learning Outcomes

1. Describe the ways poison can enter the body.
2. Describe strategies for managing a patient who has been poisoned.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 41: Poisons, page 243 – 248

Theory

Inhaled Poisons

Inhaled poisons can cause damage in three main ways:

- Reduction of the oxygen-carrying capacity of the blood, such as with carbon monoxide poisoning
- Direct irritation of the lung tissues, such as with chlorine gas poisoning
- A direct toxic effect on cells, such as with hydrogen sulphide poisoning

Ingested Poisons

Ingested poisons affect the body by destroying the tissues of the digestive tract, or by being absorbed into the body and causing adverse health effects. Accidental poisoning by ingestion is usually caused by drugs, chemicals and bacterial toxins.

Skin-Contact Poisons

Some substances cause skin destruction or irritation on contact, such as will happen with a chemical burn. Other substances like pesticides may cause adverse health effects when in contact with the skin, eyes or mucous membranes.

Class-Based Scenario Exercise

Instructions

Identify the possible cause of the altered level of consciousness and come up with strategies for managing the patient. Refer to Chapter 15 in your textbooks.

Scenarios

1. A mechanic has been complaining of a headache, dizziness and nausea. When you take him out of the shop, he begins to feel better. A co-worker checks the air quality in the shop and discovers there's been a build-up of carbon monoxide.
2. A worker at a pulp and paper plant begins to experience eye and nose irritation. She tears up excessively and can't stop coughing. There is a pain in her throat. A pungent and disagreeable rotten egg odour has come into the room.
3. A metal finishing worker says he feels weak and has trouble breathing. He is pale, sweaty and confused. His breath smells like bitter almonds.
4. A worker is walking by a landscaper and is accidentally sprayed with pesticide. His skin begins to burn.
5. A worker at a glass etching plant accidentally splashes his ankle with hydrofluoric acid. He immediately experiences excruciating pain from the chemical burn.

Answers

Summary

1. How should you manage a patient who has been exposed to chlorine gas?
2. What is the first thing you should do when responding to a worker who has been exposed to a hazardous gas?
3. How should you treat a chemical burn?
4. What is Hydroxocobalamin?

Module 15

Head and Nervous System

15. Head and Nervous System

15.1 Spinal Injuries

15.2 Altered Level of Consciousness

15.3 Seizure

15.4 Stroke

Lesson 15.1: Spinal Injuries

Learning Outcomes

1. Describe the signs and symptoms of a spinal injury.
2. Manage a patient with a possible spinal injury.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 16: Spinal Injuries, page 107 – 113
Chapter 17: Spinal Injury Management, page 114 – 115

Theory

Mechanism of Injury

You should assume that the patient has a spinal injury if any of the following mechanisms of injury occurred:

- Motor vehicle crash
- Fall from a height
- Direct blow to the spine
- Severe electrical shock
- Facial and head injury

Signs and Symptoms of Spinal Injury

The signs and symptoms of a spinal injury include:

- Pain, tenderness or stiffness in the affected area
- Numbness, tingling or weakness in one or more extremity
- Any noticeable deformity of the spine
- Swelling
- Difficulty breathing if the spinal cord was injured
- Inability to move extremities

Skill Practice

Goal	
Manage a patient with a spinal injury.	
Scenario	
A worker was struck and knocked to the ground with roof trusses. The worker is lying supine on the ground. He's complaining about hip pain and pain in the centre of the lower back. He is supporting both sides of his pelvis.	
Steps	
1. Use all appropriate personal protective equipment for the site.	
2. Conduct a scene assessment.	The trusses have been moved. One injured. Based on mechanism of injury, spinal motion restriction is required.
3. Manually stabilize patient's head and neck.	
4. Assess the patient's level of consciousness: Identify yourself and attempt to communicate. Ask the patient to lie still.	Patient responds with clear speech. Based on AVPU, patient is alert.
5. Activate workplace emergency response procedures. Due to the mechanism of injury, ask someone to call BC EHS.	
6. If possible, train a helper to take over manual stabilization: "Hands over mine, fingers and thumbs where mine are, elbows braced. Don't move while I reposition myself. Let me know if you have to move so I can help." If there is no help available, you may have to improvise. Ask the patient to lie still and use readily available materials to maintain head support until help arrives.	
7. Assess airway.	He's speaking clearly. Airway is clear.
8. Assess breathing.	Breathing is normal.

<p>9. Assess circulation</p> <ul style="list-style-type: none"> • Signs of shock (pale, cool, clammy) • Rapid body survey 	<p>No signs of shock. Severe pain on both sides of the pelvis.</p>
<p>10. Support both sides of the pelvis using rolled blankets or similar material. Be careful to not apply any pressure to the top of the pelvis.</p>	
<p>11. Apply a blanket for warmth.</p>	
<p>12. Transportation decision: rapid transport. Keep patient still until ambulance arrives.</p>	
<p>13. Complete secondary survey while waiting for transport. Update BC EHS if there are any changes.</p>	<p>This patient is showing signs of developing shock.</p>
<p>14. Check ABCs every 5 min.</p>	
<p>15. Check vitals every 10 min.</p>	
<p>16. Complete a First Aid Record and Patient Assessment chart.</p>	

Summary

1. What are the signs and symptoms of a possible spinal injury?
2. What is the main thing to remember when assessing and treating a patient with a possible spinal injury?

Lesson 15.2: Altered Level of Consciousness

Learning Outcomes

1. Describe strategies for managing a patient with an altered level of consciousness.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 14: The Patient with an Altered Level of Consciousness, page
95 – 96

Group-Based Scenario Exercise

Instructions

Identify the possible cause of the altered level of consciousness and come up with strategies for managing the patient. Refer to Chapter 14 in your textbooks.

Scenarios

1. A building maintenance worker is found lying on some cartons of paper products in the stockroom. There is a strong odour of alcohol in the immediate area.
2. An office worker is slurring her words and seems unsteady on her feet. Her skin is pale and she is confused. There is no smell of alcohol or signs of substance use.
3. A worker who came to you a few days ago with a minor wound is feeling faint.
4. A carpenter fell 5 m (3 ft) from a scaffold, striking her head on a stack of lumber. She is lying on her side with her eyes closed and she's not moving. When you assess her level of consciousness, she does not respond to verbal or pain stimulus.

Answers

Summary

1. If you know a patient is intoxicated, do you need to look for other causes of the altered level of consciousness?
2. What is the transport decision for all patients with an altered level of consciousness?

Lesson 15.3: Seizure

Learning Outcomes

1. Describe what a seizure is.
2. Describe the types of seizures.
3. Describe the signs and symptoms of a seizure.
4. Manage a patient who is having a seizure.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 15: Injuries to the Head and Brain, page 103 – 106

Theory

What a Seizure Is

A seizure is a sudden surge of electrical activity in the brain. As an OFA attendant, you may encounter tonic-clonic seizures or simple partial seizures. The primary objective of first aid treatment for a patient who is having any kind of seizure is to maintain a clear airway and protect the patient from injury.

Tonic-Clonic Seizures

With tonic-clonic (grand mal) seizures, the patient convulses, loses consciousness and drops to the ground. All of their muscles contract and their body becomes rigid. Their extremities begin to jerk rapidly, their jaw tightens and their teeth clench. The patient appears to be in danger of respiratory arrest. Loss of bladder control is common. The convulsion is followed by a period of decreased consciousness, which typically lasts 10 to 30 min. During this period, the patient gradually improves.

Simple Partial Seizures

With a simple partial seizure, only the part of the brain that controls motor activity is affected. Typically, only one part of the body begins to twitch or shake. A simple partial seizure may progress into a tonic-clonic seizure.

Treating a Seizure

To treat a seizure:

1. After the patient has stopped actively convulsing, perform a head-tilt/chin-lift.
2. Complete the primary survey.
3. Place the patient in the 3/4 prone position.
4. Apply a blanket for warmth.
5. All patients who have had a seizure require rapid transport.

Summary

1. What are the signs and symptoms of a seizure?
2. What critical interventions should be given to a patient who had a seizure?
3. What is the transport decision for patients who have had a seizure?

Lesson 15.4: Stroke

Learning Outcomes

1. Describe what a stroke is.
2. Describe the types of strokes.
3. Describe the signs and symptoms of a stroke.
4. Manage a patient who is having a stroke.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 15: Injuries to the Head and Brain, page 101 – 103

Theory

Types of Stroke

A stroke is a cerebrovascular accident in which a cerebral artery becomes blocked or ruptures.

There are two main types of strokes:

- Hemorrhagic strokes caused by rupture of a cerebral artery
- Ischemic strokes caused by blockage or narrowing of a cerebral artery

Blockage or narrowing of the cerebral artery is also the mechanism that causes a heart attack.

Signs and Symptoms of a Stroke

Signs and symptoms of a stroke include:

- Weakness in one or more limb
- Numbness in one side of the body
- Severe headache
- Nausea
- Amnesia
- Visual difficulty
- Decreased level of consciousness and confusion
- Trouble speaking
- Dizziness
- Seizures
- Sudden clumsiness
- Difficulty swallowing

A quick screen for stroke is to use the **FAST** mnemonic:

- **Face:** Look for facial droop or asymmetry.
- **Arms:** Ask the patient to hold both arms out straight in front of them with their palms up. Then ask the patient to close their eyes for 10 seconds. If one of their arms drop, it may be a sign of stroke.
- **Speech:** Is the patient speaking normally? Are they oriented in time and place? Can they understand you? Can you understand them?
- **Time:** If you think the patient may have had a stroke, quickly contact BC EHS to get them to the hospital as fast as possible.

Treating a Stroke

To treat a patient who is having a stroke:

1. If they are unresponsive, perform a head-tilt/chin-lift and assess the airway.
2. If they are unresponsive and not breathing normally, begin CPR and request an AED.

OR

If they are unresponsive and breathing normally, place them in the 3/4 prone position. There is a high risk of vomiting.

3. Apply a blanket for warmth.

All patients who have had a stroke require rapid transport.

Summary

1. What are the signs and symptoms of a stroke?
2. What is a quick way to screen for stroke?
3. What critical interventions should you give to a patient who is having a stroke, but is breathing normally?

Module 16

Multiple Patients

16. Multiple Patients

16.1 START System

Lesson 16.1: START System

Learning Outcomes

1. Describe the START system for triage and management of multiple injured or ill workers.

Required Reading

Occupational First Aid Level 2: A Reference and Training Manual, 2018 edition
Chapter 48: Multiple Casualties, Disaster and Triage, page 278 – 281

Theory

Triage

The first rule of triage is to do the greatest good for the greatest number. Sorting and prioritizing injuries and allocating limited resources requires skill, judgment and experience. The OFA attendant must initiate a triage process, but responsibility for triage should be handed over to a more experienced person as soon as possible.

The following rules of triage apply:

1. Only immediately life-threatening conditions are identified and treated in the initial triage round.
2. Salvage of life takes precedence over salvage of limbs.

Sorting

START stands for Simple Triage and Rapid Treatment. Tag the patients using the following colour codes:

- Green: minor injury, walking wounded
- Yellow: delay, can wait
- Red: immediate
- Black: expectant or deceased

You need to sort the patients as quickly as possible. Ask anyone who can hear you and walk, to come forward. Tag these people as green and get them to wait nearby. Some of these people may be able to help you assess and provide life-saving interventions to the other patients.

Assessment

Using the primary survey and Rapid Transport Criteria, move rapidly from one patient to another, identifying those who require immediate treatment and prioritizing patients for transport to hospital. Pause only to treat life-threatening conditions.

Use the following acronym when assessing triage patients:

R = Respiratory

P = Perfusion

M = Mental Status

Summary

1. What are the four categories used to triage patients?
2. What sort of critical interventions would you provide during triage?

Certification of Occupational First Aid Attendants

Certification Requirements

To qualify for an initial OFA 2 certificate, you must successfully complete this OFA 2 training course. You must also achieve a grade of at least 70% on the final written test and each part of the summative skills assessment.

The course must be taught and evaluated by a person authorized by WorkSafeBC. If you fail to complete any part of the course, you will have to complete the components you missed before you can be tested. This must be done without undue delay and at the discretion of the approved training agency.

Remediation

If you fail any part of the written test or summative skill assessments, you may be allowed a second attempt, subject to approval from the training agency. If you do not pass on your second attempt, you will have to repeat the entire course before becoming eligible for another assessment.

On the second attempt, you must retake the failed portions of the assessment in their entirety. Passing grades that were obtained on other parts of the assessment during your first attempt will be carried forward to the second assessment.

Your second attempt can be no sooner than 24 hours after the first failed assessment. If you don't make a second attempt within 30 days of the first examination, you will have to repeat the entire course before being assessed again.

Challenging the Assessment

You can ask to take the assessments without completing the course if you have both of the following:

- A current valid intermediate first aid certificate (a current first aid or pre-hospital emergency care course consisting of approximately 35 hours), and
- A current valid CPR/AED certificate issued not more than 6 months prior to the examination

However, consider this choice carefully. Depending on the nature of the course you completed, there may be equipment, protocol, and procedural differences that could impact your ability to pass the WorkSafeBC OFA 2 course.

Duration of Certificates

OFA 2 certificates and certificate endorsements are valid for three years from the date of completion of the examination. Extensions of the duration of certificates are not permitted.

Renewal of Certificates

To renew a certificate or certificate endorsement, you must meet the same training and assessment requirements you underwent for your initial certificate, unless you choose to challenge the assessments.

You can only take the OFA 2 assessments without repeating the course if you have both of the following:

A current valid OFA 2 or OFA 3 certificate

- A CPR/AED certificate that was issued not more than 6 months prior to the examination date
- The OFA 2 assessment consists of the last day of the course.

Terms and Conditions of Certification

To keep your OFA 2 certificate, you must continue to do all of the following:

- Follow the principles of first aid treatment as outlined in this WorkSafeBC OFA training program.
- Comply with the Occupational Health and Safety Regulation (OHSR), and the other responsibilities of attendants in this training program.
- Comply with any other terms and conditions provided to you by the training agency when you were granted certification, or provided to you by WorkSafeBC at any other time.

Inappropriate Conduct

Prevention Policy Item D12-195-1 states that a first aid certificate may be suspended, cancelled or have conditions placed upon its use if the OFA attendant engages in inappropriate conduct, including any of the following:

- Smoking while assessing or treating an injured or ill worker, and/or while handling oxygen therapy equipment, or permitting others to do so
- Failure to use the assessment and injury treatment techniques outlined in first aid training courses unless conditions precluded them
- Conduct that poses an unreasonable threat to the safety and well-being of other workers or the public
- Removing themselves from being able to see or hear any summons for first aid at a workplace
- Abandonment of an injured worker after beginning assessment or treatment
- Refusal to treat an injured worker when acting as the designated attendant
- Treating or transporting an injured worker while impaired or under the influence of drugs or alcohol

Failure to Comply with Requirements

If WorkSafeBC has reasonable grounds for believing that a person who holds a first aid certificate has breached a term or condition of the certificate, or has otherwise contravened a provision of the Workers Compensation Act or the OHSR, WorkSafeBC may, under section 195 of the Workers Compensation Act:

- a) Cancel or suspend the certificate, or
- b) Place a condition on the use of that certificate that WorkSafeBC considers is necessary in the circumstances.

WorkSafeBC will consider the nature of the violation, the circumstances surrounding the incident, and the past history of the attendant in determining the action to be taken.

In order of severity, the possible actions that may be taken are:

- a) A warning is issued,
- b) A condition is placed on the use of the certificate,
- c) The certificate is suspended for a period that ends before the normal expiry of the certificate, or
- d) The certificate is cancelled.

In addition to or instead of these actions, WorkSafeBC may do any of the following:

- Require the attendant to renew their existing certificate or obtain a different certificate.
- Place conditions on the attendant's certificate.
- Disallow the attendant from having a certificate for a period of time.

Reviews and Appeals

An order to cancel or suspend a certificate may be appealed. Section 96.2(1)(c) of the Workers Compensation Act provides that a person may request a review officer to review "a Board order, a refusal to make a Board order, a variation of a Board order or a cancellation of a Board order respecting an occupational health or safety matter under Part 3."

Within 90 calendar days of the order issue date, an attendant may request in writing that the Review Division of the WCB conduct a review of the order.

A final decision made by a review officer in a review under section 96.2, pertaining to an order made under section 195 to cancel or suspend a certificate, may be appealed to the Workers' Compensation Appeal Tribunal.

Within 30 calendar days of the final decision of the Review Division, an attendant may request in writing that the Workers' Compensation Appeal Tribunal conduct a review.

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