

TOPIC 8

Life Saving First Aid

Quick Find

The information provided here will help to ensure that you can cope with an emergency situation that requires life saving first aid treatment. Completion of this topic gives you competency as an initial response first aider. It seeks to provide you with sufficient information and skills to sustain life until qualified first aid help arrives. On most mine sites, this should only take a few minutes.

This topic also provides information on providing basic care for those suffering from some of the more common workplace injuries.

1. BASIC LIFE SUPPORT

All mine sites have a fully equipped first aid room, which is staffed by people who are fully trained in first aid. They may be summoned to deal with injuries to people who cannot be moved, or alternatively, coal mine workers may present themselves at the first aid room for treatment.

The first aid room is equipped to deal with injuries ranging from splinters and minor cuts through to the stabilising of major traumas (amputations, etc.) prior to the casualty's evacuation.

You should ensure you are familiar with the location of the first aid room and the methods by which help can be summoned. Your life, or the life of a workmate, could depend on this knowledge.

Despite the provision of first aid facilities, you may find yourself in the position of having to administer some emergency first aid treatment. Again, this section provides you with some basic first aid information so that you can provide basic assistance until you can either get the victim to qualified medical assistance or get qualified medical assistance to the victim.

a) DRABC

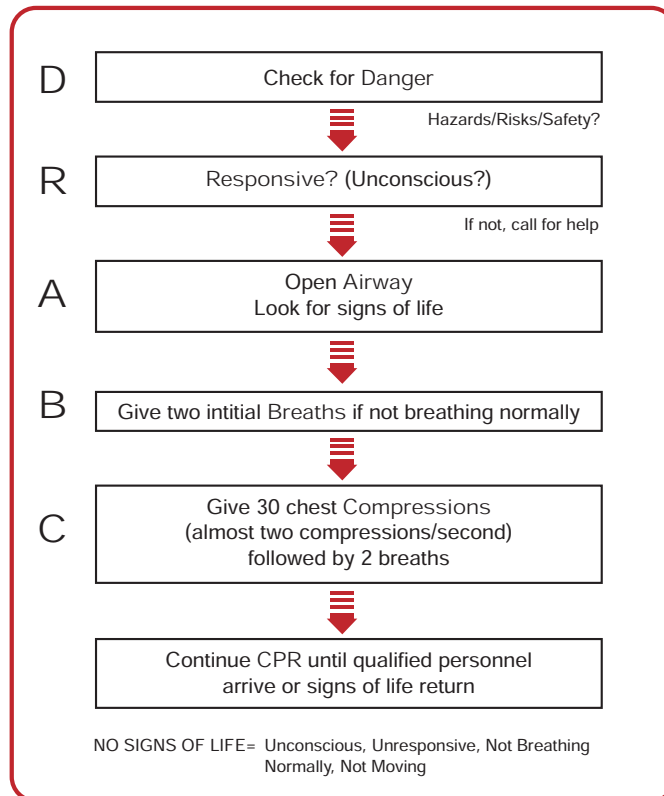
The accident or emergency scene may be quite traumatic and lives can depend on how you react. The most important actions you can take to help the situation are to **control your emotions and to think clearly**.

By following a simple five point procedure, known as **DRABC**, you will ensure your own safety as well as significantly improving the accident victim's chance of survival and minimising the damage caused by injury.

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BASIC LIFE SUPPORT FLOW CHART



Danger

- Quickly assess the situation for danger.
- Ensure the safety of yourself, bystanders and the victim in that order.
- Call for help
- Move the victim as little as possible. If they can be treated where they are, do not move them. The victim should be moved only if they are in further danger or it is necessary to establish and maintain a clear airway.

Response

Assess the victim's state of consciousness and responsiveness, ensuring that this does not aggravate their injury. Give simple commands such as 'open your eyes, squeeze my hands, and let them go'. A person who fails to respond, or a person who shows only a minor response (eg. groans without opening their eyes) should be managed as unconscious.

Where there is more than one victim in an emergency situation, the care of an unconscious victim has priority. The rescuer should not be distracted by victims calling out; their needs are less urgent since they are breathing.

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Airway Management

Once the rescuer has checked the response of the casualty the next step is to ensure the casualty has a clear airway. Airway management is required to provide an open airway when the casualty:

- is unconscious
- has an obstructed airway
- needs rescue breathing

When a victim is unconscious, all muscles are relaxed. If the victim is left lying on their back, the tongue, which is attached to the back of the jaw, falls against the back wall of the throat and blocks air from entering the lungs. Other soft tissues of the airway may worsen this obstruction. The mouth falls open but this tends to block, rather than open, the airway.

The obstruction to the airway by these soft tissues may be overcome by applying a **Backward Head Tilt** in combination with **Chin Lift**.

Note of Caution:

With the unresponsive casualty on their back, the mouth should be opened first to see if any foreign substance/s (eg blood, vomit) are present prior to tilting the head, as any presence of fluids may result in obstruction to the airway.

Once the mouth has been checked and no foreign substances are present, proceed with backward head tilt and chin lift.

In the event of any foreign substance/s in the mouth, casualties should be carefully positioned on their side with head tilted slightly down and back and with the finger sweep method being used to remove any foreign substances.

The victim should not be routinely rolled onto the side to assess airway and breathing - leave them on their back or in the position they have been found to avoid movement and save valuable time.

Breathing

Check if the victim is breathing (more than an occasional gasp). You should:

- **LOOK** and **FEEL** for movement of the upper abdomen or lower chest and;
- **LISTEN** and **FEEL** for the escape of air from the nose and mouth.
- If not breathing, give 2 initial breaths.
- Quickly check for signs of life. If no signs of life are present the rescuer will need to commence chest compressions immediately.

No Signs of life = unconscious (unresponsive), not breathing normally and not moving

Compression

Give 30 chest compressions (almost 2 compressions per second) followed by 2 breaths.

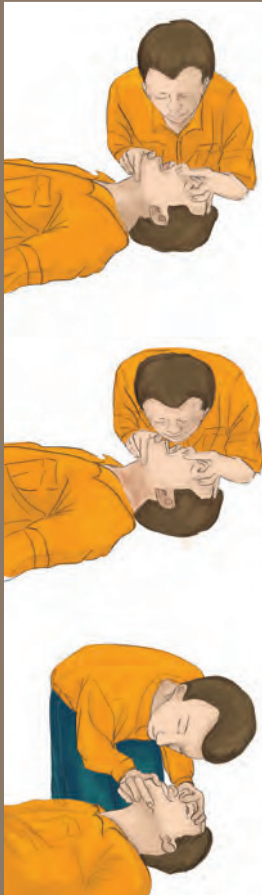
Further details on rescue breathing and compressions follow.

b) RESCUE BREATHING

As stated above, if the unconscious victim is not breathing normally after the airway has been opened and cleared, the rescuer must immediately commence Rescue Breathing by giving **two initial breaths** allowing about one second per inspiration and then check for signs of life.

This may be mouth-to-mouth, mouth-to-nose or mouth to mask. All are equally effective. To ensure the rescuer's safety, mouth-to-mask rescue breathing should be administered when available and if the rescuer is trained to use a mask.

Mouth-To-Mouth Rescue Breathing



Backward Head Tilt / Chin Lift

Kneel beside the victim's head and maintain an open airway by applying the Backward Head Tilt technique in combination with Chin Lift. Place the palm of one hand on top of the head, support the chin with the other hand, and firmly but gently tilt the head backwards avoiding excessive force to the neck.

The chin is held up by the rescuer's thumb and fingers. Placing the thumb over the chin below the lip and supporting the tip of the jaw with the knuckle of the middle finger. Care is required to ensure the little and ring fingers are clear of the neck and jaw.

Blow

Take a deep breath, place your wide-open mouth over the victim's slightly open mouth, sealing his/her nose with your cheek or by pinching the victims nostril and blow to inflate the victim's lungs.

Look, Listen and Feel

- Look for a rise in the victims chest during each inflation, if the chest does not rise possible causes are:
- Obstruction in the airway (inadequate head tilt, chin lift, tongue or foreign material)
- Insufficient air being blown into the lungs
- Inadequate air seal around mouth and or nose

Following the inflation of the victim's lungs, and an obvious rise to the chest, lift your mouth from the victim's, turn your head towards his/her chest and listen and feel for air being exhaled from the mouth and nose.

Observe the victim's stomach to ensure it has not been distended with air. If the stomach is distended, check the airway for obstruction and ensure you are not over-inflating the victim's lungs. Do not apply pressure to the stomach.

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Mouth-to-Nose

The technique for mouth-to-nose is similar to that for mouth-to-mouth, except for the method of sealing the airway. To seal the airway, close the victim's mouth and seal the lips by pressing the lower lip on to the upper lip with your thumb. Take a deep breath and place your wide-open mouth over the victim's nose. Ensure that your mouth encloses the bridge of the victim's nose. Do not compress the soft part of the victim's nose with your lips. Continue as for mouth-to-mouth.

The mouth-to-nose technique should be used:

- when the rescuer prefers to use this method
- when the jaws are clenched
- for resuscitation in deep water
- in the resuscitation of infants and small children when the rescuer covers the mouth and nose.

c) COMPRESSION

As mentioned in the airway section above, rescuers should start chest compressions if the victim has no sign of life - unconscious (unresponsive), not moving and not breathing normally.

• Locating the Chest Compression Point

Direct visualisation may be used to locate the compression point and should be around the lower half of the sternum in all age groups. The lower half of the sternum equates to the 'centre of the chest'.

More exactly, the position of the compression point on the sternum (breast bone) is found by:

- Place the index finger of one hand at the notch at the top of the sternum (breast bone)
- Place the index finger of the other hand at the bottom of the sternum where the ribs join
- Use your thumbs to divide the sternum into two equal parts (see diagram)
- The pressure point is between the thumb and the finger on the lower hand
- The compression point can also be located by drawing an imaginary line connecting the nipples in most cases.



Avoid compression applied beyond the lower limit of the sternum. Compression applied too high is ineffective and if applied too low may cause regurgitation and/or damage to internal organs.

- **Method of Compression**

Once the compression point is found, the rescuer places the heel of their hand on this point, with the fingers parallel to the ribs and preferably slightly raised, so that pressure is not exerted directly on the ribs. The rescuer then places their other hand securely on top of the first.

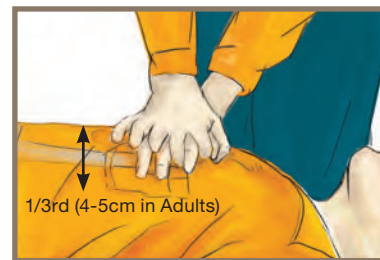
All pressure is exerted through the heel of the bottom hand and the rescuer's body weight is the compressing force therefore the rescuer's shoulders should be vertically over the sternum and the compressing arm kept straight

Compressions should be rhythmic with equal time for compression and relaxation. The rescuer must avoid rocking backwards or forwards, using thumps or quick jabs and should allow complete recoil of the chest after each compression.



- **Depth of Compression**

The lower half of the sternum should be depressed by one third of the depth of the chest with each compression. This equates to at least 4-5cm in adults



- **Rate of Chest Compressions**

Rescuers should perform chest compressions for all ages at a rate of approximately 100 compressions per minute (almost 2 compressions/second). This does not imply that 100 compressions will be delivered each minute since the number will be reduced by interruptions for breaths given by rescue breathing.

d) CARDIO-PULMONARY RESUSCITATION (CPR)

Cardio-pulmonary Resuscitation (CPR) is a technique using rescue breathing combined with chest compressions. The purpose of cardio-pulmonary resuscitation is to temporarily maintain circulation sufficient enough to preserve brain and organ function until specialised treatment is available.

Rescuers should start CPR if the victim has 'no signs of life'. If the victim takes occasional gasps, rescuers should suspect that cardiac arrest has occurred and start CPR.

- **Compression - Ventilation Ratio**

A universal compression-ventilation ratio of 30:2 is recommended for all ages regardless of the numbers of rescuers present. Compressions must be paused to allow for ventilations.

30:2 Ratio = 30 compressions followed by 2 ventilations

When providing 30 compressions at approximately 100/min and giving 2 breaths (each breath is given over 1 second per inspiration) this should result in the delivery of **5 cycles in approximately 2 minutes**.

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Do not interrupt the cycle to check the victim's breathing or circulation. Constantly watch for the signs of life returning.

- **Compression only**

If the victim's face is badly injured or if the rescuer is unwilling or unable to do rescue breathing, they should do chest compressions only. If chest compressions only are given, they should be continuous at a rate of approximately **100 compressions per minute**.

- **Multiple Rescuers**

If there is more than one rescuer available ensure the following:

- that an ambulance is called
- all available equipment has been obtained eg. defibrillator
- frequent rotation of rescuers is undertaken approximately every 2 minutes to reduce fatigue

- **When to cease CPR**

The rescuer should continue CPR until:

- Signs of life return
- Qualified help arrives
- It is impossible to continue from exhaustion
- An authorised person pronounces life extinct or the rescuer finds themselves in a dangerous situation.

Remember that any attempt at resuscitation is better than no attempt.

Recovery Position

Once the victim is showing signs of life, they should be placed on their side in the lateral or recovery position. Continue to monitor the victim to ensure their situation remains stable, and manage any injuries.

The information contained within has been taken from the Australian Resuscitation Council guidelines by permission and reflects the current February 2006 Guidelines 4 / 5 / 6 / 7 and Guideline 8.9.1 February 2005

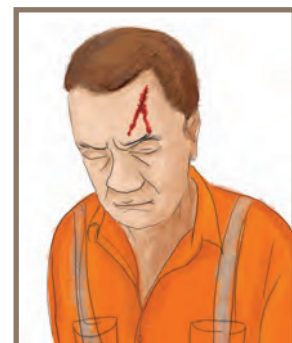


2. BASIC CARE FOR THE INJURED

i) CLINICAL SHOCK

Victims of accidents or traumas may go into shock.

Shock is a medical term used to describe the ashen pallor, sweating clammy skin and bluish extremities, mental confusion (sometimes unconsciousness), rapid thready (feeble) pulse and erratic breathing that can occur after a trauma.



Shock may be caused by any of the following.

- Loss of blood — reduced circulating volume.
- Loss of plasma in the blood (as may occur in burns accidents).
- Loss of fluids due to vomiting or dehydration.
- Reduction in the heart's pumping ability.
- Blood pooling caused by toxins (e.g. with some infections).

Treatment

- If the casualty is unconscious, turn them on to their side.
- Ensure the airway is clear and breathing and circulation are okay.
- Stop any bleeding.
- Elevate the legs, if possible, but keep the rest of the body lying flat — the head should be level with the heart.
- Do not allow the casualty to become either excessively hot or cold.
- Do not give anything by mouth, but the lips may be moistened.
- Do not give the casualty any alcohol.
- Obtain qualified medical help as soon as possible.

ii) BLEEDING CONTROL



In many instances, first aid equipment and personnel will not arrive at the scene of an accident until some minutes after the accident has occurred. In the intervening period, bleeding may need to be stopped, or reduced to the point that could save a life.

These instructions are written on the basis that a simple first aid kit is available at the scene of the accident. However, guidance is also given on how to control bleeding where no first aid supplies are immediately

available. You may need to improvise in the materials used, but the principles of treatment will remain the same.

Note:

If you are administering bleeding control, surgical gloves should be worn (if available) to prevent the possible transfer of a blood related virus. This is especially important if you have open cuts or abrasions on your hands.

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External Bleeding

Sufficient pressure applied to the wound will almost always control bleeding by compressing the blood vessels leading to the wound, and retaining blood in the wound long enough for it to clot. Inspect the wound for embedded objects that may increase damage if pushed further into the wound. If no embedded object is evident, apply direct pressure. If an embedded object is present, apply indirect pressure.

- **Direct Pressure method**

If a specific bleeding point can be identified, apply direct pressure to that point using your hand or a pad, or instruct the victim to apply pressure. Squeeze the edges of the wound together if possible. This could introduce infection but it is justified and may be life-saving where bleeding is severe.



If you have a pad, place it over the wound. It should extend well beyond the edges of the wound and be held in position by a firm bandage. If bleeding is not controlled by the initial pad, leave it in place and apply a second pad and bandage over the first. Never remove a dressing once applied unless major bleeding continues. This will only lead to further bleeding by dislodging the blood clot.

Occasionally, when a large artery is involved, bleeding can only be controlled by constant pressure with the hand over the cut vessel. **This pressure should not be released until the casualty receives qualified medical assistance.**

Elevate the bleeding part in order to decrease the blood flow to the affected area. With minor bleeding the casualty may rest, partly sitting up, with the bleeding part elevated if possible. In cases of severe bleeding, elevate the casualty's lower limbs and keep them elevated to allow venous blood from the legs to drain to the main circulating system. Do not elevate the legs if they are broken.

- **Indirect Pressure Method**

Do not attempt to remove the embedded object because it may be plugging the wound and restricting bleeding. Removal may also cause further tissue injury.

Control bleeding by applying pressure to the surrounding areas but not on the impaling foreign body. Place padding or a ring pad around the object and bandage firmly over the padding.



If bleeding is not controlled by the first pad, apply a second pad and bandage over the first.

Do not exert any pressure on the object itself.

Do not try to shorten an impaling object unless its size makes it unmanageable.

- **Constrictive Bandage**

Occasionally, in major limb injuries such as amputations, or severe crush injuries, life threatening bleeding cannot be controlled by the measures outlined above. Only then, is it permissible to resort to the application of a constrictive bandage above the elbow or knee.

Apply a wide bandage (at least 5cm) directly above the elbow or knee. The bandage should be tight enough to stop circulation to the injured limb and control the bleeding.

Note the time of application and inform the medical aid of this when they arrive.

Internal Bleeding

Internal bleeding may be difficult to recognize, but should always be suspected after an injury. Symptoms and signs may include:

- Obvious symptoms of clinical shock
- Pain, tenderness or swelling over or around the affected area
- Appearance of blood from a body opening

Internal bleeding cannot be controlled by a first aider, but you should administer the following basic care:

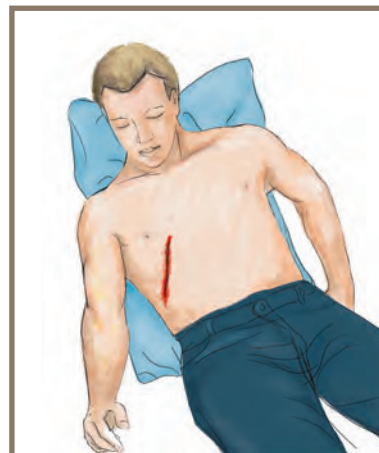
- reassure the victim to minimise anxiety and stress.
- make the victim lie down.
- elevate the legs if injuries permit.
- monitor airway, breathing and circulation at frequent intervals
- make the casualty comfortable but do not allow them to get too hot.
- loosen any tight clothing.
- do not give any medications or alcohol.
- do not permit any food or drink, but lips may be moistened.

iii) PENETRATING CHEST WOUNDS

An open chest wound is a very serious condition which, if not treated correctly, could result in death. An open chest injury may result in air being sucked into the spaces between the chest wall and the lungs, and not into the lungs themselves, during inspiration, and forced out of the chest cavity during expiration. There may be a 'sucking noise'. As air moves into the chest cavity it causes collapse of the lung on the injured side and internal bleeding often results in blood accumulating between the collapsed lung and the chest wall.

Symptoms:

- pain at the site of the injury
- shortness of breath, increasing.



Signs may include:

- the presence of a wound, blood on clothing
- bluish colour of the lips, which is becoming more pronounced
- breathing difficulty, which is increasing
- sucking noise
- unconsciousness developing

Management of Chest Wounds

The aim is to prevent air from entering the chest and to encourage air trapped within the chest to be expelled.

- If there is more than one chest wound, treat the most serious one first.
- If conscious, place the casualty in a comfortable position, normally half-sitting with the injured side down (this will make breathing easier). If the casualty is unconscious, they should be laid in the recovery position with the injured side down.
- Expose the wound.
- Place your hand over the wound until an airtight dressing is available — plastic sheet, a plastic bag or aluminium foil are ideal materials for such a dressing.
- Apply the airtight dressing to the wound and tape down the top and both sides but do not tape the bottom edge; this acts as a one-way valve, allowing the air to escape from the chest cavity but not to enter. The dressing should extend at least 5cm beyond the edges of the wound.

If an airtight dressing and adhesive tape are not available:

- place an ordinary sterile (or clean) dressing over the wound and bandage or hold in place.
- if the casualty's breathing becomes worse or distress increases, remove the dressing/your hand
- it may be necessary to assist the casualty's breathing with rescue breathing

iv) SNAKE BITE

Snake bites may be painless and without visible marks. Other symptoms or signs may include:

- paired fang marks, a single mark, or a scratch
- headache
- nausea and vomiting
- initial collapse or confusion
- abdominal pain
- blurred or double vision



- difficulty in speaking, swallowing or breathing
- swollen tender glands in the groin or armpit
- limb weakness or paralysis
- respiratory weakness or arrest

In the treatment of snake and spider bites it is important to slow the movement of venom through the blood stream.

- ✓ Apply DRABC – resuscitation takes precedence.
- ✓ Keep the casualty calm and do not let them move around.
- ✓ If the bite is on a limb, apply a pressure bandage over the bite site as soon as possible. The bandage should be as tight as one applied to a sprained ankle. If the bite is not on a limb, apply firm pressure to the site of the bite.
- ✓ Apply a second pressure bandage, commencing at the fingers or toes and extending as far as possible along the limb to the armpit or groin. This firm bandaging above the bite limits the spread of venom. Leave the bandage on - some components of the venom remain active at the site of the bite for several hours.



- ✓ Splint the limb to keep it as still as possible. Do not elevate it. If the bite is on the hand or forearm, put the splinted forearm in a sling.
- ✓ Keep the victim and limb completely at rest.
- ✓ Closely observe the casualty and if breathing or circulation fails, resuscitation should be commenced.
- ✓ Bring emergency transport to the victim if possible – minimize the victim’s activity.
- ✓ Manage pain by applying ice packs or a cold compress.
- ✗ Do not use an arterial tourniquet when treating snake bite.
- ✗ Do not attempt to ‘cut and suck’ the bite area to remove venom.
- ✗ Do not wash the wound since venom on the skin can be used to identify the snake or spider.

v) BURNS

This section provides basic information on the treatment of burns. Burns can be categorised under a number of different headings as follows:

- flame burns
- electric burns
- scalds
- chemical burns
- airway burns.



Essentially, a burn is damage caused to the skin, and sometimes the deeper tissues, by heat or chemical agents. Depending on the severity of the burn, one of the biggest risks is that the casualty may go into shock. Immediate and correct treatment of burns will help to minimise any long-term damage to the casualty.

In the event of burn injuries, the following procedures should be adopted.

- **General treatment**

The following steps and precautions apply to all types of burns except airway burns.

DO:

- ✓ flush the burnt area of skin with cool water for at least 20 minutes until the burning sensation stops or qualified help arrives. Do not overcool.
- ✓ if no water is available, remove any smouldering, wet or contaminated clothing
- ✓ get the casualty to qualified medical attention as soon as possible



DO NOT:

- ✗ pull smouldering or contaminated garments over the face
- ✗ attempt to peel away any melted clothing or other substance which is sticking to the skin
- ✗ break any blisters
- ✗ apply any lotions, creams or powders because this makes later assessment of the injury very difficult.

- **Flame Burns**

If the victim's clothes are still burning, you should put out the flames as quickly as possible using a safety shower or a coat or cloth as a smothering agent. This may require you to force the victim on to the floor. Once the flames are out or the flame source has been removed you should cover the burnt area with a clean dry cloth, if available.

- **Electric Burns**

Electric burns may be deceptive. Frequently, the only physical evidence may be small entry and exit burns which do not indicate the severe damage that has occurred to deeper tissue. In the event of an electric burn you must not proceed with treatment until you have:

- Disconnected the power source from the victim.
- Checked for breathing and circulation — commence resuscitation techniques as necessary.

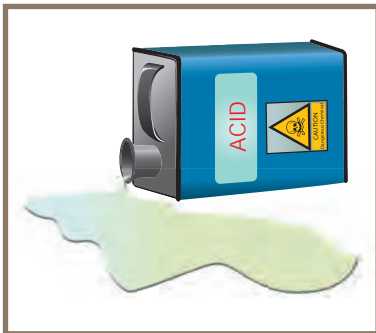
Caution:

Do not use water unless you are certain that you and the casualty are fully isolated from any electrical power source.

- **Scalds**

Scalds are caused by an area of the body being burned by hot liquids. The severity of the burn will vary with the type and temperature of the liquid. In the event of a scald burn, you should also be sure to check for “pools” of hot liquid trapped in natural body creases (neck, groin, inner elbow etc)

- **Chemical Burns**



Chemical burns may be caused by either strong acid or strong alkali substances. Importantly, you should remember that the damaging effect can continue long after immersion or contamination by the substance. Flooding the affected area with water is critical in dealing with chemical burns – often a safety shower is the ideal way of flushing the chemical away. If the chemical is powdered, brush any remaining chemical from the skin prior to flooding with water. You should also identify the chemical, if possible, so that correct neutralization can take place when medical help arrives.

Note:

In areas where certain chemicals are used regularly, specific procedures will have been put in place to deal with chemical contamination. If you work in such an area, ensure you familiarise yourself with the appropriate procedure.

- **Airway Burns**

These are burns to the inner lining of the throat and lungs through the inhalation of hot gases or smoke. If the victim has suffered burns to the face or the front of the body's trunk, you should suspect that the airways have been burnt.

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If there is any risk that the casualty has received burns to the airways they should be checked as soon as possible by qualified medical personnel.

Caution:

In these cases, medical assessment is critical because symptoms and breathing difficulties may not develop for hours or even days after the incident.

vi) ELECTRIC SHOCK

In the cases of electric shock, you may have no external indication of what has caused the problem. Therefore you may need to make careful observations to establish what has occurred.

Examine the area to establish the cause of the situation. The symptoms of severe electric shock are as follows.

- Breathing ceases or becomes inadequate.
- Heart function may cease.
- Burns may be present from electrical heat production.

Electric shock should be handled as follows.

1. Assess the danger — do not add to the problem by becoming a victim yourself. Stay well clear of any energized material (the victim, machinery, pools of water, etc).
2. Turn off or isolate the electric current as soon as possible. If the power cannot be turned off, do not attempt to remove the victim from the power source as they may be energised.
3. Assess the victim's condition — follow the DRABC regime until qualified help arrives.

Warning:

Take care not to become a victim of electric shock yourself.

vii) FOREIGN BODY IN THE EYE

Despite the requirement to wear eye protection around the site, it is possible that you may encounter a situation in which a person has a foreign body in the eye. In this case, the following procedure should be adopted.

- Advise the casualty not to rub the eye.
- If the foreign body is on the **inner surface of the lower lid** it may be removed using the moistened corner of a clean handkerchief.
- If the foreign body is on the **inner surface of the upper lid** it may be removed by pulling the upper lid over the lower lid — the lower eyelash may 'sweep' the speck out.

A second method of dealing with the problem is to attempt to flush the eye with water. This may be done using an eyewash station, a sterile eyebath or using water collected in cupped hands. In this case, it is probably easier for the casualty to administer the treatment him/herself.

If the foreign body is on the surface of the eyeball, leave it there.

Cover both eyes with eye pads or clean gauze and obtain qualified medical assistance as soon as possible. Once you have covered both eyes do not lose physical contact with the casualty, as having both eyes covered can be extremely stressful.

Caution:

An untrained person attempting to remove a foreign body from the eyeball can inflict further damage to the eye.

viii) CRUSH INJURIES

In the event of an accident in which a crushing force is being applied to the casualty, you should observe the following procedures for the removal of the crushing force and the management of the crushed victim.



The procedure for the removal of a crushing force is:

- All crushing forces should be removed within 30 minutes after the crush injury if this is physically possible. After 30 minutes there is the potential that the sudden removal of the crushing force will cause immediate death due to the sudden release of toxins into the blood. This effect is known as 'crush syndrome'. If more than 30 minutes has passed since the crushing injury, seek urgent medical advice before removing the force.
- If a crushing force is applied to the head, neck, chest or abdomen, and is not removed promptly, death may occur from breathing failure, heart failure or blood loss
- An object crushing a limb should be removed immediately
- If it is physically impossible to remove the crushing force, you should send for the appropriate emergency services, including a medical team.

The first aid management of a crush casualty is:

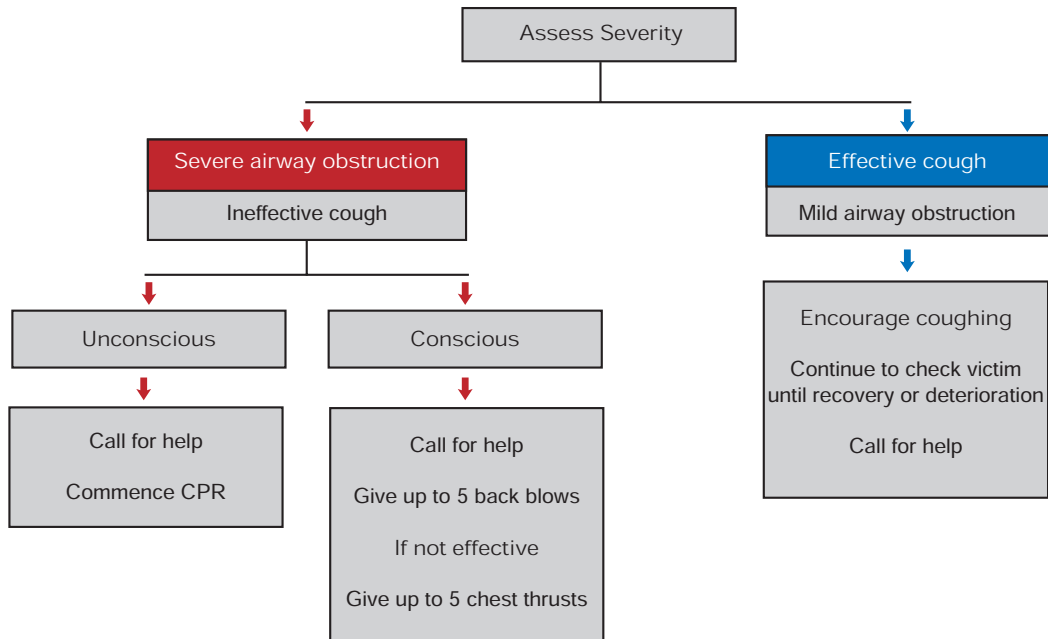
- relieve the crushing force as quickly and gently as possible, while exercising caution to prevent further injury to the victim or to other personnel
- send for an emergency medical team, especially if the victim cannot be released without assistance
- keep the victim comfortable
- assist the emergency medical team in the resuscitation and extrication of the crushed victim.

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ix) CHOKING

The first aid treatment for choking is as follows:



Australian Resuscitation Council

SUMMARY

This topic has provided some basic information on how to deal with certain first aid emergencies. You should re-read this topic periodically to refresh your memory so that you can provide adequate assistance should the need arise.