

Basic Street First Aid Training Supplements

This packet is intended as a study aid for students training to be basic level action medics: street clinicians, street medics and affinity group medics. The training supplements included here were designed to enhance an 8-hour training in “Basic Street First Aid” provided by the On the Ground Street Medic Collective (OtG), but they should be generally applicable to similar trainings offered by others, especially trainers affiliated with the NorthEast Action Medics Association (NEAMA). On the Ground trainers are certified by NEAMA.

Numerous resources were consulted in the development of the Basic Street First Aid trainings offered by OtG. Specific treatments for all typical injuries and illnesses are based strictly on protocols promoted by American Red Cross and/or national Emergency Medical Services standards. The exception to this rule is singular: treatment of chemical weapons contamination and reactions is based on the discoveries and teachings of various action medical activists/collectives, including the Colorado Street Medics/Medical Committee for Human Rights and the Black Cross Health Collective of Portland, Oregon. These groups, having conducted extensive field/clinical testing, deserve much credit for information specific to chemical weapons response and treatment, but responsibility for the information provided here is that of On the Ground alone.

Please feel free to issue these training materials to anyone who has attended trainings in street first aid, but take caution when providing them to those who have not been trained. These guides are meant to supplement trainings, rather than take their place, and they may be more confusing or misleading than helpful to those who have not had oral and hands-on instruction.

This information is provided for one reason only: to help empower activists engaged in the struggle for social change to better care for one another at mass gatherings, direct actions and social uprisings. We hope it contributes to that cause.

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Still in Production:

Patient Assessment Worksheets: Sample Scenarios for Applying Your Knowledge

Also Look For:

Intermediate Street First Aid Training Supplements
Basic Street First Aid Training Manual (Coming Soon)
Health and Safety at Militant Actions
Affinity Group Medic’s Field Guide
Street Medic’s Field Guide (Coming Soon)

To contact On the Ground about the availability of trainings:

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To access printable, updated versions of these documents, visit www.ontheground.org.

To learn more about action medical, or about NEAMA: www.action-medical.net

Setting the Scene

Assess, Approach, Secure (AssApp-S)

When encountering the scene of an injury, the action medic must carefully but quickly take appropriate steps to assess the scene, approach the victim(s) and secure an area for treatment.

Assess Scene Safety

Gather a general impression of persisting dangers

- between you and the victim(s)
- in the vicinity of the victim(s)
- anything nearby that might cause a shift in the level of safety
- check for persistence of mechanism of injury (MOI)

Assess the safety of individuals in the following order

- yourself
- your partner/team
- the victim
- bystanders

Be aware of the proximity of possible hazards

- police and counter-demonstrators
 - note proximity, attitude, activity
- chemicals in the air or on the ground
- traffic
- other environmental hazards

Approach the Scene

Verify scene safety assessment with your partner/teammates

Verify decision to approach the scene with your partner/teammates

Approach the scene with caution

Gather a general impression of the number and severity of injuries

Consider Body Substance Isolation (BSI)

Reconsider scene safety as you approach

Find / Secure Treatment Area

Decide on a safe treatment area

- optimal treatment area
 - shelter and cover on at least 3 sides
 - removed from source of injury
 - near enough to potential scenes of injury that treatment area can be easily found

If victim(s) can be easily moved to a better area (walking wounded)

- inform bystanders of the treatment area location
- help victim(s) move

If victim(s) cannot be moved, or there is no better area available

- secure the immediate vicinity of the patient(s)
 - have bystanders form a perimeter
 - protect victim with your own body (your back toward hazards)

Vocabulary

Body Substance Isolation (BSI):

precautions taken to control infection, including barriers such as gloves and mask; based on the assumption that all bodily fluids are infectious

Mechanism of Injury (MOI):

force or forces that may have caused injury; MOI is not assumed to be only the most obvious cause of injury, but can include secondary or peripheral hazards/factors; a persistent MOI is one that continues to harm/threaten the patient or bystanders (e.g. tear gas)

Initial Encounter and Assessment

Approaching & Evaluating a Sick or Injured Comrade

The most crucial part of any first aid response is the initial assessment of the injury or illness at hand, as it determines each subsequent step. Learning to become familiar with a patient and their condition in the first moments of an encounter is thus an important skill.

Approaching the Victim

Consider mechanism of injury (MOI)

If MOI is obviously severe...

establish immediate c-spine stabilization (see “Head and Neck Injuries” training supplement)

Introduce yourself immediately

Determine level of alertness (AVPU)

- fully alert
- responds to verbal stimuli (“Hey, are you alright!?”)
- responds to painful stimuli (sharp pinch)
- unresponsive

If victim is responsive (A or V)...

request permission to examine and treat

Do not touch the victim until you have received permission

If the victim declines treatment...

- persist in urging treatment
- never attempt to treat a patient who declines
- consider reasons patient may decline
 - lack of trust
 - would prefer caregiver of other sex
 - fear attracting attention
 - don’t believe injury warrants attention
 - are afraid of treatment leading to arrest
- try to find a solution so the patient can be treated
 - get rid of media
 - find another provider
 - reassure that you are a comrade

If the victim is unresponsive...

- consent to be treated is implied
- call for EMS backup!

(continued...)

Initial Encounter and Assessment

Continued...

Initial Patient Assessment

This is a suggested procedure, but it will need to be adapted to particular circumstances; be familiar with these guidelines, but be prepared to interrupt assessment to perform necessary interventions, and do not expect this assessment procedure to flow, or even be necessary, with every patient.

Assess Airway, Breathing and Circulation (ABCs)

- airway
 - is the patient's airway fully open?
 - signs of insufficient airway include: snoring, choking, gurgling, etc
- breathing
 - is the patient breathing adequately
 - signs of insufficient breathing include: shallow, deep or labored breaths; irregular breath rhythm; nasal flaring; skin discoloration
- circulation
 - check for pulse *and* for life-threatening bleeding
 - pulse should be strong and even
 - skin temperature, color, moisture

Treat any life-threatening injuries, as they are discovered in ABCs

Look for signs of shock (see "Shock" training supplement)

Ask questions and reconsider the cause (MOI)

- consider secondary injuries

If the patient is unresponsive...

rely on bystanders for description of MOI and other useful information

Perform a focused assessment of the site of injury

Begin treating any injuries/illnesses

Obtain and note partial vital signs

- breathing
 - rate
 - depth
 - regularity
 - sound
 - strain
- pulse
 - rate
 - strength
 - regularity
- skin condition
 - temperature
 - moisture
 - color

Reconsider calling for EMS backup

Consider transporting patient

Baselines

"Obtaining partial baseline vitals" refers to establishing an initial assessment of circulation and respiration (beyond determining their presence). This information is not particularly valuable on its own, but when compared to vital signs taken later, deterioration or improvement of the patient's condition can be more clearly assessed.

Baseline vitals are especially valuable to EMS and emergency room personnel, or other action medics who may arrive on the scene. However, you should never delay or interrupt care for severe injuries in order to obtain vital signs.

Capillary Refill

A good way to test circulation in a child is to press down on their fingernail and check how long it takes for the color to return. The capillaries under the nails should take less than 2 seconds to replenish.

Breathing

Normal breath rates for an adult are between 12-20 breaths per minute.

Breathing assessment includes rate, regularity, symmetry (between lungs), and sound

Pulse

Normal pulse rates are between 60-100 beats per minute.

Pulse assessment includes rate, strength, and regularity.

A "thready" pulse is indicated by an abnormally thin vessel; you can actually feel the narrowness of the artery

Triage — Principles and Practice

Prioritizing Patient Care in the Field

When there are more victims than there are medics, triage assures that the most critical patients are cared for first. The purpose of triage is to quickly assess each patient's condition, determine the urgency of the patient's condition and assign a treatment priority.

Triage Steps and Guidelines

Direct injured persons who can walk on their own to designated treatment area

- have assistants physically guide anyone whose vision is compromised
- these people are generally considered to be low priority on the triage scale
- these people need to be triaged at the treatment area

Assign a medic to assess victims

- medic's sole purpose is to sweep the area and assess all injured persons
- does not begin treatment until all injured people are assessed
- should be most medically knowledgeable/experienced medic available

Carry out initial assessment procedures for each victim

Assign available medics to conduct specific interventions for severe/critical injuries as discovered

Be sure to look for people who are unconscious or otherwise unable to seek medical attention on their own

Remember that people most aggressively seeking treatment aren't necessarily the most in need of it

After all victims have been assessed, they are put in order for treatment according to the urgency of their conditions

Begin treating victims once triage has been completed

Continue monitoring victims awaiting treatment for degenerating condition

As injured people arrive at the treatment area they need to be assessed and assigned a treatment priority

Open Wounds

Controlling External Bleeding

Bleeding emergencies can range from very minor to life-threatening. Action medics need to be able to recognize the severity of bleeding, as well as control it.

Assess the Wound

Identify the type of *bleeding*

- capillary
 - scrapes / shallow cuts
 - light bleeding, oozes
- venous
 - minor to moderate cuts, tears, small punctures
 - dark red blood, steady flow
- arterial
 - inherently serious cuts, punctures, tears, etc
 - bright red blood, spurts with pulse

Identify the type of *wound* and determine special treatment, if any

- abrasion (scrape)
 - no special considerations
- cut (laceration / incision)
 - no special considerations
- avulsion (missing / dangling skin, tooth, eye, etc)
 - high infection risk
 - rinse missing piece in water
 - wrap missing piece in dry, sterile gauze
 - place wrapped piece on ice, do not freeze
 - send missing piece along with patient
 - return partially-attached flesh to its proper position
- puncture
 - high infection risk
 - check for perforation (exit wound)

Standard Open Wound Treatment

Take body substance isolation (BSI) precautions

Expose the wound (remove/cut away clothing)

Apply direct pressure to wound

If bleeding is not severe...

- irrigate wound by squirting approximately 1 cup of water

Apply dressing to wound

Continue direct pressure

Elevate the wound site, if on extremity (arm or leg)

continued...

Open Wounds

Continued...

Standard Open Wound Treatment (Continued)

If bleeding persists...

- call for EMS backup
- apply pressure to appropriate arterial pressure point (if applicable)
- cease arterial pressure once bleeding is controlled

If bleeding soaks through dressing...

- add more dressings
- never remove dressings

Once bleeding is controlled...

- apply pressure bandage

Always look for signs of hypovolemic shock!

With any moderate or severe bleeding, always *treat for shock*

See "Shock" training supplement

Special Types of Wounds: Impaled Objects

Never remove an impaled object larger than a slight splinter

Stabilize the object by supporting it with cushioning

Bandage *around* the object to hold it secure

Apply direct pressure only away from edges of wound

Special Types of Wounds: Missing Teeth

Treat missing tooth as avulsion (see above)

Check patient's airway

Tilt patient's head forward

If the patient is alert, place waded gauze in space against gum, and have the patient bite down

Special Types of Wounds: Nose Bleeds

Use pinching pressure at end of cartilage

Tilt patient's head forward

If a fracture is suspected...

Use ice and loose dressings

Do not stick anything up the nostrils

Special Types of Wounds: Eye Injuries

If there are particles in the eye...

- flush gently with water
- do not allow patient to rub eye
- promote tear production by gently pulling upper eyelid

Shock

Identifying and Treating Severe Reactions

Nearly any injury can lead to complications. The most serious short-term complication is known as “shock,” which can be deadly. Early identification and treatment of shock is a vital skill for the action medic. The two types of shock with which action medics need to be most concerned are “hypovolemic” (caused by bleeding) and “anaphylactic” (severe allergic reaction).

Hypovolemic Shock

Treat as part of any serious trauma injury, especially

- head injuries
- bleeding (external or internal)
- broken bones

Signs / Symptoms (in order of typical onset/severity)

general restlessness or combativeness; unconsciousness;
 profuse external bleeding; vomiting/loss of bodily fluids; shaking/trembling;
 altered mental status; shallow/rapid breathing; increasingly weak/rapid pulse;
 pale or gray cool clammy skin; cyanotic lips, tongue, earlobes; dilated pupils

Call for EMS backup!

Reassure and comfort patient

Have patient lie down

Maintain attention and communication

Control external bleeding (see “Open Wounds” training supplement)

Immobilize broken bones (see “Breaks, Sprains and Strains” training supplement)

Raise patient’s legs 8-12 inches (if no spinal/pelvic injury)

Monitor for vomiting

If the patient experiences trouble breathing and no spinal injury is suspected...

- raise upper torso 45 degrees

Monitor pulse and respirations for any changes

Anaphylactic Shock

Allergic reaction to environmental variables

Signs / Symptoms (in order of typical onset/severity)

shallow/rapid breathing; burning/itching/rash on skin; breathing difficulty
 (wheezing, strained, shallow, rapid); weak/rapid pulse; cyanotic lips;
 swelling of throat/face; restlessness; fainting/unconsciousness

Call for EMS backup!

If victim has “epi-pen,” help patient find and administer

- press tip into patient’s thigh tissue and hold for at least 10 seconds

Follow same considerations as hypovolemic shock

Monitor airway/breathing closely

Vocabulary

cyanosis: the bluish/greyish color resulting from lack of oxygen in the body

dilation: increase in size (in pupils, also referred to as “blown” when fully enlarged)

epinephrine: a hormone produced by the body as medication to dilate respiratory passages; comes in a synthesized drug form to supplement natural epinephrine

Cold-Related Ailments

Hypothermia and Frostnip/Frostbite

Demonstrations which involve prolonged exposure to adverse conditions of cold tend to lead to numerous and significant cases of hypothermia, including localized hypothermia (a.k.a. “frostbite”). Along with heat-related ailments, hypothermia is one of the most common and dangerous conditions encountered by the action medic.

Generalized Hypothermia

Signs / Symptoms (in order of typical onset / severity)

shivering; numbness; apathy/lethargy; glossy stare; muscle rigidity;
lowered body temperature; slowed pulse; blurred vision;
lack of coordination; unconsciousness

Call EMS at the onset of severe symptoms!

Remove the patient from the cold

Remove any wet clothing and dry the patient

Cover the patient with blankets / dry clothing

Use hot packs at arteries (armpits, groin, neck, etc)

If the patient is fully conscious...

- offer warm beverage

Do not allow patient to consume alcohol or stimulants (cigarettes, coffee, etc.)

Localized Cold Injuries (LCI -- frostnip/frostbite)

Signs / Symptoms of *early stage* LCI (in order of typical onset / severity)

reddened skin (light skinned patients) / lightened skin (dark skinned patients);
blanching skin (whitening); numbness in affected area

Move patient to warm place

Warm the affected area

If injury is on extremity, splint and cover it

Do not re-expose to cold

Do not rub or massage affected area

If condition does not improve...

treat as late stage LCI

Signs / Symptoms of *late stage* LCI (in order of typical onset / severity)

white/waxy skin; blotchy skin; greyish / yellow skin; greyish blue skin;
swelling blistering

Call for EMS or transport to medical facility without delay

Protect area by covering, handling gently

If transport is delayed, move patient to warm place

Do not allow alcohol or stimulants

Do not risk warming if there is any chance of refreezing

Early vs. Late Stage LCI

Early (superficial) LCI: a.k.a., frostnip; brought about by direct contact with cold. Tissue damage is minor and response to care should be good. The injury is localized with clear demarcation of its limits

Late (deep) LCI: a.k.a., frostbite. Develops if frostnip goes untreated. Skin and underlying tissue are both affected. Muscles, bones, deep blood vessels and organ membranes can become frozen.

Warming the LCI

Warmth to improve the state of a localized cold injury can come from bare hands, breathing air on the site, or placing fingers in armpits. It is best to provide a moderate heat source as opposed to merely wrapping the injury which is not providing much heat of its own.

Heat Related Ailments

Heat Cramps, Heat Exhaustion and Heat Stroke

Heat related ailments are some of the most commonly seen and treated medical problems at demonstrations. Prolonged exposure to heat and sun, plus poor planning are the major factors contributing to the high numbers of heat related injuries.

Heat Exhaustion and Heat Cramps

Signs / Symptoms

Muscular cramps (also known as heat cramps) typically in the legs and abdomen; exhaustion; dizziness; rapid shallow breathing; weak pulse; moist grayish or pale skin (which may feel normal to cool when touched); heavy perspiration; altered mental status possible

Remove the person from the heat/sun immediately

Loosen or remove clothing

Place cold packs on the patient's arterial lines (watch for shivering)

Elevate the patient's legs

If the patient is experiencing muscular cramps put a moist towel over the cramped areas

If the patient is responsive and not nauseated give water to drink (watch for vomiting)

It is extremely important to monitor and care for a person that is experiencing heat exhaustion and/or heat cramps. If not cared for in a proper manner the chances of a more severe condition occurring are greatly increased.

Heat Stroke

Signs / Symptoms

Rapid, shallow breathing; full and rapid pulse; generalized weakness; hot dry or possibly moist skin; little or no perspiration; loss of consciousness or altered mental status; dilated pupils; seizures may be seen; no muscle cramps

Call EMS immediately

Protect the person from the heat, do not have them move a significant distance

Loosen restrictive clothing

Apply moist towels (moisten towels with room temp. water only, do not use cold water)

Monitor symptoms

Do not use ice packs or cold water to cool a person experiencing heat stroke. This may cause the person to go into extreme shock or even cardiac arrest.

Strains, Sprains and Breaks

Muscle, Joint and Bone Injuries

It can be impossible to determine in the field whether an injury is a strain, sprain or break. For this reason, it is vital to always refer the injured person to aftercare.

Strains

Signs / Symptoms

swelling; pain; deformity; bruising or discoloration

Treat with RICE

Send to clinic or recommend aftercare

Consider calling EMS if signs/symptoms are severe or if a fracture is suspected

Sprains

Signs / Symptoms

swelling; pain; deformity; discoloration

Treat with RICE

Send to clinic or aftercare if injured person is mobile (x-rays are recommended)

Call for EMS back up if patient can't be moved

Breaks

Signs / Symptoms

swelling; pain; deformity; discoloration; loss of use; tenderness; exposed bone;
loss of distal pulse; numbness and tingling; patient hears sound of break;
grating; slow capillary refill

Cut away or remove clothing to expose site of injury

- apply dressing if there is an open wound
- use direct pressure with extreme caution and only for severe bleeding
- check for distal pulse

Immobilize the extremity

Call for back up or ensure aftercare

Elevate injured extremity if a splint or sling has been applied and there is no spinal or pelvic injury suspected

Apply cold pack to injury site to control bleeding and reduce swelling and pain

Watch for signs/symptoms of shock (see "Shock" training supplement)

Vocabulary

Strain: overexertion, overworking, or tearing of muscles and tendons between joints

Sprain: twisting, tearing or stretching of ligaments at the joints

Break: breaking, chipping, cracking, or splintering of a bone

RICE

Stands for *Rest*, *Ice*, *Compression*, *Elevation*: four important steps in caring for sprains or strains. Rest means keeping the injury site unused and immobilized; ice means applying cold packs to injury site (15 min. on, 15 min. off); compression means wrapping the injury site in ace bandages; elevation means raising the injury site above the heart.

Capillary Refill

A good way to test circulation in a child is to press down on their fingernail and check how long it takes for the color to return. The capillaries under the nails should take less than 2 seconds to replenish.

Head and Neck Injuries

Significant Trauma to the Skull or Spine

Among the most serious injuries encountered at demonstrations are those resulting from severe blows to the head, back or neck. Substantial or awkward falls can also result in these types of injuries. The action medic needs to be able to give initial care for spinal and brain injuries while awaiting EMS backup.

Head Trauma / Brain Injury

Signs / Symptoms (when associated with a possible blow to the head)

- unresponsiveness/unconsciousness; deep cuts/tears in scalp;
- exposed brain; penetrating injury to head; swelling/discoloration;
- edges/fragments of bone seen/felt; deformity; uneven pupils;
- discoloration/bruising behind ears or around eyes;
- clear fluid/blood from ears/nose/mouth; any headache after injury;
- altered mental status/personality change; confusion;
- paralysis/loss of motor function; paralysis of facial muscle;
- impaired airway/speech; disturbed/impaired vision/hearing/balance;
- changing respiratory patterns; seizures

Call for EMS immediately!

If blow was severe, *always suspect and treat for spinal trauma* (see below)

If patient is unconscious...

- assume spinal injury
- maintain airway with jaw-thrust maneuver

Treat for shock (see "Shock" training supplement)

Control any bleeding/fluids with loose, bulky dressings, *no direct pressure*

Keep conscious patient alert and aware

If no spinal trauma is suspected...

- elevate patient's torso 45 degrees

If patient is unconscious...

- talk to and reassure the patient

Spinal Trauma (Suspected or Certain*)

Signs / Symptoms

- the most telling indicator is mechanism of injury...
- weakness/numbness/tingling in arms/legs; paralysis of arms/legs;
- painful movement of arms/legs; lack of pain/sensation;
- pain/tender along spine/neck; burning sensation in spine or extremities;
- deformity of spine; loss of bladder/bowel control; difficulty breathing;
- breathing with slight movement in abdomen; persistent erection

Call for EMS or advanced AMS backup!

Stabilize head and cervical spine (c-spine)

- kneel at patient's head
- place hands firmly along sides of head/face with fingers positioned below the jaw

Instruct the patient to remain still

Protect patient's entire body from disturbance by any activity around you

Vocabulary

Cervical Spine (c-spine): the top 7 vertebrae of the "backbone"; most susceptible to injury and of critical importance for the nervous system

Motor Function: The strength and movement in the extremities; *tested* by having patient grip your fingers, press against your hands, etc.

Trauma: an injury caused by force

Mechanism of Injury: Spinal

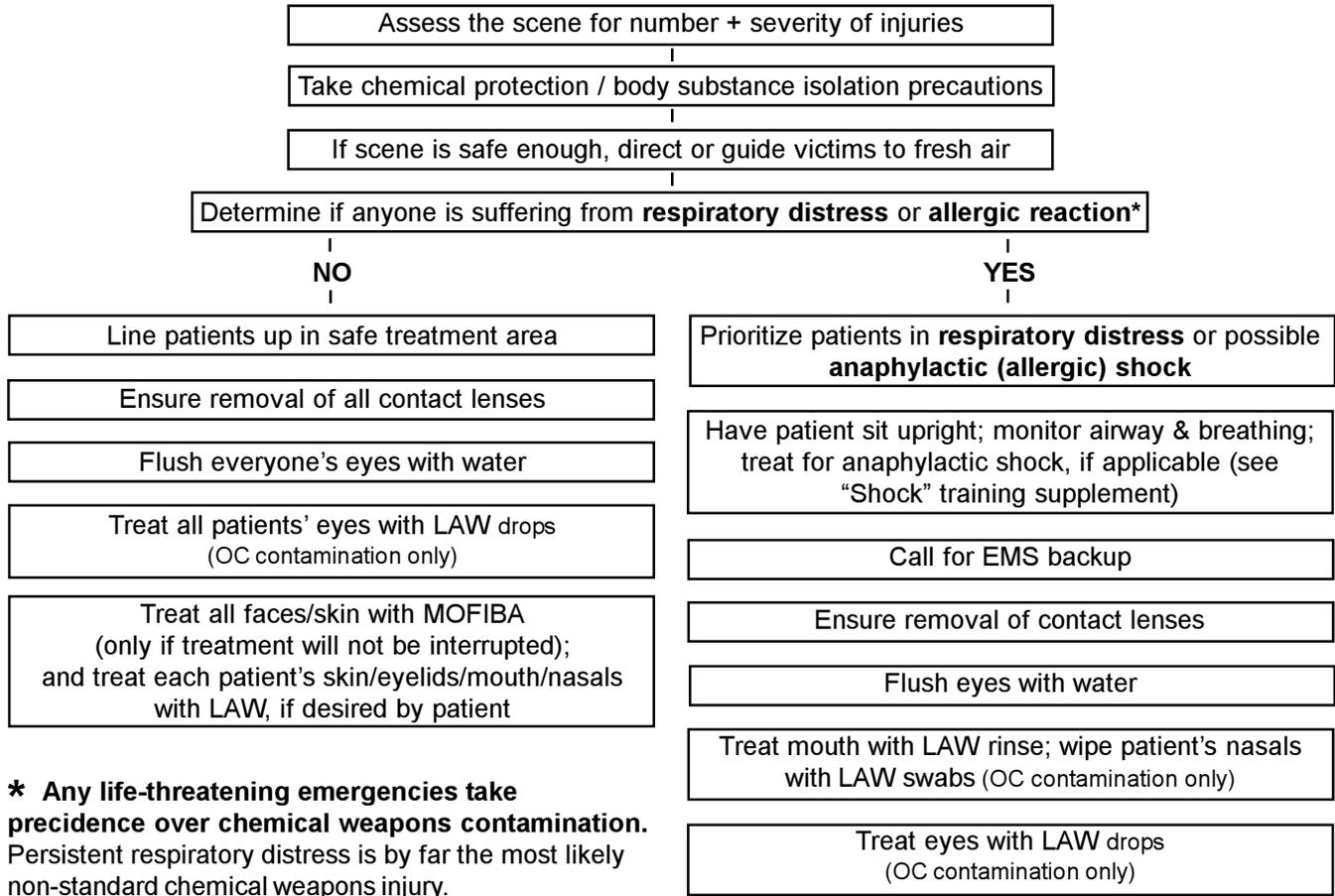
As an action medic, you will often be called on to use your judgement to assess the severity of an injury. When the mechanism of injury suggests the possibility of spinal trauma, it is safest to err on the side of overcautiousness, and await assessment by someone with more advanced skills.

Suspicion vs. Certainty of Spinal Trauma

Action medics should always assume spinal trauma if the mechanism of injury suggests the possibility or likelihood of a spinal injury. Suspected spinal injury is "treated" the same as certain spinal injury: stabilization of the spinal cord.

Chemical Weapons Contamination

Multiple Casualty Incident Scenario Flow-Chart



Miscellaneous Chemical Weapons Treatment Info

Liquid Container Color Codes

BLUE = WATER (Rescue Remedy optional)

GREY = MINERAL OIL

RED = ALCOHOL (70%)

WHITE = L.A.W. (liquid antacid and water)

L.A.W. Recipe

One part liquid antacid (generic Maalox/Mylanta, original or mint flavor) +

One part water

Remember: the treatment for OC and CS/CN chemical contamination of eyes/skin is the same, except LAW is an *additional protocol* used for OC; using LAW on CS/CN victims will *not* have a detrimental effect, so when chemical weapon MOI is in doubt, LAW is part of treatment protocol.

Vocabulary

CS/CN: types of tear gas used against civilian populations; though they differ in contents and effects, treatment of each is the same, and determining which is in use is difficult

MOFIBA: mineral oil *immediately followed by* alcohol

OC: Oleoresin Capsicum, a.k.a., pepper spray. Actually refers to the active ingredients contained in pepper spray, which can be deployed by methods other than "spraying"

Respiratory Distress: difficulty breathing (see "Initial Encounter and Assessment" training supplement)