
VDF DISASTER MEDICAL OPERATIONS — PART 2

SEPTEMBER 2015 (EXTRACT FROM CERT UNIT 4, JANUARY 2011)

In this unit you will learn about

- **Patient Evaluation:** How to perform a head-to-toe assessment to identify and treat injuries.
- **Basic Treatment—How to:**
 - Treat burns
 - Dress and bandage wounds
 - Treat fractures, dislocations, sprains, and strains
 - Treat hypothermia
 - Treat heat-related injuries
 - Control nasal bleeding
 - Treat bites and stings

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INTRODUCTION AND UNIT OVERVIEW

UNIT OBJECTIVES

At the end of this unit, you should be able to:

- Perform head-to-toe patient assessments.
- Apply splints to suspected fractures and sprains
- Employ basic treatments for other injuries

UNIT TOPICS

The unit topics are:

- Conducting Head-to-Toe Assessments
- Treating Burns
- Wound Care
- Treating Fractures, Dislocations, Sprains, and Strains
- Nasal Injuries
- Treating Cold-Related Injuries
- Treating Heat-Related Injuries
- Bites and Stings

CONDUCTING HEAD-TO-TOE ASSESSMENTS

The first steps that you will take when working with a victim will be to conduct triage and rapid treatment. After all victims in an area have been triaged and moved to a medical treatment area, team members will begin a thorough head-to-toe assessment of each victim's condition.

During triage, you are keeping an eye out for “the killers”:

- Airway obstruction
- Excessive bleeding
- Signs of shock

A head-to-toe assessment goes beyond the “killers” to try to gain more information to determine the nature of the victim's injury. The entire assessment must be performed before initiating treatment.

OBJECTIVES OF HEAD-TO-TOE ASSESSMENTS

The objectives of a head-to-toe assessment are to:

- Determine, as clearly as possible, the extent of injuries
- Determine what type of treatment is needed
- Document injuries

Remember to always wear your safety equipment when conducting head-to-toe assessments.

CONDUCTING HEAD-TO-TOE ASSESSMENTS (CONTINUED)

WHAT TO LOOK FOR IN HEAD-TO-TOE ASSESSMENTS

The medical community uses the acronym DCAP-BTLS to remember what to look for when conducting a rapid assessment. DCAP-BTLS stands for the following:

- Deformities
- Contusions (bruising)
- Abrasions
- Punctures
- Burns
- Tenderness
- Lacerations
- Swelling

When conducting a head-to-toe assessment, team members should look for DCAP-BTLS in all parts of the body.

Remember to provide IMMEDIATE treatment for life-threatening injuries.

You should pay careful attention to how people have been hurt (the mechanism of injury) because it provides insight to probable injuries suffered.

CONDUCTING HEAD-TO-TOE ASSESSMENTS (CONTINUED)

HOW TO CONDUCT A HEAD-TO-TOE ASSESSMENT

Whenever possible, ask the person about any injuries, pain, bleeding, or other symptoms. If the victim is conscious, team members should always ask permission to conduct the assessment. The victim has the right to refuse treatment. Talking with the conscious patient reduces anxiety.

Head-to-toe assessments should be:

- Conducted on all victims, even those who seem all right
- Verbal (if the patient is able to speak)
- Hands-on. Do not be afraid to remove clothing to look.

It is very important that you conduct head-to-toe assessments systematically; doing so will make the procedure quicker and more accurate with each assessment. Remember to:

- Pay careful attention
- Look, listen, and feel for anything unusual
- Suspect a spinal injury in all unconscious victims and treat accordingly

Remember to check your own hands for patient bleeding as you perform the head-to-toe assessment.

CONDUCTING HEAD-TO-TOE ASSESSMENTS (CONTINUED)

Check body parts from the top to the bottom for continuity of bones and soft tissue injuries (DCAP-BTLS) in the following order:

1. Head
2. Neck
3. Shoulders
4. Chest
5. Arms
6. Abdomen
7. Pelvis
8. Legs

While conducting a head-to-toe assessment, team members should always check for:

- PMS (Pulse, Movement, Sensation) in all extremities
- Medical ID emblems on bracelet or on neck chain

CLOSED-HEAD, NECK, AND SPINAL INJURIES

When conducting head-to-toe assessments, rescuers may come across victims who have or may have suffered closed-head, neck, or spinal injuries.

A closed-head injury for the participants is a concussion-type injury, as opposed to a laceration, although lacerations can be an indication that the victim has suffered a closed-head injury.

The main objective when team members encounter suspected injuries to the head or spine is to do no harm. Minimize movement of the head and spine while treating any other life-threatening conditions.

Signs of a Closed-Head, Neck, or Spinal Injury

The signs of a closed-head, neck, or spinal injury most often include:

- Change in consciousness
- Inability to move one or more body parts
- Severe pain or pressure in head, neck, or back
- Tingling or numbness in extremities
- Difficulty breathing or seeing
- Heavy bleeding, bruising, or deformity of the head or spine
- Blood or fluid in the nose or ears
- Bruising behind the ear
- “Raccoon” eyes (bruising around eyes)
- “Uneven” pupils
- Seizures
- Nausea or vomiting
- Victim found under collapsed building material or heavy debris

If the victim is exhibiting any of these signs, he or she should be treated as having a closed-head, neck, or spinal injury.

CONDUCTING HEAD-TO-TOE ASSESSMENTS (CONTINUED)

STABILIZING THE HEAD

In a disaster environment, ideal equipment is rarely available. Team members may need to be creative by:

- Looking for materials that can be used as a backboard — a door, desktop, building materials — anything that might be available.
- Looking for items that can be used to stabilize the head on the board — towels, draperies, or clothing — by tucking them snugly on either side of the head to immobilize it.

Remember: Moving victims with suspected head, neck, or spinal injury requires sufficient victim stabilization. If the rescuer or victim is in immediate danger, however, safety is more important than any potential spinal injury and the rescuer should move the victim from the area as quickly as possible.

EXERCISE: CONDUCTING HEAD-TO-TOE ASSESSMENT

Purpose: This exercise will give you a chance to practice conducting head-to-toe assessments.

Instructions:

1. After breaking into pairs, the person on the right will be the victim.
2. The rescuer will conduct a head-to-toe assessment following the previously demonstrated procedure. Repeat.
3. After making two observed head-to-toe assessments, the victim and the rescuer swap roles.

TREATING BURNS

As always, the first step in treating burns is to conduct a thorough size up.

A few examples of burn-related size up questions to ask are:

- What caused the burn?
- Is the danger still present?
- When did the burning cease?

The objectives of first aid treatment for burns are to:

- Cool the burned area
- Cover with a sterile cloth to reduce the risk of infection (by keeping fluids in and germs out)

Burns may be caused by heat, chemicals, electrical current, or radiation. The severity of a burn depends on the:

- Temperature of the burning agent
- Period of time that the victim was exposed
- Area of the body that was affected
- Size of the area burned
- Depth of the burn

BURN CLASSIFICATIONS

The skin has three layers:

- The epidermis, or outer layer of skin, contains nerve endings and is penetrated by hairs.
- The dermis, or middle layer of skin, contains blood vessels, oil glands, hair follicles, and sweat glands.
- The subcutaneous layer, or innermost layer, contains blood vessels and overlies the muscles.

Depending on the severity, burns may affect all three layers of skin.

VDF DISASTER MEDICAL OPERATIONS — PART 2

SEPTEMBER 2015 (EXTRACT FROM CERT UNIT 4, JANUARY 2011)

TREATING BURNS (CONTINUED)

BURN CLASSIFICATION

Classification	Skin Layers Affected	Signs
Superficial	<ul style="list-style-type: none">▪ Epidermis	<ul style="list-style-type: none">▪ Reddened, dry skin▪ Pain▪ Swelling (possible)
Partial Thickness	<ul style="list-style-type: none">▪ Epidermis▪ Partial destruction of dermis	<ul style="list-style-type: none">▪ Reddened, blistered skin▪ Wet appearance▪ Pain▪ Swelling (possible)
Full Thickness	<ul style="list-style-type: none">▪ Complete destruction of epidermis and dermis▪ Possible subcutaneous damage (destroys all layers of skin and some or all underlying structures)	<ul style="list-style-type: none">▪ Whitened, leathery, or charred (brown or black)▪ Painful or relatively painless

<h3>LIST OF GUIDELINES FOR TREATING BURNS</h3>
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- Remove the victim from the burning source. Put out any flames and remove smoldering clothing unless it is stuck to the skin.
- Cool skin or clothing, if they are still hot, by immersing them in cool water for not more than 1 minute or covering with clean compresses that have been soaked in cool water and wrung out. Cooling sources include water from the bathroom or kitchen; garden hose; and soaked towels, sheets, or other cloths. Treat all victims of full thickness burns for shock.

Infants, young children, and older persons, and persons with severe burns, are more susceptible to hypothermia. Therefore, rescuers should use caution when applying cool dressings on such persons. A rule of thumb is do not cool more than 15% of the body surface area (the size of one arm) at once, to reduce the chances of hypothermia.

- Cover loosely with dry, sterile dressings to keep air out, reduce pain, and prevent infection.
- Wrap fingers and toes loosely and individually when treating severe burns to the hands and feet.
- Loosen clothing near the affected area. Remove jewelry if necessary, taking care to document what was removed, when, and to whom it was given.
- Elevate burned extremities higher than the heart.
- Do not use ice. Ice causes vessel constriction.
- Do not apply antiseptics, ointments, or other remedies.
- Do not remove shreds of tissue, break blisters, or remove adhered particles of clothing. (Cut burned-in clothing around the burn.)

TREATING BURNS (CONTINUED)

DOS AND DON'TS OF BURN TREATMENT

When treating a burn victim, **DO**:

- Cool skin or clothing if they are still hot.
- Cover loosely with dry, sterile dressings to keep air out, reduce pain, and prevent infection.
- Elevate burned extremities higher than the heart.

When treating a burn victim:

- **Do NOT** use ice. Ice causes vessel constriction.
- **Do NOT** apply antiseptics, ointments, or other remedies.
- **Do NOT** remove shreds of tissue, break blisters, or remove adhered particles of clothing. (Cut burned-in clothing around the burn.)

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GENERAL GUIDELINES FOR TREATING CHEMICAL AND INHALATION BURNS

Chemical and inhalation burns vary from traditional heat-related burns in their origin and treatment. Keep in mind that suspicion of either chemical or inhalation burns elevates the victim's status to "I."

TREATING BURNS (CONTINUED)

GUIDELINES FOR TREATING CHEMICAL BURNS

Unlike more traditional burns, chemical burns do not result from extreme heat, and therefore treatment differs greatly.

Chemical burns are not always obvious. You should consider chemical burns as a possibility if the victim's skin is burning and there is no sign of a fire. If chemical burns are suspected:

1. Protect yourself from contact with the substance. Use your protective gear — especially goggles, mask, and gloves.
2. Ensure that any affected clothing or jewelry is removed.
3. If the irritant is dry, gently brush away as much as possible. Always brush away from the eyes and away from the victim and you.
4. Use lots of cool running water to flush the chemical from the skin for 15 minutes. The running water will dilute the chemical fast enough to prevent the injury from getting worse.
5. Apply cool, wet compress to relieve pain.
6. Cover the wound very loosely with a dry, sterile or clean cloth so that the cloth will not stick to the wound.
7. Treat for shock if appropriate.

GUIDELINES FOR TREATING INHALATION BURNS

Remember that 60 to 80% of fire fatalities are the result of smoke inhalation. Whenever fire and/or smoke is present, team members should assess victims for signs and symptoms of smoke inhalation. These are indicators that an inhalation burn is present:

- Sudden loss of consciousness
- Evidence of respiratory distress or upper airway obstruction
- Soot around the mouth or nose
- Singed facial hair
- Burns around the face or neck

TREATING BURNS (CONTINUED)

GUIDELINES FOR TREATING INHALATION BURNS (CONTINUED)

The patient may not present these signs and symptoms until hours (sometimes up to a full 24 hours) after the injury occurred, and such symptoms may be overlooked when treating more obvious signs of trauma.

Smoke inhalation is the number one fire-related cause of death. If team members have reason to suspect smoke inhalation, be sure the airway is maintained, and alert a medical professional as soon as possible.

WOUND CARE

The main treatment for wounds includes:

- Control bleeding
- Clean the wound
- Apply dressing and bandage

Treatment for controlling bleeding was covered in Unit 3. The focus of this section is on cleaning and bandaging, which will help to prevent secondary infection.

CLEANING AND BANDAGING WOUNDS

Wounds should be cleaned by irrigating with clean, room temperature water.

NEVER use hydrogen peroxide to irrigate the wound.

You should not scrub the wound. A bulb syringe is useful for irrigating wounds. In a disaster, a turkey baster may also be useful.

When the wound is thoroughly cleaned, you will need to apply a dressing and bandage to help keep it clean and control bleeding.

There is a difference between a dressing and a bandage:

- A dressing is applied directly to the wound. Whenever possible, a dressing should be sterile.
- A bandage holds the dressing in place.

If a wound is still bleeding, the bandage should place enough pressure on the wound to help control bleeding without interfering with circulation.

WOUND CARE (CONTINUED)

RULES OF DRESSING

You should follow these rules:

1. If there is active bleeding (i.e., if the dressing is soaked with blood), redress over the existing dressing and maintain pressure and elevation to control bleeding.
2. In the absence of active bleeding, remove the dressings, flush the wound, and then check for signs of infection at least every 4 to 6 hours.

Signs of possible infection include:

- Swelling around the wound site
- Discoloration
- Discharge from the wound
- Red striations from the wound site

If necessary and based on reassessment and signs of infection, change the treatment priority (e.g., from Delayed to Immediate).

AMPUTATIONS

The main treatments for an amputation (the traumatic severing of a limb or other body part) are to:

- Control bleeding
- Treat shock

When the severed body part can be located, team members should:

- Save tissue parts, wrapped in clean material and placed in a plastic bag, if available. Label them with the date, time, and victim's name.
- Keep the tissue parts cool, but NOT in direct contact with ice
- Keep the severed part with the victim

WOUND CARE (CONTINUED)

IMPALED OBJECTS

Sometimes, you may also encounter some victims who have foreign objects lodged in their bodies — usually as the result of flying debris during the disaster.

When a foreign object is impaled in a patient's body, you should:

- Immobilize the affected body part
- Not attempt to move or remove the object, unless it is obstructing the airway
- Try to control bleeding at the entrance wound without placing undue pressure on the foreign object
- Clean and dress the wound making sure to stabilize the impaled object. Wrap bulky dressings around the object to keep it from moving.

TREATING FRACTURES, DISLOCATIONS, SPRAINS, AND STRAINS

The objective when treating a suspected fracture, sprain, or strain is to immobilize the injury and the joints immediately above and below the injury site.

Because it is difficult to distinguish among fractures, sprains, or strains, if uncertain of the type of injury, team members should treat the injury as a fracture.

FRACTURES

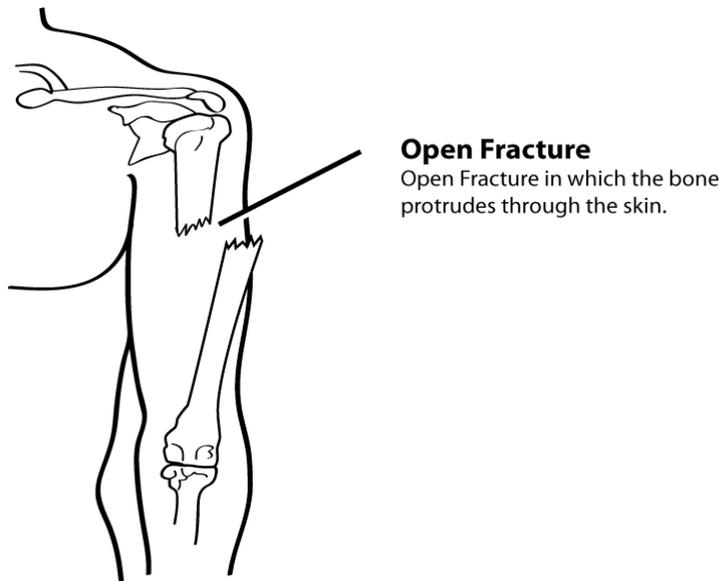
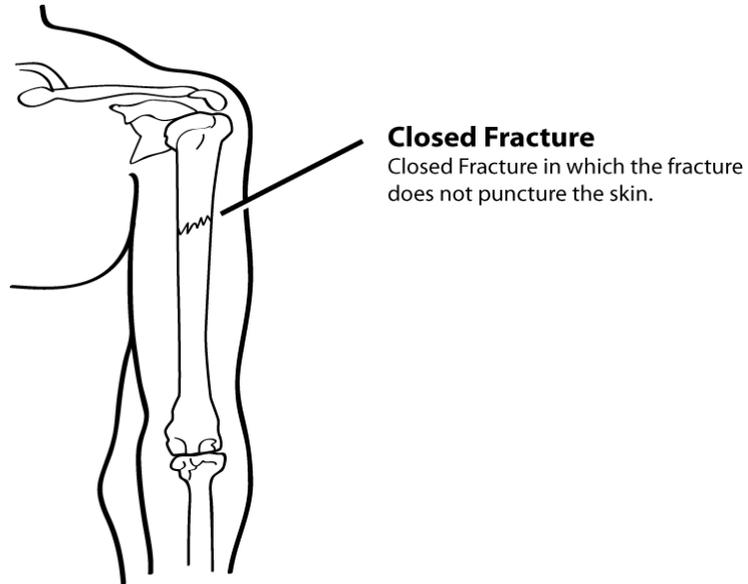
A fracture is a complete break, a chip, or a crack in a bone. There are several types of fractures.

- A closed fracture is a broken bone with no associated wound. First aid treatment for closed fractures may require only splinting.
- An open fracture is a broken bone with some kind of wound that allows contaminants to enter into or around the fracture site.

VDF DISASTER MEDICAL OPERATIONS — PART 2

SEPTEMBER 2015 (EXTRACT FROM CERT UNIT 4, JANUARY 2011)

Closed and Open Fractures



TREATING FRACTURES, DISLOCATIONS, SPRAINS, AND STRAINS (CONTINUED)

TREATING AN OPEN FRACTURE

Open fractures are more dangerous than closed fractures because they pose a significant risk of severe bleeding and infection. Therefore, they are a higher priority and need to be checked more frequently.

When treating an open fracture:

- Do not draw the exposed bone ends back into the tissue.
- Do not irrigate the wound.

You should:

- Cover the wound with a sterile dressing
- Splint the fracture without disturbing the wound
- Place a moist 4 by 4-inch dressing over the bone end to keep it from drying out

If the limb is angled, then there is a displaced fracture. Displaced fractures may be described by the degree of displacement of the bone fragments.

Nondisplaced fractures are difficult to identify, with the main signs being pain and swelling. You should treat a suspected fracture as a fracture until professional treatment is available.

VDF DISASTER MEDICAL OPERATIONS — PART 2

SEPTEMBER 2015 (EXTRACT FROM CERT UNIT 4, JANUARY 2011)

	<h3>Displaced and Nondisplaced Fractures</h3>
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Nondisplaced Fracture

Nondisplaced Fracture in which the fractured bone remains aligned.



Displaced Fracture

Displaced Fracture in which the fractured bone is no longer aligned.

TREATING FRACTURES, DISLOCATIONS, SPRAINS AND STRAINS (CONTINUED)

DISLOCATIONS

Dislocations are another common injury in emergencies.

A dislocation is an injury to the ligaments around a joint that is so severe that it permits a separation of the bone from its normal position in a joint.

The signs of a dislocation are similar to those of a fracture, and a suspected dislocation should be treated like a fracture.

If dislocation is suspected, be sure to assess PMS (Pulse, Movement, Sensation) in the affected limb before and after splinting/immobilization. If PMS is compromised, the patient's treatment priority is elevated to "1."

You should not try to relocate a suspected dislocation. You should immobilize the joint until professional medical help is available.

SPRAINS AND STRAINS

A sprain involves a stretching or tearing of ligaments at a joint and is usually caused by stretching or extending the joint beyond its normal limits.

A sprain is considered a partial dislocation, although the bone either remains in place or is able to fall back into place after the injury.

The most common signs of a sprain are:

- Tenderness at the site of the injury
- Swelling and/or bruising
- Restricted use or loss of use

The signs of a sprain are similar to those of a nondisplaced fracture. Therefore, you should not try to treat the injury other than by immobilization and elevation.

A strain involves a stretching and/or tearing of muscles or tendons. Strains most often involve the muscles in the neck, back, thigh, or calf.

In some cases, strains may be difficult to distinguish from sprains or fractures. Whether an injury is a strain, sprain, or fracture, treat the injury as if it is a fracture.

TREATING FRACTURES, DISLOCATIONS, SPRAINS AND STRAINS (CONTINUED)

SPLINTING

Splinting is the most common procedure for immobilizing an injury.

Cardboard is the material typically used for makeshift splints but a variety of materials can be used, including:

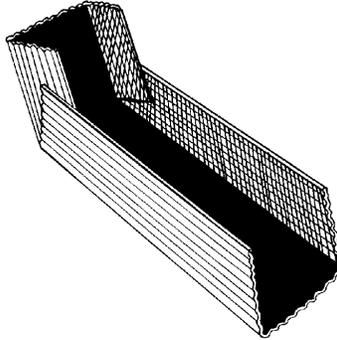
- Soft materials. Towels, blankets, or pillows, tied with bandaging materials or soft cloths
- Rigid materials. A board, metal strip, folded magazine or newspaper, or other rigid item

Anatomical splints may also be created by securing a fractured bone to an adjacent unfractured bone. Anatomical splints are usually reserved for fingers and toes, but, in an emergency, legs may also be splinted together.

Soft materials should be used to fill the gap between the splinting material and the body part.

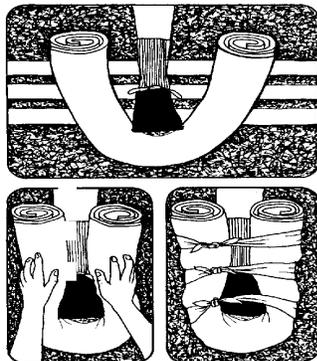
With this type of injury, there will be swelling. Remove restrictive clothing, shoes, and jewelry when necessary to prevent these items from acting as unintended tourniquets.

SPLINT ILLUSTRATIONS



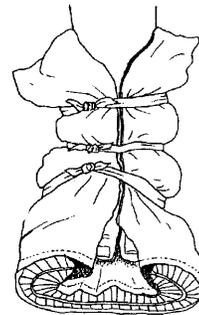
Cardboard Splint

Cardboard Splint in which the edges of the cardboard are turned up to form a “mold” in which the injured limb can rest.



Splinting Using a Towel

Splinting using a towel, in which the towel is rolled up and wrapped around the limb, then tied in place.



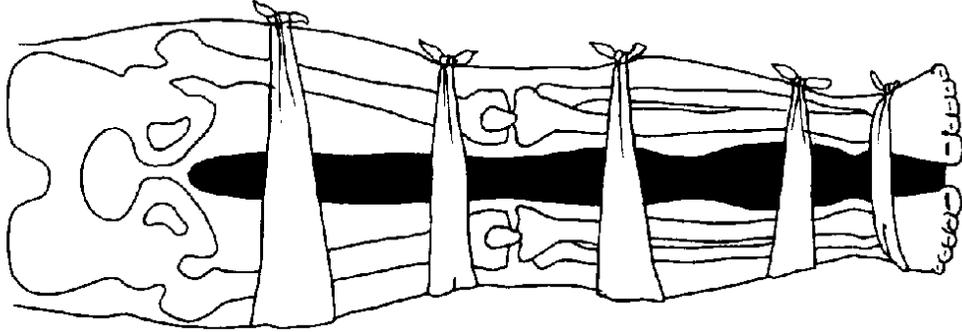
Pillow splint

Pillow splint, in which the pillow is wrapped around the limb and tied.

VDF DISASTER MEDICAL OPERATIONS — PART 2

SEPTEMBER 2015 (EXTRACT FROM CERT UNIT 4, JANUARY 2011)

Splint Illustrations



Anatomical Splint

Anatomical splint in which the injured leg is tied at intervals to the non-injured leg, using a blanket as padding between the legs.

TREATING FRACTURES, DISLOCATIONS, SPRAINS AND STRAINS (CONTINUED)

EXERCISE: SPLINTING

Purpose: This exercise will provide you with a chance to practice your splinting techniques.

Instructions:

1. Break down into pairs of two. One person will be the rescuer; the other will be the victim.
2. The rescuer will place a splint on the victim's upper arm, and then one on the victim's lower leg.
3. After several observed attempts at splinting, the rescuer and the victim will swap roles.

NASAL INJURIES

Bleeding from the nose can have several causes. Bleeding from the nose can be caused by:

- Blunt force to the nose
- Skull fracture
- Nontrauma-related conditions such as sinus infections, high blood pressure, and bleeding disorders

A large blood loss from a nosebleed can lead to shock. Actual blood loss may not be evident because the victim will swallow some amount of blood. Those who have swallowed large amounts of blood may become nauseated and vomit.

These are methods for controlling nasal bleeding:

- Pinch the nostrils together
- Put pressure on the upper lip just under the nose

NASAL INJURIES (CONTINUED)

While treating for nosebleeds, you should:

- Have the victim sit with the head slightly forward so that blood trickling down the throat will not be breathed into the lungs. Do not put the head back.
- Ensure that the victim's airway remains open
- Keep the victim quiet. Anxiety will increase blood flow.

TREATING COLD-RELATED INJURIES

Cold-related injuries include:

- Hypothermia, which is a condition that occurs when the body's temperature drops below normal
- Frostbite, which occurs when extreme cold shuts down blood flow to extremities, causing tissue death

HYPOTHERMIA

Hypothermia may be caused by exposure to cold air or water or by inadequate food combined with inadequate clothing and/or heat, especially in older people.

The primary signs and symptoms of hypothermia are:

- A body temperature of 95° F (37° C) or lower
- Redness or blueness of the skin
- Numbness accompanied by shivering

In later stages, hypothermia will be accompanied by:

- Slurred speech
- Unpredictable behavior
- Listlessness

TREATING COLD-RELATED INJURIES (CONTINUED)

Because hypothermia can set in within only a few minutes, you should treat victims who have been rescued from cold air or water environments.

- Remove wet clothing.
- Wrap the victim in a blanket or sleeping bag and cover the head and neck.
- Protect the victim against the weather.
- Provide warm, sweet drinks and food to conscious victims. Do not offer alcohol.
- Do not attempt to use massage to warm affected body parts.
- Place an unconscious victim in the recovery position:
 1. Place the victim's arm that is nearest to you at a right angle against the ground, with the palm facing up.
 2. Move the victim's other arm across his or her chest and neck, with the back of the victim's hand resting against his or her cheek.
 3. Grab a hold of the knee furthest from you and pull it up until the knee is bent and the foot is flat on the floor.
 4. Pull the knee toward you and over the victim's body while holding the victim's hand in place against his or her cheek.
 5. Position the victim's leg at a right angle against the floor so that the victim is lying on his or her side.
- If the victim is conscious, place him or her in a warm bath.

TREATING COLD-RELATED INJURIES (CONTINUED)

HYPOTHERMIA (CONTINUED)

Do not to allow the victim to walk around even when he or she appears to be fully recovered. If the victim must be moved outdoors, cover the victim's head and face.

FROSTBITE

A person's blood vessels constrict in cold weather in an effort to preserve body heat. In extreme cold, the body will further constrict blood vessels in the extremities in an effort to shunt blood toward the core organs (heart, lungs, intestines, etc.). The combination of inadequate circulation and extreme temperatures will cause tissue in these extremities to freeze, and in some cases, tissue death will result. Frostbite is most common in the hands, nose, ears, and feet.

There are several key signs and symptoms of frostbite:

- Skin discoloration (red, white, purple, black)
- Burning or tingling sensation, at times not localized to the injury site
- Partial or complete numbness

A patient suffering from frostbite must be warmed slowly! Thawing the frozen extremity too rapidly can cause chilled blood to flow to the heart, shocking and potentially stopping it.

- Immerse injured area in warm (NOT hot) water, approximately 107.6° F.
- Do NOT allow the body part to re-freeze as this will exacerbate the injury.
- Do NOT attempt to use massage to warm body parts.

Wrap affected body parts in dry, sterile dressing. Again, it is vital this task be completed carefully. Frostbite results in the formation of ice crystals in the tissue; rubbing could potentially cause a great deal of damage!

TREATING HEAT-RELATED INJURIES

There are several types of heat-related injuries that you may encounter in a disaster scenario:

- Heat cramps are muscle spasms brought on by over-exertion in extreme heat.
- Heat exhaustion occurs when an individual exercises or works in extreme heat, resulting in loss of body fluids through heavy sweating. Blood flow to the skin increases, causing blood flow to decrease to the vital organs. This results in a mild form of shock.
- Heat stroke is life-threatening. The victim's temperature control system shuts down, and body temperature can rise so high that brain damage and death may result.

HEAT EXHAUSTION

The symptoms of heat exhaustion are:

- Cool, moist, pale, or flushed skin
- Heavy sweating
- Headache
- Nausea or vomiting
- Dizziness
- Exhaustion

A patient suffering heat exhaustion will have a near normal body temperature. If left untreated, heat exhaustion will develop into heat stroke.

TREATING HEAT-RELATED INJURIES (CONTINUED)

HEAT STROKE

Heat stroke is characterized by some or all of the following symptoms:

- Hot, red skin
- Lack of perspiration
- Changes in consciousness
- Rapid, weak pulse and rapid, shallow breathing

In a heat stroke victim, body temperature can be very high — as high as 105° F. If an individual suffering from heat stroke is not treated, death can result

TREATMENT

Treatment is similar for both heat exhaustion and heat stroke.

1. Take the victim out of the heat and place in a cool environment.
2. Cool the body slowly with cool, wet towels or sheets. If possible, put the victim in a cool bath.
3. Have the victim drink water, **SLOWLY**, at the rate of approximately half a glass of water every 15 minutes. Consuming too much water too quickly will cause nausea and vomiting in a victim of heat sickness.
4. If the victim is experiencing vomiting, cramping, or is losing consciousness, **DO NOT** administer food or drink. Alert a medical professional as soon as possible, and keep a close watch on the individual until professional help is available.

BITES AND STINGS

In a disaster environment, everything is shaken from normalcy, including insects and animals. In this time of chaos, insect bites and stings may be more common than is typical as these creatures, like people, are under additional stress.

When conducting a head-to-toe assessment, you should look for signs of insect bites and stings. The specific symptoms vary depending on the type of creature, but, generally, bites and stings will be accompanied by redness and itching, tingling or burning at the site of the injury, and often a welt on the skin at the site.

Treatment for insect bites and stings follows these steps:

1. Remove the stinger if still present by scraping the edge of a credit card or other stiff, straight-edged object across the stinger. Do not use tweezers; these may squeeze the venom sac and increase the amount of venom released.
2. Wash the site thoroughly with soap and water.
3. Place ice (wrapped in a washcloth) on the site of the sting for 10 minutes and then off for 10 minutes. Repeat this process.

You may help the victim take his or her own allergy medicine (Benadryl, etc.), but you may NOT dispense medications.

BITES AND STINGS AND ALLERGIC REACTIONS

The greatest concern with any insect bite or sting is a severe allergic reaction, or anaphylaxis. Anaphylaxis occurs when an allergic reaction becomes so severe that the airway is compromised. If you suspect anaphylaxis:

1. Check airway and breathing.
2. Calm the individual.
3. Remove constrictive clothing and jewelry as the body often swells in response to the allergen.
4. If possible, find and help administer a victim's Epi-pen. Many severe allergy sufferers carry one at all times.
 - a. DO NOT administer medicine aside from the Epi-pen. This includes pain relievers, allergy medicine, etc.
5. Watch for signs of shock and treat appropriately.

UNIT SUMMARY

- Head-to-toe assessments should be verbal and hands-on. Always conduct head-to-toe assessments in the same way — beginning with the head and moving toward the feet. If injuries to the head, neck, or spine are suspected, the main objective is to not cause additional injury. Use in-line stabilization and a backboard if the victim must be moved.
- Burns are classified as superficial, partial thickness, or full thickness depending on severity and the depth of skin layers involved. Treatment for burns involves removing the source of the burn, cooling the burn, and covering it. For full thickness burns, always treat for shock.
- The main first aid treatment for wounds consists of:
 - Controlling bleeding
 - Cleaning
 - Dressing and bandaging

In the absence of active bleeding, dressings must be removed and the wound checked for infection at least every 4 to 6 hours. If there is active bleeding, a new dressing should be placed over the existing dressing.

- Fractures, dislocations, sprains, and strains may have similar signs. Treat all suspected fractures, sprains, and strains by immobilizing the affected area using a splint.
- The key to treatment of cold-related injuries such as hypothermia and frostbite is to warm the victim slowly.
- Anaphylaxis is the most critical concern when an insect bite is suspected. Know how to use an Epi-pen and make sure to monitor the victim's airway until professional help arrives.

UNIT SUMMARY (CONTINUED)

- The main first aid treatment for wounds consists of:
 - Controlling bleeding
 - Cleaning
 - Dressing and bandaging

In the absence of active bleeding, dressings must be removed and the wound checked for infection at least every 4 to 6 hours. If there is active bleeding, a new dressing should be placed over the existing dressing.

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- The key to treatment of cold-related injuries such as hypothermia and frostbite is to warm the victim slowly.
- Anaphylaxis is the most critical concern when an insect bite is suspected. Know how to use an Epi-pen and make sure to monitor the victim's airway until professional help arrives.

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