HLTAID014

Provide Advanced First Aid

RTO: 31124 / 2022

Post HLTAID011 Gap Training

Standards & Regulatory Requirements

Who decides the standards and regulatory requirements?

- Australian Resuscitation Council
- Relevant State and Territory Regulation

Duty of Care

All employees have a duty to take all reasonable care in all the things that you do at work or when providing first aid.

Duty of care is based on and informed by three (3)

sets of standards:

1. Community Standards
2. Professional Standards
3. Agency Standards

Duty of Care – Legal requirements

Whilst at work you will need to consider your duty of care, ask yourself the following questions:

- ✓ "Am I in a situation where the person is relying on me to be careful? "
- ✓ "Is it reasonable to believe that this person, or other people, could suffer harm or injury if I am not careful? "
- ✓ "Have I done everything that any reasonable person would/could do in this situation? "
- ✓ "Am I complying with all laws, regulations and standards that govern this situation and require exercise of a duty of care? "

Legal Responsibilities

- Be aware of the rights of the casualty.
- Provide first aid care that is respectful, culturally aware and sensitive.
- 4 legal considerations an advance first aider should be aware of:
    1. Consent
    2. Duty of care
    3. Negligence
    4. Recording /Reporting.

Negligence

Negligence is a failure to take reasonable care to avoid causing injury or loss to another person.

There are four (4) steps in proving negligence:

1. Duty of Care
2. Standard of care
3. Breach of duty
4. Damage

Duty to Act

- The duty to act requires that an Occupational First Aider must respond to the aid of an injured person.
- You have a duty of care to provide help until further medical assistance arrives.

The Standard of Care

One should have the knowledge about, what they are doing, laws, standards, policies, and guidelines that provide the basis of practice.

Examples:

- Basic infection control guidelines
- Protocols
- State regulations
- State laws may also define testing standards.

Australian standards and regulatory requirements

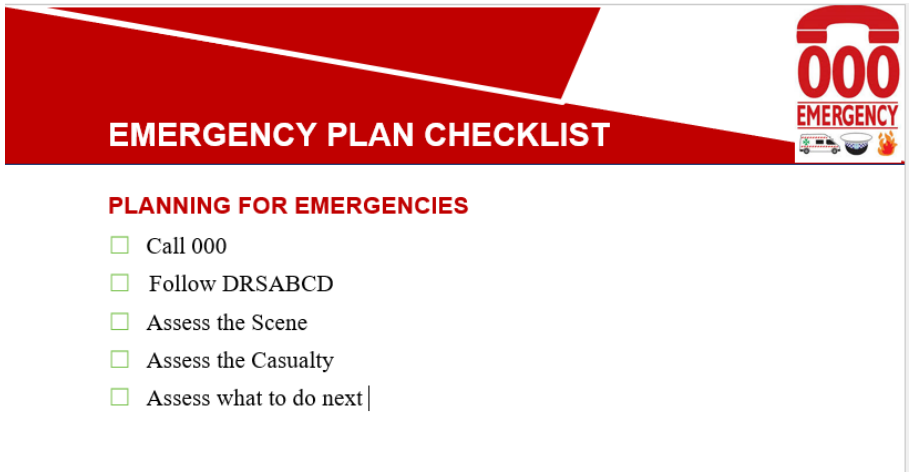
- For further information concerning Australian Standards that are relevant to resuscitation and the policy statements can be found at The Australian Resuscitation Councils website at www.resus.org.au

AUSTRALIAN RESUSCITATION COUNCIL

Emergency Plan / Strategy

Emergency plans help deal with emergency situations & help us to:

- Remain calm
- Keep you safe
- Act in a structured approach
- Focus on the important sequences
- Effectively treat the casualty.



Develop Emergency Plan

Assess the scene:

- Hazard Identification
- Confined space issues
- Infection Control
- Risk Assessment
- Standard Operating Procedures (SOPS)
- Logistics of the scene and situation control
- Deploy resources
- Legal Responsibilities.

Assess the casualty:

- D.R.S. A.B.C.D action plan and vital signs.

Assess what to do next:

- Get assistance, provide treatment, undertake debrief and self evaluation after the event.

Emergency Management Plan

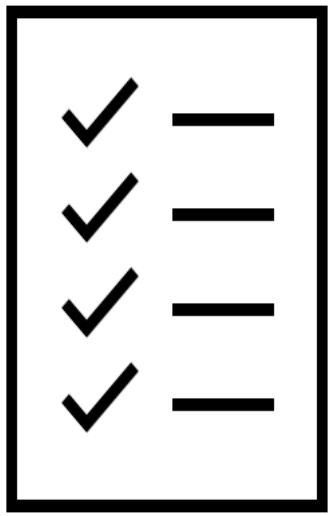
Steps to follow:

- ✓Plans must be in line with established first aid principles, policies & procedures, ARC Guidelines the law & industry requirements.
- ✓Respond in line with own level of skills and knowledge, available equipment, the condition of the patient, & special requirements of certain conditions.
- ✓Make
- ✓ prompt & appropriate decisions relating to managing an incident .
- ✓Monitor casualty's condition & undertake ongoing first aid procedures as required.
- ✓Use available resources to manage pain.
- ✓Administer medication under direct instruction from an authorised health worker and in accordance to the law.
- ✓Document condition of casualty over time to assist in on-going management.

Assess the Scene

Prioritise actions to be taken during emergencies

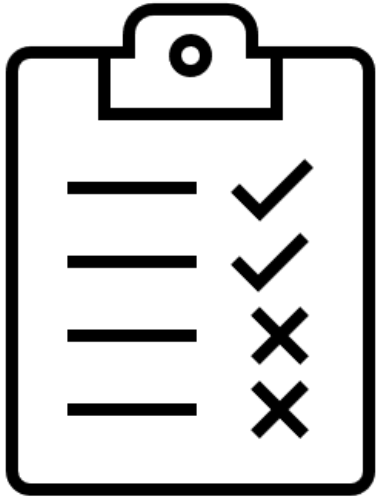
- Level of response;
- Who is to be contacted;
- Sequence of any evacuation;
- Allocation of personnel; and
- Actions to be taken to contain any hazards.



Assess the Scene

Prioritise actions to be taken during emergencies:

- Evaluation the scene.
- Ensure safety of yourself, others & casualty.
- Look for common indicators such as noises, sights, smells, symptoms, and behavior to identify hazards & risks.
- Hazard & risk assessment.
- Control or minimise hazards & risks.



Hazards

What is a Hazard?

- Anything with the potential to cause harm to life, health or property, the environment, or any combination of these.

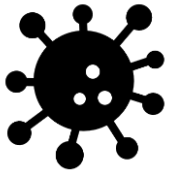
Hazards should be identified, minimised and if possible removed.

Classes of Hazards

1. Physical	▪ Incorrect manual handling ▪ Noise, light, UV radiation, air quality, poor ventilation, room temperature, too hot/cold ▪ Cause physical injury, such as hearing damage, eye damage or damage to cells, blood vessels or the skin (e.g. Noise, radiation, light, heat and cold).
2. Chemical	▪ Poisons, dusts, hazardous substances, chemicals in marker pens, whiteboard cleaner ▪ Poison people, or trigger allergic reactions, cause cancer and genetic changes, and interfere with the normal organic functions of body cells (e.g. Toxic gases, poisons, dusts and fumes, corrosive liquids).
3. Biological	▪ Viruses, plants, parasites, 'flu' ▪ Cause disease when germs and other plant or animal material gain entry and interfere with the body's normal functions (e.g. infected blood or other body fluids, bacteria and viruses).
4. Mechanical/ Electrical	▪ Slips, trips & falls, plant & equipment, electrical cords, hot water urns, inadequate seating, objects in walkways ▪ Plant and equipment and electricity that can cause slips, trips and falls, injuries when people knock against objects or objects fall on them from a height, sprains and strains, electrical burns and cardiac arrest.
5. Psychological	▪ Stress, boring/repetitive work, shift work, training environment stressful for some ▪ Workplace stressors arising from a variety of sources that can affect people's mental and social health, resulting in stress symptoms (e.g. high blood pressure, nervous disorders, and stomach ulcers).

Possible First Aid Hazards

- HIV & other Infectious Diseases
- Toxic Chemicals
- Biological Hazards & Infection
- Confined Spaces.

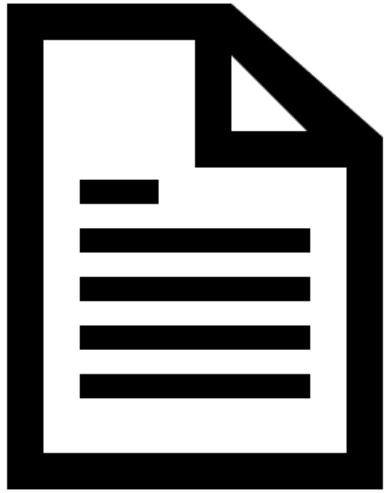


Material Safety Data MSDS's

Different chemicals can cause different health problems.

MSDS Sheets give advice on:

- ingredients of a product
- health effects of the product
- first aid instructions
- precautions for use
- safe handling and storage information.



Confined Space Issues

Often a person who is working in a confined space can require first aid.

- Regardless of severity do not enter unless you are trained in confined space entry.
- Usually low oxygen in confined spaces.

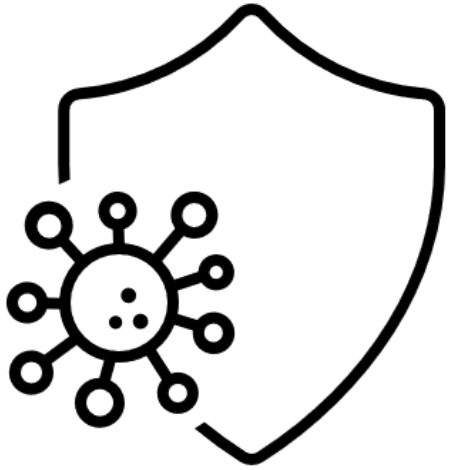
Infection Control

The purpose of infection control guidelines is to assist first aiders to develop practices that prevent or minimise the spread of biological hazards such as infection, illness and disease.

An Infection Control Guideline should be based on the adoption of standard precautions.

Standard Precautions: the assumption that all blood and body fluids are potentially infectious, and could transmit disease.

Standard precautions should be used as a first-line approach to preventing infection and should be adopted for contact with all blood and body fluids.



Successful Infection Control

Five (5) elements:

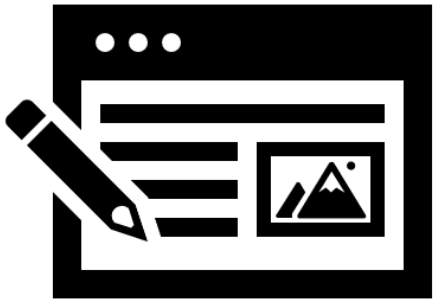
1. Basic strategies: PPE, hand washing etc.
2. Adopting quality management practices.
3. Developing effective work practices.
4. Managing specific infectious agents.
5. Identifying infection control strategies in specialised health care settings.

Risks

What is a Risk?

The consequences and the likelihood of an injury or illness occurring from exposure to the hazard.

RISK ASSESSMENT



- Establish the priorities
- Communicate effectively
- Risk control/Minimisation
- Manage bystanders
- Minimisation according to OHS requirements
- Safe treatment areas.

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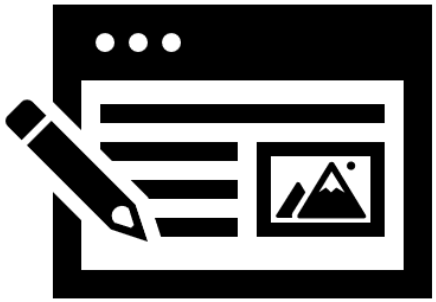
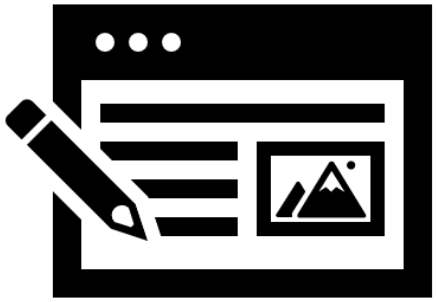
To determine the level of risk consider the following:

- The number of risk factors
- The exposure
- The severity
- Human differences
- Environmental factors.



Principles of Risk Management

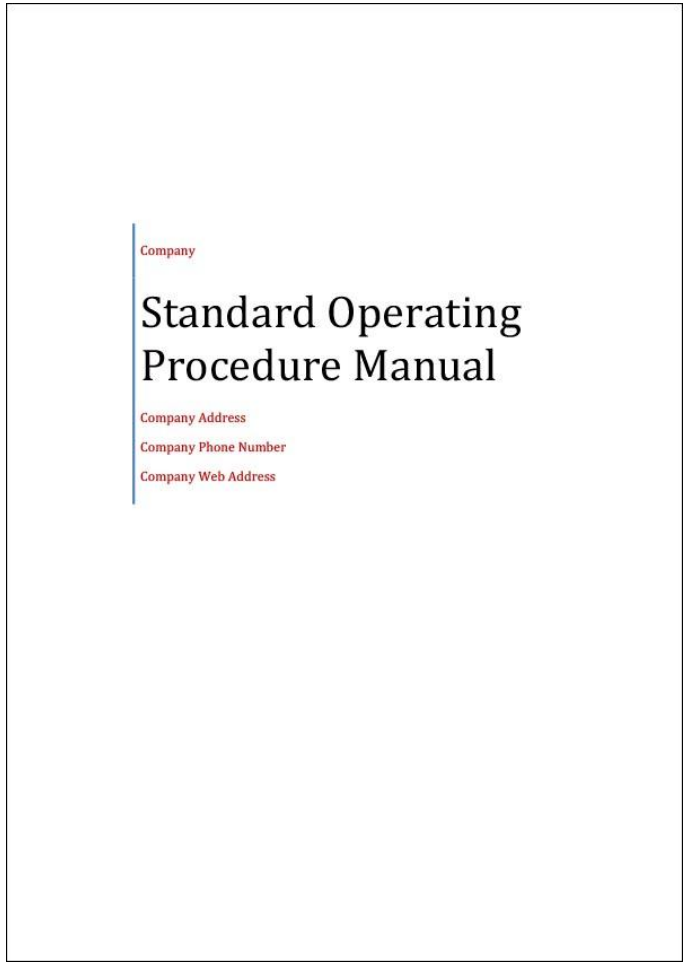
- Identify hazards
- Assess the risks involved
- Consult and report
- Control the hazard
- Review to identify the change or improvement.



STANDARD OPERATING PROCEDURES (SOPS)

SOP's detail the treatments and procedures for emergencies in the workplace and can be found on:

- Notice boards
- Staff intranets
- Web pages



Logistics of the scene and situation control

Emergency Plan or Strategy

- Assess scene swiftly & appropriately then evaluate what to do.
- Consider conditions such as:

- Weather conditions
- Potential dangers
- Vehicles
- Chemicals
- Persons injured or trapped
- Crowds
- Traffic conditions
- Further danger

Deploy Resources

Develop your action plan by taking into account the issues at hand. Then deploy your first aid resources to the casualties that require rescuing or treatments in order of priority, in a safe manner.

- Traffic control
- Park vehicle to protect scene
- Deploy resources safely
- Improvise where necessary.

Improvising in First Aid

The need to improvise and use whatever resources are available may be required in some cases for first aid. You made need to find alternatives for items such as:

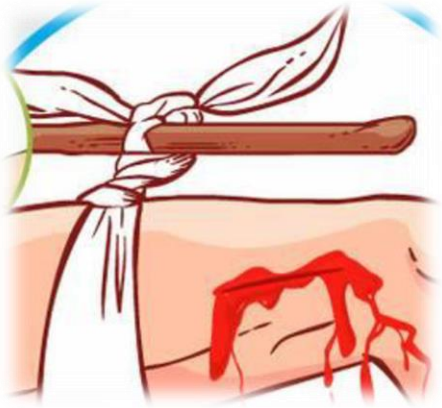
- Dressings
- Bandages
- Splints and slings
- Stretchers and transporting.

Ie: socks, t-shirts, cardboard, newspaper, sticks

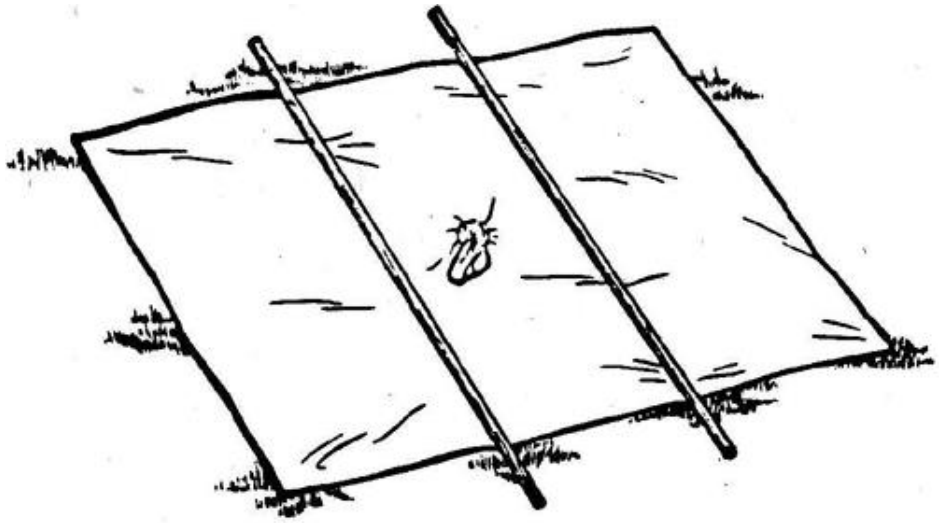
Real Deal Tourniquet bandage

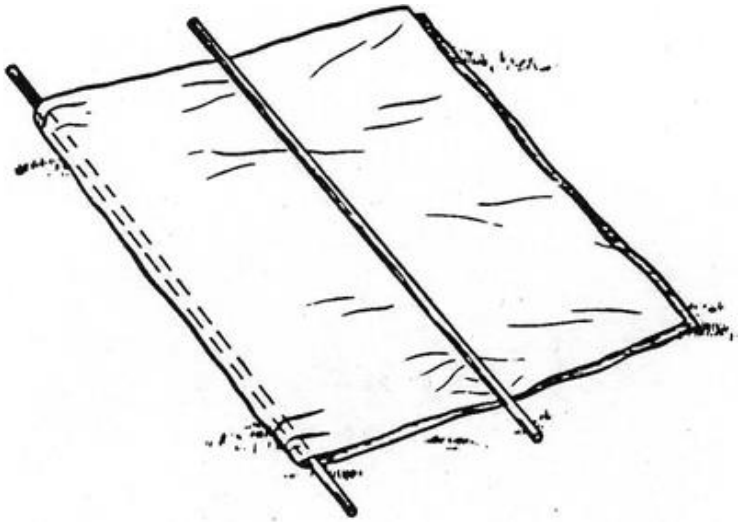
Improvised Tourniquet

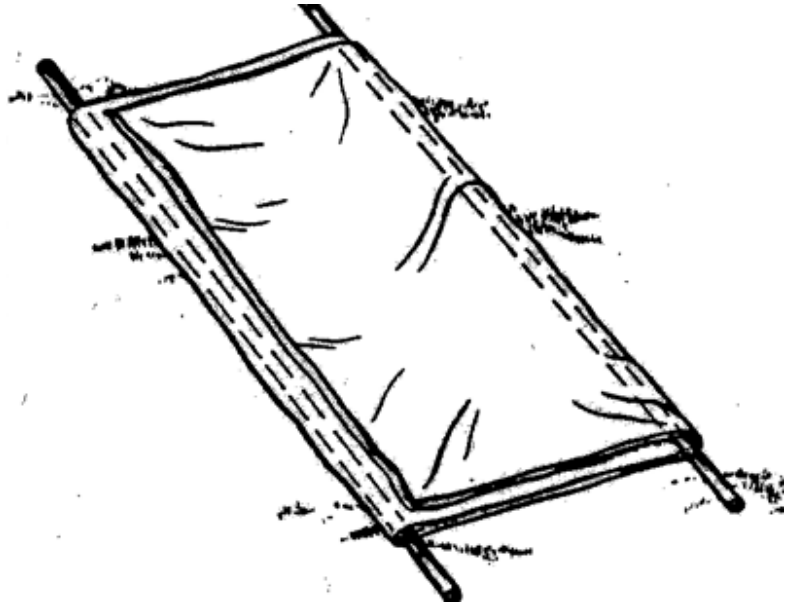
Using Stick & Bandage



Improvised Litter With Poncho and Poles







Free edges of poncho are folded over the second pole.

Assessment of the Casualty

- Have a system to evaluate condition or illness.
- Provide protection.

2 stages of casualty assessment:

First stage - is to ask the question "Are they alive?" and use

D.R.S.A.B.C.D

Second stage - "What is wrong with the conscious casualty?," gain consent to examination of his/her injuries.

- Listen carefully to the casualty's responses.
- Observation & questioning will depend upon casualty status.
- Be aware of your own skills and limitations and do not go beyond them.

Reassure casualty and place them in a suitable position

- ✓ Calmly provide information & reassurance.
- ✓ Adopt an appropriate communication style.
- ✓ Show leadership.
- ✓ Determine & explain the nature of the injury/condition and procedures.
- ✓ Seek consent.
- ✓ Competent adults are legally entitled to refuse treatment.
- ✓ Carers, parents or guardians can refuse treatment but only if it is in the 'best interests' of their charge.
- ✓ Respond in a culturally aware, sensitive and respectful manner .

Reassure casualty and place them in a suitable position

Initial Examination

- The safest method can be done without touch.
- This is for the initial examination.
- Using physical touch to 'feel' the body of an injured or ill person is considered inappropriate at this stage, especially if the person is of the opposite sex or a minor.
- If injuries are found, then further evaluation of the necessary treatment can be considered.

Vital Signs & History

Consider potential impacts of causes of disease, and factors responsible for abnormal readings.

- External factors
- Internal factors
- Other factors.

- The First Aid Responder should be considering all vitals as part of their observations with or without additional equipment
- Breathing will be an indicator of body stress and body physiology
- Temperature may be evident by touch or colour observation
- Skin sensation in touch relative to cold or hot by touch
- Blood pressure without measurement may again be evident by flushed colour and other possible symptoms
- Observation of eyes or inner mouth for pale colour may be necessary when assisting a dark-skinned casualty

Knowing how to check vital signs and conscious state, helps in planning the required first aid equipment you may need.

VITAL SIGNS

Pulse

Normal pulse ranges are:

Adult 60 to 100 Beats per minute

Child 90 to 130 Beats per minute

Infant 120 to 160 Beats per minute

Conscious State

The conscious state may change to

- Conscious and Alert
- Uncooperative and Aggressive
- Drowsy or Unconscious

It is important to monitor any changes.

The best example of a person most to suffer changes to conscious state is a person with a head injury

Skin State

- Pale skin and pale lining of the inside of the lips could indicate low blood pressure
- Blue Appearances, could indicate a lack of oxygen
- Red skin could indicate infection

Temperature

Cool and moist to touch may be an indicator of loss of circulating fluid. i.e. fainting or blood loss

Warm to touch may be an indicator of a temperature. i.e. fever

Normal temperature is approx. 36.5 °C - 37°C

37.5 °C and 38 °C mildly elevated

38.5 °C – 39 °C significantly raised

39 °C or higher is regarded as Very high temperature

Agonal Gasps

Agonal gasps are common during cardiac arrest, they are not normal breathing. Agonal gasps should be recognised as a sign of cardiac arrest

Blood Pressure

A BP machine is most commonly not available to a first Aider in order to check a casualties Blood Pressure. The best indicator in this instance is the casualties skin colour (perfusion)

i.e. Pale skin and pale lining of the inside of the lips could indicate low blood pressure

Breathing

Watch for the rise & fall off the chest, feel for the breath on the back of your hand. For infants, watch for the rise & fall of the stomach. Normal Breathing Rates. Adult 16-20 Breaths per min; (1-5yrs) 25-40 breaths per min; Child (6-12yrs) 16-25 Breaths per min; Infants (1mth-12mths) 25-40 Breaths per min

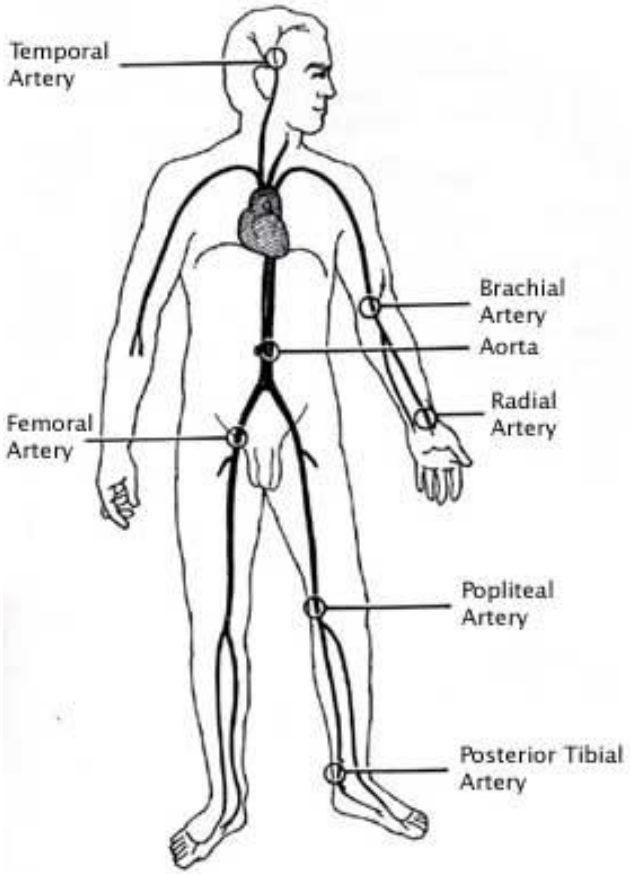
Note- if the breathing is regular & the depth of the breath ; if there are any noises such as crackling or wheezing.

Health history

- Presenting problems
- Actual or potential problems associated with activities of daily living
- Casualty concerns and beliefs
- Past health history

- Medication
- Allergies
- Family circumstances
- Environmental health
- Basic dietary information.

Arterial Pulses can be checked at various locations



FEELING THE PULSES
Figure 3A

Reference:
http://www.redlightwarningsignals.com/dochollywoodproject/chapter3.htm

Assess what to do Next!

- Evaluate options for transporting casualty or waiting for medical assistance in relation to environmental issues, transport availability and casualty's condition.
- Decide on how to implement your management plan based on the assessment.
- Analyse this information to determine the course of treatment to be given.
- Make the casualty comfortable in relevance to their condition.
- Only move the casualty if their condition requires and/or allows you to do so.

- After all these conditions have been considered, identify requirements for liaison with emergency agencies.

- How you notify and liaise with emergency authorities will depend on the type of incident or emergency, legal requirements, the emergency plan and access to communications.

Key requirements:

- capability and capacity of the first responder agencies;
- response time for arrival at site;
- on-site resources to support response;
- communication of worksite emergency response plan to emergency agencies;
- how you can help.

Communication

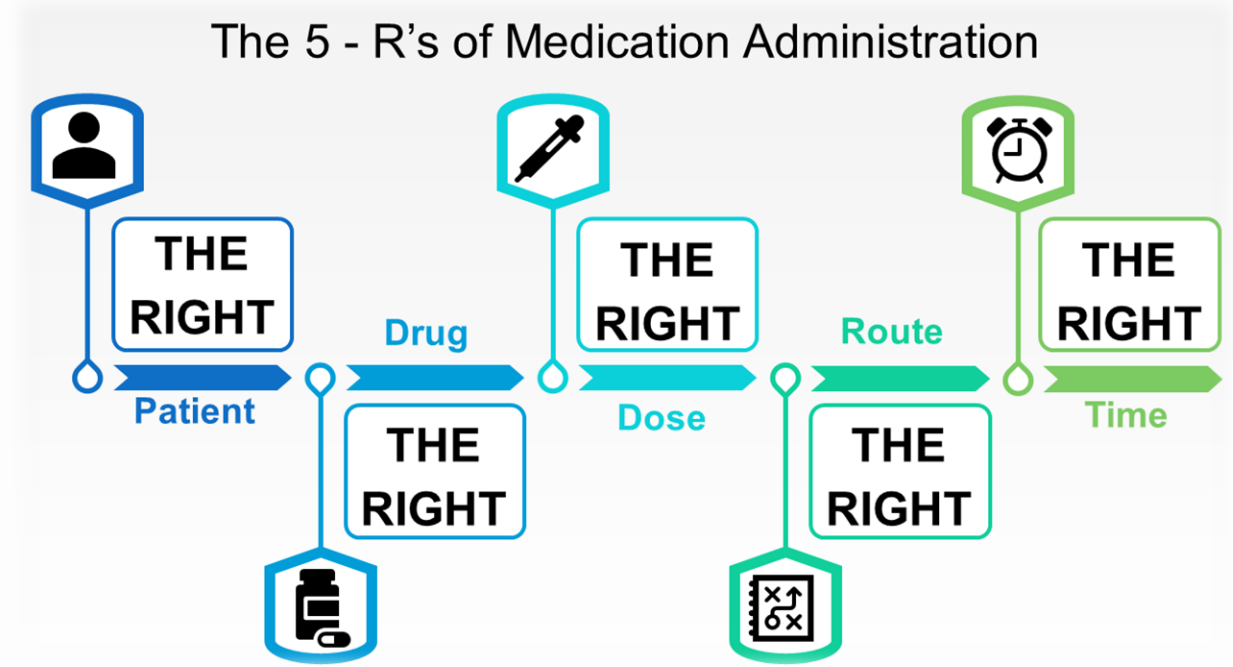
It is important to communicate with bystanders, people assisting with first aid, emergency staff and the casualty.

Communicate first aid information with other providers/carers as appropriate to meet their needs and in accordance with legislative requirements.

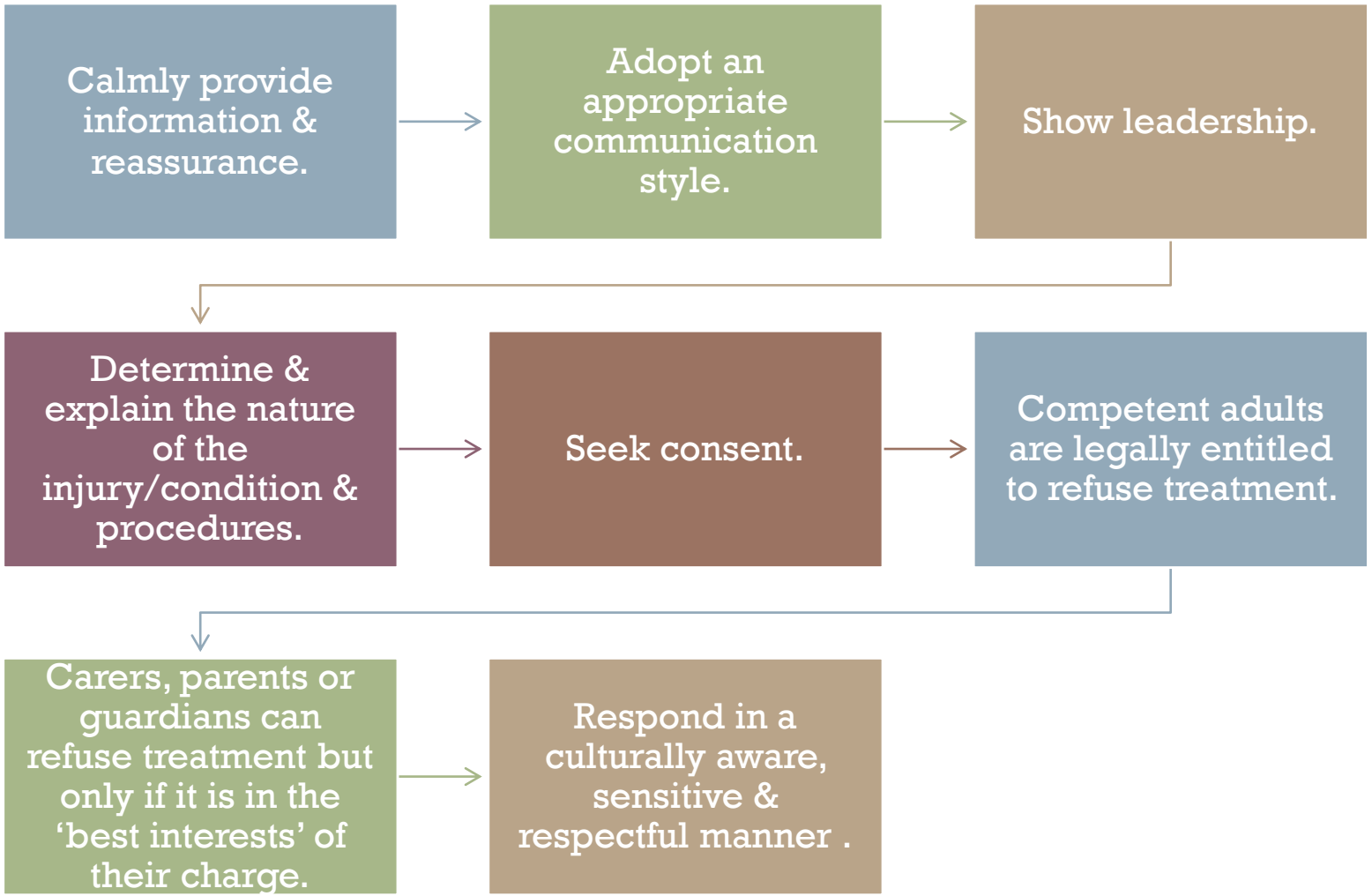
Ongoing Care / Continuing Treatment

- Following your initial first aid treatment, there may be a time period before the ambulance arrives, especially in remote locations.

- You may be required to assist with the administration of the casualty's medications such as asthma medications, as well as ensuring that you provide vital reassurance to the casualty at all times.



Ongoing care



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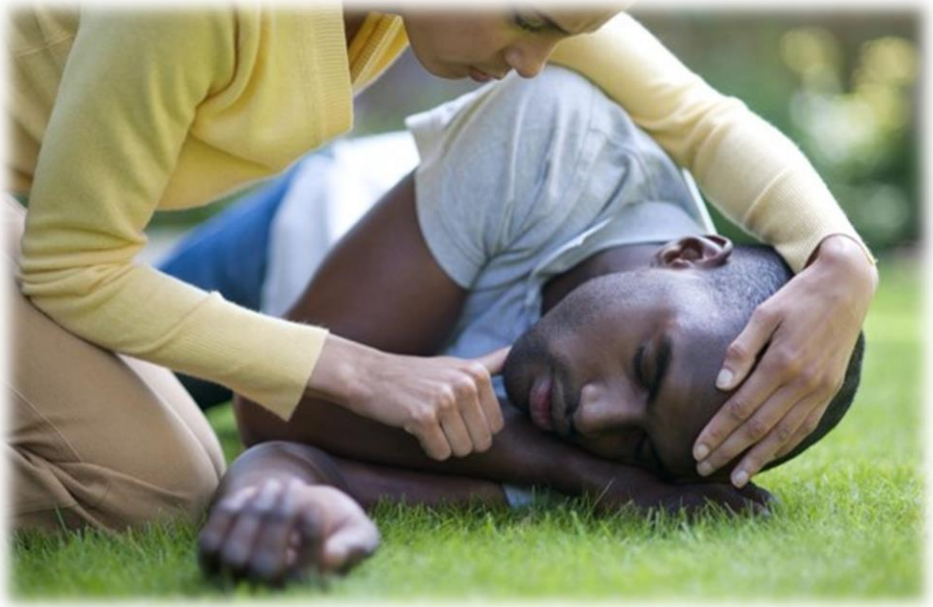
Secondary Survey

- The secondary survey is a systematic check of the victim from the head to the toes to rule out any injuries or abnormalities that are not immediately obvious.
- The First Aider should begin at the head & work downwards.
- When conscious this can be done by asking questions.
- Examine all unconscious casualties on their side in a recovery position in order to protect their airway.



Triage

It may be required that you undertake triage.

Triage:

- Is the sorting of casualties by the severity of injury or illness.
- Identifying casualties with: obstructed airway; excessive bleeding; or shock.
- Applies to large numbers of casualties
- A tagging system
- Begins at the incident site.

Following your initial First Aid treatment, there may be a time period before the ambulance arrives, especially in remote locations.

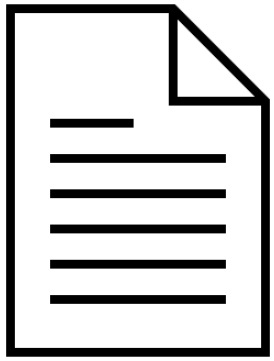
You may be required to assist with the administration of the casualty's medications such as asthma medications, as well as ensuring that you provide vital reassurance to the casualty at all times.

Details of the incident

Documentation

Advanced first aiders:

- Must prepare a written report after an incident stating only state facts, not comments.
- Should have literacy and numeracy skills that enable them to read, interpret and apply guidelines and treatment protocols.



Skills and limitations

- Be aware of your own skills and limitations
- Evaluating your own performance can provide you with an opportunity for self improvement
- Speaking with the paramedics who attended the incident may be beneficial to:
  - help you gain additional skills and knowledge;
  - may help you cope.

Know YOUR Skills & Limits

Evaluate OWN Performance

Debrief

Critical Incident Stress

People involved in first aid or an emergency may experience emotional or psychological distress, critical incident stress and post-traumatic stress after the event.

- Must be aware of own needs and responses.
- Symptoms can develop into a chronic illness.
- Speak to counsellors & partake in personal debriefing.
- Debriefing is a method used to try and resolve stressors experienced.

Debriefing

A Debrief is:

- A structured 'conference' in which participants can identify experiences and problems from an operation which will assist in handling similar situations in the future; and
- An opportunity for participants to express and share some of the personal experiences encountered during what is usually a hectic and sometimes stressful period.

A Debrief is not:

- A 'witch-hunt' of particular groups or individuals. If there are any lessons to be learned, it is to discover 'what went wrong' and any improvements that can be made, rather than 'who went wrong'.

To help focus your observations and information collection you could consider these questions and factors:

Were the main priorities for the incident met, including:

- checking and accounting for people;
- appropriate timelines;
- adequate provisions.

Were the needs of emergency response agencies met, including provision of information on arrival and response times?

Were there any circumstances that inhibited the treatment of the casualty, the function of any emergency equipment, getting medical assistance and or evacuating the casualty?

Were hazards identified and management effectively?

Does the evacuation process need to be modified?

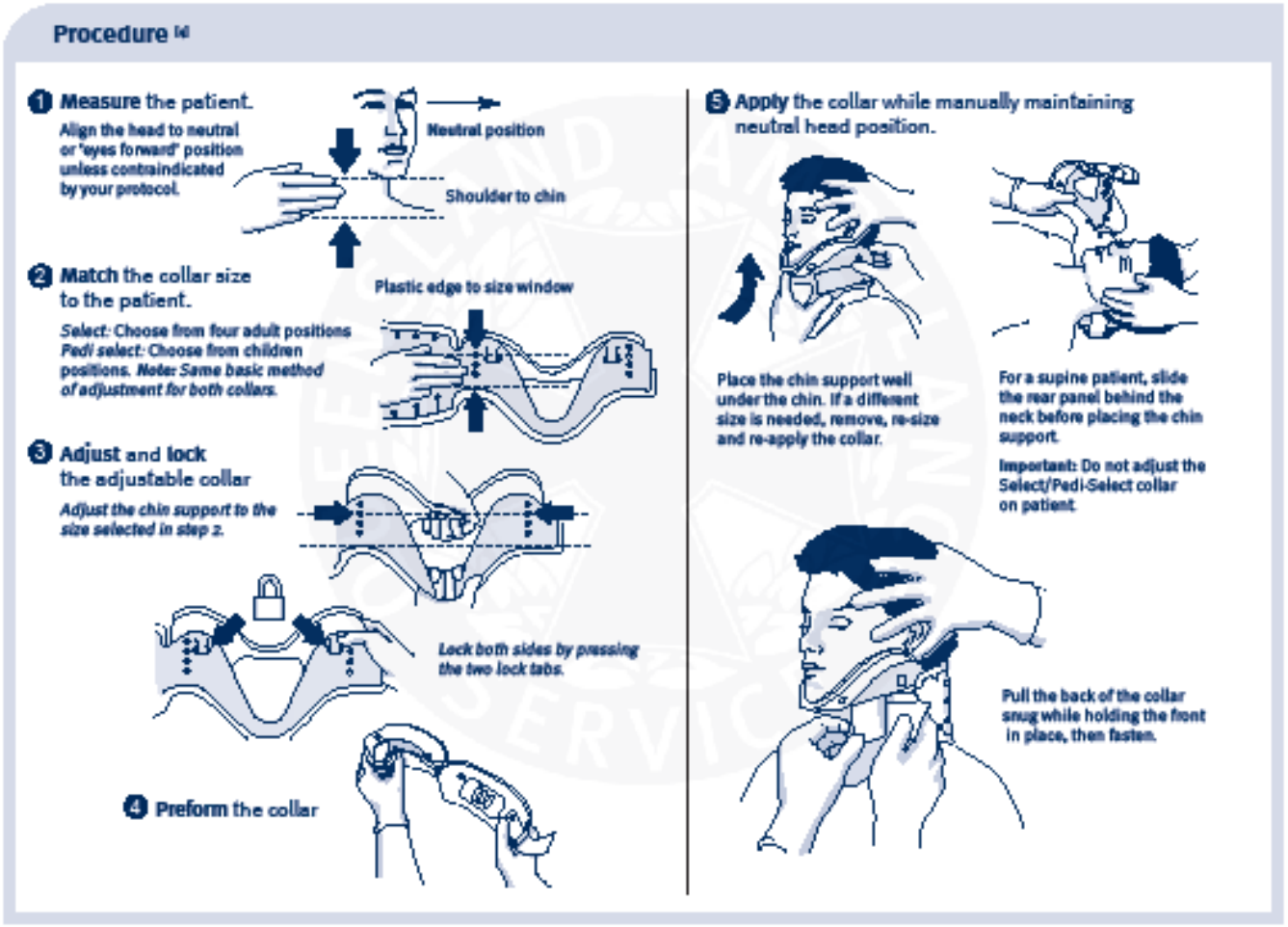
Taking Notes

- Notes should be taken as soon as possible.
- A checklist or similar method will assist in recording observations.
- These notes will assist with the debriefing process.
- These contributions will contribute to a more structured review of events and support a formal review for future recommendations.
- You then need to formulate and review contingency planning to identify and select improved or alternative management principles and procedures.

Additional Resources sometimes used by Advanced First Aiders

- Cervical collars
- Vacuum Splints
- Air Splints
- Hard Board Extrication Stretchers
- Scoop Stretchers
- Haemostatic dressings
- Tourniquet bandages

Cervical Collars Suspicion of a cervical spine or spinal cord injury



Application of Stifneck® cervical collar – Page 2 of 2

Vacuum Splints

Clinical practice procedures

Use of vacuum splints

Version 1.0 – September 2011

Authorisation to practice

Use of vacuum splints

Vacuum splints are used to provide immobilisation and support to extremity injuries.

Indications

- Suspected fractures and dislocations of arms, legs, or joints

Contraindications

- Nil in this setting

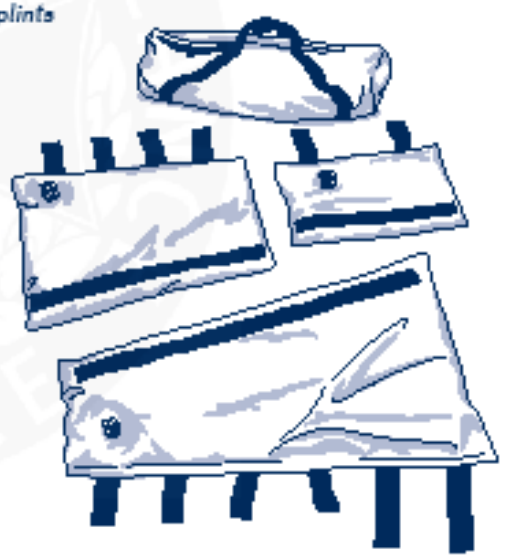
Complications

- Vacuum splints may require further extraction of air to maintain rigidity during aeromedical transport.

Types of vacuum splints

- Two types of vacuum splint remain in use within QAS. Whether the valve remains open, or is required to be closed for air extraction, changes depending on the type. Additionally, it should be noted that the extraction pumps are not interchangeable between splint types.
- The type of splint and matching pump must be examined as part of each pre-shift equipment check.
- If the pump fails, the wall suctioning unit and tubing in the vehicle can be used to help extricate air from the vacuum splint.

Vacuum splints



Procedure – Vacuum Splints

- Explain procedure to the patient and gain consent.
- Open air valve fully to ensure the splint is flexible.
- Close the valve or leave open, depending on the splint used.
- Place affected limb or body part carefully into the splint, moulding the splint to the contours of the body.
- Secure the Velcro® straps.
- Ensure the valve is in the appropriate position and then connect outlet pipe to the valve.
- Extract air using the pump until the splint becomes rigid.
- Disconnect the outlet pipe.
- Re-adjust Velcro® straps if required.
- Check distal circulation regularly. Applying a pulse oximeter probe to a distal extremity affords a level of continued monitoring.

Additional Info

- In the setting of a suspected pelvic fracture and femur fracture , a full leg vacuum splint takes precedence over a traction splint, as it allows concentrated management of the suspected pelvic fracture with a pelvic binder.
- At times it may be appropriate to reduce and realign fractures prior to splinting, but this must be done with care so as not to open a closed fracture. This should not be attempted by First Aiders other than Paramedics
- A large vacuum splint can be used to manage spinal precautions in small children, employing it in a similar fashion as a vacuum mattress for adults.

Air Splints

- Air splints are inflatable braces made from clear plastic and designed to fit around a damaged area
- Air or vacuum splints conform well to the injured extremity. According to "Sheehy's Emergency Nursing Principles and Practice," excessive pressure from these type splints can compromise circulation. The air splints also stick to the skin and can cause irritation.
- They are a temporary measure of immobilisation prior to transportation of a casualty
- Check circulation and capillary refill as with all splints

Application – Air Split

- Gently fit around the limb, as it is
- Without changing or forcing movement
- Zip together
- Pump in air until firm
- Apply finger pressure and your finger
- should be able to make contact
- With the skin surface
- Release pressure if this requires effort
- Check for circulation
- Organise transportation

Extrication board

Clinical practice procedures — **Use of an extrication board**

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Authorisation to practice

Use of an extrication board

The extrication board is designed to facilitate the extrication of a patient onto an ambulance stretcher. **An extrication board is not to be used during transport.**

Extrication board

Indications

- Extrication of a patient onto the ambulance stretcher

Contraindications

- Maximum load limit for the extrication board is 159 kg. This limit must not be exceeded. [1]

Complications [1]

- Pressure points
- Misalignment of the spine
- Pain and discomfort

Scoop Stretcher

Clinical practice procedures | **Use of a scoop stretcher**

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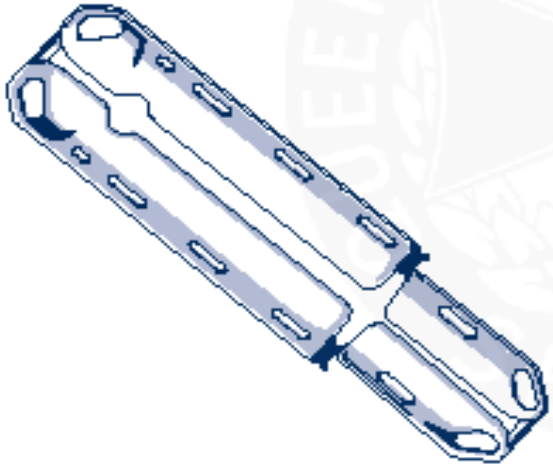
Authorisation to practice

Use of a scoop stretcher

The scoop stretcher is designed to facilitate the movement of a patient, particularly those who cannot be rolled or slid onto an extrication board.

Scoop stretcher



Indications

- Extrication of a patient onto the ambulance stretcher

Contraindications

- Maximum load limit for all scoop stretchers currently approved is 159 kilograms. This limit must not be exceeded.[iv]

Complications

- Exercise caution during application of the scoop to avoid pinching, or pulling the patient's skin, hair, or clothing.[v]

Application - Scoop Stretcher

- The scoop stretcher can be applied without separating, or it can be divided into two basic sections:
- Separate the end couplings by depressing the lock lever button on the inside of the top and bottom frames and pull the halves apart.
- To re-join couplings simply push them together.
- The lock levers need not be depressed.
- To adjust the length, disengage the latch lock pins on both sides by pulling the pins outwards. The foot section can be extended and, when the desired length has been obtained, engage the lock pins on both sides by pushing the pins inwards. The stretcher halves should remain coupled for this process to ensure equal length.
- Push and pull the foot section of the frame to check for positive engagement of the locking pins.

Application - Scoop Stretcher

• If restraints are stored on the scoop they should be removed and reapplied after the patient is on the scoop.

This ensures the restraints are not caught under the stretcher or the patient.

• Position the scoop to one side of the patient and adjust the length as required.

• Place two halves of the scoop either side of the patient and work inwards, under the patient until the end couplings can be engaged.

Additional information

• Ensure the scoop stretcher is maintained as per manufacturer's guidelines. [2]

• The scoop can also be applied by log rolling the patient carefully to one side and placing the stretcher one half at a time. Or it can be applied coupled by log rolling the patient completely onto their side then back onto the intact scoop.

Note: The scoop stretcher is to be removed prior to transport for distances > 10 minutes to hospital. If scoop remains in situ pad head with towel or blanket to provide support. [3]

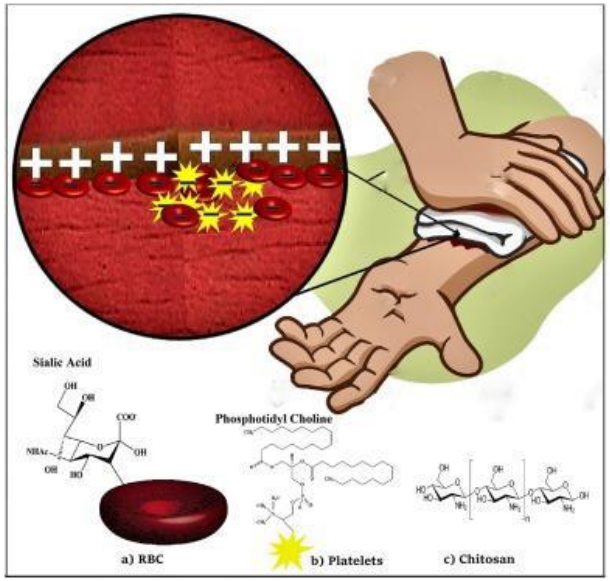
Haemostatic Dressing

Haemostatic dressings are a valuable adjunct in external hemorrhage control when the source of bleeding is a location not amenable to tourniquet placement, such as in junctional regions (i.e: neck, axilla, and groin)

Wound Dressing Selection:
Types and Usage

Gauze Dressings. Gauze dressings are made of woven or non-woven materials and come in a wide variety of shapes and sizes for example:

- Transparent Films.
- **Foams**.
- Hydrocolloids.
- **Alginates**.
- Composites.

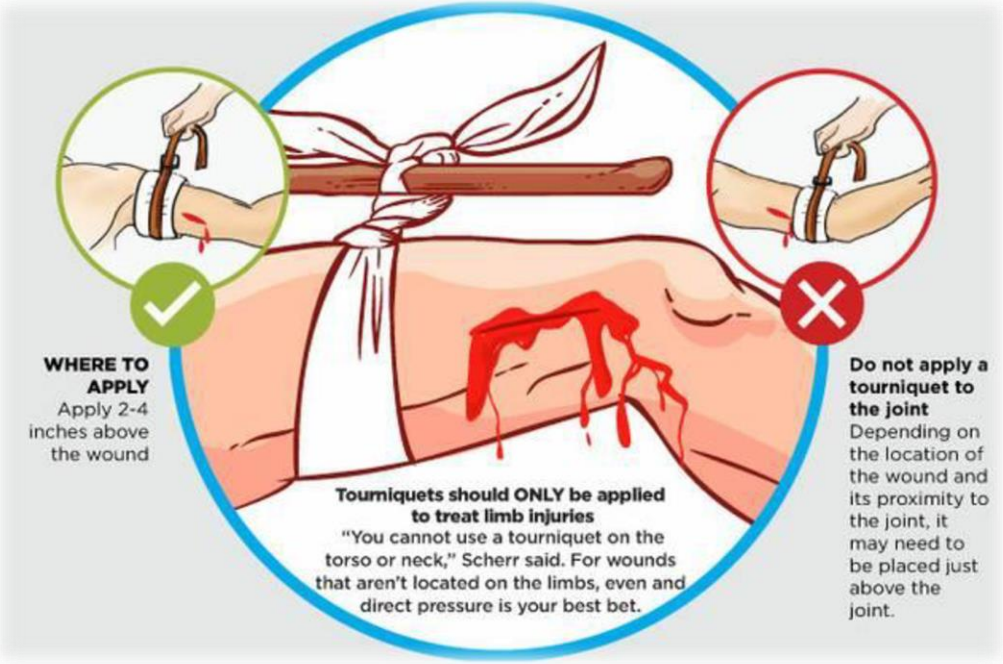


If a gauze packing was put in your wound, it should be removed in **1 to 2 days**.

Tourniquet Bandage

A **tourniquet** is a device that is placed around a bleeding arm or leg. **Tourniquets** work by squeezing large blood vessels. The squeezing helps stop blood loss

Applying a tourniquet too tightly or loosely can pose danger to nearby tissue and increase the odds of irreversible nerve and muscle damage. The tourniquet should provide only as much pressure as needed to halt arterial **blood loss**.



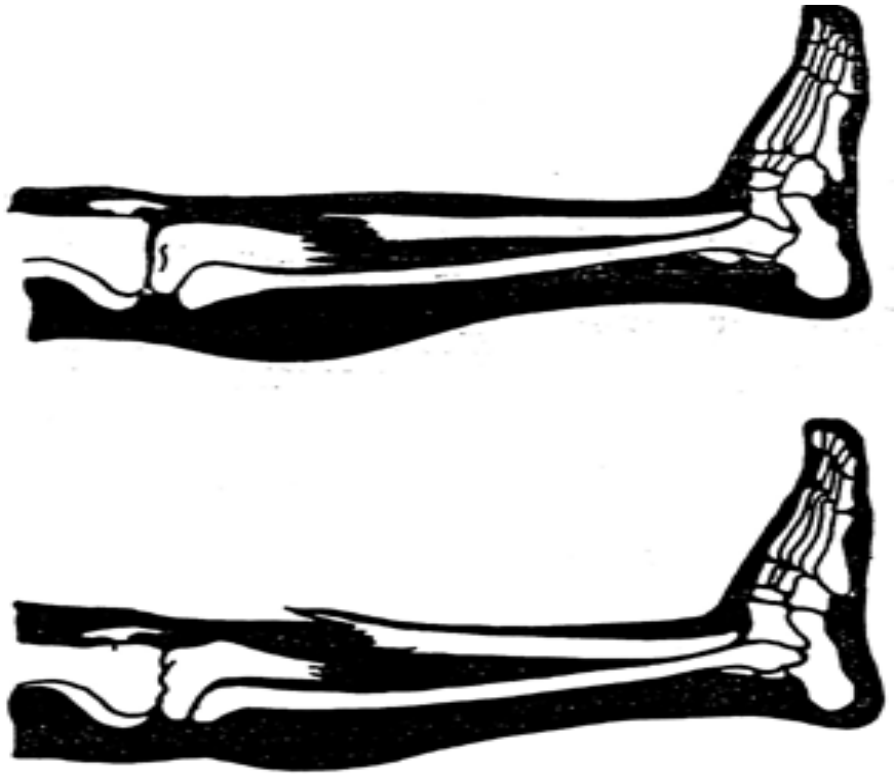
Care of injured

If stranded in a remote area it might take time for help to arrive, or help to be contacted. In some cases, it may be some time before anyone knows that you are missing.

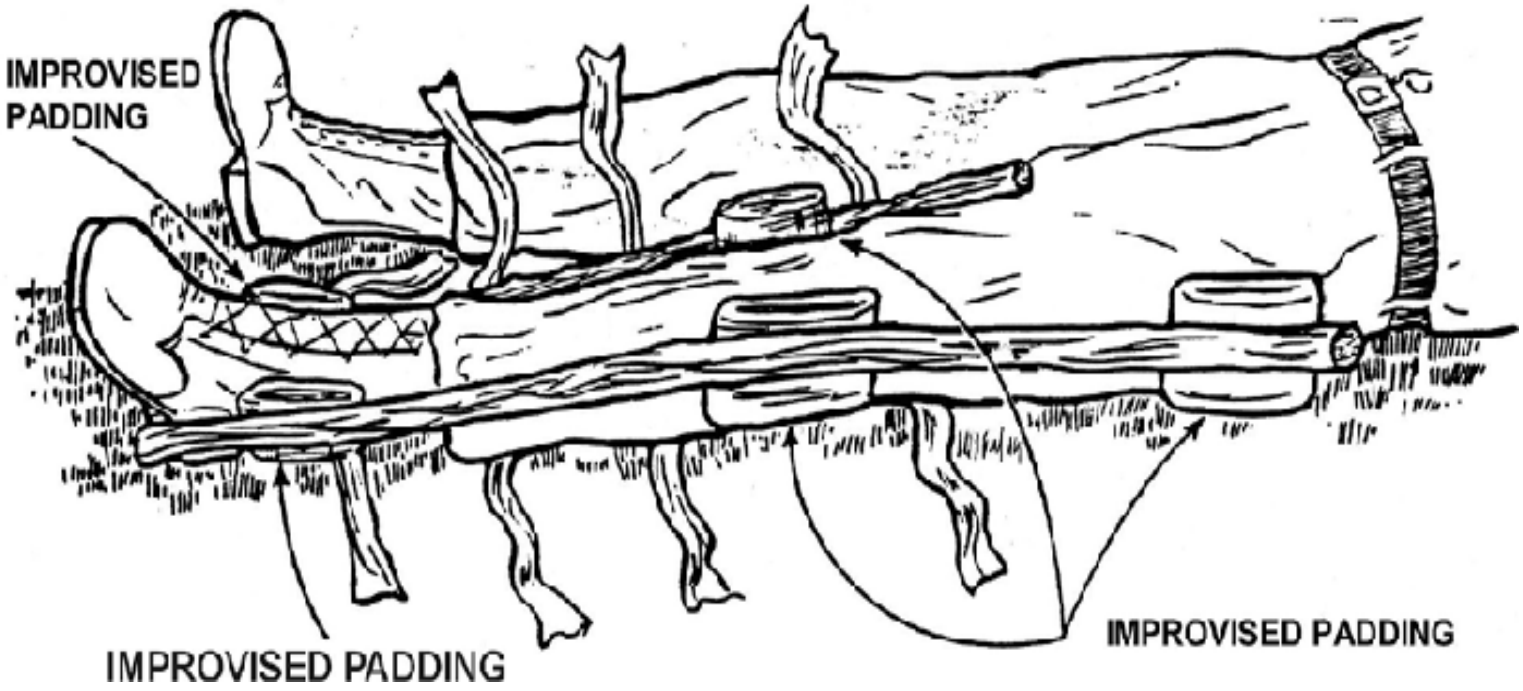
In cases like these there are long term care procedures for casualties' and members of the party who are stranded in a remote area.

Treatment of injured

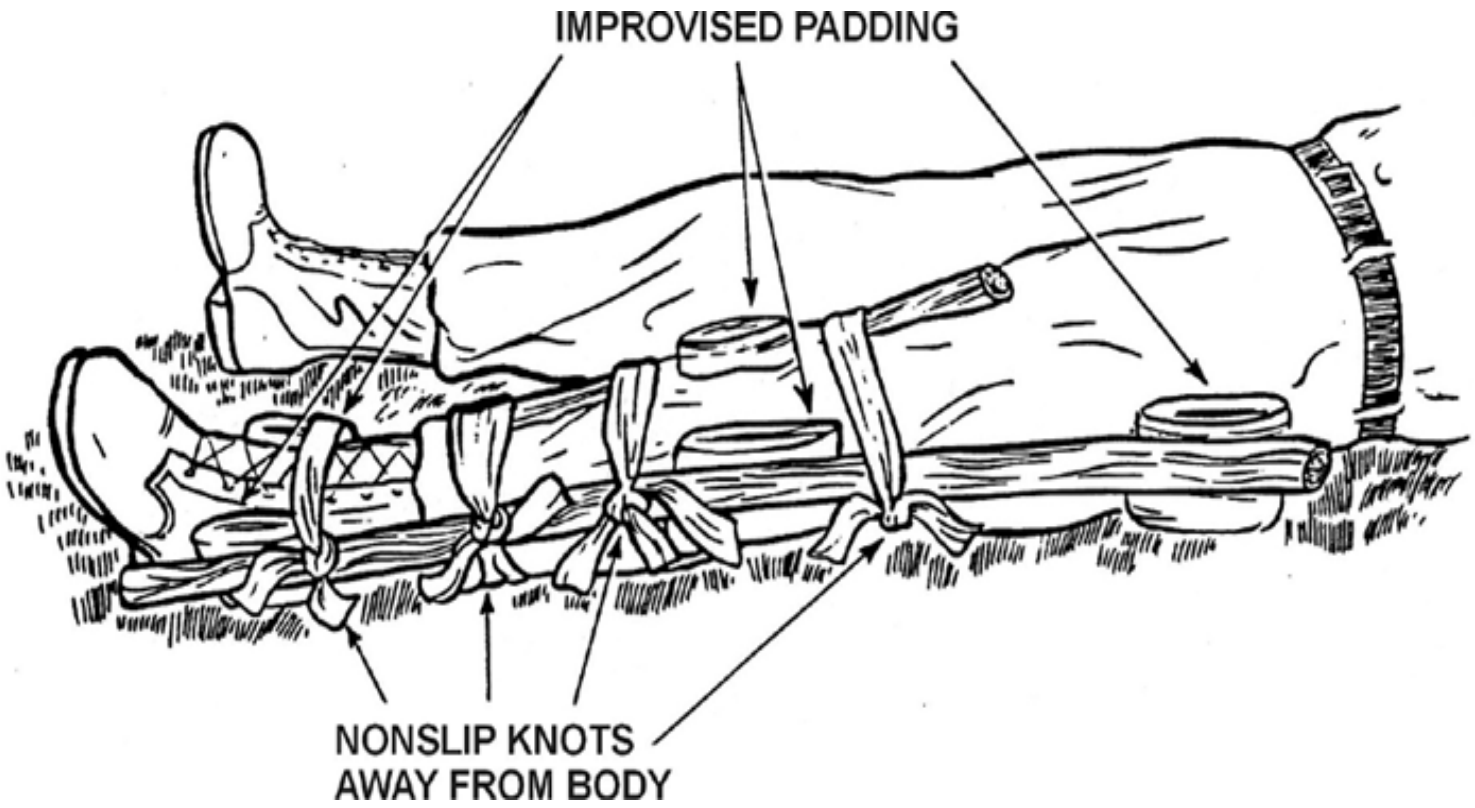
- Apply Standard First Aid Procedures
- FRACTURES- open and closed
- Check for circulation



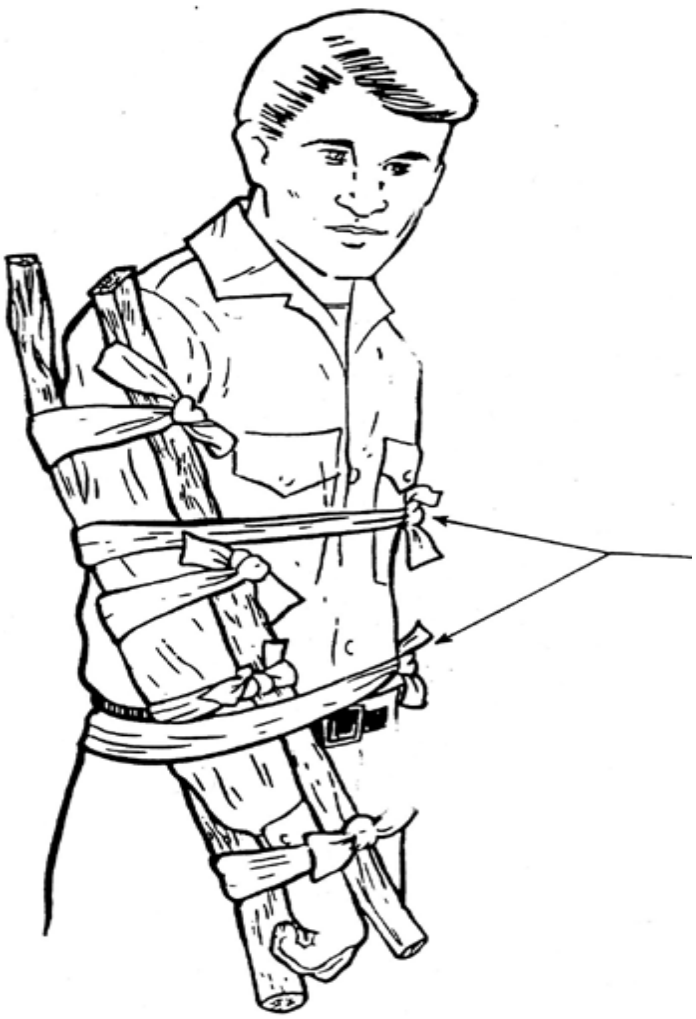
Splints


IMPROVISED
PADDING
IMPROVISED PADDING
IMPROVISED PADDING

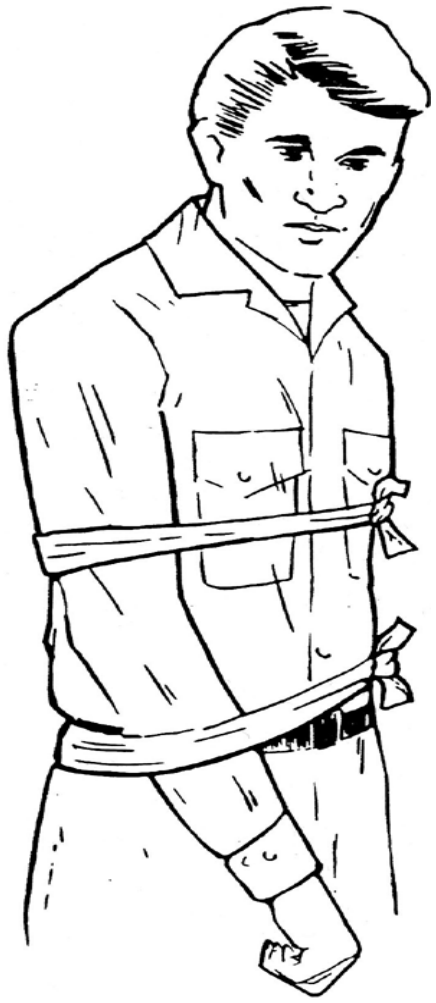
Make sure knots wont slip



Immobilise elbow or arm

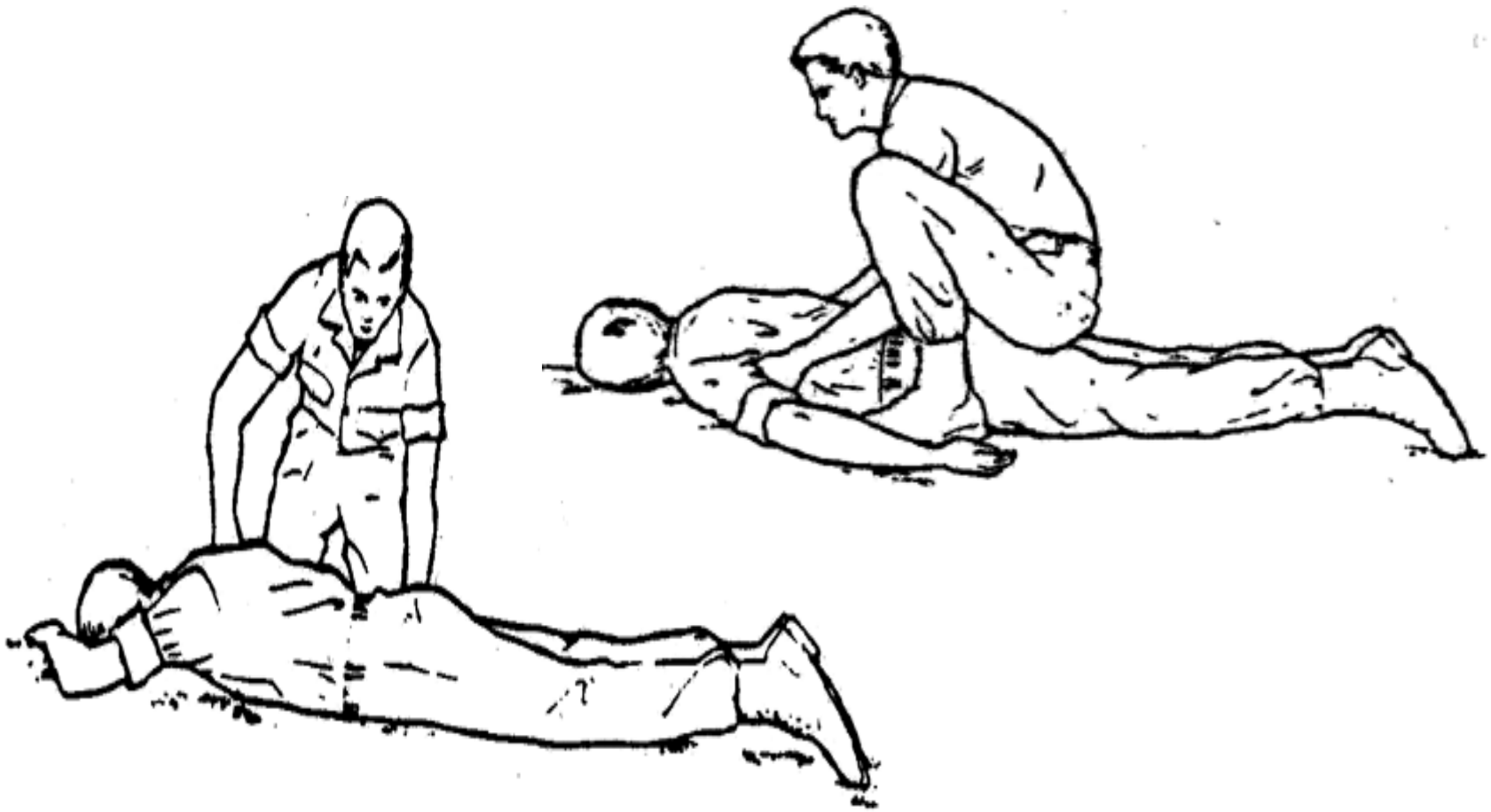


Immobilise extremity



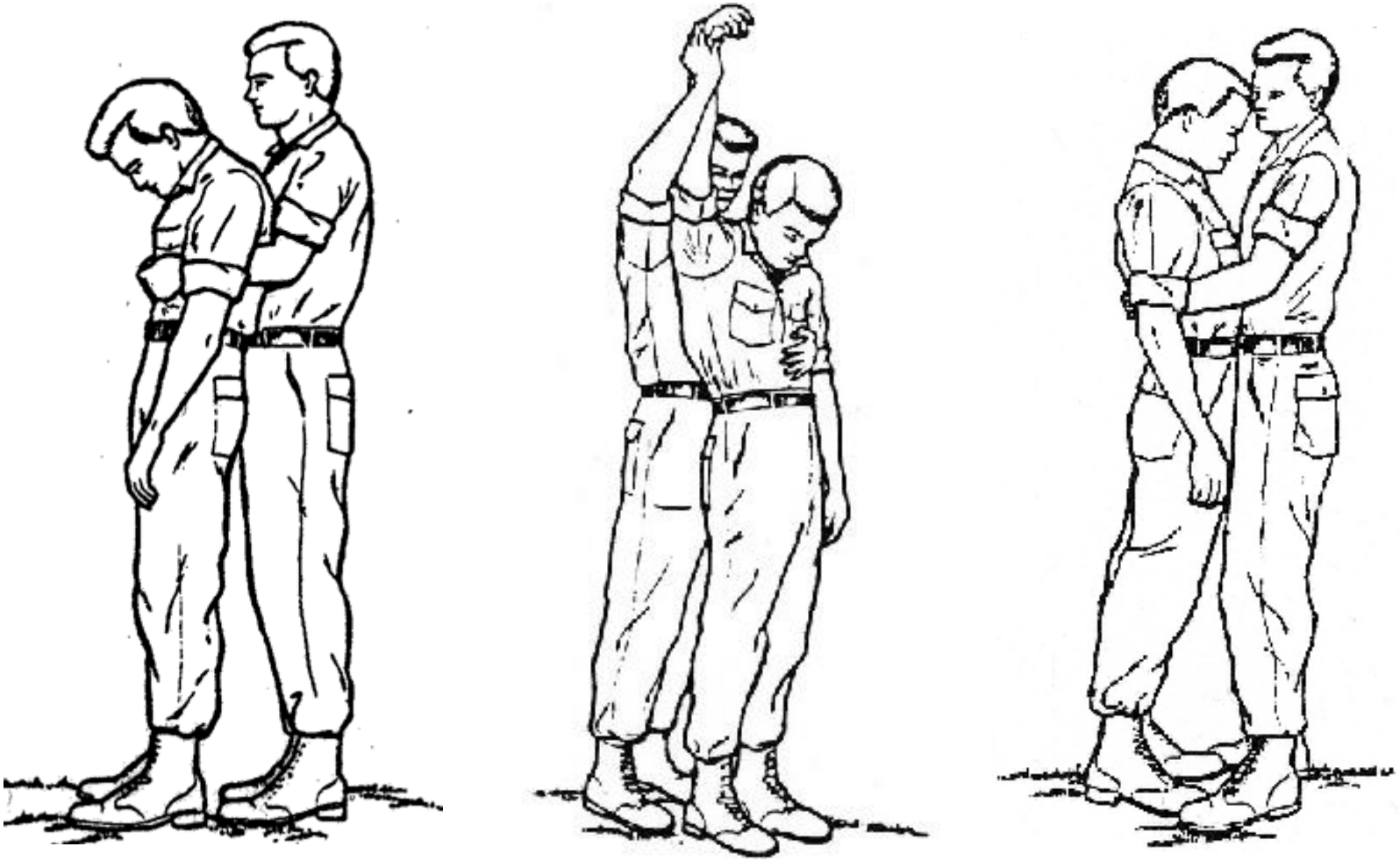
Assistance

Fireman's carry



Fireman's carry

Fireman's carry



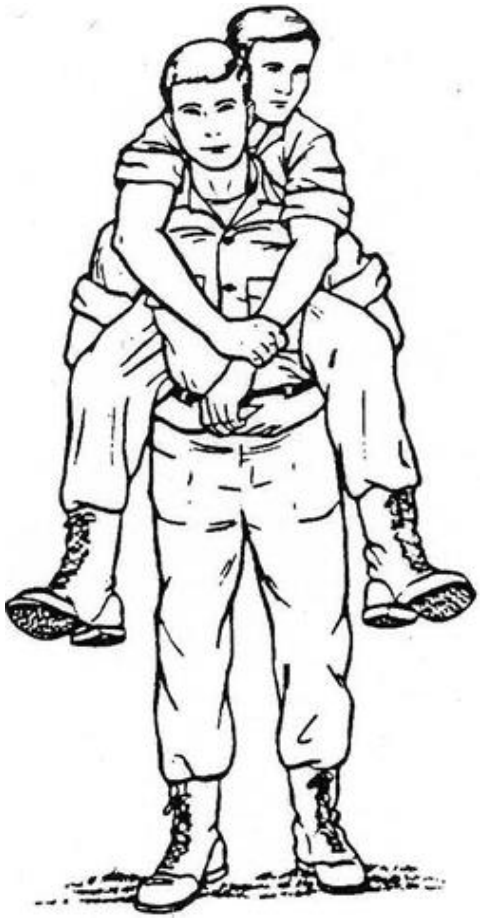
Fireman's carry

Fireman's carry

Arms carry

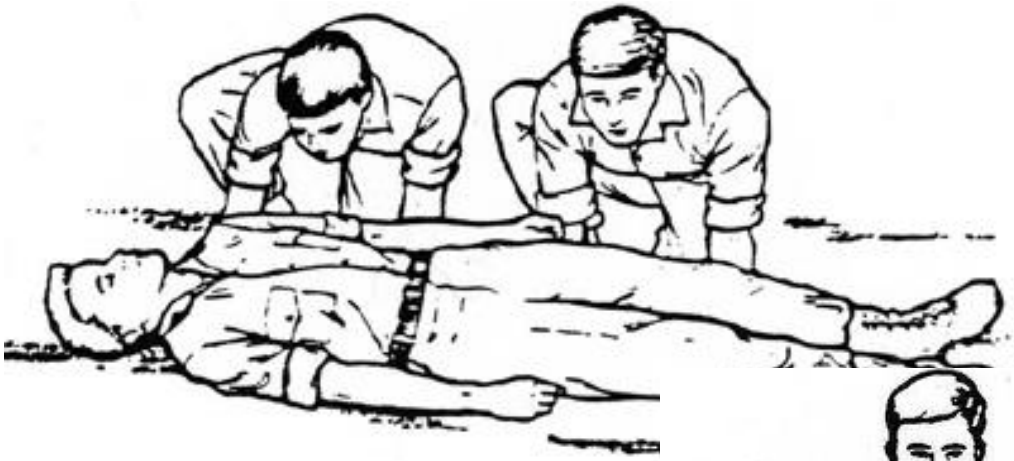
Pack strap carry

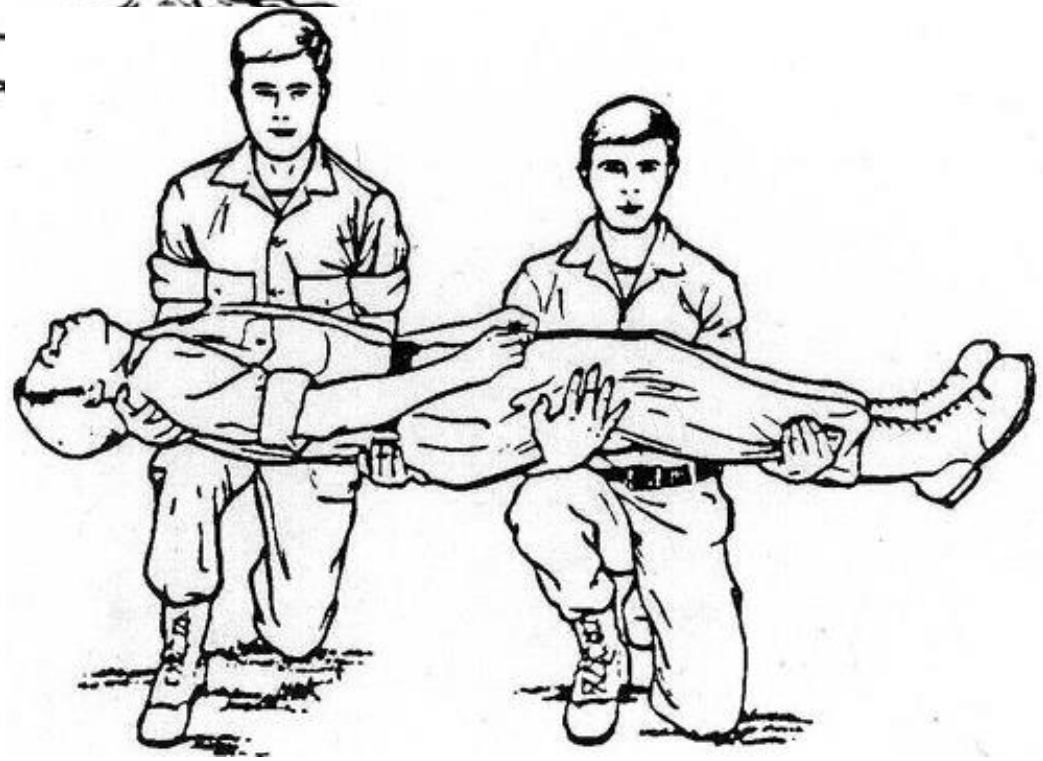
Saddle back carry



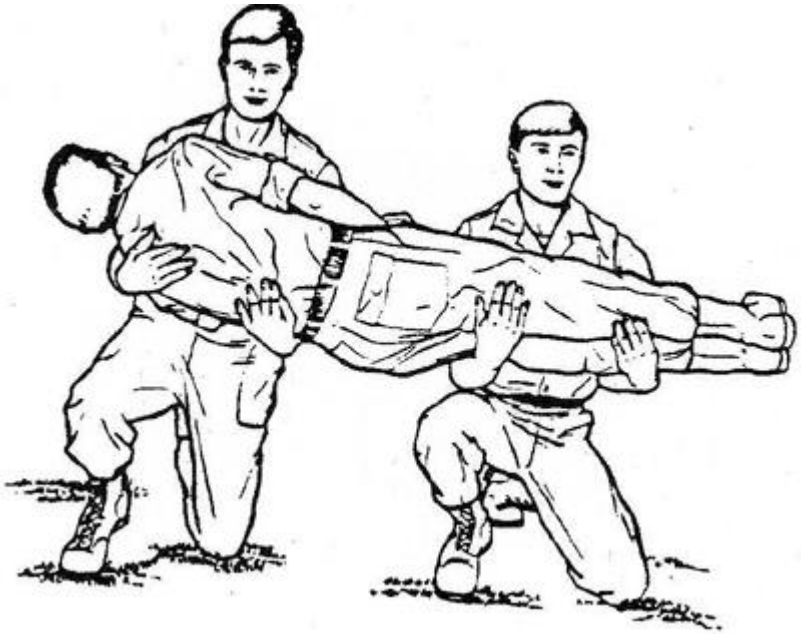
2 person support carry

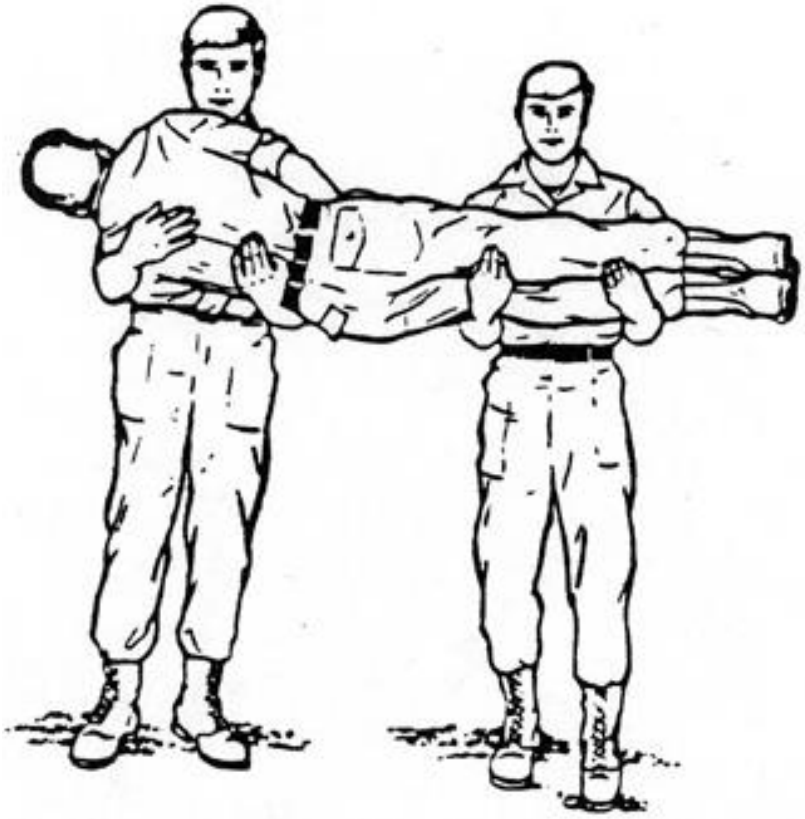
2 person arms carry



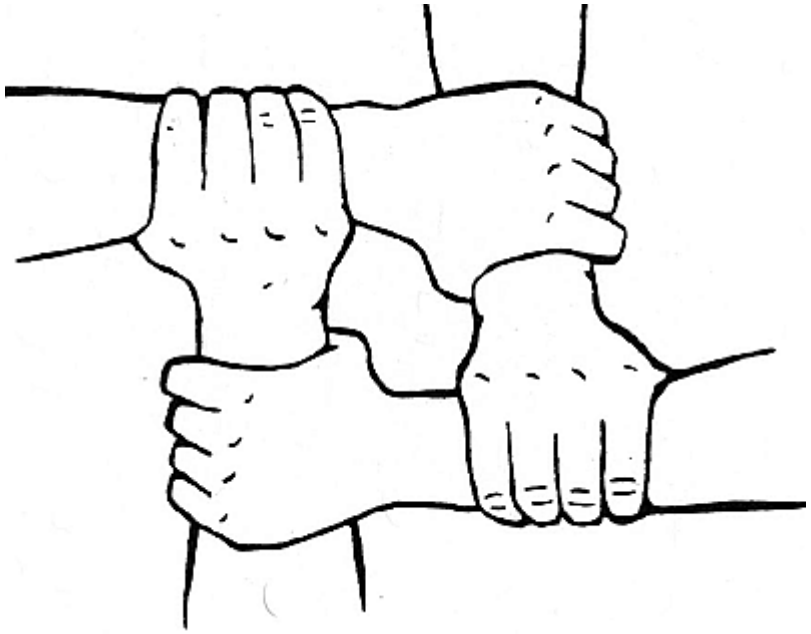


2 man arms carry

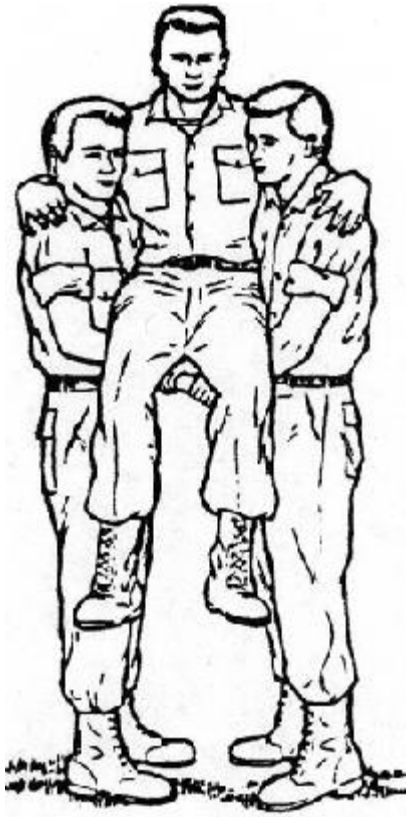




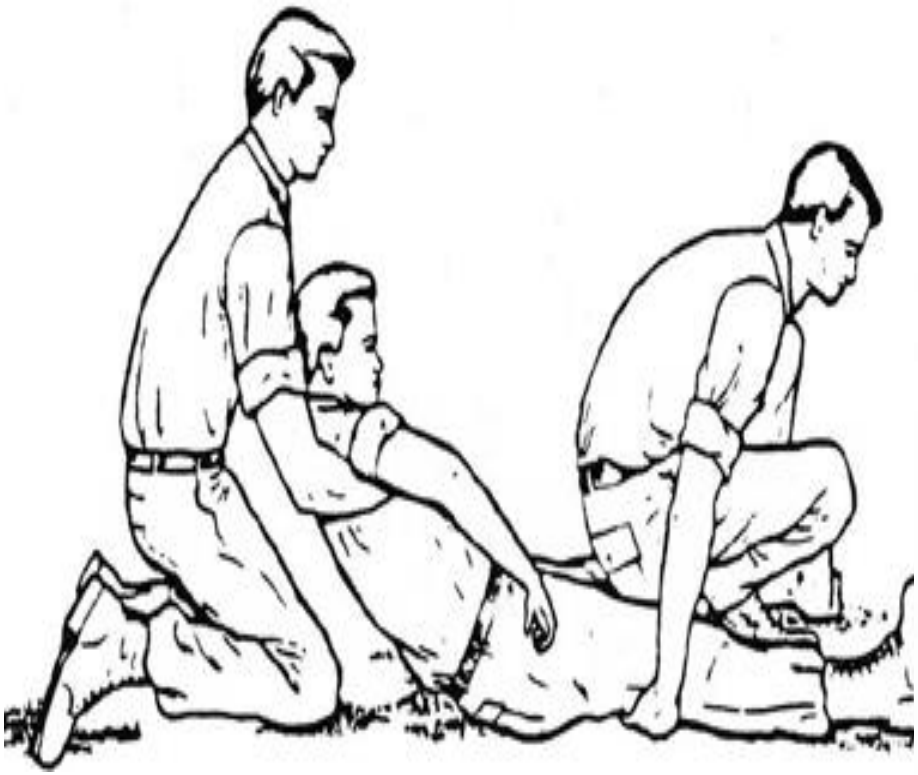
4 hand seat



4 hand seat carry



Fore and aft carry



Fore and aft carry

Child Birth

Be familiar with complications, process and infection.

ALWAYS:

- Scrub your hands and nails thoroughly with warm water and soap.
- Allow your hands to air dry
- If you have an infectious disease (such as a Cold/ Flu) wear a mask - improvise with a clean handkerchief if necessary.
- Wear gloves, eye protection and gowns (if available).

Cervix is thick and closed

Cervix is open about 2 cm

Cervix is thinning and open to about 6 cm

First Aid Role in Child Birth

CALL TRIPLE ZERO-000 or 112 IMMEDIATELY:

- Get to a hospital if possible
- Support the mother & make her comfortable
- Make preparations
- Ensure that the ambulance is on the way
- Care for the mother and baby after the birth

Signs and Symptoms of Labour

USUALLY:

- Cramp-like pains in the lower abdomen
- Occurring every 10-20 minutes
- Lasting 15-30 seconds.
- A ‘show’ of bloodstained mucus,
- ‘Waters breaking’.

Preparation for Childbirth

PREPARE A CLEAN SURFACE :

- Place a large sheet of plastic under
- A clean sheet over the plastic
- Have a towel or second sheet ready to place the baby on
- Tissues or toilet roll to clean soiling
- Sterile cord ties (boiled for 10 minutes)
- Sterile scissors
- Cotton wool swabs or a clean soft cloth
- A blanket and sheet to cover the mother
- Sanitary pads (or disposable nappy)
- Spare blankets to wrap around the baby
- Extra towels
- A situable container (e.g. bucket).

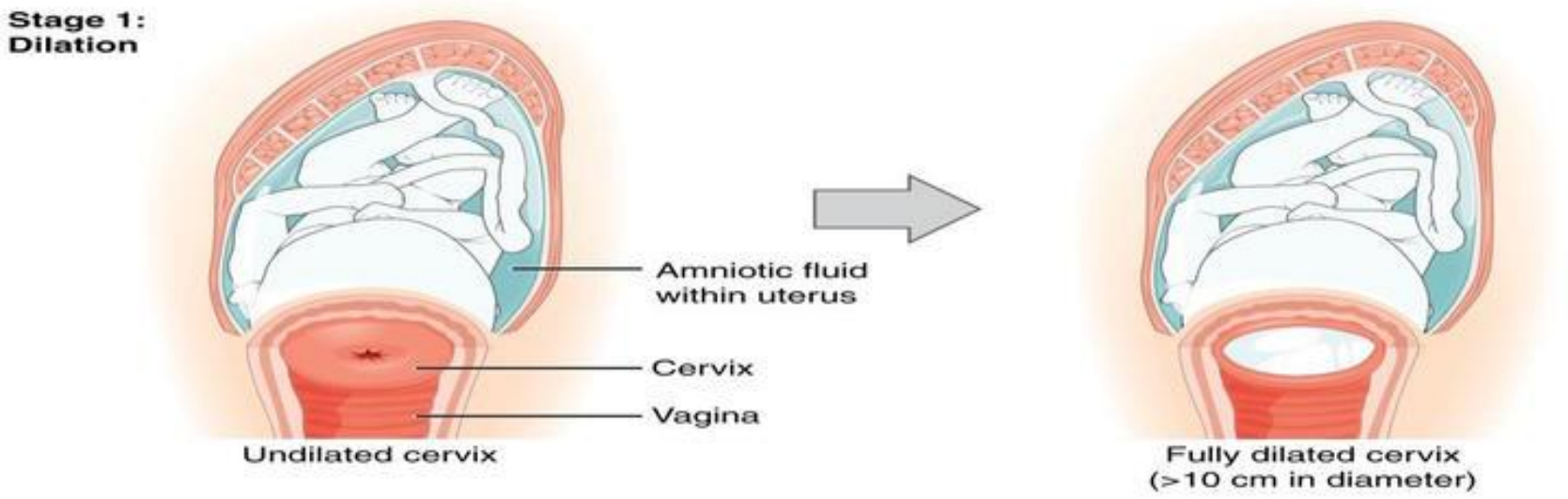
First Stage - Onset

- ✓ Usually last from 6 to 24 hours (may be quicker if already had children)
- ✓ Reassure
- ✓ Make arrangements for transport
- ✓ Seek medical aid
- ✓ For severe bleeding or signs and symptoms of shock, call Triple Zero - 000 *immediately*
- ✓ Collect the required equipment
- ✓ Support the mother in her most comfortable position
- ✓ Ask how to help with the pain
- ✓ Encourage her to breathe out.

Dilation Stages

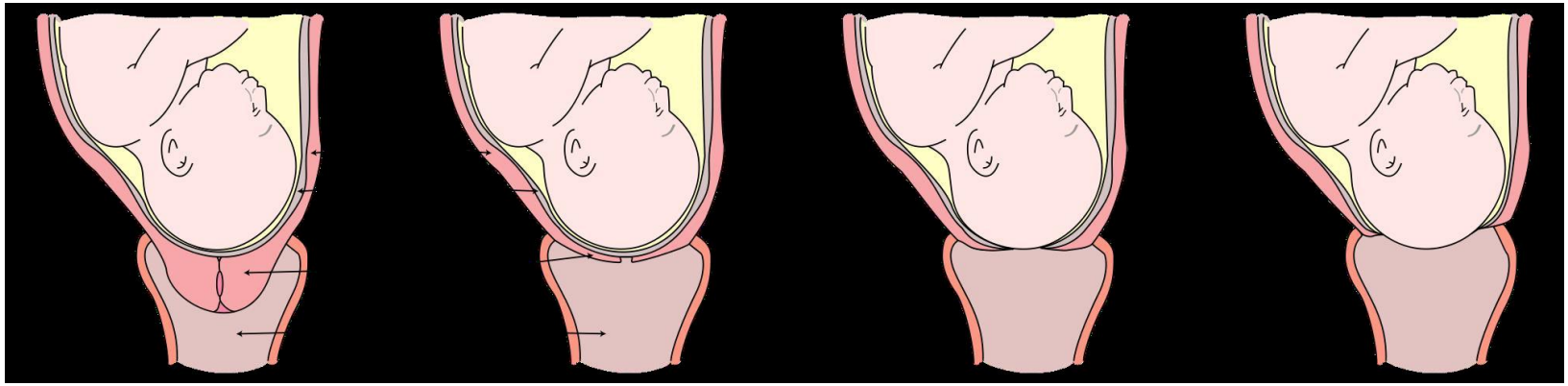
- CHILD BIRTH

- Crowning of the baby's head
- Increase in the flow of bloodstained mucus
- May feel the need to have a bowel movement



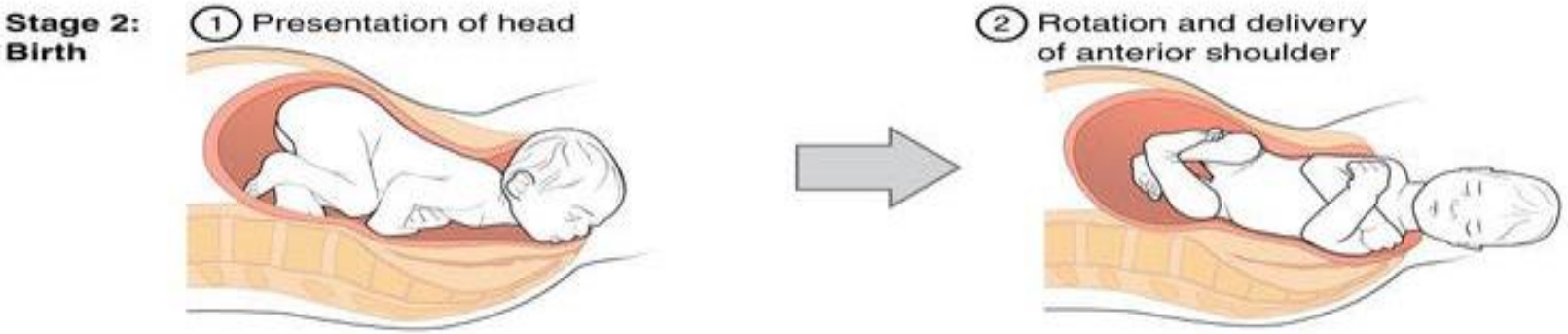
Second Stage - Birth

- Begins when the birth canal is fully dilated and ends with the birth of the baby.
- Contractions - occur every 2-3 minutes or more, and last 1-1½ minutes
- Change in the contractions to 'bearing down' pains
- Strong urge to push
- Bulging of the perineum,



Second Stage - Birth

- Warning: if the baby's buttocks appear first
- Don't interfere
- *Seek urgent medical aid*

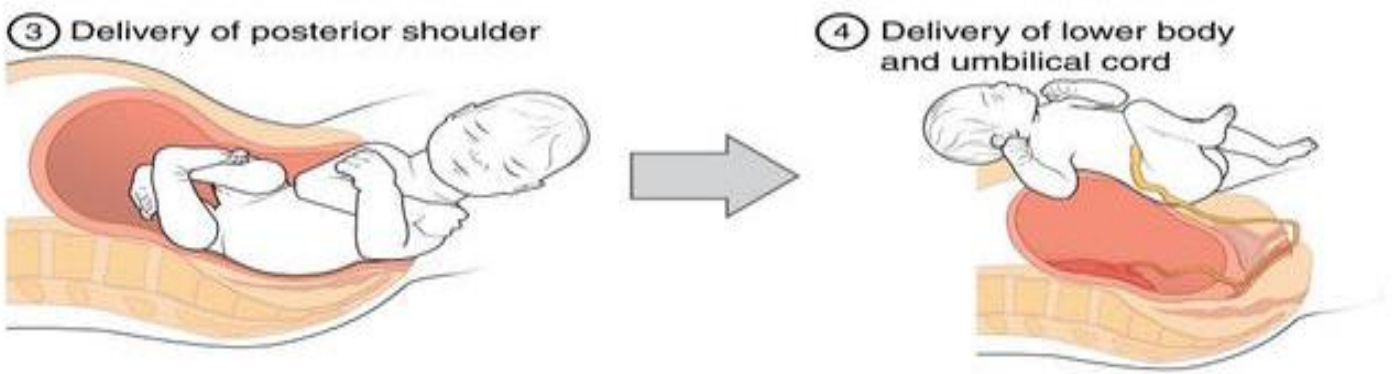


Second Stage - Birth

- SEEK MEDICAL AID URGENTLY
- The ambulance control or midwife may be able to give you instructions over the phone
- Wear gloves, eye protection and gowns
- Ensure privacy
- Remove the clothes from lower body
- help the woman into a comfortable position
- Support while she pushes the baby out
- Encourage her not to hold her breath and push, but to keep her mouth open and pant.

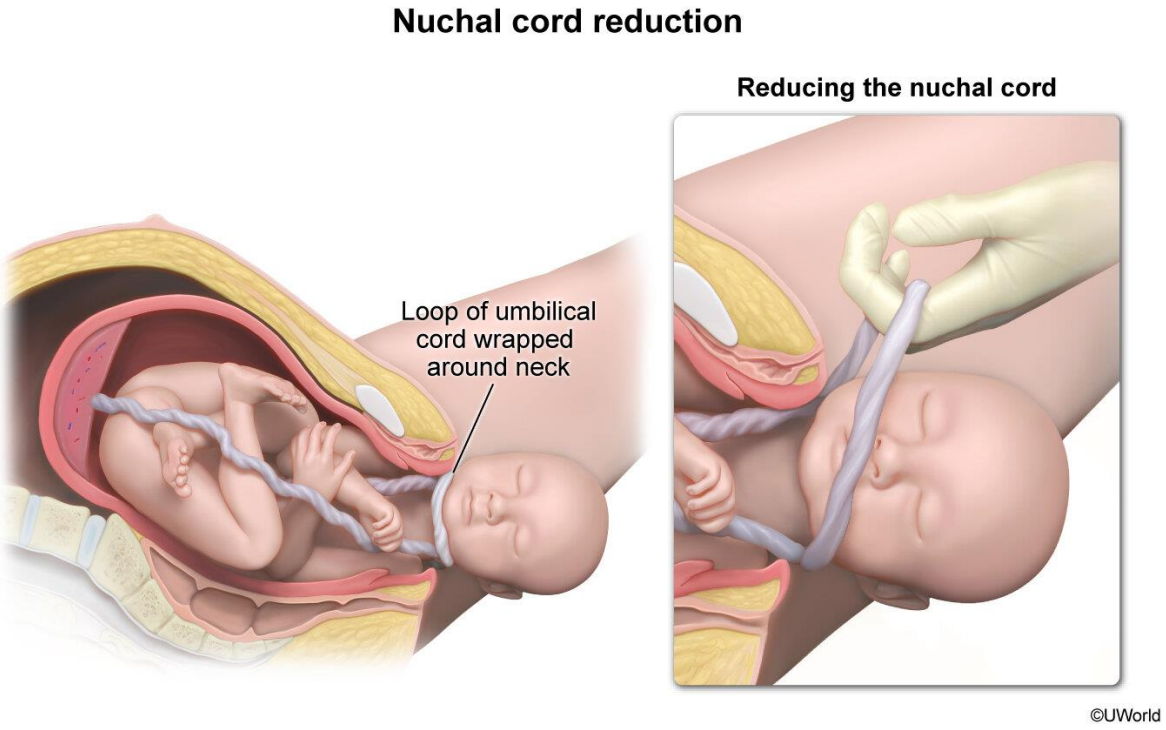
The Delivery

- Normal Delivery means with the head presenting first
- Control the baby's head with gentle but firm pressure
- The head will appear with the face towards the mother's anus, but will then rotate to face one side
- Do not pull the baby
- Support the baby's head in the palms of your hands and wait
- The next contraction delivers the baby's shoulders
- During the next contraction, hold the baby under the armpits and lift up towards the mother's abdomen
- No need to cut the cord



The Cord During Delivery

- If the cord is around the neck:
- Slide two fingers underneath it
- Easing it carefully over the baby's head
- As a last resort, apply two ties to the cord, using string or similar, and then cut between the two ties



Care of the Baby

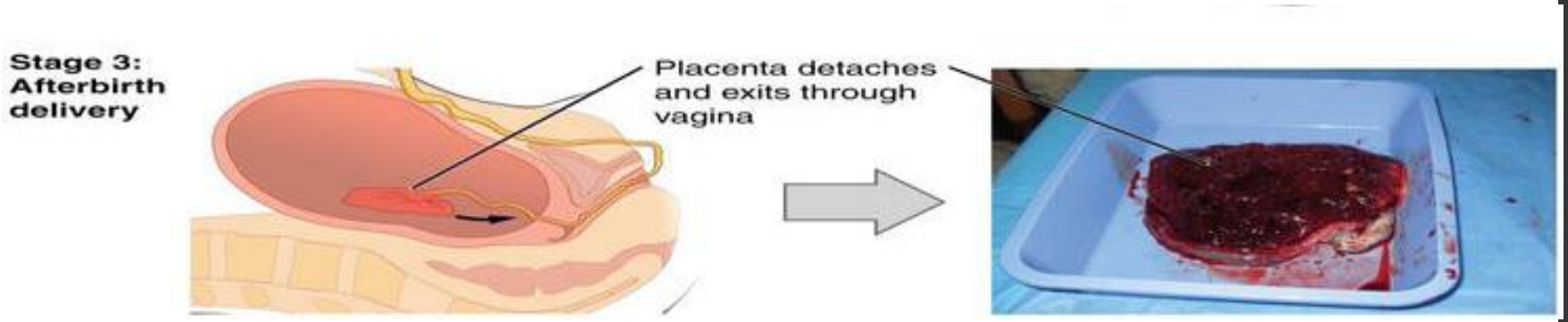
- The baby will be wet and slippery.
- Take care not to drop him/her
- Don’t pull on the cord.
- Dry the baby quickly but thoroughly.
- Wrap the baby and keep him / her warm.
- Place on side to allow fluid to drain from mouth and nose - on the baby’s mother’s stomach is ideal.

Care of the Baby

- The baby will probably let you know that he/she is breathing (e.g. he/she will cry).
- Let the baby remain on its mother's abdomen/chest (again, be careful not to pull the cord, which will still be attached to the placenta) and keep both mother and baby warm.
- If the baby **does not cry** or show signs of response or breathing after 1 minute, follow the **DRS ABCD** action plan.

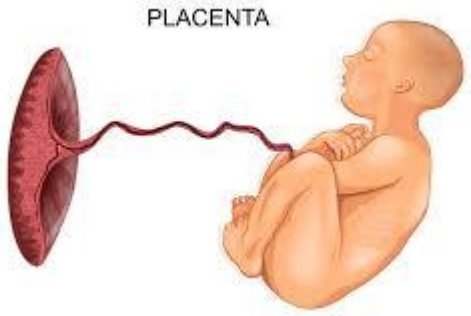
Third Stage – After Care

- The placenta and cord will be expelled
- The mother should not be given food or drink until after the placenta is delivered.
- May not be delivered until 10 or more minutes after the birth
- Help the mother into a comfortable position, as for the birth.
- If the cord is long enough, encourage the mother to put the baby to her breast. This will help the uterus to contract, expelling the placenta and controlling bleeding.



Third Stage – After Care

- Do not pull on the cord - this may cause excessive bleeding.
- After delivery there will normally be enough blood flow to fill a sanitary pad approx every 5 minutes.
- If blood is gushing, or fails to slow down, or increases suddenly, seek urgent medical attention.
- Retain placenta/ cord for medical inspection.
- Gentle massage of the mother's abdomen below the navel until it becomes firm will help to reduce excessive bleeding.



The Umbilical Cord

- Leave the cord intact. Only cut the cord if the baby must be moved away from the mother, or if in a remote area isolated from medical aid.

To cut the cord:

- Wait 2-3 minutes after the birth of the baby;
- Tie the cord very firmly in three places - 10 centimeters, 15 centimeters, and 20 centimeters from the baby's navel.
- Securely tie to prevent bleeding after it is cut. If the cord is cut, leave two ties on the baby's side.

Care of the Mother

- Wash and help change any stained clothing
- Place a sanitary pad or disposable nappy in position
- Give her hot drinks
- Encourage her to rest while waiting for medical aid
- Monitor her regularly
- Regularly check for excessive blood loss;
- Place all bloodstained material in a sealed plastic bag
- Retain used sanitary pads for medical inspection
- Clean all surfaces contaminated by blood and body fluids.