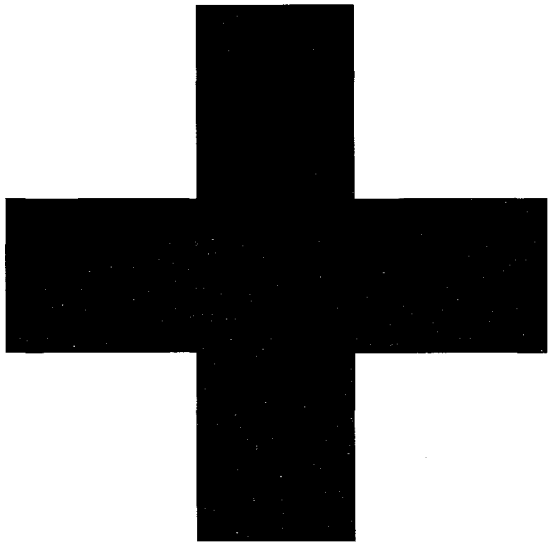
LIFEBOAT / LIFE-RAFT FIRST AID GUIDANCE BOOK



INSTRUCTIONS FOR USE OF FIRST AID OUTFITS CARRIED IN LIFEBOATS and LIFERAFTS LIST OF CONTENTS (Category C/EEC/MCA kit only)

1) **Glyceryl trinitrate patches** - for the treatment/relief of chest pain associated with angina and heart attacks. Apply one patch to the chest or upper arm. The patch may be replaced every 24 hrs if necessary. If possible obtain radio medical advice before using this item.
2) **Phytomenadione 10mg/ml (Vitamin K1) ampoule or 1 Omg tablets** - special antidote to be used only on casualties on anti-coagulant medication that are suffering acute blood loss. Use only on radio medical advice.
3) **Syntometrine 1 ml ampoules** - each ampoule contains - Ergometrine malleate 0.5mg and Oxytocin 5 units. For the treatment and prevention of post-partum haemorrhage - following delivery of an infant. Usually give by intramuscular injection but may be given orally in extreme cases. Seek radio medical advice if available.
4) **SEASICKNESS** - Hyoscine 0.3mg tablets OR Promethazine Theoclate 25mg tablets.
5) **Codeine Phosphate 30mg Tablets** - These can be used for 1) Severe or persistent coughing : Adult dose one tablet every 4 hours as required: 2) Diarrhoea: adult dose - one tablet every 4-6 hours as required. Maximum 4 tablets in 24 hours.: 3) Painkiller - for use in conjunction with paracetamol for moderate to severe pain relief: Adult dose - 1-2 tablets every 4 hours. Maximum 6 tablets in 24 hours.
6) **Paracetamol 500mg tablets** - General Pain Killer - adult dose 2 tablets every 4-6 hours as required. Maximum dosage 8 tablets in 24 hours.
7) **Antiseptic wipes**
8) **Antiseptic cream - CETRIMIDE** - General antiseptic cream primarily for small wounds. Large wounds and burns shou Id be treated with standard dressings, without antiseptic cream and burns should be treated with paraffin dressings or plastic burn bags
9) **"Laerdal Type" pocket mask** - for use in artificial respiration
10) **Adhesive Elastic bandage** 7.5cm x 4m
11) **Disposable polythene gloves** - these should be worn when treating **any** injury.
12) **Adhesive dressings (plasters)** - for minor cuts etc
13) **Wound dressings** - Non -medicated (sterile pad and bandage): small (No.13), medium (No.14) and large (No.15) sizes are provided for dressing wounds
14) **Adhesive Suture Strips 75mm ("steristrips")** - for use as a skin closure device for cuts and skin lacerations.
15) **Sterile Gauze Swabs**
16) **Scissors**
17) **Triangular bandages** - used mainly to make arm slings in injuries involving the shoulder, arm, wrist and hand. When folded they can be used to secure splints. They also make convenient head bandages for scalp wounds.
18) **Safety pins** - to secure bandages
19) **Sterile Paraffin Gauze dressings** - used as burn dressings
20) **Sterile plastic burn bag** - a simple but very effective method of dressing a burnt hand or foot to prevent infection.
21) **Extra SEASICKNESS** tablets and Vomit bags are packed separately.

SEASICKNESS

Hyoscine Hydrobromide O.3mg tablets: Adult Dose - one tablet at onset of symptoms or an hour before they may be expected. Repeat dosage at intervals of six hours as required. Maximum 3 tablets in 24 hours.
OR
Promethazine theoclate 25mg BP tablets - Adult Dose - one tablet at onset of symptoms or 1-2 hours before they may be expected. Maximum 3 tablets in 24 hours

Caution - both these tablets may cause drowsiness, blurred vision, dry mouth and urinary retention. Avoid alcohol.

Vomit bags are enclosed for use as and when required

TREATMENT OF WOUNDS

AIM - 1) to stop the bleeding: **2)** Prevent infection
In nearly every case bleeding can be arrested with firm DIRECT PRESSURE on the wound area by a suitable dressing.

1) Expose the wound area - cut clothing if necessary.
2) Apply a suitable sized (n013, 14, 15) sterile dressing to the area and fix in place with the attached bandage - make sure all the wound is covered by the dressing. If the wound is obviously dirty or contains foreign matter some Antiseptic cream may be applied to the dressing pad before it is used. Caution - If there is an embedded object in the wound - do not remove it - but apply pressure on either side of the area, and pad around it (gauze pads) before bandaging.
3) Apply direct pressure over the wound site with fingers or the palm of your hand. Raise the injured area above the level of the patients' heart.
4) Do not disturb the original dressing until medical attention is available. Bandage another dressing pad on top if blood seeps through.
5) Check the circulation beyond the bandage and for swelling in the limb at intervals -loosen the bandages if needed

Precautions - Do not apply a tourniquet. Tourniquets incorrectly applied cause more harm than good and may increase bleeding. Torrential bleeding from a large artery requiring a tourniquet is rare - firm pressure with elevation of the wounded area will often stop the bleeding.

Wounds causing severe pain and blood loss can give rise to shock.

TREATMENT OF SHOCK

Shock is a state of collapse that may occur following severe wounds, burns, broken bones, or any injury causing loss of blood or other body fluids.
Recognition -Initially - rapid pulse, grey-blue skin especially on lips, sweating and cold - clammy skin.
Later - weakness/giddiness, nausea or thirst, rapid shallow breathing, a weak pulse
Eventually - restlessness, gasping for air, unconsciousness, cardiac arrest.

1) Lay casualty down - raise and support the legs as high as possible to improve blood supply to the vital organs. Treat any direct cause of shock - such as bleeding etc.
2) Loosen clothing that constricts the neck, waist and chest. Keep the patient warm (but avoid overheating).
3) Do not leave the casualty alone. Monitor pulse and breathing every 10 minutes - and be prepared to resuscitate if necessary.
4) Do not let the casualty eat, move, smoke, or drink.

TREATMENT OF BURNS and SCALDS

AIMS -1) to stop the burning: **2)** relieve pain and swelling: **3)** mini mise the risk of infection

1) Cool the burn - pour cold water onto the injury for 10 minutes.
2) Remove any items of clothing and jewellery from the affected area before the injury starts to swell.
3) Apply Paraffin gauze dressing(s) gently to affected areas. Secure lightly in place with a wound dressing ensuring the whole burn and surrounding area is covered. If the bandages or paraffin gauze have been used a clean handkerchief/triangular bandage or any other non-fluffy material will suffice. Do not apply any adhesive dressing/tape to the burn area - the burn may be more extensive than it first appears. Burns to the hands and feet, which may be difficult to dress, can be covered with the Sterile Burn Bag to prevent infection. Burns to the arms and hands should be supported, after dressing, in a broad sling using a triangular bandage.

4) Do not disturb the original dressing until proper medical attention is available. If swelling or constriction should occur bandages should be loosened.

Caution - do not apply lotions, ointments, or fat to the burn. Do not touch the area or burst any blisters. Do not remove anything sticking to the burn.
If the burn is large or deep - treat the casualty for shock

TREATMENT OF FRACTURES

AIMS -1) immobilise the affected limb: 2) ensure the patient is comfortable

1) Do not remove clothing unless there is a wound near by ..
2) Do not try to set the broken limb.
3) Immobilise the affected limb. as much as possible. This should be done by applying slings or improvised splints. Folded triangular bandages can be used for binding limps to splints.
4) For breaks at the collarbone, shoulder (including dislocation), arm or wrist - support the area across the chest and apply a sling using a triangular bandage. The limb may then be further secured to the chest by applying a broad -fold bandage around chest and over the sling.
5) Broken thighs, knees or lower legs - straighten and immobilise the limb and bandage to a long splint (if available), or bandage both legs together. Ensure the feet are bandaged together, with a figure of eight formation ,to minimise movement of the full leg
6) Broken foot or ankle - bandage above the ankle and around the toes rather than in a figure of eight.

Caution - treat for shock as necessary but do not raise the patients legs if the thigh, knee, lower leg or ankle are broken

TREATMENT OF FROSTBITE

Occurs in freezing and often dry and windy conditions. The tissues of the extremities (fingers and toes primarily) freeze leading in severe cases to permanent loss of sensation and gangrene. It is often accompanied by hypothermia which should be treated accordingly (see below).
Recognition - pins and needles, paleness followed by numbness, a hardening and stiffening of the skin. A colour change to the skin is seen - first white, then mottled and blue, and eventually black, Once frozen the skin remains unchanged until it thaws - when it becomes red, hot, painful and blistered.
PREVENTION - Avoid cramped positions. Keep moving as much as possible. Wear all available clothing. Keep socks dry. Protect ears, hands and all other exposed areas. Do not touch metals with bare skin.
TREATMENT - Gently remove gloves, rings and and any other constrictions such as boots. Warm the affected area with your hands, in your lap, or in the casually's armpit. Avoid rubbing because it can damage skin and tissue. On thawing wrap in a clean dressing any areas that become blistered or broken. Do not put affected part by direct heat or thaw it if there is danger of it re-freezing.

IMMERSION (TRENCH) FOOT

This is caused by prolonged exposure to near-freezing temperatures in damp/wet slushy conditions - and can be aggravated by lack of mobility, tight shoes and wet socks. The feet become white, cold, numb and swollen - then red, hot and painful on re-warming. The skin may become broken and ulcerate.
PREVENTION - Keep feet out of water. Wear seaboots if available. If socks become wet, empty boots, wring out socks and replace them rapidly. Keep feet and toes moving.
TREATMENT - as for frostbite. Dry skin gently, do not rub. Apply Antiseptic cream and a clean dry dressing to any area where the skin has broken. Keep legs elevated if possible.

HYPOTHERMIA

This condition develops when the body temperature falls below 35C (95F). the effects vary with speed of onset and to the level to which the temperature falls. Moderate hypothermia can usually be completely reversed.
Recognition - as hypothermia develops, there may be - shivering, and cold, pale, dry skin: apathy, disorientation, irrational behaviour, occasionally belligerence: lethargy or failing consciousness: slow and shallow breathing: a slow and weakening pules: cardiac arrest in extreme cases.
AIMS - 1) to prevent the casualty from losing more body heat: 2) to re-warm the casualty
Insulate the casualty with extra clothing or blankets and cover his head. Protect and shelter the casualty from the elements as

much as possible - keep them dry, cover with blankets, newspapers, plastic or foil bags
Do not give **the casualty alcohol.**

HEATSTROKE

This condition develops when the brains "thermostat" fails. The body dangerously overheats due to high fever or prolonged exposure to heat. In some cases it follows heat exhaustion. Heat stroke can occur suddenly, causing unconsciousness within minutes. **It** may be signalled by the casualty feeling uneasy and ill.
Recognition - headache, dizziness, and discomfort: restlessness and confusion: hot, flushed and dry skin: a rapid deterioration in the level of response: a full bounding pulse: body temperature over 40C (104F)

1) Quickly move the casualty to a cool/shaded place. Remove as much of their outer clothing as possible.
2) Wrap the casualty in a cold, wet sheet and keep it wet until his temperature falls. If no sheet is available, constantly fan the casualty or sponge with cold water.
3) When the patients' temperature has fallen and their condition has improved -replace the wet sheet with a dry one.

HEAT EXHAUSTION

This condition usually develops gradually and is caused by a loss of salt and water from the body through excessive sweating.
Recognition - Symptoms are similar to those of Heat Stroke - together with excessive sweating, with pale, clammy skin: cramps in the arms, legs or the abdominal wall: rapid, weakening pulse and breathing.

Treatment - 1) Place the casualty in a cool place and raise their legs.
2) Give plenty of water, and a weak salt solution if available (one teaspoon of salt per litre of water) - or rehydration sachets if available

HEART ATTACK

Recognition - Persistent, vice -like central chest pain spreading often to the jaw and down the left arm (unlike angina the pain does not ease once the patient is at rest) : breathlessness, and discomfort high in the abdomen - similar to severe indigestion: sudden faintness / giddiness: a sense of impending doom: "ashen" skin and blue lips: A rapid, weak, or irregular pulse: collapse often without warning.

1) Make the casualty as comfortable as possible to ease the strain on the heart. A half-sitting position with the head and shoulders well supported and knees bent - is preferable.
2) If the patient has tablets or a "puffer" aerosol for angina help them take it. Alternatively apply one Glyceryl trinitrate patch to the chest or upper arm.
3) Be prepared to resuscitate if necessary.

Angina - this presents with symptoms similar to those of a heart attack but the pain will ease once the casualty is at rest. Treatment is as for a heart attack.

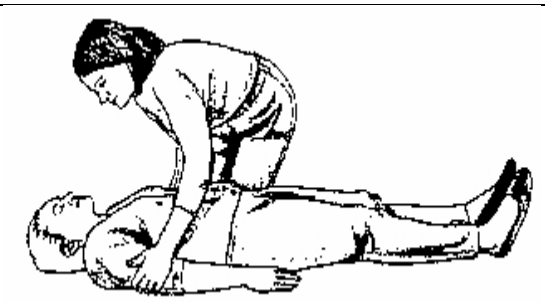
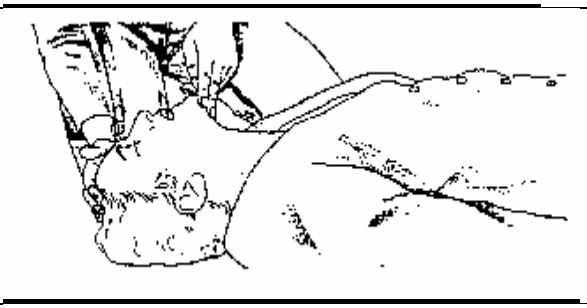
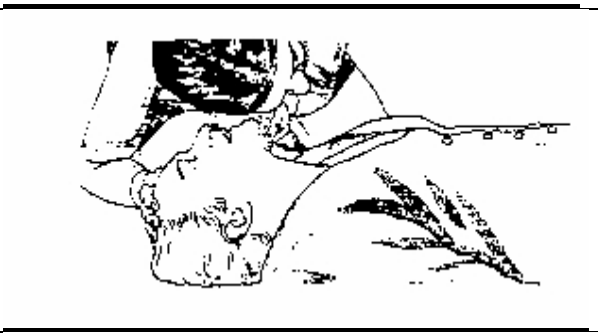
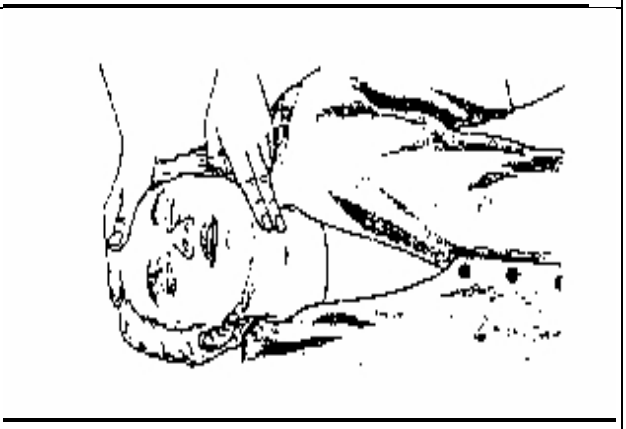
DROWNING

AIM - 1) to restore adequate breathing: 2) to keep the casualty warm

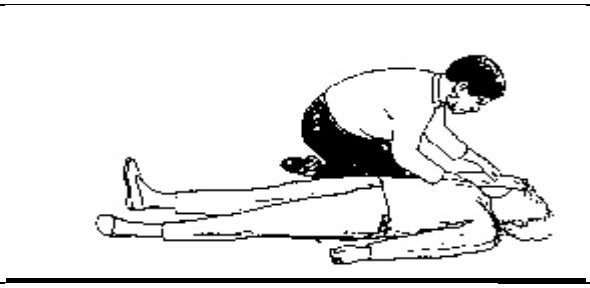
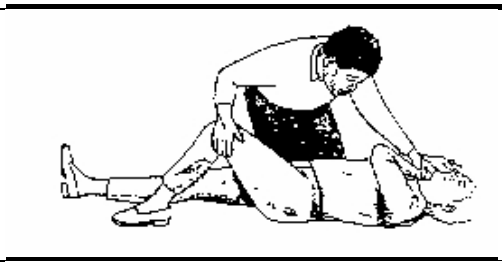
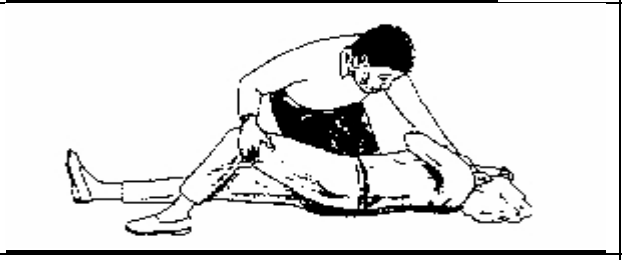
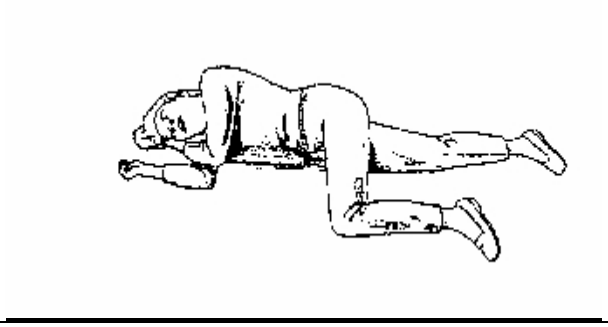
1) If carrying the casualty from the water to safety, keep the head lower than the rest of the body to reduce the risk of inhaling water.
2) Lay the casualty on their back. Open the airway, check breathing and pulse and be prepared to resuscitate if necessary.
3) Treat the casualty for hypothermia: remove wet clothing and protect from the cold. Place in recovery position.

Caution - if resuscitating a semi-drowned casualty be aware that water in the lungs and the effects of cold can increase resistance to artificial ventilation and chest compression - so you may need to do both at a slower rate than normal.

ASSESS THE CASUALTY

1) **Check for consciousness** - **GENTLY** shake or squeeze the casualty and say loudly" Can you hear me". If there is no response the casualty is unconscious.	
2) **Clear the Airway (in an unconscious** casualty) Look in the mouth. With one or two fingers scoop out any objects such as food, vomit or loose dentures etc. Place two fingers under the chin and lift the jaw. At the same time, with the palm of the other hand on the forehead - **GENTLY** tilt the head back (this prevents the tongue from falling to the back of the throat and blocking the airway)	
3) Check for breathing Maintaining the "chin lift" and "head tilf', • look for chest movement • listen for breathing and feel for breath on your cheek. Check for 5 seconds before deciding whether breathing is absent. If in doubt assume there is no breathing.	
4) Check the Pulse With head tilted back feel for the carotid pulse in the neck. Feel initially for the "Adam's" apple, then slide your fingers down towards the neck until you reach the gap between the windpipe & the neck muscle. Press **GENTLY** and feel for the pulse for 5 seconds. Now make an initial assessment - **1** .Conscious casualty - treat any external bleedinglinjuries 2. Unconscious breathing casualty - place in recovery position 3. Pulse present but no breathing -"Breathe for the patienf' 4. No breathing or pulse - "Commence CPR	

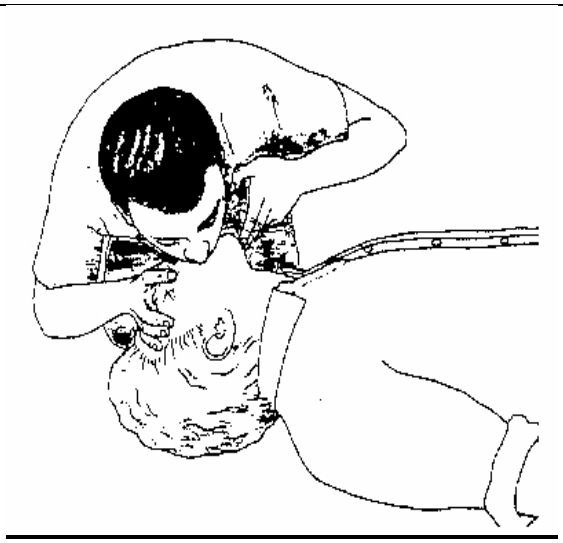
THE RECOVERY POSITION

Kneel beside the casualty.Lift the chin & tilt the head to open the airway.Straighten the legs.Place the casualty`s near arm at right angles to the body,bent at the elbow with the palm uppermost.	
Bring the far arm across the casualty's chest and hold the hand, palm outwards, against the near cheek. With your other hand, grasp the far thigh and pull up the knee, whilst keeping the foot flat on the ground	
Using the knee as a lever pull the casualty towards you, ensuring the casualty`s hand remain pressed against the cheek	
Tilt the head back to maintain the open airway. Use the hand to ensure the head is well supported. Move the upper leg so that the hip and knee are at right angles. Re-check the breathing and pulse.	

MOUTH-TO-MOUTH RESPIRATION

1) Kneel beside the casualty. Place the casualty flat on his back. Maintain the "head tilt" and "chin lift" to ensure the airway remains open. Pinch the casualty's nostrils closed. Alternatively use a "pocket resuscitation face mask" if available
2) Take a moderately deep breath. Form a good seal with your lips around the casualty's open mouth, or the "resuscitation face mask" if available. Blow into the patient's mouth until the chest rises, taking up to 2 seconds for a full inflation.
3) Keeping the head tilted remove your lips and allow the chest to fall.
   Repeat mouth-to- mouth once more. Check the pulse again and look for signs of recovery.

If the pulse is absent start CPR. If the pulse is present, continue with mouth-to-mouth resuscitation at a rate of 10 breaths per minute. Check the pulse and look for other signs of recovery. If breathing returns place the casualty in the recovery position.



CPR-CARDIO-PULMONARY RESUSCITATION

CPR - CARDIO - PULMONARY RESUSCITATION

1) Check the pulse for up to 10 seconds and look for any signs of recovery.
   Remember - if the casualty is conscious or breathing, the heart is beating.

With the casualty lying on a flat surface, place the heel of one hand on the breastbone in the centre of the chest, 2 finger widths up from the bottom of the breastbone. Place the heel of your other hand over the first and interlock your fingers