LOS ANGELES CITY
POOL LIFEGUARD RECERTIFICATION
STUDY GUIDE

Patient Assessment Skills

You will be tested in one (1) of two (2) skills

1. Patient Assessment: **Trauma**
2. Patient Assessment: **Medical**

Each assessment will require that once injuries or symptoms has been managed, that you complete a medical history and physical examination.

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General Impression: An assessment based on the environment and the patient's chief complaint.

Initial Assessment: assists the Lifeguard in identifying immediate threats to life.

Vital Signs: in order to assess the most basic body functions. During the reassessment, compare vitals to baseline vitals to determine if the condition of the patient is improving or deteriorating.

SAMPLE History: may be completed prior to the physical exam.

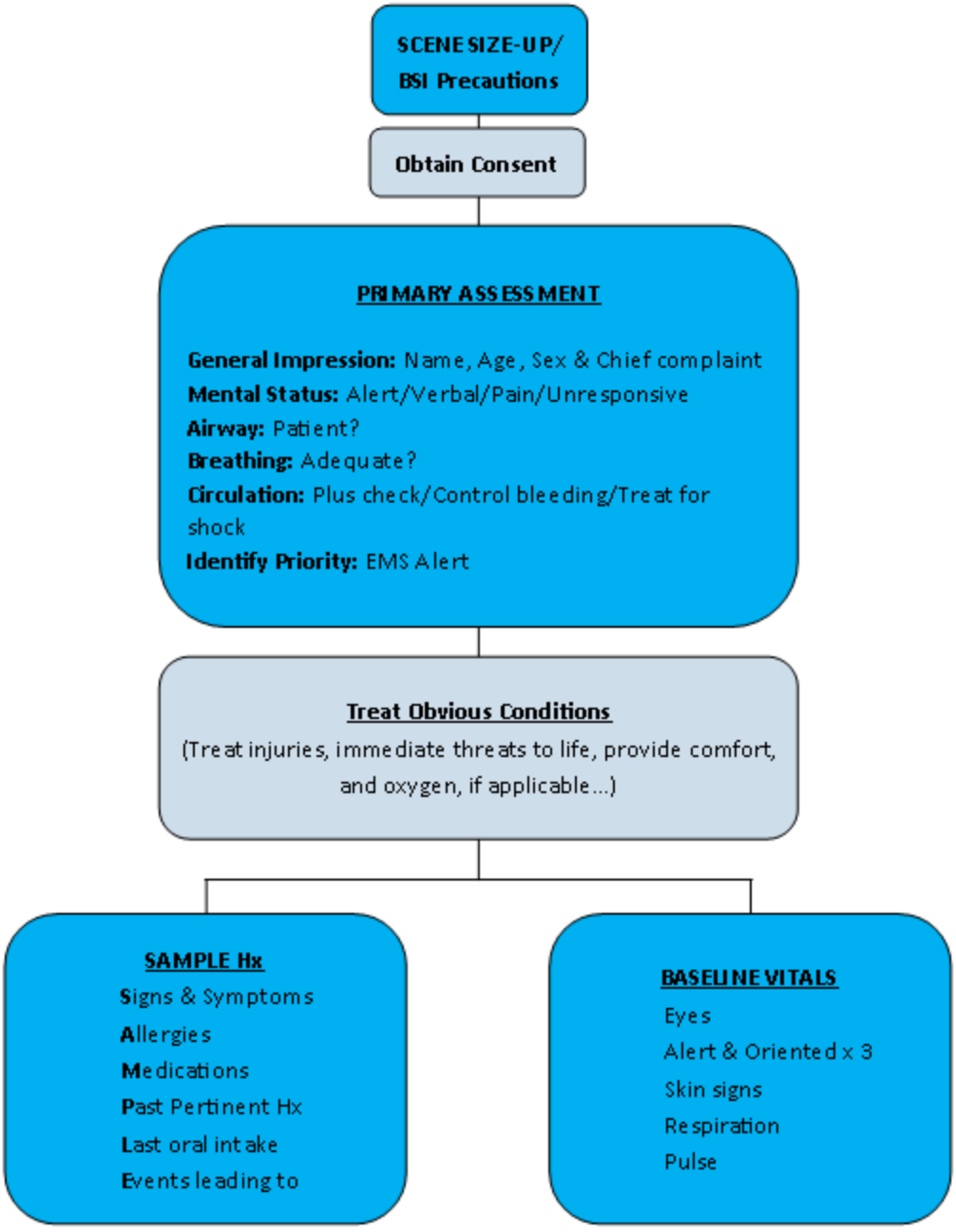
Detailed Physical Exam: Designed to begin the initial management of the patient's signs and symptoms of illness or injury. A patient physical exam must be completed following the initial assessment, whether or not the person is responsive or unresponsive (Injury specific).

Ongoing Assessment: While awaiting the additional EMS resources, Lifeguards should continue to assess the patient

For an Unstable Patient: Repeat every 5 minutes

For a Stable Patient: Repeat every 15 minutes

PATIENT ASSESSMENT AND MANAGEMENT ALGORITHM



STEP BY STEP REFERENCE GUIDE	
TRAUMA	**MEDICAL**
Treat Obvious Conditions	
1. Detailed Physical Exam	1. SAMPLE Hx
2. Baseline Vitals	2. Baseline Vitals
3. SAMPLE Hx	3. Detailed Physical Exam
On-going Assessment	

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LOS ANGELES CITY
RECERTIFICATION
BASIC LIFE SUPPORT SKILLS

PATIENT ASSESSMENT

Performance Objectives
The examinee will demonstrate proficiency in performing a Patient Assessment involving scene size-up, initial assessment, baseline vitals, medical history, and a detail physical exam.

Condition
The examinee will require lifeguards to assess and manage a simulated patient that may be experiencing a medical problem or had been exposed to some type of trauma.

Performance Criteria
100% accuracy required on all items designated by a diamond (♦) for skills testing. Make documentation, identified by the symbol (Φ).

Scene Size-up	
Skill Component	**Comments**
♦ Take Body Substance Isolation Precautions	Mandatory personal protective equipment
♦ Assess scene safety/scene size-up	● Discourage blind reciting of (PENMAN) ● Verbalize what is actually seen. ● Is the scene safe to provide care? .
NOTE: Complete Initial assessment before providing care. Do not be distracted by the injury before completing the initial assessment.	
Skill Component	**Comments**

♦ Consider: ● General Impression ● Observe for major disabilities	● The general impression is determined by observing the appearance, hygiene, patient position, sounds, smell, and mechanism of injury. It establishes the overall condition of the patient and if immediate interventions are needed. Does the patient appear stable, potentially unstable, or unstable? ● The primary assessment should be completed in 60 - 90 seconds ● Manage life-threatening situations when found.
Skill Component	**Comments**
♦ Establish patient rapport: ● Obtain Consent ● Name ● Age ● Sex ● Determine chief complaint ● **Medical or Trauma?** ♦ Assess mental status (AVPU Scale) ● Alert ● Verbal Stimulus ● Painful Stimulus ● Unresponsive	● Situation and patient condition determines the level of rapport that is possible. ● Asking what the problem is assists is in determining the preliminary chief complaint and patient symptoms. Ask questions such as, “What happened? How may I help you? Tell me what hurts? ● Responding with empathy develops trust and encourages essential patient communication. ● All patients have the right to be treated with respect and should receive non-judgmental and impartial treatment. ● Body language (non-verbal communication) refers to facial expressions, gestures and body movements that communicate a variety of messages to the patient regarding impressions of the healthcare provider; i.e. caring, helpful, dismissive, hostile, confident, incompetent, etc. This is NOT the time to obtain a comprehensive orientation level. ● Use Lowest level of stimuli to determine mental status ● If unresponsive begin assessment for CPR, Compression, Airway, Breathing (C-A-B)
♦ Assess ● Airway – patent? ● Breathing – Adequate or inadequate ● Circulation – pulse, bleeding, skin ♦ Manage life-threatening situations ● Control life-threatening external bleeding Place in shock position - <u>if signs of hypo perfusion</u>	● Noisy respirations indicate an obstructed airway and airway positioning or maneuvers must be instituted to provide a patent airway. ● Assess for foreign body such as food, gum, etc. ● Visualize chest and signs of inadequate breathing ● Check radial or carotid pulses. Radial pulse may be absent due to decreased blood pressure. ● Capillary refill is most appropriate in pediatric patients. Not accurate in cold environments ● Capillary refill can be taken at any skin area such as: fingernail bed, palm, chest, forehead., etc. (if using the ball of the foot in pediatric patients, must be in a supine position)
♦ Priority Patient? ● CALL 911	♦ Altered, unresponsive, sudden illness, uncontrolled severe bleeding or broken bones is IMMEDIATE EMS CALL

NOTE: During the Primary Assessment, begin treatment of obvious conditions. Sample History and Baseline Vitals can be taken while caring for the injury.

Secondary Assessment - Baseline Vitals	
Skill Component	**Comments**
EYES	
EYES ♦ Assess pupils for equal reaction to light	● Make sure to complete cover the eye to obtain a good assessment
LEVEL OF CONSCIOUSNESS	
♦ Alert and Oriented to: ● To name ● To place ● To time	Assessment can be verbalized as patient being Alert and Orientated times the number of questions they are able to answer (example: Patient is A & O times 3)
SKIN SIGNS	
♦ **Assess for:** ● Color ● Temperature ● Moisture	● Color: Pale/normal to patient/flush(red) poor perfusion; cyanotic (bluish) ● Temperature: Hot/warm/cold ● Moisture: Dry/normal/diaphoretic(sweaty)
RESPIRATIONS	
♦ **Assess for:** ● Rate ● Quality: Normal, shallow, labored or noisy ● Tidal Volume	Respiratory rates: Adult 12-20/minute Child 15-30/minute Infant 25-50/minute ● Rate can be calculated by counting for 30 seconds and multiplying by 2. • Abnormal pattern should be counted for 1 full minute ● Quality: (Normal, shallow, labored or noisy) • Evaluated by the use of accessory muscles, patient position. ● Tidal Volume (How much effort vs work needed to breath ● Determine if Normal, increased, or decreased
PULSE	
♦ **Assess for:** ● Rate ● Rhythm: regular or irregular ● Quality: strong or weak	**Pulse rates**: Infant 100-190/minute Child 60-140/minute Adult 60-80/minutes

	● **Rate** • Can be calculated by counting for 30 seconds and multiplying by 2. • An irregular pulse should be counted for 1 full minute ● **Rhythm** • Regular rhythm – consistent interval between beats • Irregular rhythm – a beat may be early, late or missed. **ALL IRREGULAR RHYTHMS ARE ABNORMAL** ● **Quality** • Strong (normal) • Weak (difficult to feel)

Secondary Assessment - SAMPLE Medical History	
Skill Component	**Comments**
Signs and Symptoms	● Evaluate if the current illness or injury reflects chief complaint ● Determine what occurred to onset the incident ● For more detailed information on signs and symptoms look at the Medical Care chart
Allergies	● Determine if patient is allergic to any medications, food or other substance ● Also determine what reactions the patient had to any of them
Medications	● Determine what medications was the patient prescribed and dosage amount ● Determine when the medication was last taken
Past Pertinent History	● Obtaining information as to whether the patient is under physician care and the name of primary medical doctor or health plan, assists in eliciting medical history and transport destination. *Obtain information from family or bystanders if patient is unable to provide the needed information*
Last Oral Intake	● Last oral intake is important when there is a possibility the patient may require surgery or if there is a potential for aspiration or if the person is having an allergic reaction
Events Leading	● What are the key events that led up to this incident?

For Medical Patient Care
See Medical Care Chart

Detailed Physical Examination	
NOTE: Physical Examination is injury specific; once injured area is examined the rest of the examination can occur after caring for the injury.	
Skill Component	**Comments**
♦ **Assess for:** ● Deformities ● Open Injuries ● Tenderness ● Swelling	● Adults - head to toe examination works best ● Children - toe to head examination works best to gain child's confidence
♦ **Assess the scalp/head** ● Inspect and palpate the scalp and ear ● Assess the eyes ● Assess the facial areas including oral and nasal area	Asymmetry of head and face may be due to trauma or medical problem such as stroke or Bell's palsy (unilateral facial paralysis of sudden onset and unknown cause) Battle signs – bruising over the mastoid process indicates a basilar skull fracture or fracture of the temporal bone Raccoon eyes – bruising of one or both orbits indicates facture of the sphenoid sinus. Battle signs and raccoon eyes develop some time after the injury and generally are not seen upon EMS arrival, if noted, this may be due to a previous injury

	Fluid from the ear or nose (Cerebral Spinal Fluid or CSF) also may indicate leakage of spinal fluid resulting from a basilar skull fracture
♦ **Assess the neck** ● Inspects and palpates the neck ● Assess for Jugular Vein Distention (JVD) ● Assess for Tracheal Deviation (TD)	● JVD presents with enlarged jugular veins protruding from under the skin ● TD presets with the trachea off to the left or right of center ● If suspected, Lifeguards shall perform spinal immobilization based on mechanism of injury
♦ **Assess the shoulder** ● Inspects ● Palpates	
Assess the chest/ribs ● Equal rise and fall of the chest ● Stability of the sternum ● Equal expansion of the chest	● Maintain patient modesty and perform chest palpation in a manner as to avoid any inference of impropriety
♦ **Assess the abdomen/pelvis** Assess the abdomen Assess the pelvis	Lifeguards providers should palpate each of the 4 quadrants bilaterally one time only to assess for rigidity and guarding. Further palpation does not add to examination findings and results in unnecessary pain. Guarding is a reflexive tightening of abdominal muscles as depth of palpation is increased. Use finger pads to palpate, **Do Not Use** finger tips to palpate. Pelvic injuries are critical and have the potential for major blood loss. DO NOT palpate if there are obvious pelvic injuries or patient complains of pelvic pain, **IMMEDIATE EMS CALL SHOULD BE INITIATED**

Detailed Physical Examination - Continued	
Skill Component	**Comments**
♦ **Assess the extremities – lower** ● Inspects and palpates each extremity ● Assess CMS	● Compare bilateral pulses, motor movement and sensation ● Abnormal sensations may be tingling, burning or numbness. ● Inspect and palpate extremities utilizing offset pressure.
♦ **Assess the extremities – upper** ● Inspects and palpates each extremity ● Assess CMS	● Compare bilateral pulses, motor movement and sensation ● Abnormal sensations may be tingling, burning or numbness. ● Inspect and palpate extremities utilizing offset pressure.

On-going Assessment	
Repeat initial assessment Comfort and reassure Reassess care provided Transfer care and information to EMS	Priority patients are patients who have abnormal vital signs, S/S of poor perfusion or if there is a suspicion that the patient's condition may deteriorate. Evaluating and comparing results assists in recognizing if the patient is improving, responding to treatment or condition is deteriorating. Communication is important when dealing with the patient, family or caregiver. This is a very critical and frightening time for all involved and providing information helps in decreasing the stress they are experiencing. Report should consist of all pertinent information regarding the assessment findings, treatment rendered and patients response to care provided.

Medical Care Chart		
Sudden Illness	**Signs and Symptoms**	**General Care**
Shock – Hypo perfusion	● Extreme thirst ● Restlessness, anxiety ● Rapid, weak pulse ● Rapid, Shallow respirations ● Mental Status Changes ● Pale, cool, moist skin	● Keep patient calm, in position of comfort. ● Keep patient warm – attempt to maintain normal body temperature. ● Do Not Give Food or Drink ● Lay patient in supine position

Anaphylactic Shock Can occur when people come into contact with a substance to which they are allergic	● Burning, itching, or "breaking out" (Such as hives or rash) ● Difficult and rapid breathing, with possible chest pain and wheezing. ● Rapid, very weak or not detected pulse ● Restlessness, often followed by fainting or unconsciousness	● SAMPLE History and Vitals ● Consider assist with inhaler or Epi Pen ● Treat for shock ● Make sure EMS has been called
Respiratory Distress	● Labored or difficult breathing, a feeling of suffocation ● Unusual breathing sounds ● Rapid or slow breathing ● Unusual pulse rate and character ● Changes in color of lips, skin, and nail bed: usually, color will change to blue or gray ● Confusion or hallucinations	● Monitor ABC ● Comfort and reassure ● SAMPLE history & Vitals ● Keep patient at rest ● Place in sitting position, allowing proper drainage from mouth ● Reassess
Stroke Blocking or bursting of vessels that supplies blood to the brain.	● Looking or feeling ill ● Changes in LOC ● Numbness of face, arm, leg ● Difficulty talking or understanding ● Blurred or dimmed vision, unequal pupil size ● Severe headache, dizziness, confusion ● F.A.S.T. (facial drooping, arm movement, slurred speech, time to call EMS)	● Check Pronator Drift – Arms out in front, close eyes (if there is stroke usually once side drifts) ● Call 911 ● Monitor ABC ● Comfort and reassure ● SAMPLE History & Vitals ● Reassess
Heart Attack Failure of circulation to the heart muscle that damages or kills portion of the heart	● Chest or upper abdominal sensation of pressure or burning, often mistaken for indigestion. ● Pain may localize behind sternum and radiate to either arm or shoulder. Pain may extend to hand, neck, jaw, teeth, upper back, upper and middle abdomen ● Shortness of breath, nausea, and sweating. ● Increased pulse rate, irregular pulse	● Call 911 ● Monitor ABC's ● Comfort and reassure ● SAMPLE history & Vitals ● Call EMS ● Get AED/BVM Prepare to preform CPR ● Reassess

Medical Care Chart - Continued

Sudden Illness	Signs and Symptoms	General Care
Diabetic Emergency	● Hyperglycemia: Insulin level too low and sugar level to high ● Hypoglycemia: Insulin level to high and sugar level to low.	● SAMPLE History ● Look for medical tag ● Sugar if conscious

Fainting Can happen when not enough oxygen flows through your blood into your brain **Seizure** Can result from altered or irregular electrical activity in the brain caused by: fever infection, chronic epilepsy.	• Standing up to fast • Vigorous exercise • Hyperventilating • Getting very upset • Lung Buster • Aura: unusual sensation or feeling prior to onset. • Drooling, body may become rigid • Eyes roll upward, may urinate or defecate • May experience sudden, uncontrollable, muscular contractions	• Call 911, if patient has history of fainting, or other medical history • Rest and “catch” breath • Breath at normal rate • Calm and Reassure • Do not restrain, protect from injury • Maintain airway, place in recovery position after convulsion • SAMPLE history and Physical exam
Hot & Cold Emergencies	**Signs and Symptoms**	**General Care**
Heat Exhaustion	• Muscle cramps in legs and abdomen • Warm, moist flushed skin • Headache, nausea, weakness, dizziness • Loss of consciousness • Weak, pulse and rapid shallow breathing • Heavy perspiration	• Move patient to cool area • Loosen or remove clothing • Provide fluids • Treat for shock & monitor ABC’s • Apply moist towels over cramped muscle • Apply gentle, but firm pressure on cramped muscle
Heat Stroke	• Rapid Shallow breathing • Rapid pulse • Weakness, loss of consciousness • No Perspiration • Large (Dilated) Pupils • Seizures, muscular twitching, or coma	• Move patient to cool area • Rapidly cool patient • Keep skin wet by applying wet towels • Fan the patient, to increase heat loss • Place cold packs on neck, armpits, wrists, ankles, and groin • Monitor ABC & make sure EMS is called
Hypothermia	• Shivering • Delayed capillary refill • Altered Level of Consciousness • Large (Dilated) Pupil	• Remove patient from cold • Gradually re-warm • Monitor vitals • Make sure EMS has been called
Hot & Cold Emergencies	**Signs and Symptoms**	**General Care**

Frostbite	● White, cold skin ● Painful or painless extremities ● Delayed capillary refill ● Occurs deep in affected tissue	● Remove patient from cold ● Limit movement of injured part ● Cover affected area w/dressing and bandage loosely. ● Treat for shock ● Make sure EMS has been called

Musculoskeletal Injuries

Note: Don't be alarmed by the nature of the injury provide standard care.

Emergency	Signs and Symptoms	General Care
Fractures	Broken skin tissue, tender swollen tissue, bruising, pale, cool skin, protruding bone, Increased respiratory and pulse rate Nausea and vomiting. Thirst Mental Status Changes.	● Lessens pain. ● Prevents further damage. ● Reduce the risk of serious bleeding. ● Reduce possibility of loss of circulation to injured part. ● Immobilize bone by splinting joints above and below injury. ● Immobilize joint by splinting bone above and below injury.
Types of Splints:	*Rigid *Anatomic *Soft *Traction *Circumferential * Vacuum	
Rules of Splinting:	● Splint before moving the patient, only if environment is life threatening. ● Expose injury site. ● Control all major bleeding. ● Dress open wounds before splinting ● Check Circulation, Sensation, and Motor Function before and after splinting	
Sprain/ Strains	● Utilize the R.I.C.E method: Rest, Ice, Cold, & Elevation	

Burn Care

Burn Classification	● Superficial: Sun burn ● Partial Thickness: unopened blisters ● Full Thickness: open blisters
All Burn Care	Flush affected area with large amounts of water. Remove all smoldering Clothing Continue to flush affected Area Apply dry sterile dressing loosely

Identifying Critical Burns	• Burns causing breathing difficulty • Burns cover more than one body part • Burns to head, neck, feet, or genitals • Any partial or full thickness burn to children or senior citizens • Burns resulting from explosion • Call 911
Electrical Burns - General Care	Flush area with large amounts of water, Apply dry sterile dressing loosely
Rule of 9's	A method for estimating the extent of a burn; divides the body into 11 surface areas, each of which comprises approximately 9 percent of the body, plus the genitals, which are approximately 1 percent.
Dry/Liquid Chemical Burns – General Care	Brush off dry chemical, Flush area with large amounts of water, Apply dry sterile dressing loosely

Drug Abuse and Misuse	
Narcotic	Stupor, euphoria, s

	i m i l a r s i g n s t o d e p r e s s a n t s
Stimulant	Moist skin, sweating, chills, nausea, vomiting, fever, dizziness, rapid pulse and breathing, chest pain, excited, restlessness, talkative, irritable
Hallucinogen	Sudden mood changes, flushed face, hallucinations, anxious, and frightened
Depressant	Drowsiness, confusion, slurred speech, slow pulse and breathing, poor coordination

General Care for Drug Abuse and Misuse	● Monitor personal safety ● Monitor ABC's – Be alert for respiratory arrest ● Gain patient confidence/ maintain LOC's ● Protect from further harm ● Care for shock and continue to reassure
P o i s o n s	
Routes: **Ingestion – T**aken into the body by way of mouth **Inhalation – T**aken in by breathing **Absorption – A**bsorbed through the skin and body tissue **Injection –** Enters directly into the bloodstream	
General Care for Poisoning	● Monitor ABC's ● SAMPLE History ● Make sure EMS has been called
E m e r g	

Emergency Childbirth		
1st Stage (Dilat	**2nd Stage (Expulsion):** Full dilation of the cervix to the delivery of the infant	**3rd Stage (Placenta):** Delivery of infant to the delivery of the placenta, 30 mins after childbirth

ion): Regular utterings contractions to fulfill duties of the service		

History of Pregnancy Pertinent questions asked to provide adequate care)	#of pregnancies**,** Total # of live births, Prenatal care**,** Expected Due date, Broken water, Last menstrual cycle**,** Expected complications
Imminent Delivery	Contractions increasing in intensity and frequency (2 mins. Apart 60-90 sec. intervals), Urge to Push**,** Sensation to move bowels**,** Crowning
Crowning	Infant's head is at the vaginal opening

Emergency Child Birth	
Delivery of the infant	Support the infant's head Check for the umbilical cord and that it's not wrapped around the infant's neck Delivery of the upper shoulders Suction of the mouth and nose with bulb emptying it before inserting it into the mouth or nose. Umbilical cord; double camp cord 6" or greater from infant, use clean scissors or scalpel
Care for Newborn	If newborn is not actively crying, stimulate by rubbing the baby's back and flicking the feet. If the heart rate is less than 100 or respirations < 30, perform neonatal CPR (3 compressions to 1 breath)
Special Situations	
Nuchal Cord (when the umbilical **cord** becomes wrapped around the fetal neck 360 degrees)	If unable to slip cord overhead, clamp the cord in two places three inches apart and cut between the clamps in the middle.
Prolapsed Cord (umbilical cord presents first)	Elevate hips with pillows or put the patient in a "knee chest" position Cover the cord with a dressing moistened with sterile saline

Breech Presentation (Limb presentation)	Left lateral Trendelenburg position If baby's body delivers and head fails to deliver in one to two minutes, create an airways by placing a gloved hand into the vagina and making space for the infant until the head delivers. Be sure to explain the procedure to the mother.
Limb Presentation	Left-lateral Trendelenburg position
Meconium Stains (A sign of fetal or maternal distress Results from the fetus defecating Stains the amniotic fluid greenish or brownish-yellow in color)	Reduce the risk of aspiration by not stimulating the infant before suctioning the airway Suction the mouth and nose
Post Delivery Care	Fundal massage**,** Allow infant to breast feed Treat mother for shock

Trauma Care	
Note: Dressing: A clean or sterile pad placed directly over a wound to absorb infection **Bandage:** Material used to apply pressure to a wound or support an injured body part.	
Skill Component	**Comments**
<u>Bleeding Control</u> ◆ Remove enough clothing to expose entire wound	
◆ Manage bleeding by applying direct pressure with dressing and elevate the wound	● Direct pressure may involve just the finger tips or may require hand pressure
◆ Apply roller bandage	● Apply roller bandage whether or not bleeding has stopped. DO NOT remove original dressings.

Life threatening extremity bleeding ♦ Apply a commercial tourniquet as distal as possible on the extremity, at least 2 inches above the wound ♦ Apply a hemostatic dressing for wounds not on an extremity or when a tourniquet is not available or effective ♦ **IF unavailable**, an improvised tourniquet may be considered. Constricting band and dowel to control continued bleeding	● Application of a tourniquet is a last resort. All other possibilities must be exhausted prior to the application of a commercial device. ● Note time tourniquet was applied in bold notes ● When using a hemostatic dressing make sure to apply firm direct pressure.
Musculoskeletal Injuries ◆ Stabilize and expose the injured extremity: ● Cut clothes away ● Remove shoes and socks ● Remove jewelry	● Shoes must be removed to assess for pulse and sensation ● Some extremities may be readily exposed and do not require that clothes are cut ● Jewelry must be removed
◆ Assess the injury	● Do not move if painful
◆ Assess extremity distal to injury for: ● Circulation ● Motor function ● Sensation	● Circulation - check for present pulse ● Motor function - have patient wiggle fingers ● Sensation - pinch digits
◆ Select and prepare proper splint for stabilization and immobilization:	● The splint should achieve the goal of stabilization and immobilization of the joint above and below the fracture site. ● The splint should achieve the goal of stabilization and immobilization of the bone above and below the fracture site. ● Shimming involves padding the extremity in the splint to decrease movement of the extremity. Make sure there is even pressure and contact ● Apply cold pack, if needed to reduce swelling
◆ Re-assess extremity distal to injury for ● Circulation ● Motor function ● Sensation	● Every 5 to 15 minutes and make adjustments as necessary
For Trauma Patient Care	
See Trauma Care Chart	

Skin injuries	Signs and Symptoms	General Care
Contusion (Internal Bleeding – Closed Wound)	Discolored, tender swollen hard tissue, Increased respiratory and pulse rate, Pale, cool skin Nausea and vomiting. Thirst Mental Status Changes	Apply direct pressure, Rest immobilize, cold
Abrasion	Scrapping or rubbing of skin	Apply Direct Pressure w/dressing Pressure Bandage, Apply additional dressing & bandage
Laceration	Cut Skin	Apply Direct Pressure w/dressing Pressure Bandage, Apply additional dressing & bandage, tourniquet
Puncture - Penetration	Impaled Object	Expose wound Apply bulky dressing around object Bandage the bulking dressing
Protruding Organs	Usually around abdomen	Cover the wound and/or organs with moist, clean dressing.
Amputation	Complete loss of extremity or digit	Wrap completely in sterile dressing Place in plastic bag and seal Place bag on ice
Chest Injuries	**Signs and Symptoms**	**General Care**
Sucking chest wound **Flail Chest**	Crushing injury Two or more ribs broken in 2 or more places May cause difficulty breathing	Lessens pain, dress any open injuries with sterile gauze, prevents further damage. Keep patient in most comfortable position calm and reassure.
Tension Pneumothorax	complete collapse of lungs	Lessens pain, dress any open injuries with sterile gauze, prevents further damage. Keep patient in most comfortable position calm and reassure

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BLEEDING

Procedure			
Skill Component	**Yes**	**No**	**Comments**
♦ Apply dressing ♦ Apply direct pressure			
NOTE: THE EXAMINER MUST NOW INFORM THE LIFEGUARD THAT THE WOUND HAS STOPPED BLEEDING.			
♦ Apply pressure bandage to secure dressings			
♦ Call 911 – If bleeding becomes unmanageable *If bleeding becomes unmanageable jump down to the next table*			
♦ Properly position the patient and continue to care			
After proper management of injury, obtain vitals, SAMPLE history, begin detailed physical exam.			

If bleeding becomes unmanageable:			
♦ Add additional dressing and bandage ♦ Apply direct pressure ♦ Continue until paramedics arrive and take over or until bleeding become manageable.			
♦ Properly position the patient and continue to care			

After proper management of injury, obtain vitals, SAMPLE history, begin detailed physical exam.

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RIGID SPLINT/SLING

Procedure			
Check Circulation, Sensation, and Motor Function before and after splinting			
Skill Component	**Yes**	**No**	**Comments**
♦ Assess Circulation			
♦ Assess Motor Function			
♦ Assess Sensory Function			
♦ Applies SAM Splint to Extremity o Properly measure, form, & places the splint			
NOTE: THE EXAMINER GIVES CONDITIONS OF "CMS".			
♦ Immobilizes Above and Below Injury Site			
♦ Applies Sling and Swathe			
♦ Assess Circulation			
♦ Assess Motor Function			
♦ Assess Sensory Function			
NOTE: THE EXAMINER GIVE CONDITION OF "CMS".			
- If indicated ♦ Corrects intervention to obtain initial CMS			

♦ Properly position the patient and continue to care			
After proper management of injury, obtain vitals, begin detailed physical exam and obtain SAMPLE history.			