



THE DIGITAL MANUALS

Sports First Aid

 **First Aid Training**
Co-operative

QUALITY TRAINING SAVES LIVES

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Introduction to First Aid for Fitness and Sports



About this manual

This series of first aid manuals is designed to compliment our first aid training courses and to act as a stand-alone learning resource. Participants on our courses receive a free PDF copy of the manual to accompany their course. This manual does not replace the requirement for appropriate first aid training. This manual is part of a series. To purchase additional First Aid Manuals, visit our [website](#).

First Aid Training Co-operative courses are quality assured and all trainers undergo advanced training and are qualified trainers and assessors of first aid. Trainers take part in annual CPD and are monitored regularly.

This manual has been written by Cory Jones of the First Aid Training Co-operative. Cory has been running advanced first aid courses worldwide since 2001. The content of this manual follows the European Resuscitation Council's latest guidance 2025.

The style of this manual is to give you clear instruction on what to do in a first aid incident. This includes links to training videos on our [You Tube channel](#), blogs on our website and other relevant pages within the manual. These can be helpful for a deeper understanding of a particular technique or protocol, or refreshing your memory in the future.

First Aid in a sports or fitness context can present a wide range of challenges. As often as not there will be bystanders, possibly a large number of them at a big match. There is a often lot of pressure to resume play or activity, and the first aider needs to be able to make strong decisions in the casualty's best interest under significant pressure.

The first aid incident procedure is covered throughout this manual.

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Contact the First Aid Training Co-operative for any First Aid enquiries.

VISIT THE WEBSITE

A Assess / Airway / Alertness

B Breathing

C Circulation

D Disability/Discover/Damage

E Emotions / Environment / Ensure / Evacuate / Expose

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What is First Aid?



First aid is immediate care given to a person who is injured or taken ill. The immediate nature of first aid incidents makes them stressful to deal with. The good news is with most incidents, your role as a first aider is a temporary one, looking after casualties until support arrives.

People are often worried about doing the wrong thing which prevents them from doing first aid. If a casualty is not breathing or bleeding badly, prompt immediate action can save a life. It is important to stay calm in an emergency situation. To help you stay calm it is important to try and stick to the [Incident Procedure](#).



Aims of First Aid

- 1. Preserve life – Assess the scene to ensure it is safe to approach and treat the casualty. Check for potential cross contamination issues at the scene. Consider the welfare of bystanders and colleagues.
- 2. Prevent worsening – Use the Incident Procedure to assess the casualty and help you make decisions about any treatment required. Only do what is reasonable and what you have been trained to do.
- 3. Promote recovery - Reassure casualty and contact emergency services if required.

Responsibilities of a First Aider

- 1. Preserve life – The rescuer, bystanders and the casualty
- 2. Prevent worsening – Protect casualty from further harm
- 3. Promote recovery – Treat illness or injury. Reassure casualty and bystanders

READ THE RESPONSIBILITIES BLOG

Emergency Planning



As the first aider you must take charge of an incident and decide whether to call for the emergency services. Every emergency is different; by following an Incident Procedure you can gather information as to the seriousness of the situation.

First aiders in the workplace should have access to a suitable first aid kit.

An **Emergency Action Plan** can help to make incidents less stressful and save precious time. A workplace specific protocol should be created for each work site, including information such as: location, access to location, nearest hospital, closest AED, closest mobile phone reception, personnel to notify including their contact details, plus other applicable information.



Calling for HELP

- 1. Call 999 or 112 if you need to contact the emergency services. 999 is the UK emergency response number and 112 works anywhere in the European Community, plus many other countries.
- 2. If the casualty refuses help, still dial 999 if the situation is serious and inform the call handler.
- 3. A bystander can call for help for you but make sure they have good basic information to pass onto the call handler. Ask the caller to return and inform you that help is on its way.

Give Good Information

- L – Location
- I – Incident
- O – Other services required e.g. police
- N – Number of casualties
- E – Extent of injuries
- L – Location (confirm)

Handover Information

- A – Age of casualty
- T – Time of Incident
- M – Mechanism of injury
- I – Injury details
- S – Signs and Symptoms
- T – Treatment given (and impact of treatment)

Legislation and Regulations



In the UK, first aid must be carried out in line with the *Health and Safety Executive (HSE) First Aid Regulations*. All employers and self-employed businesses have a duty to have provision for first aid in the workplace.

HSE states that in specific sectors, staff are required to undertake appropriate first aid training. Sports coaches and fitness instructors have a Duty of Care to look after

those in their charge and a reasonable level of first aid competence is required as part of this.

The leisure and sports sectors National Governing Bodies set the requirements for first aid in their area.



First Aid Needs Assessment

The HSE requires every employer to carry out a first aid needs assessment. This is to work out the level of first aid cover required within the business and what first aid training staff need. First Aid Training Co-operative have a FREE resource available to help an employer carry out this needs assessment.

GET THE FREE
RESOURCE HERE

READ THE
DUTY OF CARE
BLOG

First Aid Provision

[Health and Safety
Executive First Aid
FAQ's](#)

[Approved Code of
Practice and Guidance
L74 2018](#)

Scene Survey

When you arrive on scene, carry out a Scene Survey in order to assess for dangers and hazards. Removing a hazard may include turning off electricity or stopping traffic at a road incident. You should leave dangerous situations to the emergency services to manage and call 999 immediately.

Thought	Action
Assess the scene for danger	Use all your senses. Stop and look, take your time. Don't approach unless safe to do so. Call 999 immediately if not safe to approach.
Assess for Hazards	Remove these if safe to do so or move the casualty if the situation is life threatening.
Assess for Cross contamination	Look for cross contamination hazards at the scene, including life-threatening bleeding.



Cross contamination / Infection Control

Take care when approaching the casualty to check for broken glass or other objects that might cause hazard to you or the casualty. Look for any vomit, blood or other fluids on the ground.

Wear nitrile gloves when possible. After an incident wash your hands with soap and water, followed by proper hand drying.

[HSE guidance on blood borne viruses in the workplace.](#)

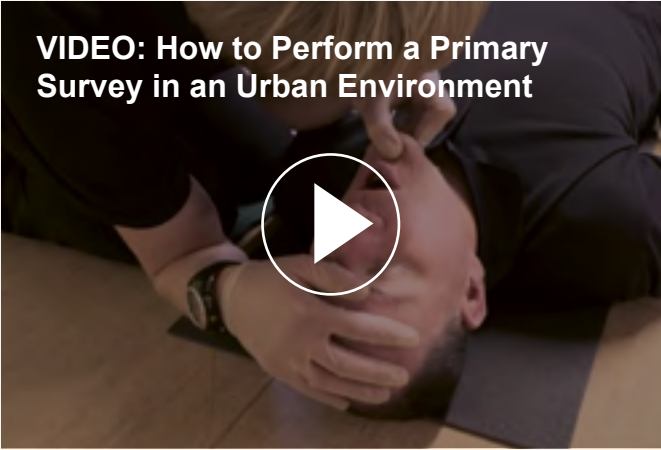


Incident Procedure (ABC)

This is the initial assessment of the incident scene and a primary survey of the casualty. It provides a systematic way of assessing what has happened and what to do next. The ABC procedure will help you stay calm under pressure and guide you through an incident.

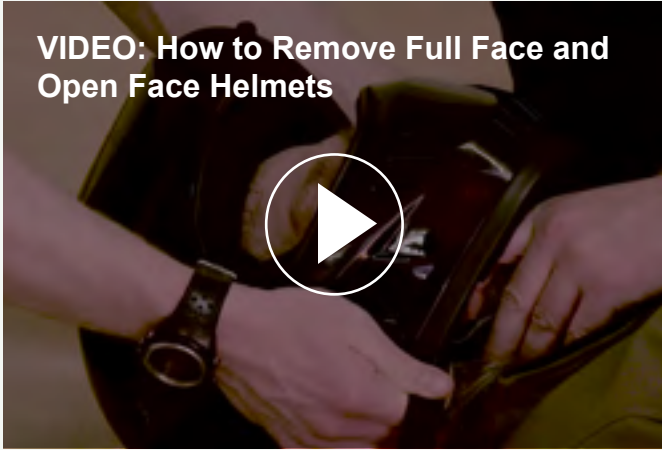
Thought	Action
A - Assess the scene and casualty	Stop and look, is it safe to approach? Think cross contamination, consider gloves.
A - Alert response (ACVPU)	Ask a question, shout command and touch shoulders. If no response, shout or call for 'Help!'
A - Airway	Head tilt and chin lift. Check mouth. Keep head tilted and chin lifted.
B - Breathing	Look, listen and feel for breathing for up to 10 seconds with chin lift ON and then OFF.
C - Circulation	Look for significant bleeds. Look for significant bleeds – including on clothing and ground.

Watch the Videos



Incident Procedure in an Urban Setting

The first aid priority is always to keep checking the airway is open and the casualty is breathing effectively. If the airway is compromised, put the casualty immediately into the [recovery position](#).



Helmets

If the airway and breathing are compromised by a casualty's helmet, you will need to remove it.

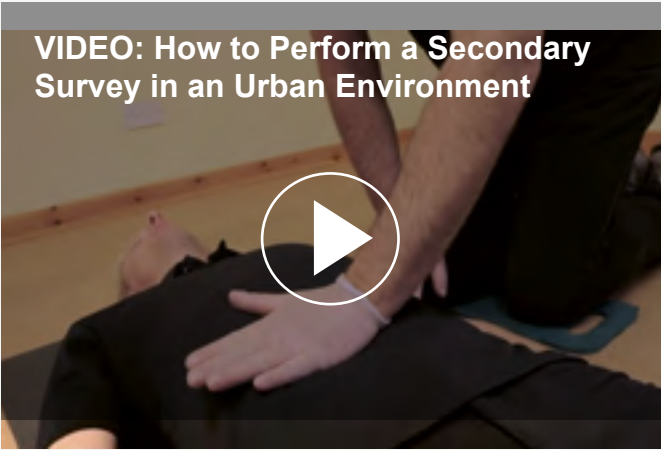
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Secondary Survey

Once you have completed the primary survey and dealt with any life-threatening conditions, it is safe to perform a secondary survey to check for injury or illness. This can be carried out on a conscious or unconscious casualty. If the casualty is conscious, talk to them in order to ascertain whether they are fully alert (A on the ACVPU scale) or appear to be confused relevant to their own "normal" (C on the ACVPU scale).

'Head to Toe' casualty assessment	A systematic search for evidence of damage or illness
Head and neck	Feel around head and face for swelling / deformity. Check pupil response and ears/nose for discharge. Feel neck bones to check alignment.
Shoulders and chest	Feel around and compare shoulders. Does chest flex? Is breathing equal in both lungs?
Abdomen and pelvis	Compare quarters of the abdomen and feel for differences. Check for abnormalities. DO NOT squeeze or spring pelvis.
Legs and arms	Check for deformity.
Clothing and pockets	Look for clues, ID, medi-tags or medication. Watch out for sharp objects. Loosen tight clothing.

Watch the Videos



In a **Secondary Survey**, evidence may include include medi-tags or medical information on mobile phones or in wallets or pockets. Carefully remove and check anything you find but ensure belongings are kept safe.



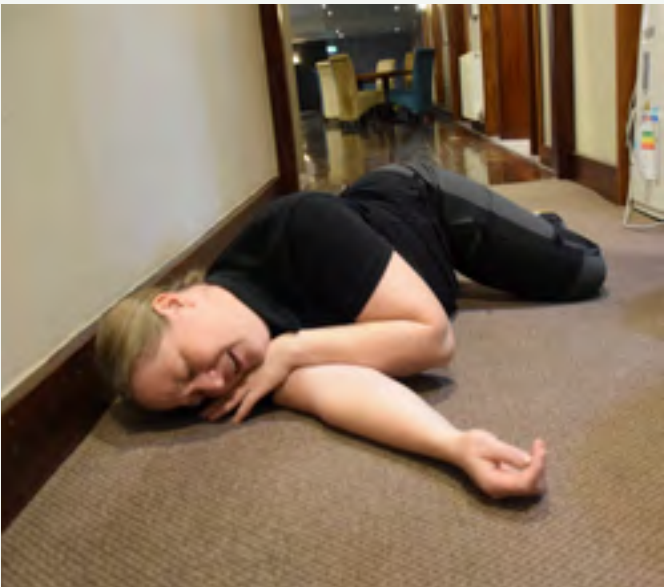
Insulate and Shelter. Think how you can protect them from the elements.

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Recovery Position

The **Recovery Position** provides a safe airway position. For a non-alert casualty it maintains an open airway and promotes normal breathing. It helps fluids (saliva, vomit, mucus) drain from the casualty's airway. Never leave an unconscious breathing casualty on their back, it risks obstructing their airway.

Sequence	Action
Preparation	Remove glasses, obstructions in pockets, loosen tight clothing. Check ground for obstructions.
Initial position	Kneel beside the casualty, move their nearest arm out to the side. Lift up their far knee and hold it, bring the casualties far arm across to the side of their cheek.
Head support	Bring their hand under their head and use your hand to support the head in preparation for the roll.
Roll casualty towards you	Pull the casualties lifted knee towards you; support their head as they roll onto their side. Ensure they are stable, roll their shoulder over too if necessary.
Re-check breathing	Tilt the casualty's head back and pull chin forward to reopen the airway, keep the face tilted down to allow draining. Re-check their breathing.



On uneven ground or in enclosed spaces it may not be possible to use the technique as described above. Try and move the casualty as carefully as you can to give them a **Safe Open Draining Airway**.

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Watch the Video



After 30 minutes you should roll the casualty onto their other side, unless they have an injury that prevents this.

Pregnant women should be rolled onto their left hand side if possible.

Casualty Vital Signs and Monitoring

Vital Signs and Monitoring. If you are with the casualty for some time before the emergency services arrive, monitoring the casualty is essential. This information should be recorded and handed to emergency services on their arrival. Changes to vital signs will help inform your decision-making.



Colour of the blood is an indication of oxygen levels in the body. Red / pink blood is well oxygenated, blue blood or pale skin may indicate low oxygen levels. Look under eyelids and at gums to check colour.

Temperature can be taken by using your hand on a casualty's skin. Take a core temperature in the casualty's armpit or under their collar. Normal temperature is warm on dry skin. Cold skin may indicate hypothermia (dry skin) or shock (clammy skin). Hot skin may indicate heat stroke (dry skin) or infection (wet skin).

Breathing rate and quality are important. An average adult breathes between 12-18 breaths per minute (2-3 in 10 seconds). To measure breathing, look, listen and feel. Place your cheek next to the casualty's mouth, feel and listen for breathing. Look down the line of the body for abdominal movement.

Pulse is a measure of the heartbeat. Take it at the wrist (radial) and neck (carotid) using your fingers, not thumb, pressing lightly on the skin. As well as recording a rate, feel for strength (strong or weak) and rhythm (regular or irregular). An average adult pulse is 60-90 beats per minute.



DOWNLOAD
FREE CASUALTY
MONITORING CARD

PREPARE FOR
CASUALTY
HANDOVER
READ THE ATMIST BLOG

Level of Consciousness
A – Alert, “Can answer questions sensibly”
C – Appears confused compared to normal
V – Responds to verbal commands
P – Responds to a pressure or pain stimulus
U – Unresponsive to any stimulus

Seizures

Seizures are caused by sudden abnormal brain activity. They are not always caused by Epilepsy. They can be caused by electric shock, head injuries and some illnesses. Major seizures can cause convulsions which can be frightening for bystanders.

What do I see?	What do I do?
A casualty having convulsion/seizure	Do not move casualty unless they are in danger. Protect them with cushions and by moving objects out of the way if possible.
What time is it?	Note the time. If the seizure lasts longer than 5 minutes call an ambulance.
When the seizure finishes	Place the casualty in the recovery position. If they regain consciousness, reassure and find out history.
What should I ask?	Do you know what happened? Has it happened before? Is this normal for you?
Bystanders	Reassure and move them away from the scene. Think about casualty dignity.



Absence Seizure

Some seizures are relatively minor. Casualties may present as if daydreaming or be clothes picking or similar. There is little you can do apart from reassure and make sure the casualty is safe from harm. Logging the incident may be useful.

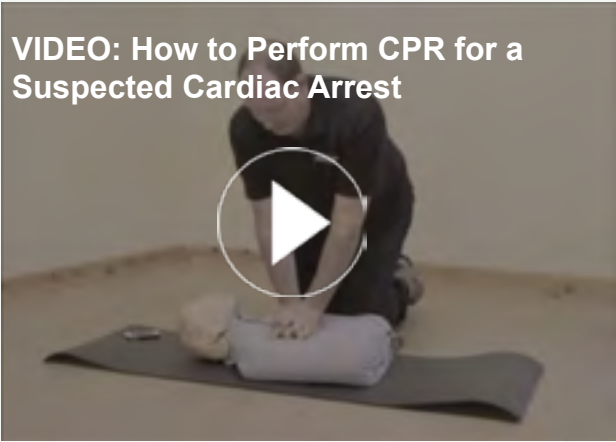
Call an ambulance for a casualty who's seizure is abnormal to them: If it is their first seizure, if the seizure is repeated, continues for longer than 5 minutes or if there is associated damage or injury.

- Do not restrain casualty
- Do not place anything in their mouth

Adult Cardiac Arrest CPR (Non-Breathing Adult)

A casualty who is unresponsive and not breathing can be assumed to have suffered Cardiac Arrest. Such casualties run out of oxygen quickly and brain cells can only live a few minutes without oxygen. Cardio Pulmonary Resuscitation (CPR) is designed to keep blood and oxygen flowing around the body. If you have a helper(s), change over every minute. Use a CPR face shield to help prevent cross contamination.

Sequence	Action
A - Assess for danger	Stop and look, is it safe to approach? Think cross contamination and consider gloves.
A - Alert response	Ask a question, shout command and touch shoulders. If no response, shout for 'Help!' Phone 999 - if on your own activate speaker. UNRESPONSIVE CASUALTY.
A - Open airway	- Head tilt, check mouth, chin lift. - Keep head tilted and chin lifted.
B - Check breathing	- Look. Listen. Feel. (up to 10 seconds) Is breathing effective? - IF BREATHING IS INEFFECTIVE - INFORM 999 CALL HANDLER. - Request/ retrieve defib if available. Return & ensure safety for all.
C - CPR	- Kneel by the side of the casualty. - Heel of hand in centre of chest. - Fingers interlocked or hands crossed. - Arms straight & vertical. Press down to a depth of 5 – 6 cm and allow for recoil of chest after each compression. 30 compressions at a rate of 100 – 120 per minute. - Head tilt. Chin Lift. Pinch Nose. - Open mouth with chin lift maintained. - Perform 2 breaths (1 second between breaths.) 30 compressions. 2 breaths. Continuously (30:2).



Chain of Survival

Early CALL

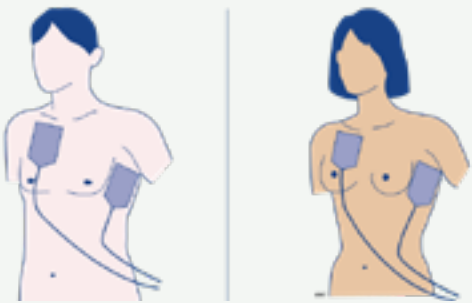
Early CPR

Early DEFIB

Early CARE

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AED (Defibrillator) Use



A casualty suffering from **Cardiac Arrest** is very unlikely to survive without an **Automatic External Defibrillator (AED)**. However if defibrillation is delivered promptly, survival rates are significantly increased. Optimal conditions for defibrillation are present only for the first few minutes after the cardiac arrest. Success rates decrease thereafter by at least 10% per minute of delay.

An AED is a computer and battery with two self-adhesive pads that attach to the casualty's chest. These read heart signals from the casualty to indicate if an electric shock is required to reset the heart. The AED will only shock a heart that is not working effectively. The AED will only deliver a shock where one is necessary. Voice prompts from the AED will tell you what to do



DON'T HESITATE TO USE AN AED, EVEN IF YOU HAVEN'T BEEN TRAINED TO USE ONE

To find your nearest AED, check defibfinder.uk, or phone 999.

When using a defibrillator:

- Cut away clothing or jewellery that might interfere with the pads
- Shave chest hair if necessary where pads are going to be placed
- Dry the casualty's skin if it is moist, before attaching the pads
- Make sure you don't touch the casualty as the shock is delivered
- Casualty may appear to jump when they are shocked, this is normal
- AED's are now available in many public spaces and increasingly in rural areas
- If pads are reversed, leave them in place
- AEDs are used alongside CPR



READ THE AED BLOG

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Heart Attack

A heart attack is usually caused by a clot in one of the blood vessels feeding the heart with blood (oxygen). The signs of a heart attack do vary but some are included on the list below. Don't forget to ask the casualty if they have angina and let them take their medication if they have it.

What you see	What you do
Some or all of the following: • Tight pain in the chest. • Pain can move down the arm/s, neck or shoulder. • Pale, cold, clammy skin. Grey/blueness around the lips. • Casualty may have 'an impending sense of doom'. • Dizziness, shortness of breath.	• Sit casualty down and reassure. • Place in the lazy W position, leaning back against the wall with knees raised. • Call 999/112 immediately, prepare to resuscitate if necessary. Send helper for defibrillator. • If they are not allergic and consent to doing so, they can take an 'Aspirin' chewed slowly in the mouth. • Reassure, reassure, reassure.

Angina

Often found in older people this is a narrowing of the blood vessels that feed the heart with blood. Symptoms are similar to those of a heart attack. Most people with angina know they have the illness and have medication. If they have their medication, let them take it. Often it is a spray, which is administered under the tongue. Placing in the lazy W position may make them more comfortable.

If the symptoms do not diminish quickly, assume a heart attack and follow instructions above.

Put the casualty into the Lazy W position



READ THE ANGINA BLOG

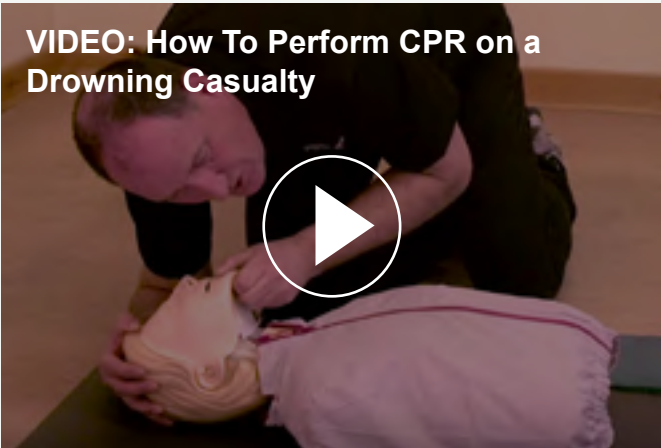
READ THE HEART ATTACK BLOG

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CPR for Drowning

If the incident indicates a history of drowning, an alternative CPR protocol is used. Drowning essentially means the body is being denied oxygen. Therefore the protocol requires you to help the casualty by delivering oxygen into their blood stream. This may be enough to bring them round immediately.

Action for drowning	
A - Assess for danger	Stop and look, is it safe to approach? Think cross contamination and consider gloves.
A - Alert response	Ask a question, shout command and touch shoulders. If no response, shout for 'Help!' Phone 999 - if on your own activate speaker. UNRESPONSIVE CASUALTY.
A - Open airway	- Head tilt, check mouth, chin lift. - Keep head tilted and chin lifted.
B - Check breathing	- Look. Listen. Feel (up to 10 seconds). Is breathing effective? BREATHING IS INEFFECTIVE - Perform emergency breathing - Head Tilt. Chin Lift. Pinch nose. - Open mouth with chin lift maintained. - Perform 5 breaths (1 second between breaths, letting chest fall between breaths).
C - CPR	- Kneel by the side of the casualty. - Heel of hand in centre of chest. - Fingers interlocked or hands crossed. - Arms straight & vertical. Press down to a depth of 1/3 of the chest and allow for recoil of chest after each compression. 30 compressions at a rate of 100 – 120 per minute. 2 breaths after every 30 compressions. If no helper or phone available, continue with CPR for 1 minute then leave casualty to make a 999 call. Request or Retrieve Defibrillator if available. Return and ensure safety for all. 30 compressions. 2 breaths. Continuously (30:2). - Always be ready to deal with vomiting.



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Fluid in the airway?

To clear any fluid from the airway, put the casualty into the [recovery position](#). This will help to drain fluid from the airway.

Secondary (dry) Drowning occurs when water enters the lungs in small quantities, usually following a near drowning incident. Over time (hours), the lungs become irritated and are less efficient at oxygen transfer. Watch for difficulty breathing, coughing, chest pain, blue lips or pales skin. The casualty may vomit. If you suspect secondary drowning, call the emergency services.

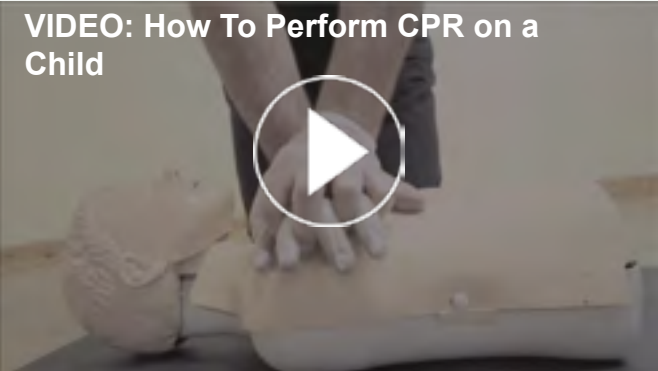
Child and Infant CPR

A child or infant who is not breathing is likely to be asphyxiating, causing a lack of oxygen in their blood. As children are smaller, use less force to compress their chest. Compressions are more effective if done with the casualty on a hard surface.

Action for children / infants	
A - Assess for danger	Stop and look, is it safe to approach? Think cross contamination and consider gloves.
A - Alert response	Ask a question, shout command and touch shoulders. If no response, shout for 'Help!' Phone 999 - if on your own activate speaker. UNRESPONSIVE CASUALTY.
A - Open airway	- Head tilt, check mouth, chin lift. - Keep head tilted and chin lifted.
B - Check breathing	- Look. Listen. Feel (up to 10 seconds). Is breathing effective? BREATHING IS INEFFECTIVE - Perform emergency breathing - Head Tilt. Chin Lift. Pinch nose. - Open mouth with chin lift maintained. - Perform 5 breaths (1 second between breaths, letting chest fall between breaths).
C - CPR	- Kneel by the side of the casualty. - Heel of hand in centre of chest. - Fingers interlocked or hands crossed. - Arms straight & vertical. Press down to a depth of 1/3 of the chest and allow for recoil of chest after each compression. 15 compressions at a rate of 100 – 120 per minute. 2 breaths after every 15 compressions. If no helper or phone available, continue with CPR for 1 minute then leave casualty to make a 999 call. Request or Retrieve Defibrillator if available. Return and ensure safety for all. 15 compressions. 2 breaths. Continuously (15:2). - Always be ready to deal with vomiting.

For **Child CPR** aim to compress the chest by 1/3 of its normal size. If the casualty is a large child, treat them as an adult: 'Treat as you See'.

For **Infant CPR**, (less than 1 year old) you may need to give ventilations by making a seal with your mouth over their nose and mouth. Ensure you support the head to maintain an open airway. Clasp the infant's chest in your hands and use two thumbs to do chest compressions



Dealing with Choking (in Adults)

Choking occurs when a foreign object blocks the airway. Coughing can clear mild obstructions, indicated by the casualty's ability to speak. Severe obstructions (full choke) require your physical intervention.

Sequence of increasing intervention for a fully choking adult

- Seek permission to help the casualty.
- Ask the casualty to cough.
- If they cannot cough, support them and try a firm backslap, followed by 4 more if the object is not dislodged, continually checking if the casualty can cough or speak.
- Attempt an abdominal thrust. Try a further 4 thrusts, continually checking if the casualty can cough or speak.
- If a bystander is present, ask them to call 999/112 and ask for an ambulance.
- Continue with 5 back slaps followed by 5 thrusts until the object is dislodged.
- If the casualty collapses and stops breathing, start CPR.

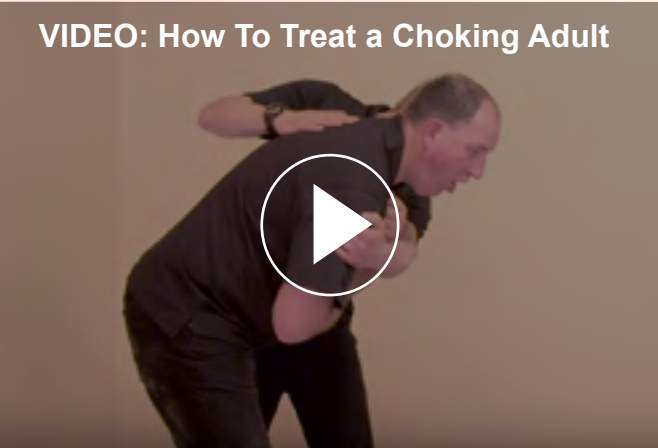
Where an abdominal thrust is not possible, e.g. a pregnant women or an obese casualty, a chest thrust can be given as an alternative. Lean the casualty against a hard surface and compress their chest firmly.

If you have attempted an abdominal thrust, advise the casualty to go to hospital for a check up, as internal damage may have occurred.

READ THE CHOKING BLOG

Watch the Video

VIDEO: How To Treat a Choking Adult



Dealing with Choking (Children and Infants)

Choking occurs when a foreign object blocks the airway. In first aid, individuals who have not yet reached puberty are considered to be children.

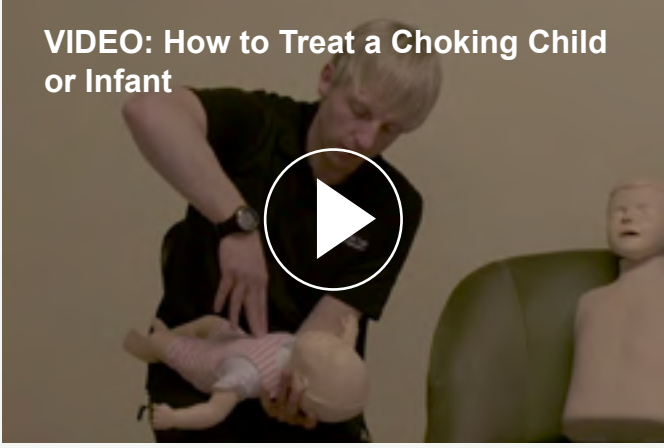
Sequence of increasing intervention for a choking child or infant

- Encourage the child to cough.
- If they cannot cough, try a firm backslap; leaning the child over your knee, with their head below their chest.
- Followed by 4 more backslaps if the object is not dislodged, continually checking if the casualty can breath or speak (cry).
- Attempt an abdominal thrust. This can be achieved by kneeling behind the child.
- Try a further 4 thrusts, continually checking if the casualty can breath or speak (cry).
- If a bystander is present, ask them to call 999/112 and ask for an ambulance.
- Continue with 5 back slaps followed by 5 thrusts until the object is dislodged.
- If the casualty collapses and stops breathing, start CPR.



Watch the Video

VIDEO: How to Treat a Choking Child or Infant



For infants (less than 12 months old) lay the baby face down over your thigh to perform backslaps. For chest thrusts lay them face up across your thigh, with head below shoulders. Perform chest thrusts using two fingers.

DO NOT attempt Abdominal Thrusts on an Infant (<12 months).

Bleeding Management

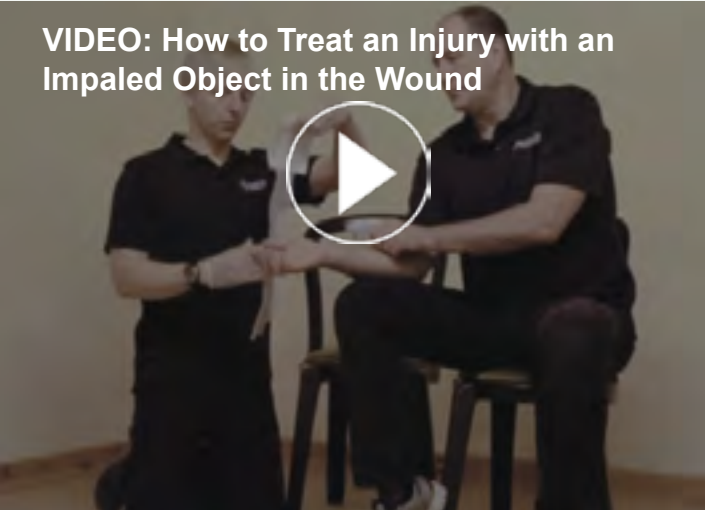
Bleeds can be caused by an abrasion (friction grazes), amputation, incision (a cut with clean edges), laceration (a cut with jagged edges) or a puncture (object passes through or becomes impaled in the skin). Do not remove impaled objects, bandage around them instead.

How to manage a bleed	
C - Check the wound.	Visually inspect the wound for impaled objects. Clean the wound with water to remove soil and dirt. Ensure safety, wear nitrile gloves.
A - Apply pressure. 10 minutes of direct pressure stops most bleeds.	Direct pressure with an absorbent, non-adherent dressing. If there is an impaled object, apply indirect pressure by bandaging around it.
R - Raise limb above level of the heart.	This will reduce blood flow and promote clotting.
E - Ensure bandage is effective.	Check if too loose, or too tight by checking <u>capillary refill</u> beyond the injury. If bleeding continues, add an additional bandage. If the second bandage is ineffective, remove both and reassess injury.

Watch the Video



VIDEO: How To Treat a Major Bleeding Incident



VIDEO: How to Treat an Injury with an Impaled Object in the Wound

Other Bleeding Problems

Internal bleeding can result from injuries to chest, abdomen, upper leg and pelvis. Significant volumes of blood can be lost but still remain within the casualty's body, therefore internal bleeding can be difficult to recognise but should still be considered a life threatening emergency.

What do you see	What do you do
- Swelling, tenderness, distended (swollen) muscles. - Discolouration of the skin. - Guarding of the injury. - Signs of <u>SHOCK</u>.	- Suspect internal bleeding. - Treat for SHOCK. - Do not elevate legs if this may compromise the injury. - Call 999 / 112 and report suspected internal injury.

Crushing injuries need special care. Release the pressure quickly if possible and inform the emergency services. Do not release a casualty who has been crushed by a heavy object for more than 15 minutes as toxins may have built up in the blood.

Nose bleeds - Lean the casualty forward, pinching the fleshy lower part of the nose. If bleeding has not stopped after 10 minutes, seek medical advice.

Plasters should be used to cover small cuts and grazes. This helps to prevent infection and aid healing.

READ THE
CRUSHING INJURIES
BLOG

Monitor the wound for any changes in colour, sensation or movement and the casualty for any changes in vital signs.

READ THE
CASUALTY
MONITORING BLOG

Watch the Video



VIDEO: How To Treat a Minor Amputation

Minor Amputation – Control blood loss first, do not let casualty eat or drink. Put the severed part in a plastic bag and wrap in a dressing or small towel.

Keep the part cool by placing in a bag of cool water or a filled water bottle. Note the time and take the casualty to hospital urgently.

Shock and Life Threatening Bleeding

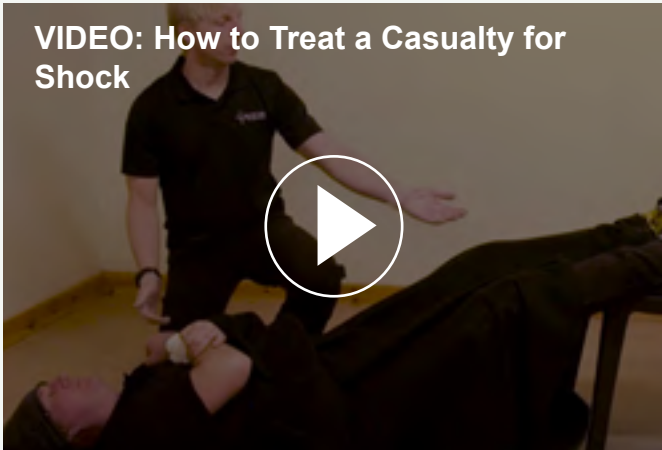
Shock is lack of oxygen to our vital organs, in particular the brain, caused by blood loss or a major burn. Shock is a life threatening emergency and a life saving priority. If in doubt, treat for shock in the case of any significant bleed or burn, even before you see signs or symptoms.

What do you see	What do you do
• Pale, cold, clammy skin. • Fast shallow breathing. • Worried, anxious casualty. • Fast weak pulse. • Drop in level of alertness eg: dizziness or confusion.	• Lie down a conscious casualty, elevate legs and keep warm. • Put unconscious casualty in recovery position. • Call 999/112. • Reassure the casualty and try not to leave alone. • Monitor the casualty's vital signs.

Watch the Videos



Life-Threatening Bleeds need to be treated very quickly, once you have assessed the scene for danger. You may need to apply wound packing bandages along with lots of pressure. You may need to improvise bandages with clothing and in extreme cases use emergency or trauma bandages, clotting (haemostatic) bandages, or tourniquets.



Serious burns can lead to shock. [Follow burns advice.](#) For serious burns call 999/112 immediately. Cool with clean water. Do not break blisters; do not remove bitumen from skin. Do remove tight objects (e.g. rings). Remove clothing unless it is sticking to the skin.

READ THE
MAJOR BLEEDS
BLOG

Minor Injuries (cut/splinter/minor burn/bruise)

Minor Injuries are often treated in the workplace or home and do not require a visit to the hospital. As with all first aid cases it is important to talk to the casualty, build rapport and trust.

What do you see	What do you do
• Small cut	• Clean the wound, dry and cover with a sterile dressing (plaster).
• Splinter	• Clean the area. Use clean tweezers to remove the object carefully. Allow wound to bleed a little to flush dirt. Clean and cover the wound.
• Minor burn	• Run under tepid water for a minimum of 20 minutes or until the pain stops. Remove any jewellery, cover with a sterile dressing.
• Bruise	• Apply a cold compress to the bruise, this helps reduce swelling and pain.



24 Hour Medical Advice

With all of these injuries if you are not sure what to do, seek medical advice. In the UK, DIAL 111 for the free NHS 24 helpline.

The helpline is open 24 hours a day, 7 days a week. NHS 111 also offers a video relay service that allows you to make a video call to a British Sign Language (BSL) interpreter.

Sepsis

Sepsis is a form of blood poisoning caused by the immune system over reacting to an infection or injury. This leads to the immune system attacking organs and tissues rather than fighting the infection.

Sepsis is hard to diagnose and is easily missed by both first aiders and medical professionals.

How to Spot Sepsis	
Sepsis in Adults	
• Slurred speech or confusion • Extreme shivering or muscle pain • Passing no urine	• Feeling of impending doom • Skin mottled or discoloured
Sepsis in Children	
• Breathing very fast • Fitting or convulsing • Skin mottled, bluish or pale	• Rash that does not fade when pressed • Very lethargic or difficult to wake • Abnormally cold to touch
Sepsis in Under 5's	
• Not feeding • Vomiting repeatedly • Has not passed urine in 12 hours	

If you suspect **Sepsis** call 999 or 112 immediately, especially if the casualty appears to be deteriorating.

In minor cases, call 111 or contact your GP and monitor the casualty.



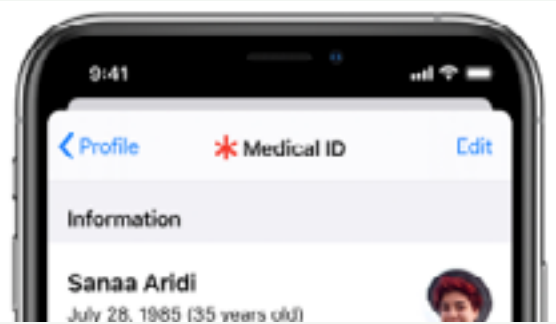
When talking to any healthcare professional, ask:

“Could it be Sepsis?”

READ THE SEPSIS BLOG

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S.A.M.P.L.E.



The acronym **SAMPLE** is used in the assessment of casualties. It is a way to help first aiders remember the correct information to gather at the incident scene, it often referred to 'Taking a SAMPLE history'.

Signs and symptoms - A sign is something you observe. A symptom is something the casualty feels and tells you about.

Allergies, age, athleticism - Ask if the casualty has ever had any allergic reactions to any medications or foods. Ask them their age. Do they look athletic? This will affect their baseline vital signs.

Medications - Ask if the casualty takes any prescription medicines or is taking any other drugs.



SAMPLE information together with [vital signs information](#) is important to hand over to medical staff once they arrive on scene. It will give great assistance to the medical staff that take over casualty care. Ensure that information is kept confidential.



Past medical history - Ask about relevant medical history.

Last oral intake - Ask about the casualty's last intake of food and drink, this is especially important if the condition could be caused by food or drink.

Events leading up to the illness or injury – Ask what happened in the time leading up to the injury or illness?

SAMPLE

S – Signs and symptoms

A – Age, athleticism, allergies

M – Medication

P – Past history

L – Last oral intake

E – Events leading up to incident

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First Aid Kits

All employers and sole traders should have access to a first aid kit; this includes all works vehicles. Sufficient stock should be kept at hand to cover your workplaces' requirements.

A white cross on a green background should identify first aid kits. Boxes should be visible and easily accessible.

There is a British Standard for workplace first aid kits (BS 8599-1) and kits for vehicles (BS 8599-2) but these are not compulsory contents. The employer is required to assess potential hazards in the workplace and compile a first aid kit accordingly.

Contents of the kit should be checked regularly by a responsible person to ensure that there is sufficient quantity and none of the items' use-by date has expired.

BS 8599-1:2019 First Aid Kit Contents List				
Contents	Small	Medium	Large	Travel
F/A guidance leaflet	1	1	1	1
Medium sterile dressing	4	6	8	1
Large sterile dressing	1	2	2	1
Triangular bandage	2	3	4	2
Safety pin	12	12	24	12
Eye dressing	2	3	4	1
Adhesive dressing	40	60	100	20
Sterile wet wipe	20	30	40	4
Microporous tape	1	1	1	1
Nitrile gloves - pair	6	9	12	1
Face shield	1	2	3	1
Foil blanket	1	2	3	1
Burn dressing 10 x 10cm	1	2	2	1
Clothing shears	1	1	1	1
Conforming bandage	1	2	2	1
Finger dressing	2	3	4	0
Sterile eyewash 250ml	0	0	0	1

Clean Up

- Clean up the scene and any equipment used
- Bag up any wastes (body fluids, used dressings etc.) or sharps and dispose of in accordance with current standards
- Restock the first aid kit
- Compete and file documentation

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READ THE FIRST AID KIT BLOG

First Aid Reporting



First aid incidents should be recorded in an **incident/ accident/ near miss book** (different organisations use differing terminology) within 24 hours of the incident occurring. Anyone with knowledge of the incident (including the casualty) can complete the form but it is often your job as the first aider to do so.

Serious accidents at work (e.g. result in death, major injury, injuries lasting more than 7 days) must be reported directly to the HSE in line with the [RIDDOR regulations](#).

Employers can use the information from the accident report to identify improvements in the workplace. The reports are also legal documents and may be used for insurance or investigative purposes. These documents should be saved for at least 3 years.



After an Incident ...
After an incident it is important to put some time aside for yourself. It is common for the first aider to feel they didn't do enough or worry that they made mistakes. Often just talking through the incident will allow you to clear your head. If feelings persist or return in the future it is important to seek counselling.

First Aid Report Form includes as a minimum

- Date, time and place of incident.
- Name, job and date of birth of casualty.
- Details of illness or injury and treatment or advice given.
- What happened immediately afterwards (hospital, went home, etc.).
- Name and signature of person dealing with the incident.
- Name and signature of witness.

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Soft Tissue Injuries

Commonly caused by trips, slips and falls in a variety of sporting activities. Sprains and strains affect joints and surrounding soft tissues, which can be overstretched or torn.

What do you see	What do you do
• Pain and tenderness at injury site. • Swelling and discolouration. • Loss of movement.	• Rest – Sit down and support the injury. • Ice – Apply a cold compress to reduce pain and swelling. • Compression or comfort bandage - Optionally, use an elasticated bandage to support injury and help reduce swelling. Bandages should not be left on overnight. • Elevation – Raise the injury above the level of the heart if possible.



Dislocations

Dislocations are hard to diagnose and as a general rule should only be re-located by someone trained to do so. A badly re-located dislocation will simply cause more pain and future problems. Immobilise the injury in the position you find it.

READ THE
SPRAINED ANKLE
BLOG

Ice should be applied in cycles of 10 minutes on and off the injury. Never allow ice to come into direct contact with skin or use on open wounds or broken bones. Remove ice if it causes an increase in pain.

If in doubt, treat the injury as a fracture and seek medical advice. The casualty may want to move ('walk it off') but this may cause further damage. If the casualty loses **Colour, Sensation or Movement** (CSM) seek medical advice immediately.

S.A.L.T.A.P.S. Injury Assessment

SALTAPS is a procedure for analysing an injury to a joint, to help identify whether a casualty should continue taking part in an activity. If at any point during the procedure, the casualty indicates pain or the injury appears nasty, then it is best to be cautious and make a [no return to play decision](#).

What do you see	What do you do
S - Stop/See	• See the injury occur. Assess the situation, stop play to gain access to the player.
A - Ask	• Ask for consent. What happened? • Get a detailed history. Did anyone see what happened? • Evaluate for pain, (facial expression, posture), orientation. • Are they talking sensibly?
L - Look	• Look at the limb, appearance of injury site. Bleeding, discolouration, bruising, immediate swelling, bone/joint deformity, muscle spasm.
T - Touch	• Touch injury site if the casualty will allow. Press gently to find the site of pain, note any response.
A - Active Movement	• Can the player move the limb painlessly through a full range of movement?
P - Passive Movement	• If active movement is ok, ask the player to relax their limb. The first aider can gently move the joint through its range of movement. Pain or tenderness at this point may mean there is a ligament or tendon injury. The casualty should seek medical advice.
S - Strength Test	• Move against resistance. • Stand unaided – look for guarding. • Progressive function test.

If an athlete complains about pain and reports that they can't move the injured site, it may be due to their instinct to protect the injury. A severe injury will either be obvious immediately or be identified through SALTAPS testing.

READ THE
PITCH DECISION
BLOG

Lower Leg Injury

Often called a ‘boot top’ fracture these often will show deformity and obvious damage. The first aider should immobilise the injury in a remote setting. Lower leg injuries may require re-alignment if professional help is delayed by over 30 minutes.

For ankle and lower leg injuries the first aider **MUST** remove the boot to assess for damage and colour, sensation and movement (CSM) at the end of the limb.

What do you see	What do you do
• Pain at site of injury, deformity. • Possible protruding bone. • Swelling and bruising. • Loss of power or movement in limb. • Poor capillary refill on limb below injury • Nausea and/or signs of shock.	• Immobilise the affected limb. • Monitor the casualty. • If the bone is exposed, control bleeding. Do not apply pressure directly to the bone. • Evacuate to hospital. • Do a capillary refill check on good leg and injured leg to compare and contrast • If removal to hospital is delayed, improvise a splint to immobilise the limb.

Lower leg re-alignment

Deformity should be corrected by manual traction (gentle pulling) as early as possible. Once pulled the foot can be rotated back into its correct anatomical position and immobilised. It may be necessary for a second person to hold the limb above the injury to keep it stable.

Realigning can significantly reduce pain and help circulation as well as prevent worsening of the injury.

READ THE CIRCULATION BLOG

Watch the Video



RETURN TO CONTENTS

Collar Bone and Arm Injuries

Arm and collar bone injuries are common impact injuries. These will require a sling in order to stabilise. You must ensure that any support the casualty is giving themselves is replicated by the sling. One memory aide for this is to ‘Bind as you find’.

What do you see	What do you do
Collar Bone	
• Pain at site of injury. • May notice an obvious step, skin may be stretched over bone (tenting). • Nausea and/or signs of shock.	• Immobilise the affected limb. • If the bone is exposed, control bleeding. Do not apply pressure directly to the bone. • Evacuate to hospital.
Arm and Elbow	
• Pain at site of injury, deformity. • Possible protruding bone. • Swelling and bruising. • Loss of power or movement in limb.	• Immobilise the affected limb. • If the bone is exposed, control bleeding. Do not apply pressure directly to the bone. • Evacuate to hospital.

Circulation checks

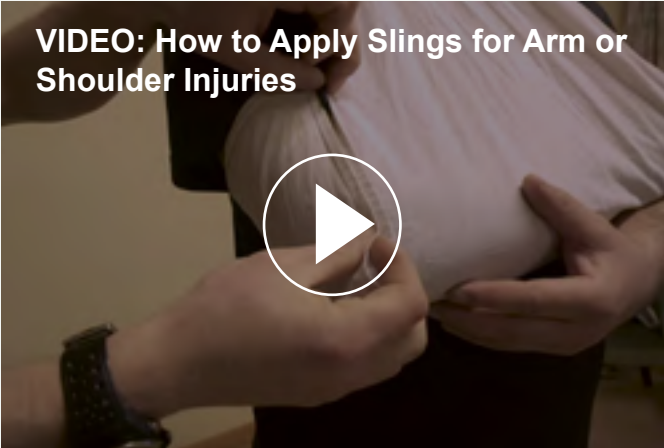
Regularly check for circulation and sensation at the wrist. If casualty has poor capillary refill or sensation (indicating a loss of circulation), evacuate immediately if possible or call emergency services.

Hand, finger and thumb injuries

Immobilise. Put a pad between fingers/thumb and lightly strap together. Place in elevated sling. Swelling will occur, loosen strapping when required. Get medical help.

READ THE CIRCULATION BLOG

Watch the Video



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Fractures



Fractures can be open, closed or complicated (involving nerves, blood vessels, or other tissues) and can be caused by direct, indirect or twisting forces. Your aim is to stabilise the injury. It can be hard to determine if an injury is a fracture, a sprain or a dislocation. Therefore it is safest to assume a fracture.

Watch the Video



Femur Splint - A broken femur can be potentially life threatening; try to immobilise the whole body. The casualty's leg may appear shortened. In a remote setting or when emergency services are significantly delayed, consider a traction splint.

Remember for serious fractures

- **ABC** - Don't be distracted by the casualty's pain or an obvious fracture.
- If the casualty loses Colour, Sensation or Movement in the limb below the site of injury, this is a medical emergency.
- **Shock is a significant risk with these injuries.**
- **Do not move casualty unless they have an airway problem.**

Concussion

Concussion is a mild form of Traumatic Brain Injury and even suspected concussions should be taken very seriously. Anyone who is suspected of suffering a concussion should not be allowed to recommence activity until certified as symptom-free by a medical professional.

Second Impact Syndrome, where a second impact occurs while concussion symptoms are still present, is fatal in up to 50% of cases, including undiagnosed concussions. It is the first aider's job to remove this possibility by monitoring the casualty.

If any of the symptoms in the following table are present, assume concussion. Some may only become apparent some time (up to 72 hours) after the incident.

Concussion Symptoms				
Headache	“Pressure in head”	Balance Problems	Nausea or vomiting	Drowsiness
Dizziness	Blurred Vision	Sensitivity to Light	Sensitivity to noise	Fatigue or low energy
‘Don’t feel right’	More emotional	More irritable	Sadness or depression	Nervous or anxious
Neck Pain	Difficulty concentrating	Difficulty remembering	Feel slowed down	Feeling “in a fog”

Concussion Testing can involve cognitive, memory and physical ability assessments as well as consideration of the history of the incident, and evidence of head trauma. This should be carried out on as part of a head injury assessment protocol.



Remember:

If in doubt,
sit them out

Concussion Recovery can take a long time, but symptoms will gradually improve with the appropriate treatment.

If in doubt, or if symptoms are getting worse, seek immediate professional help.

READ THE
CONCUSSION
BLOG

Head Injury

The brain is a soft vulnerable organ protected by the hard skull. As well as concussion, you should watch out for signs of compression and skull fractures. These often don't appear immediately and the casualty may appear OK initially before deteriorating. This is known as a Lucid Interval. If the casualty has sustained a head injury, always suspect a spinal injury too.

What do you see	What do you do
- Altered level of consciousness. <u>Signs of Concussion.</u> - Strong bounding pulse. - Face flushed. - Bleeding or bruising around eyes, mouth, ears. - Pupils NOT equal and reactive	- Lie casualty down, elevate head and shoulders. - Do not stop bleeding from nose or ears. - Call 999/112. - Monitor vital signs carefully. - Place unconscious casualty in recovery position.

Close and then open the casualty's eyes and observe any difference in the pupils as below



Remember P.E.A.R.L.

P – Pupils

E – Equal

A – And

R – Reactive to

L – Light

Cerebral compression occurs when there is a build-up of pressure on the brain caused by bleeding or swelling inside the skull – this is a life-threatening condition and you should call the emergency services immediately.

A **Skull Fracture** is where the bone is cracked or broken following a trauma. Sometimes identifiable by a soft boggy depression on the scalp, can also be hidden underneath external swelling. Skull fractures are almost always accompanied by concussion or a cerebral compression, and should be treated in hospital.



Spinal Injury

Spinal injuries can involve the back or neck bones (vertebrae), intervertebral discs or spinal cord. These can be difficult injuries to manage, especially injuries to the neck. One key indicator for spinal injury is the mechanism of injury which usually involves a fall or impact.

What do you see	What do you do
- Loss of limb control. - Casualty complains of pain in the neck or back. - Loss of feeling or a tingling sensation in limbs. - Loss of bladder or bowel control.	- Call 999/112 immediately. - Reassure casualty and maintain an open airway. - Take care to keep casualties head in line with the rest of their body – ‘Spine in Line’. - If the casualty loses consciousness, place in recovery position. - Use jaw thrust to open airway if trained to do so.



Place an unconscious casualty with a spinal injury in [the recovery position](#) to maintain an open airway. This is a higher lifesaving priority although care must be taken to maintain spinal alignment as much as possible.

Watch the Video



Spinal Log Roll. Two or more people can roll a casualty safely using a spinal roll which includes the use of a jaw thrust.

Chest Injury

A chest injury is any form of physical injury to the chest including the ribs, heart and lungs.

What do you see	What do you do
Broken rib	
• Pain when taking a breath. • Tenderness to chest or back over area of ribs. • A “crunchy” feeling under the skin • Shortness of breath.	• Very little you can do for it. Take to hospital.
Penetrating (sucking) chest wound	
• Assume all penetrating wounds are sucking chest wounds. • It can be difficult to identify when a penetrating wound is sucking air or not. They don’t always make noise.	• Leave an open wound uncovered. • Sit the conscious casualty down leaning towards the injured side. Unconscious casualties should be put into the recovery position and rolled onto the injury. • Evacuate immediately.
Flail chest	
• One or more broken ribs that are broken in more than one place each. • Uneven chest movement when breathing.	• Press a hard pad onto the flail segment to apply pressure. • Sit the conscious casualty down leaning towards the injured side. Unconscious casualties should be put into the recovery position and rolled onto the injury. • Evacuate immediately.

Monitoring

Chest injuries are complex to diagnose and treat. Deterioration is indicated by:

- Unequal chest movement (one side looks bigger than the other)
- Trachea (windpipe) moves towards uninjured lung
- Blue lips and neck

Subcutaneous emphysema is when air is in the layer under the skin. This has a crackling feel to the touch, a sensation that has been described as similar to touching Rice Krispies. This can be a symptom of an underlying chest injury.

Abdomen/Pelvis Injury

Abdominal and pelvic injuries can cause internal bleeding which may lead to [shock](#). The initial injury can be difficult to detect but there may be a history of impact to the abdomen. If casualty becomes unconscious, carefully place in recovery position.

What do you see	What do you do
Abdomen	
• Bruising, tenderness, swelling . • Hardness of abdomen near injury. • May be confused or aggressive. • May be blood in urine. • Think SHOCK.	• Find out history. • Call 999/112 and keep them calm. • Lie down and support legs if possible. • Do not remove penetrating objects. • Cover any wound but DO NOT push any protruding organs back into stomach.
Pelvis	
• Casualty unable to walk or stand. • Pain around groin, hips or back increasing with movement. • Difficulty in passing urine or priapism in men. • Think SHOCK.	• Find out history. • Do not move unless in an emergency. • Immobilise legs by tying together. • Call 999/112 and reassure and keep warm.



Internal Bleeding is often caused by impact (car crash) or fall from height. Blood (oxygen) can fill spaces between organs or drain from body (anus, ear, nose, mouth). Casualty may start to show signs of [shock](#) (cold, pale, clammy, anxious, fast shallow breathing) and require immediate evacuation.

Pelvis Splint - Move the pelvis as little as possible. Do not press or ‘spring’. If possible immobilise the legs by padding between them and bringing knees together. Gently tie a broad bandage the widest part of the pelvis like a ‘nappy’ if you need to move the casualty.

Asthma

Asthma is an allergic reaction that causes the tubes in the lungs to narrow. The amount of air (oxygen) leaving the lungs is therefore reduced meaning less fresh air can enter. This reduces the supply of oxygen to the body. Asthma triggers include: cat hair, pollen, cold air, stress or exertion.

What do you see	What do you do
• Difficulty breathing (mainly out). • Wheezing. • Tightness in chest. • Worried and anxious. • Difficulty speaking. • Blueness around lips. • Veins become prominent on neck.	• Make them comfortable, possibly by sitting them down and leaning forwards. • Assist them with the use of their inhaler. • Reassure the casualty. • Remove the factor causing the asthma. • If it doesn't improve in 5 minutes, call 999/112. • If they collapse place in recovery position. • If they stop breathing begin CPR.



Watch the Video

VIDEO: How To Use An Asthma Inhaler and Improvise a Spacer

Inhalers and spacers

Asthma sufferers should have their inhaler with them. If not, it is reasonable to ask bystanders if they have one the casualty can use. Spacers help administer the medication more effectively. Assist casualty with using their inhaler and spacer if required.

READ THE
ASTHMA BLOG

Diabetes

Diabetes results in an imbalance of the levels of sugar in the blood. Commonly we see hypoglycemia (low blood sugar levels) and occasionally we may see hyperglycemia (high blood sugar levels). Non-diabetics can also experience low blood sugar levels in certain circumstances.

What do you see	What do you do
Hypoglycemia – Low Blood Sugar Levels	
• One or more of feeling tired, weak, hungry, dizzy. • Change in personality, becoming irrational . • You may find a Medi-tag on the casualty.	• Sit casualty down and give sugar in form of a drink or glucose (sweets or biscuits). • Assist casualty to locate and use their glucose testing kit. • If casualty collapses call 999/112, try rubbing sugary gel into their gums (e.g. jam or syrup).
Hyperglycemia – High Blood Sugar Levels	
• Thirst, breathless, nausea. • Bleeding or bruising around eyes, mouth, ears. • You may find a Medi-tag on the casualty. • Fruity sweet breath.	• Call 999/112 immediately. • If casualty collapses or loses consciousness, place in recovery position.



Sugar Highs – Hyperglycemia is less likely for most casualties as it develops slowly. Medical assistance is required immediately if you suspect this.

Glucose - The brain exclusively uses glucose for energy. Hence the brain is very sensitive to changes in blood sugar level. A casualty with a poor blood sugar balance will have a disordered brain.

Stroke

Strokes are more common in later life and affect the brain. A stroke can be a blood clot or burst blood vessel in the brain. It may be possible to break up a clot with drugs in hospital. The quicker the casualty reaches hospital the better their chance of rehabilitation and recovery.

What do you see	What do you do
F – Facial weakness. Casualty can’t smile properly or may put their tongue to the side when they stick it out A - Arm weakness. Casualty can only raise one arm or has uneven strength in their hands S – Speech problems. Unable to speak clearly or understand T - Time to call 999/112	• Don’t waste time – if you suspect a stroke, call for the emergency services. • Reassure the casualty. • If conscious keep them supported in a comfortable position, possibly the lazy W position. • If the casualty becomes unconscious, place in the recovery position.

Time. It is important to note the time that the casualty was last known to be OK. This is vital information for the emergency services and may influence their decisions.

A Mini Stroke (TIA) is similar to a stroke but symptoms may only last a few minutes and may improve. A TIA may be the pre cursor to a full stroke.

If in doubt think STROKE and seek medical advice as soon as possible.

Stroke - Think F.A.S.T.

F – Face

A – Arm

S – Speech

T – Time to phone 999

Fainting

A faint is a brief loss in consciousness caused by a reduced blood flow to the brain. It may be due to stress, lack of food, pain or exhaustion. Fainting is more common in hot environments or when standing but inactive. Most people regain consciousness within a minute or two after fainting.

What do you see	What do you do
• Collapse potentially after nausea, dizziness or light-headedness. • Some casualties see white or black spots, experiencing blurry or tunnel vision . • Some casualties feel very hot or sweaty.	• Help them down. If you notice a person starting to faint, slowly lower them to the ground. • Position the casualty on their back and raise their legs. People regain consciousness quickly, usually between 20 seconds and 2 minutes. • Loosen any constrictive clothing (a tie or collar).



Fainting may be a sign that the casualty is unwell. Check history and if in doubt seek medical assistance. If the casualty does not regain consciousness quickly, place in [recovery position](#) and call 999/112.

Fainting in pregnancy – help the woman to lie down so she is leaning on her left hand side. This prevents the restriction of blood flow to the placenta.

Burns and Scalds

A range of things can cause burns such as; sunburn, electricity, hot water or chemicals. Fortunately the treatment is the same for each – cooling the affected area. If the skin is broken, take extra care, as the body’s natural infection barrier is not effective. Serious burns lead to fluid loss and [shock](#).

What do you see	What do you do
Minor Burns	
Redness on skin, painful.	- Remove heat source. - Irrigate with tepid/cool water for at least 20 minutes. - Remove constrictions (jewellery). - Prevent infection with a sterile dressing.
Major Burns	
- Skin broken (partial thickness). - Skin gone, can see fat, tendons, bone (full thickness).	- Cool quickly with cool water. - Remove clothing if loose. If clothing is stuck, leave in place. - Remove constrictions (jewellery). - Cover with sterile dressing. - Consider calling 999/112. - Lay down and treat for SHOCK.



- The following burns should be treated in hospital:
- Burns to face and mouth, hands, feet and genitals
 - Burns which completely circle a digit or limb
 - Minor burns larger than 5 times the size of the casualty’s palm
 - Partial thickness burns larger than the size of the casualty’s palm
 - Any full thickness (third degree) burn

READ THE BURNS
TREATMENT
BLOG

Poisoning

Poisoning occurs when a substance harmful to the body enters the system. This can be injected, inhaled, absorbed through skin, swallowed or eaten. Children are especially susceptible to objects that can be mistaken for sweets, such as washing machine tablets.

What do you see	What do you do
General Poisoning	
Conscious Casualty	DO NOT induce vomiting and - Seek medical advice. - Take a history from the casualty or witnesses, (What have they come into contact with?).
Unconscious casualty	Place in the Recovery Position.
Special Cases	
Absorbed poison	Irrigate the skin with water.
Swallowed poison	Keep warm, reassure and monitor.
Inhaled poison	Think ‘Airway’. If they stop breathing begin CPR. Provide a source of fresh air.
Injected poison	Stay safe. Look for needles and sharps.



- DO** - Attempt to collect or identify the poison. You can collect a sample of the vomit if you have no sample of the poison.
- In the workplace COSHH cards should be available.
- DO NOT INDUCE VOMITING**

Suspected Overdose

Drug use is the misuse or overuse of any medicine or drug, including alcohol. Any alcohol, medication, or illegal drug can cause damage if an overdose is taken.

A key thing for a first aider to always do, and especially in the case of intoxication or drug overdose, is assessing the danger to themselves. This could be danger from the casualty themselves acting irrationally, or from the substance they have overdosed on, or from things such as sharps or broken bottles laying around on the ground.

If there is a danger to the first aider that cannot be safely removed or mitigated, then calling for professional help (999/ 112 and asking for the Police) is a sensible response. After that, if you are able to do so, follow the ABCDE protocol.

What do you see	What do you do
• Blue, purple, grey lips • Cold and clammy skin • PEARL (Are pupils equal and reactive to light?) Pinpoint pupils = depressants (eg: Opiates/ Opioids) Pupils wide open – stimulants (eg: Ecstasy/ MDMA) • Breathing – may be very slow, weak, gurgly, snoring sounds, or absent • Not fully alert (Confused or lower on ACVPU scale)	• Assess for Danger (eg: Sharps, the Casualty – altered level of consciousness) • If unresponsive and breathing normally – Recovery Position, call for help (999/ 112) and monitor carefully • If unresponsive and breathing is ineffective call for help (999/ 112) and start CPR • If severe respiratory depression with suspected opiate/ opioid overdose, administer Naloxone/ Narcan if trained to do so.



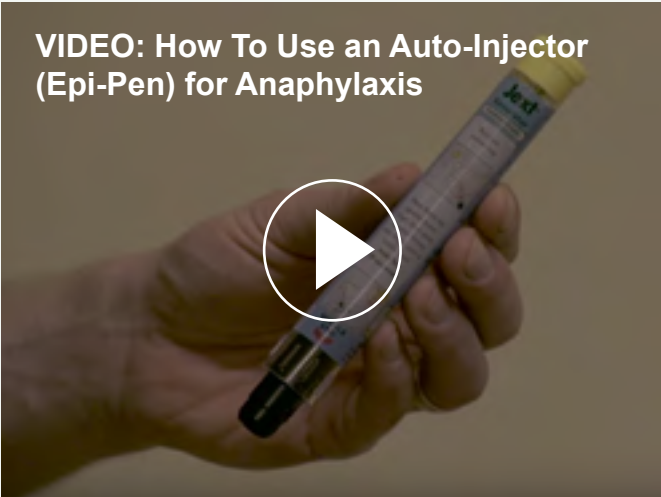
For more information on Naloxone/ Narcan go to the Scottish Drugs Forum or contact your local NHS Trust.

Anaphylaxis

Anaphylaxis is an extreme allergic reaction to a substance that is introduced to the casualty’s body. The body releases histamine as a natural defence mechanism and this causes swelling. If the swelling is in the mouth or throat, airway management becomes critical. Common causes of anaphylaxis include bee stings, latex, nuts, seafood and many fruits.

What do you see	What do you do
• Swelling of face, lips, neck, eyes. • Red blotchy patches on skin. • Difficulty in breathing. • Anxiety.	• Call 999/112 immediately. • Make the casualty comfortable. • Use their auto-injector if they have one. • If the casualty becomes unconscious put them in Recovery Position. • If the casualty stops breathing, start CPR.

Watch the Video



Can a first aider give an auto-injector? – YES. In the UK, a first aider should help the casualty use their auto-injector (Epi-pen, Amerade, Jext), even if the casualty is unconscious. Instructions are written on the side of the pen. Remove cap, press into thigh (through clothing), hold for 10-15 seconds, remove and rub the thigh. Use a second pen in the other leg if symptoms don’t improve after 5 minutes.

READ THE
EPI-PEN USE
BLOG

Eye Injury

Eye injuries are painful and troubling. They can cause permanent sight loss or severe damage to sight. Prevention is better than cure and correct personal protective equipment should be worn when needed. Chemicals, wind blown particles, impaled objects and bright light injuries are all of concern.

What do you see	What do you do
• Chemical burn. • Grit, sand, or dust in eye. • Impaled objects. • Sunlight (ultra violet exposure) and flash burn (glare from welders torch). Gritty feeling in eyes. Redness and watering of eyes. Symptoms may develop slowly.	• Irrigate with copious amounts of water. Ensure water drains away from good eye. Seek medical assistance if required. • Lay the casualty flat, irrigate, then cover the affected eye with a non fluffy dressing. If possible cover both eyes. Take to hospital. • Reassure, cover eyes with light, moist bandages and take to hospital. Do not try and remove contact lenses. Protect from further brightness.



Eye protection – sunglasses

Look for sunglasses that protect you from 99 to 100% of both UVA and UVB light. This includes those labelled as “UV 400”. Consider wrap-around sunglasses to prevent harmful UV rays from entering around the frame. Some contact lenses provide UV protection but they don’t cover the whole eye and protection will still be required.

READ THE
EYE FIRST AID
BLOG

Facial Injury

Immediate problems concern breathing issues. Maintaining the airway is a priority for facial issues. Always monitor the airway and casualties level of consciousness.

Problem area	What do you see and do
• Scalp wound	• Can bleed heavily. Help the casualty apply direct pressure with their hand to stem the blood loss.
• Gum shield	• Are typically removed (in conscious and unconscious casualties) as blood can accumulate behind the shield.
• Jaw	• Stepped appearance in teeth or unable to bite normally. Casualty can hold their jaw for support.
• Nose bleed	• Lean forward and pinch fleshy part of nose. Should stop within 10 minutes.
• Nose fracture	• Pain and deformity around nose. Do not touch, or blow nose. Go to hospital.
• Cheek fracture	• Try not to cough, sneeze or blow nose. Go to hospital.
• Teeth	• If tooth is still attached, leave in situ. If tooth has come out take to dentist with tooth in milk or saline solution.



Seek Medical Advice

If in doubt, especially with injuries involving the face and a potentially compromised airway, seek medical advice.

Hypothermia

Hypothermia is caused by the cooling of the body’s core organs when cold blood from the body’s surface reaches the body core. This affects the function of the heart and brain. It can occur in the outdoors in cold temperatures, or on warm days if casualties have been active e.g. runners after finishing a marathon.

What do you see	What do you do
Mild Hypothermia	
• Conscious and violently shivering. • Significantly reduced physical ability. • Cold, pale and dry skin.	• Insulate and wrap in foil or plastic blanket. • Shelter the casualty and insulate from the ground. • Remove and replace wet clothing. Rewarm slowly, give warm drinks and high energy food if available. • Keep casualty horizontal and handle with care.
Moderate Hypothermia	
• Conscious and fully alert on the ACVPU scale. • Shivering. • Cold, pale, dry skin.	• If conscious, as above but no food or drink. • Must be kept horizontal. • Call 999/112, ask for advice and arrange for professional evacuation as quickly as possible.
Severe Hypothermia	
• No response. • No apparent breathing. • Cold dry skin to touch.	• Treat as for Moderate Hypothermia. • Handle with extreme care. • Call 999/112 and arrange professional evacuation as quickly as possible.



Casualties who are cold but not yet hypothermic may be classed as ‘Cold Stressed’. They will be shivering, but mental and physical ability remain constant. Provide shelter, change them out of wet clothes, provide high calorie food & drink, and encourage exercise to generate heat.

In all cases beware of Circum-Rescue Collapse, which can be caused by cold blood circulating, incorrect rewarming, or rough handling.

Prevention of hypothermia is better than cure. Remind others to zip up coats and put on gloves and hats. If one person is cold and shivering it is a sign others may be close to becoming mildly hypothermic. Consider shortening the activity, refueling with warm drinks and food.

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Hyperthermia

Hyperthermia is caused by the warming of the body’s core. Heat exhaustion (mild hyperthermia) can occur after exposure to high temperatures or even on colder days if the casualty has exerted themselves. It is often accompanied by dehydration. It occurs when the core body temperature rises to up to 40 °C.

If untreated, heat exhaustion can lead to heat stroke. Heat stroke occurs if the body’s core temperature rises above 40 °C when the body’s natural thermostat can’t control body temperature. The cells in the body begin to break down, important functions cease, internal organs can fail, and in extreme cases death can occur. Heat stroke is a medical emergency, and you should summon immediate medical help (call 999/ 112 for an ambulance).

What do you see	What do you do
Mild Hyperthermia (Heat Exhaustion)	
• Conscious and fully alert on the ACVPU scale. • Weak and unwell. • Thirsty. • Headache, nausea. • Moist warm skin.	• Move to a cool area. • Shade. • Fluids to drink. • Oral rehydration solution will help.
Severe Hyperthermia (Heat Stroke)	
• Apathy, disorientation, irrational behaviour. • Rapidly decreasing response • Cold, pale and dry skin. • Slow shallow breathing. • Shivering rapidly decreasing.	• If conscious, as above but no food or drink. • Must be kept horizontal. • Call 999/112 and arrange professional evacuation as quickly as possible.

Prevention

- Wear lightweight, light-colored, loose-fitting clothing and a wide-brimmed hat.
- Use a sunscreen with an SPF of 30 or more.
- Drink extra fluids. Especially before, during and after activity.
- Avoid fluids containing either caffeine or alcohol, these will cause further dehydration.

Dehydration occurs when the amount of fluid lost from the body is not replaced quickly. As well as fluid, essential salts are lost through sweating. Dehydration commonly occurs due to exercise on hot days, prolonged exposure to sun or illness such as diarrhea or vomiting.

Severe dehydration can cause muscle cramps.

Rehydrate with electrolyte solution to replace water and salt.



Cold Water Immersion

The most common misunderstanding about cold water immersion is that it leads to immediate hypothermia. In fact, immersion in cold water causes multiple problems and we tend to use the 1-10-1 rule of thumb as a guide to each stage.

Three phases of cold water immersion
Within 1 minute
Cold shock - is the body's involuntary response to being suddenly immersed in cold water. It lasts for only about a minute. On entering the water the blood vessels constrict and the heart rate increases dramatically, an involuntary "gasp" as breathing rate increases too, leading to a feeling of panic. This can cause cardiac arrest and many casualties die due to these effects. Wearing a lifejacket or buoyancy aid greatly increases survival rates.
Within 10 minutes
Cold incapacitation - Muscle and peripheral nerve cooling leads to weakness and drowning. This occurs within 5 – 15 minutes in cold water. Blood flow decreases to the extremities, to preserve warmth in the core & vital organs. Muscle and nerve fibres don't work well when cold, resulting in loss of effective movement of the hands and feet. Swimming or effecting any form of self rescue is increasingly difficult.
Within 1 hour
Hypothermia – leading to unconsciousness and drowning. While times vary with water temperature and body mass, it can take 30 minutes or more.



Treatment for a cold casualty who is removed from the water immediately is to warm them quickly. Put on dry clothes give warm drinks and food.

Any cold incapacitated or hypothermic casualty must be treated with care and handled gently. Keep horizontal and limit movement. Monitor for Circum-Rescue Collapse, which can be caused by cold blood circulating, incorrect rewarming, or inhaled water.

Return to Play Decision Making



Return to Play decisions can be difficult. Parents, motivated athletes and competitive coaches will often guide casualties back onto the field when they should not.

If there is immediate significant swelling, loss of function or severe pain, the decision is easy. Stop playing and begin [RICE treatment](#).

However when there is no significant swelling or pain should the casualty be immediately allowed back into the game?

A Progressive Function Test can help determine when an athlete can return to unrestricted activity and can aid the return to play decision-making. The test should be a progression of increasing movement and pressure on the injured area. The test should be injury site specific.

In the case of an ankle injury, the casualty should progress from walking, to running, to sprinting and include direction changes, to demonstrate that the injury is recovered.



Applying Ice to Injuries

Many coaches and players turn to ice as the first line of defense when a minor injury has occurred. Applying ice helps to reduce swelling and reduces the pain of the injury because nerve endings don't work as well when they are cold.

Once the ice has been applied, the casualty should not be allowed to return to activity. Doing so risks causing serious harm as worsening pain may not be felt.

READ THE
PITCH DECISION
BLOG

Ice rules.
Do not apply ice:

- If no sensation at injury site.
- If circulation is poor.
- Over an open wound.
- If application increases the pain.
- Over an obvious fracture.
- To head injuries.

Shin Splints & Acute Compartment Syndrome

Shin Splints is a general term for leg pain that is brought on by running and jumping activities, that involve muscle strain or inflammation of the outer most layer of bone.

Acute Compartment Syndrome is a painful and serious condition caused by bleeding within an enclosed bundle of muscles, usually by trauma to the lower leg. Fluid and / or blood accumulate within this compartment and can't escape.

What do you see	What do you do
Shin Splints	
• Pain often presents along the inner or outer portion of the shin. • Cramping pain during exercise. • Swelling muscle. • In severe cases, difficulty moving the affected body part .	• RICE: Rest, Ice, Compression, Elevation. • Reduce physical activity. • Stretch tight muscles. • Change shoes.
Acute Compartment Syndrome	
• Persistent pain that gets progressively worse. • Intense pain, especially when the muscle is stretched, which seems much worse than would normally be expected for the injury. • Visible swelling with tense muscles. • Tenderness at and below the compartment that is involved.	• Call 999 immediately or go to hospital. • Do NOT elevate the leg as this will further decrease the pressure in the arteries. • Remove any constrictive clothing or bandages.

Example Bump Card

In many sports, particularly those involving children, bump cards are issued to parents so they can monitor their child and look for signs of concussion and compression following a head knock.

Bump Card

Even a mild head knock must be monitored to ensure symptoms are not worsening. Pay attention to the following symptoms and seek medical support if any of them appear to be getting worse:

- Unconsciousness, or lack of full consciousness (for example, problems keeping eyes open).
- Any confusion (not knowing where you are, getting things muddled up).
- Any drowsiness (feeling sleepy) that goes on for longer than 1 hour when you would normally be wide awake.
- Any problems understanding or speaking.
- Any loss of balance, or problems walking.
- Any weakness in one or both arms or legs.
- Any problems with your eyesight.
- Very painful headache that won't go away.
- Any vomiting or nausea.
- Any fits (collapsing or passing out suddenly).
- Clear fluid draining from your ear or nose.
- Bleeding from one or both ears.
- New deafness in one or both ears.

Less serious signs that might also be a result of a brain injury include: a mild headache, feeling sick (without vomiting), dizziness, irritability or bad temper, problems concentrating or problems with your memory, tiredness, lack of appetite or problems sleeping.

If you feel concerned about any of these symptoms, you should seek medical advice.

In 2016 Sport Scotland issued new 'Concussion Guidance' for suspected concussion. This includes a graduated return to play protocol which is well worth reading.

READ THE
SPORTS CONCUSSION
GUIDANCE



Cramps and Winding

Cramp is when a muscle goes into spasm and cannot be relaxed. The pain in the affected muscle can range from a slight spasm to agonising pain. It can last from a few seconds to 15 minutes and can recur. There are three major factors that increase the likelihood of cramp occurring: **fatigue, hydration and conditioning.**

Winding

A blow which results in winding, causes compression of the nerves behind the stomach (solar plexus) causing the diaphragm to contract and spasm. Once the diaphragm relaxes, breathing becomes easier.

What do you see	What do you do
Cramps	
- Spasm in muscle that cannot be relaxed. - Pain and tenderness.	- Stretch and gently massage the muscle. Grasp the muscle with one hand and pull back on the toes with the other. Point toes upward to help relieve the spasm in a calf muscle. - Use ice packs for severe cases and drink water or an electrolyte sports drink. - You can continue exercising after massage but if the pain is too acute then rest for 24 hours.
Winding	
- Blow to the back or front. - Increased abdominal pain. - Tender stomach area. - Nausea.	- Sit in a crouched position as this helps the muscles to relax. - The condition should improve within 10-15 minutes. - If not, seek medical attention in case of further injury.

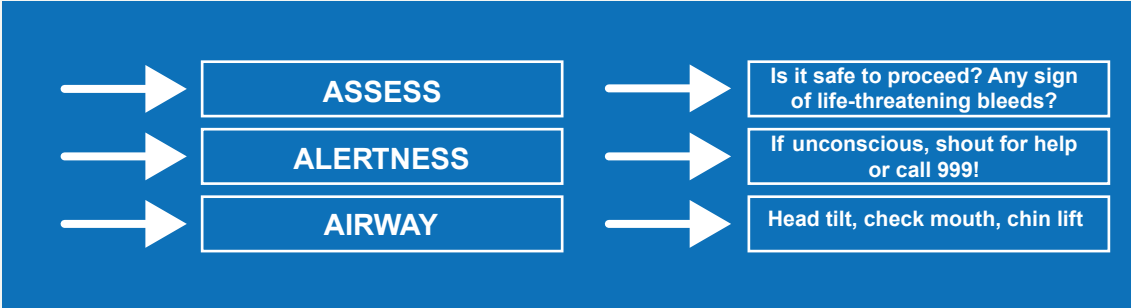


Blow to the testicles

Testicles are soft organs and a blow to them is painful and can make the casualty feel nauseas or faint. Usually symptoms settle in a few minutes but swelling can occur, as this is soft tissue. Cooling the area will help and if pain doesn't subside medical attention should be sought.

FIRST AID INCIDENT PROCEDURE

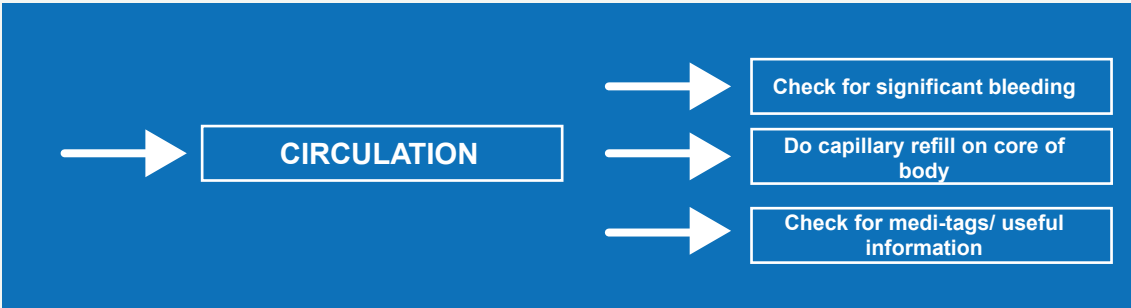
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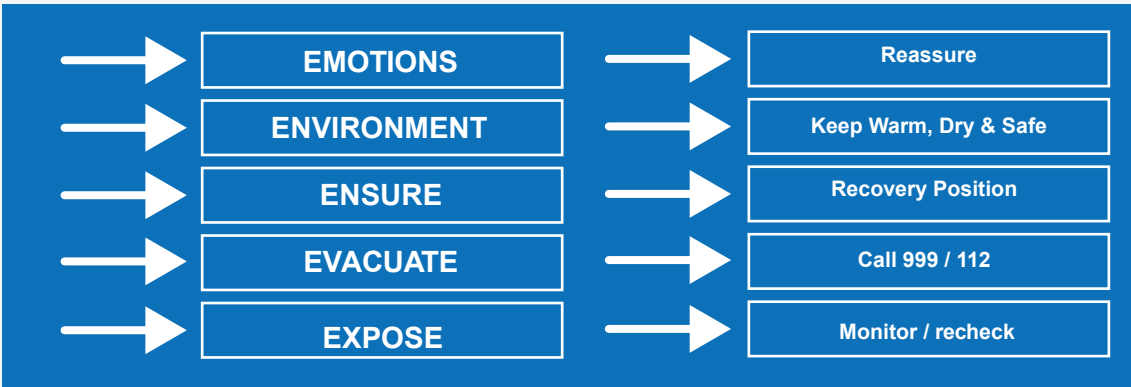
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What Next?

The Digital Manuals

This digital manual is part of a series published by the First Aid Training Co-operative, all available to purchase on our [website](#).

- First Aid at Work
- Sports First Aid
- Outdoor First Aid
- Paediatric First Aid
- Equestrian First Aid
- Mental Health First Aid

Futher Resources

Our website features a wealth of [free resources](#), including downloadable casualty monitoring cards, First Aid Hazard Assessment templates, and a library of over 250 blogs featuring in-depth information and ‘how to’ advice for multiple different first aid topics.

First Aid Courses

The First Aid Training Co-operative delivers a range of specific first aid training courses. These include:

- [First Aid at Work](#)
- [Emergency First Aid at Work](#)
- [Outdoor First Aid](#)
- [Emergency First Aid at Work + Forestry](#)
- [First Aid for Sports Coaches and Exercise Professionals](#)
- [Sports and Pitchside First Aid](#)
- [Dentists and Doctors Basic Life Support](#)
- [Advanced & Expedition First Aid](#)
- [Paediatric First Aid](#)
- [Defibrillator / AED Training](#)
- [Basic Life Support](#)
- [Equestrian First Aid](#)
- [Mental Health First Aid](#)

Join the First Aid Training Co-operative

We work hard for the benefit of our clients and trainers alike. Discover the benefits of co-operative working as a first aid trainer [here](#).

FIRST AID TRAINING CO-OPERATIVE

Web: www.fatc.uk

Email: courses@fatc.uk

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Further Resources

The First Aid Training Co-operative Video List

[Primary survey \(ABC\)](#)

[Recovery position](#)

[Recovery position alternatives](#)

[Secondary survey](#)

[Insulate a casualty urban](#)

[Insulate and monitor a casualty outdoors](#)

[Monitoring a conscious casualty](#)

[Treating a face down collapsed casualty](#)

[Adult CPR for cardiac arrest](#)

[Child CPR](#)

[Infant CPR](#)

[Adult CPR with 2 people](#)

[Adult CPR and AED](#)

[Drowning CPR](#)

[Full choking adult](#)

[Child and infant choking](#)

[Helmet removal - full face and open face](#)

[Using an asthma inhaler](#)

[Auto-injector use \(Epi Pen demo\)](#)

[Lower leg realignment](#)

[Slings for arm injuries](#)

[Improvised arm slings](#)

[Improvised femur splint](#)

[Treating a significant bleed](#)

[Bandaging impaled object](#)

[Bandaging minor amputation](#)

[Major bleeding incident](#)

[Shock treatment](#)

[Collapse in an outdoor environment](#)

[2 person spinal roll](#)

[Calling the Emergency Services in the outdoor environment](#)

[CPR for drowning outdoors](#)

[Assessing a sports injury - SALTAPS](#)

Contributors

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Support and Thanks

Thanks are due to Ann McKillop (First Aid Training Co-operative Trainer and Content Author) for proofreading the manual series.

A Note About Hygiene & Taking Care of Yourself

The first edition of First Aid Training Co-operative's Digital Manuals series was produced in 2016. This third edition of the Digital Manuals Series was published in June 2026.

The review of the digital manuals was timed to coincide with the 5 yearly European Resuscitation Council's Resuscitation Congress. This manual edition has been updated in line with the 2025 ERC Resuscitation guidelines.

A Note About Hygiene

Dealing with first aid incidents always carries some risk of cross contamination, and the lessons learnt during the Coronavirus pandemic are still relevant. It is highly recommended to implement the first rule of any first aid situation, and look after yourself as a priority.

With this in mind, consider protecting yourself by:

- Putting extra gloves and medical face masks in your first aid kit.
- Maintaining physical distancing between you and the casualty where possible.
- Wear a mask and gloves yourself and consider asking the casualty to wear a mask too if possible.
- Thoroughly cleaning up after a first aid incident. Make sure you use hand sanitiser, or better still, thoroughly wash your hands with soap and water.

Taking Care of Yourself

After an incident it is important to put some time aside for yourself. It is common for the first aider to feel they didn't do enough or worry that they made mistakes.

Often just talking through the incident will allow you to clear your head. Talking to a fellow first aider can be particularly useful if possible.

Remember that first aiders are lay-people, not professionals. You can only do your best in what is sometimes a very stressful or traumatic situation. However, if feelings persist or return in the future it is important to seek counselling.

Notes:

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