



THE DIGITAL MANUALS

Paediatric First Aid



QUALITY TRAINING SAVES LIVES

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Introduction to Paediatric First Aid



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 understanding a particular technique or protocol, or refreshing your memory in the future.

First aid for infants and children is different to first aid for adults. Infants are defined as less than 1 year old. Children are defined as being pre-pubescent and adults as post-pubescent. The main differences are in airway and vital signs management, smaller oxygen stores and the more delicate nature of the muscular skeletal system.

The First Aid Incident Procedure is covered throughout this manual.

- A** Assess / Airway / Alertness
- B** Breathing
- C** Circulation
- D** Disability/Discover/Damage
- E** Emotions / Environment / Ensure / Evacuate / Expose

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

VISIT THE WEBSITE

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



Emergency Planning

In a childcare setting it is important to think:

- What would I do if a child in our care became suddenly ill or injured?
- What would I do if a key member of staff became ill or injured?

An organisation should develop a set of procedures and an Action Plan including:

- Staff training requirements.
- Records of staff training.
- Maintaining fully equipped first aid boxes at accessible locations.

- Maintaining child care plans.
- Telephone access. Does everyone have a mobile? Is there good coverage? Do we need landline cover?
- Immediate access to important numbers.
- Post incident documentation.
- An Emergency Action Plan document that is accessible to all staff.

Depending on the incident and injuries, the first aider must take charge of the situation and make the decision whether to call for the emergency services. Every emergency is different; by following an [Incident Procedure](#) the first aider can gather information as to the seriousness of the child's situation.



Individual Child Care Plan

A care plan is for recording a family's wishes for their child. It should inform of any underlying medical issues as well as key decisions should an emergency situation arise. Regularly updated, it gives consent for childcare providers when the next of kin cannot be contacted.

What should go in your Action Plan?

- Emergency Numbers - 999/112.
- Relevant staff contact details.
- Local GP or hospital.
- Emergency back up person.
- Local GPs.
- Escape Plan and 'meeting points.'

Inform staff of the Action Plan and their responsibilities.

Legislation and Regulations



In England and Wales all providers of Early Years childcare have had a legal requirement for first aid as laid down in the [Early Years Statutory Framework](#).

'At least one person who has a current paediatric first aid certificate must be on the premises and available at all times when children are present and must accompany children on outings'.

This Paediatric First Aid qualification needs to have relevant content and be 12 hours in duration.

Scottish National Standards for Early Learning and Childcare Providers should be referred to in Scotland.



First Aid Needs Assessment

The HSE requires every employer to carry out a first aid needs assessment. This covers the requirements for employees in the workplace. A childcare setting will need staff trained in both adult and child first aid techniques. This means staff need to attend appropriate training for their requirements i.e. a course that covers child, infant and adult first aid.

First Aid training Co-operative have put together a FREE resource to help an employer carry out this needs assessment.

European Resuscitation Council Definitions

Infant = Under 12 months of age

Child = Pre puberty

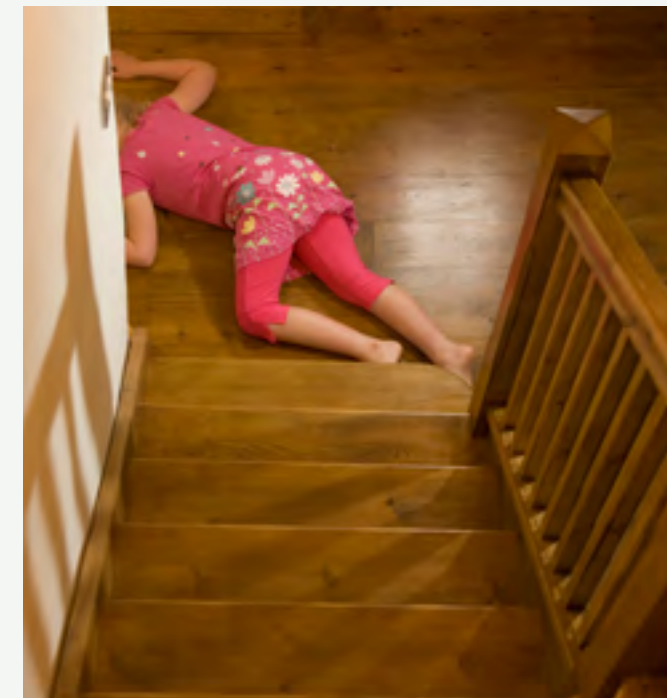
GET THE FREE ASSESSMENT FORM HERE



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. If the casualty is conscious, talk to them in order to ascertain whether they are fully alert or appear to be confused relevant to their own "normal" (C on the ACVPU scale). This could include doing a [SAMPLE](#) survey.

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.](#)

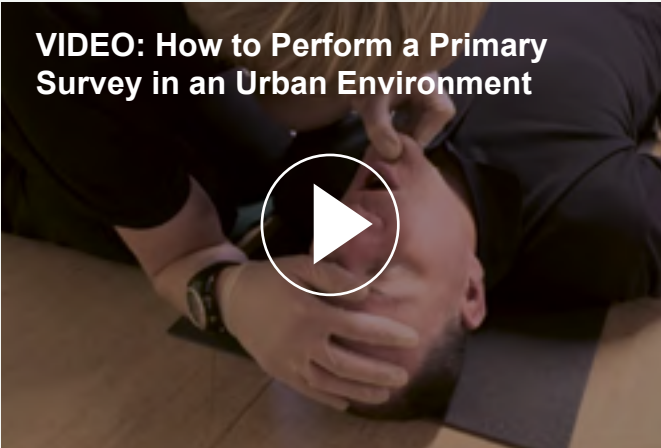


Incident Procedure (ABC)

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.

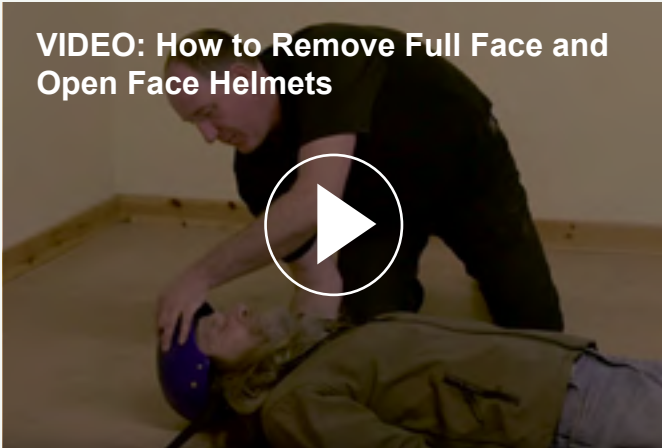
Thought	Action
A - Assess the scene and casualty	Stop and look, is it safe to approach? Think cross contamination, consider gloves.
A - Alert response (ACVPU)	Ask a question, shout command and touch shoulders. If no response, shout or call for 'Help!'
A - Airway	Head tilt and chin lift. Check mouth. 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 – 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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Recovery Position

The **Recovery Position** is 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. **Recovery position for children mimics that of an adult.**

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, hold their far knee and lift it up, 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.



Infant Recovery Position. For infants, who can be carried to help, scoop the infant, facing them towards you with head supported. Keep the infant's feet higher than their shoulders. This prevents them from choking and allows vomit to drain from the airway.

Watch the Video



Recovery Position for small children. For smaller children, up to 2 years old, it is advisable to adapt the recovery position by placing a rolled up duvet or large toy behind their back and in front of their tummy. This keeps them in a stable position.

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Vital Signs and Monitoring

Vital signs provide information about the casualty. On approaching a child or infant the initial assessment can help check vital signs. The first aider can check for alertness, movement and eye contact. This can be a 'hands off' assessment. The information can help identify what to do next and inform emergency services on the history

Vital sign	Values
• Colour (eyes and lips)	• Pink is normal. Blueness indicates low oxygen levels.
• Temperature	• Feel exposed skin or under their collar, does body feel normal – warm. Cold skin may indicate hypothermia (dry skin) or shock (clammy skin). Hot skin may indicate heat stroke (dry skin) or fever/infection (wet skin).
• Breathing (quality and rate)	• Infants: 30-40 breaths per minute (bpm) • Children <12 years: 20-30 breaths per minute (bpm) • Children >12 years: 15-20 breaths per minute (bpm)
• Level of Consciousness	• A – Alert, Can open their eyes and respond normally. • C – Appears confused compared to what is “normal” • V – Responds to verbal commands. • P – Responds to a pressure or pain stimulus. • U – Unresponsive to any stimulus.



A child or infant’s emotional state will affect their vital signs greatly. It is important to both stay calm and re-assure the child in order to assess them effectively.

Prepare for Casualty Handover
Read the ATMIST blog

Watch the Video



Monitoring should be repeated regularly and recordings written down. Give this information to the emergency services.

Download the FREE
Casualty Monitoring Card

Seizures

[Febrile Convulsions](#) are often mistaken for seizures but are caused by overheating. 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 you see	What do you 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 will be useful in alerting you to a trend.

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

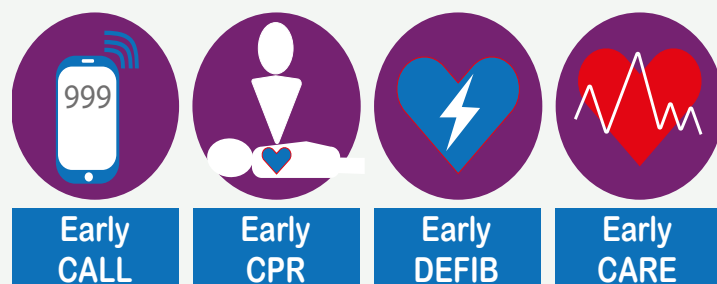
Adult Cardiac Arrest CPR (Non-Breathing Adult)

A collapsed or unresponsive adult who is not breathing and has no history of illness or injury, can be assumed to have suffered a Cardiac Arrest. Non breathing casualties run out of oxygen quickly and brain cells can only live a few minutes without oxygen. CPR – Cardio Pulmonary Resuscitation is designed to keep blood flowing and oxygen moving around the casualty's body.

Use a CPR face shield to help prevent cross contamination. If there is more than 1 first aider, change over every 2 minutes.

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



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VIDEO: How to Perform CPR for a Suspected Cardiac Arrest



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 need to be done 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.

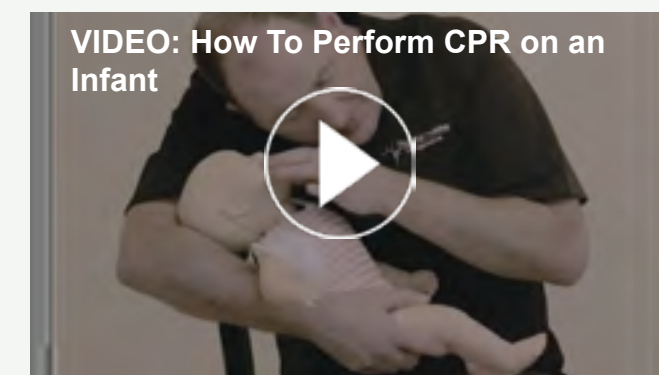
For **Child CPR** aim to compress the chest by 1/3 of its normal size. If the casualty is a large child, treat them as an adult: 'Treat as you See'.

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 torso and use two thumbs to do chest compressions.

VIDEO: How To Perform CPR on a Child



VIDEO: How To Perform CPR on an Infant



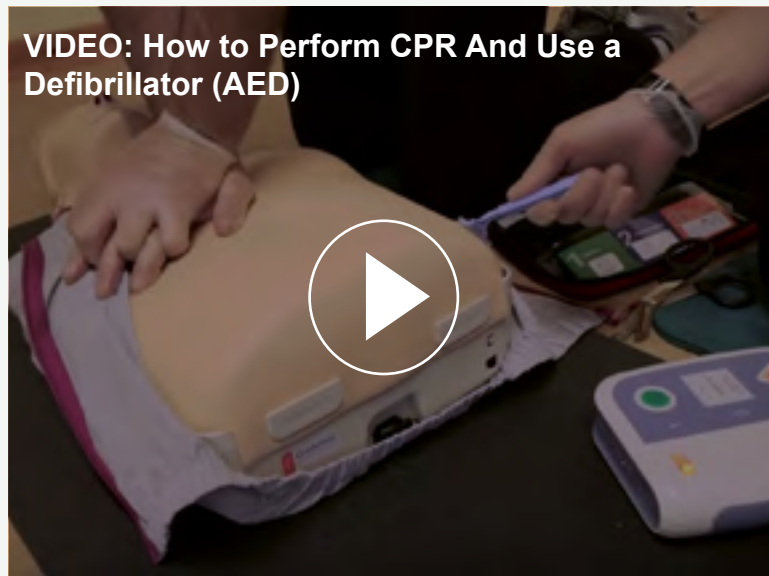
AED (Defibrillator) Use



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.

VIDEO: How to Perform CPR And Use a Defibrillator (AED)



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.

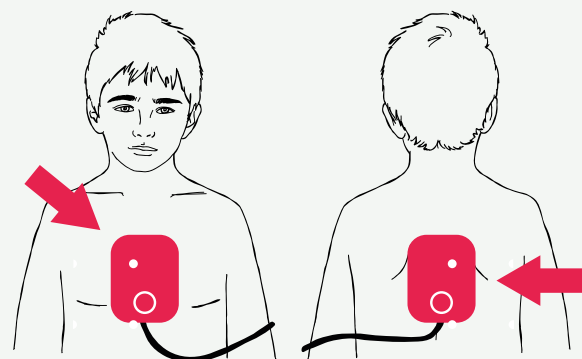


AED's and Children

Above the age of eight years, adult AED's pads can be used on children. Many AED manufacturers have modified paediatric pads that reduce the energy delivered by the AED for child under eight years old.

Paediatric pads are more appropriate to use on child under eight, however if all that is supplied with the AED device is adult pads, then these should be used on a child.

AEDs are not recommended for use on infants except by medical professionals.



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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.

Special cases – pregnancy and obesity

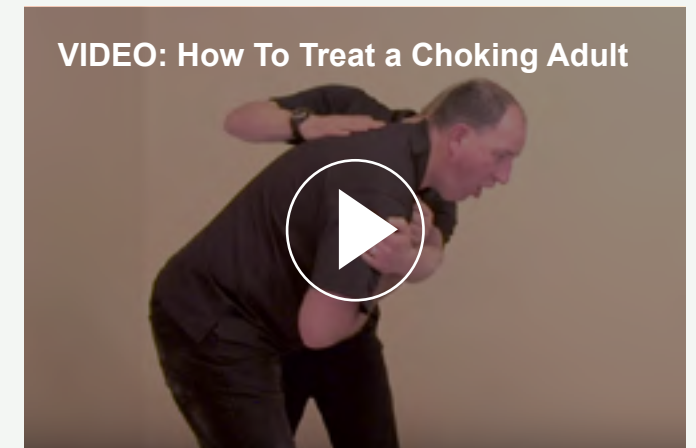
If you have attempted an abdominal thrust, advise the casualty to go to hospital for a check up, as internal damage may have occurred.

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.

[READ THE CHOKING BLOG](#)

Watch the Video

VIDEO: How To Treat a Choking Adult

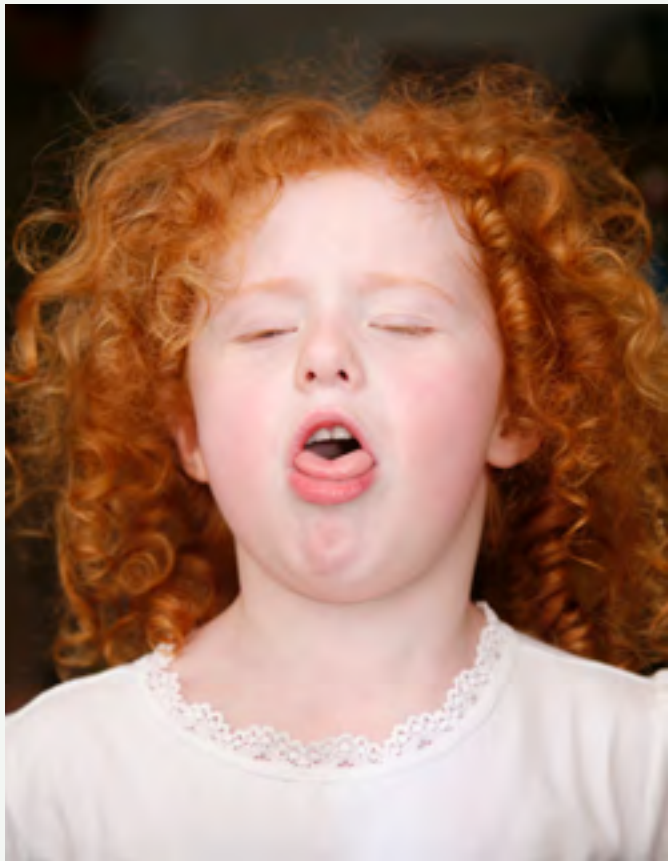


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Dealing with Choking (Children and Infants)

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, a firm backslap by 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 or sitting 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



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).

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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 Videos



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.

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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.

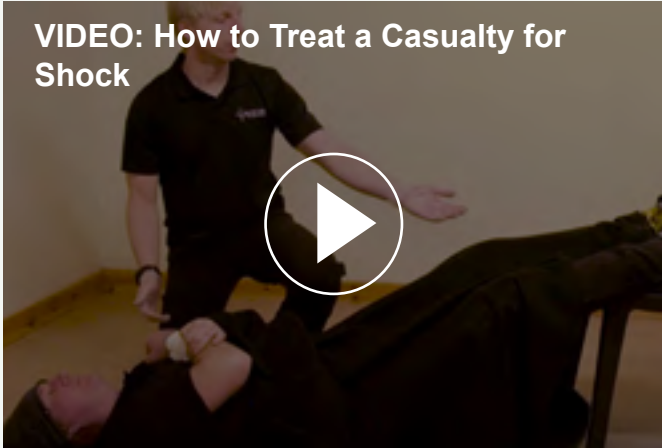
What do you see	What do you do
• Pale, cold, clammy skin. • Fast shallow breathing. • Worried, anxious casualty. • Fast weak pulse. • Drop in level of alertness eg: dizziness or confusion.	• Lie down a conscious casualty, make them comfortable, keep warm. • Put unconscious casualty in recovery position.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

READ THE BLOG
ON HOW TO TREAT
LIFE-THREATENING
BLEEDS



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.

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 jewellery, cover with a sterile dressing.
• Bruise	• Apply a cold compress to the bruise, this helps reduce swelling and pain.



24 hour NHS help and 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 overreacting 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.



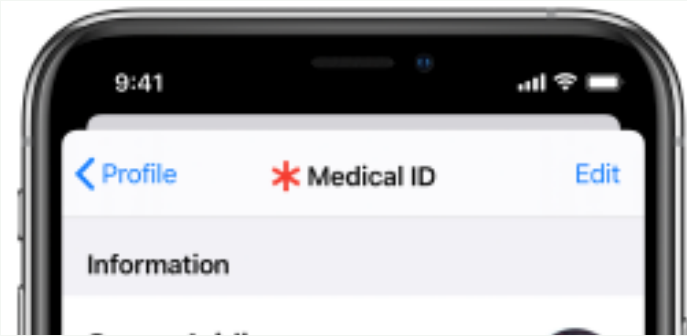
When talking to any healthcare professional ask;

“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.

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 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.

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

RETURN TO CONTENTS

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.

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. Child incident reports should be kept until the child is 21 years old.

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](#).

First Aid Report Form includes as a minimum

- Date, time and place of incident.
- Name, date of birth, and job (if appropriate) 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 or by 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.

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Limb Fractures

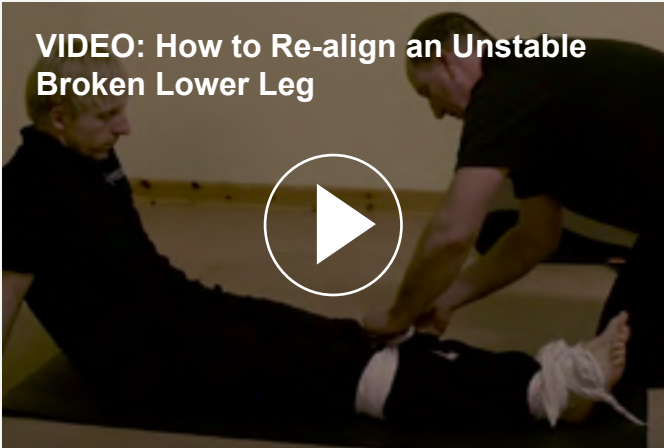
Fractures can be open, closed or complicated (involving other organs or tissues) and can be caused by direct, indirect or twisting forces. Your aim is to stabilise the injury. Do not allow the casualty anything to eat or drink, as anesthetic may be required in hospital. Also do a capillary refill check on good leg and injured leg to compare and contrast.

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. • Nausea and/or signs of shock. • Poor capillary refill on limb below injury.	• Immobilise the affected limb. • Monitor the casualty - vital signs. • Obtain history for emergency services - SAMPLE. • If the bone is exposed, control bleeding. Do not apply pressure directly to the bone. • If removal to hospital is delayed, improvise a splint to immobilise the limb. • Report poor Capillary refill when calling 999.

Watch the Videos



Arm injuries may require a sling in order to stabilise. You must ensure that any support given by the casualty is replicated by the sling. One memory aide for this is to 'Bind as you find'.



Lower leg injuries may require re-alignment if professional help is delayed by over 30 minutes or the casualty loses **Colour, Sensation or Movement** or has poor capillary refill" in the limb (below the site of the injury).

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

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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.



RETURN TO CONTENTS

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. - Signs of Concussion. - Strong bounding pulse. - Face flushed. - Bleeding or bruising around eyes, mouth, ears. - Pupils NOT equal and reactive - PEARL.	- 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

Minor head injury. Children commonly fall and bang their head. You should closely monitor them. Also ensure parents or guardians are aware of the history of the accident and know what to look for. Give them a Bump Card.

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.

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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.

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.



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 if required.

Watch the Video



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 or check their monitor. - 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. - Fruity sweet breath. - Bleeding or bruising around eyes, mouth, ears. - You may find a Medi-tag on the casualty.	- 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. - 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, or ingested. 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 Advice for All Poisonings	
• Conscious Casualty	• DO NOT induce vomiting. • 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

READ THE
POISONS
BLOG

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.



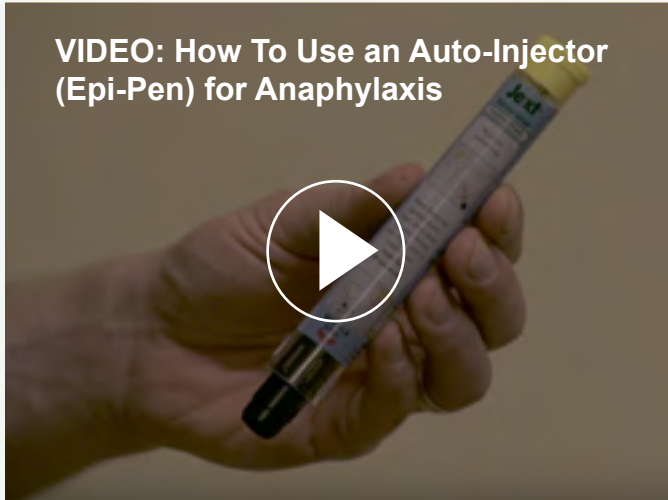
For more information on Naloxone/ Narcan go to the Scottish Drugs Forum or contact your local NHS Trust.

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.



2 epi-pens should be carried by anaphylaxis sufferers

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

Hypothermia

Hypothermia is caused by the cooling of the body’s core organs when cold blood from the body’s surface reaches the core. This affects the function of the heart and brain. It can occur in the outdoors in cold or windy weather or indoors in poorly heated homes.

What do you see	What do you do
• Shivering. • Cold, pale and dry skin. • Apathy, disorientation, irrational behaviour. • Slow shallow breathing.	• Prevent further heat loss. • Get the casualty into shelter and insulate from the ground. • Remove and replace wet clothing. • Rewarm slowly, give warm drinks and high energy food if available. • Call 999/112.



Prevention is better than cure.

Children are poor regulators of body heat. Remind children to zip up coats and put on gloves and hats. If one child is cold and shivering it is a sign others may be becoming mildly hypothermic too. At this point consider moving indoors or changing the activity to help children to maintain their temperature. Remember babies can’t add extra layers themselves.

Febrile Convulsions

Febrile convulsions (seizures) occur when a child has a sudden high temperature. The growing brains of small children are more sensitive to temperature (fever) than mature brains. When brain activity is upset, a convulsion can occur. Although convulsions are alarming, they are rarely dangerous if dealt with properly.

What do you see	What do you do
• Vigorous shaking, with clenched fists and arched back. • Obvious fever, hot, flushed • Twitching of the face or upturned eyes. • Holding breath with hot puffy face. • Possible vomiting.	• Protect the child from injury. • Cool the child, remove clothing, fan with cool air. • Reassure child and parents. • Call 999/112 for emergency help. • If unconscious place in recovery position.



Febrile convulsions are common in children between six month and six years of age. Febrile seizures can often be diagnosed from a description of what happened. It’s unlikely that a doctor will see the seizure, so it’s useful to note:

- How long the seizure lasted.
- What happened – such as body stiffening, twitching of the face, arms and legs, staring and loss of consciousness.
- Whether the child recovered within one hour.

Meningitis

Meningitis is an infection of the protective membranes that surround the brain and spinal cord (meninges). It can affect anyone but is most common in babies, young children, teenagers and young adults. Meningitis can be very serious if not treated quickly. It can cause life-threatening blood poisoning (septicaemia).

What do you see	What do you do
• High temperature (fever) over 37.5C. • Blotchy rash that doesn't fade when a glass is rolled over it (this won't always develop). • Dislike of bright lights (shielding of eyes). • Seizures (fits). • Headache, stiff neck or vomiting. • Drowsiness or unresponsiveness.	• Keep the casualty cool. • Check for meningitis rash that doesn't fade when a glass is pressed on the skin. • Give plenty of fluids to replace water lost through sweating. • Call emergency services 999/112.



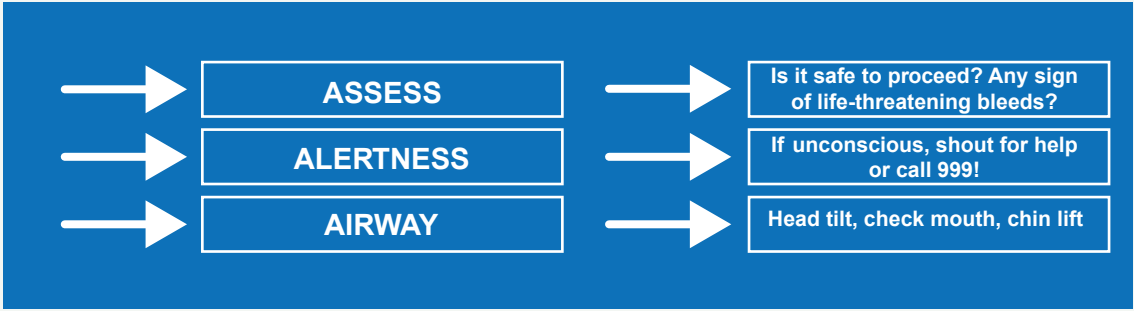
Meningitis is usually caused by a viral or bacterial infection. Viral meningitis is the most common and least serious type. Bacterial meningitis is rare but can be very serious if not treated. You can reduce the risk of contracting meningitis by ensuring all your vaccinations are up-to-date.

Meningitis Now have a webpage for downloading resources to smart phones which demonstrates signs and symptoms of meningitis.

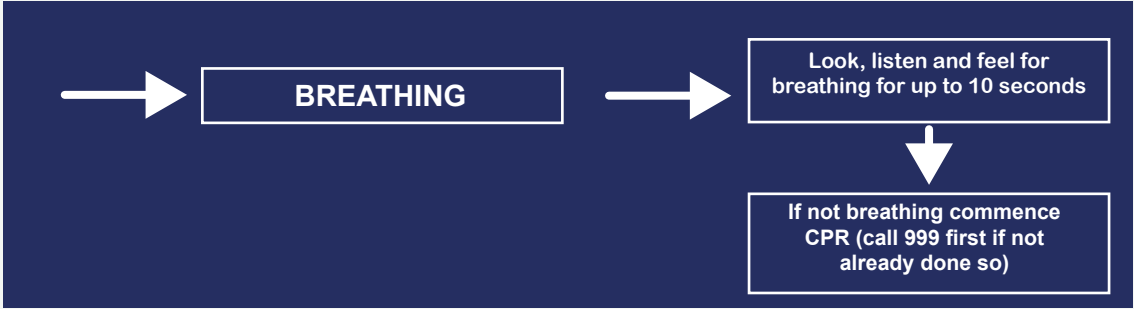
GET THE
MENINGITIS
DOWNLOADS NOW

FIRST AID INCIDENT PROCEDURE

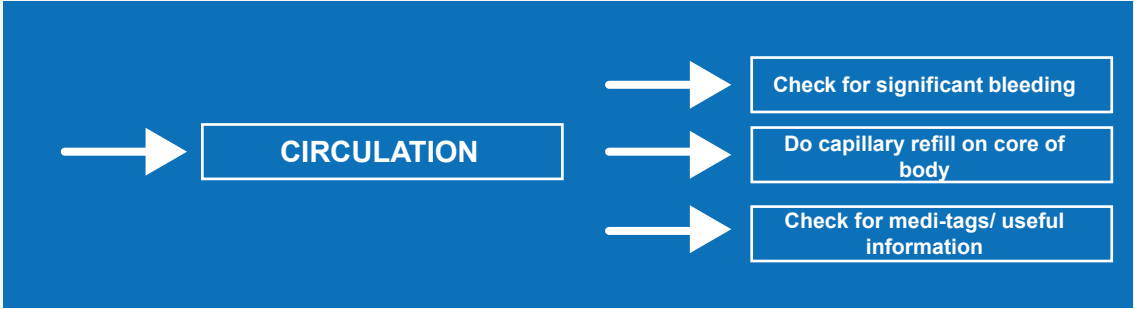
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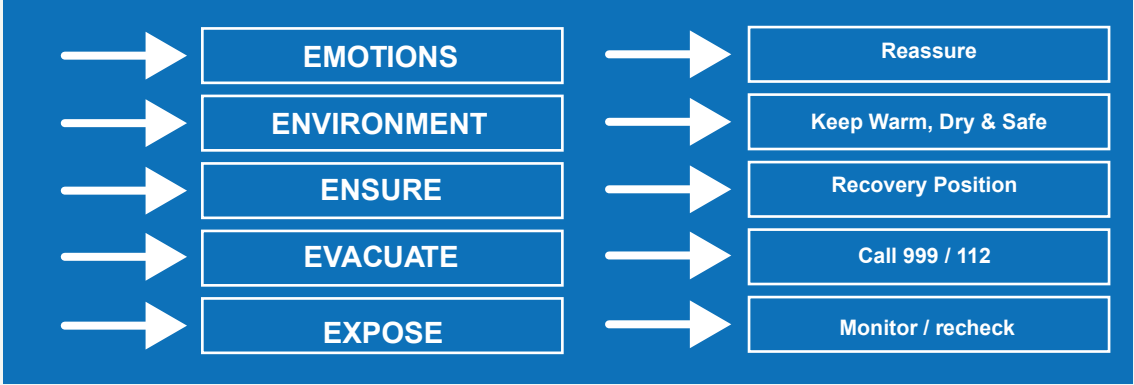
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E



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

Further 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

Tel: 0333 4330 731

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

Editorial

Cory Jones is a Director and Founder of First Aid Training Co-operative. He authored the first edition of the Digital First Aid Manuals Series. Cory is Wilderness Emergency Medical Technician, experienced expeditioner, international mountain leader, qualified sea kayak and canoe leader.

Tom Durham, Director and Founder of First Aid Training Co-operative and co-editor of this third edition of the Digital First Aid Manuals Series. He is also an alpine Mountain Bike Guide and Mountain Bike Facility Development consultant worldwide. He lives in the Italian Alps.

Technical and Medical

Mike Smith, Training and Internal Quality Assurance Manager of First Aid Training Co-operative and co-editor of this third edition of the Digital First Aid Manuals Series. Mike has been a member of Mountain Rescue since 2020, was a Remote Rescue Medical Technician for 6 years, and is the current Chair of Wasdale Mountain Rescue Team.

Steve Welsh is a Paramedic and Clinical Training Manager for Scottish Ambulance Service Special Operations Response Team. Steve provides technical and clinical expertise for First Aid Training Co-operative.

Design and Layout

Paul Sharman is the Communications Officer at First Aid Training Co-operative and is responsible for the design and layout of this third edition of the Digital First Aid Manuals Series.

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:

