# LOS ANGELES CITY
# LIFEGUARD RECERTIFICATION
# STUDY GUIDE
# 2025-26

# Patient Assessment Skills

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

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

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

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

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

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

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

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

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

**For a Stable Patient:** Repeat every 15 minutes
**For an Unstable Patient:** Repeat every 5 minutes

# Patient Assessment and Management
# Lifeguard Algorithm

**Scene Size-up/ BSI**

Obtain Consent

## Primary Assessment

General Impression: Name, Age, Sex, Chief Complaint

Mental Status: Alert/ Verbal/ Pain/ Unresponsive

Airway: Patent? Interventions, Suction, OPA/ NPA

Breathing: Adequate? Rapid Auscultation, Supp. O2

Circulation: Pulse check, Control bleeding/ treat for shock

Identify Priority: EMS Alert

## Treat Obvious Conditions

(Treat Injuries, immediate threats to life, provide comfort, oxygen…)

### Sample Hx

**S**igns, **S**ymptoms,
**A**llergies
**M**edication,
**P**ast Pertinent Hx,
**L**ast Oral Intake
**E**vents leading

### Vitals

**B**P,
**E**yes,
**L**ung Sounds SPO2,
**L**OC x 3, Skin
**S**igns,
**R**espiration
**P**ulse

## Physical Exam

(DOTS)
(CMS)
Treat for Shock

## Ongoing Assessment

Stable patient: 15 mins
Unstable patient: 5 mins

| Quick Reference Guide | |
|---|---|
| **Trauma** | **Medical** |
| *Treat Obvious Condition* | |
| Detailed Physical Exam | Sample Hx |
| Baseline Vitals | Baseline Vitals |
| Sample Hx | Detailed Physical Exam |
| Ongoing Assessment | |

**LOS ANGELES CITY**
**LIFEGUARD RECERTIFICATION**
**Emergency Medical Responder**

# PATIENT ASSESSMENT

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

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

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

## SCENE SIZE-UP

| Skill Component | Comments |
|---|---|
| ♦ Take Body Substance Isolation Precautions | Mandatory personal protective equipment |
| ♦ Assess scene safety/scene size-up | • Discourage blind reciting of (PENMAN)<br>• Verbalize what is actually seen.<br>• Is the scene safe to provide care?<br>. |

NOTE: Complete Initial assessment before providing care. Do not be distracted by the injury before completing the initial assessment.

| Skill Component | Comments |
|---|---|
| ♦ Consider:<br>• General Impression<br>• Observe for major disabilities | • The general impression is determined by observing the appearance, hygiene, patient position, sounds, smell, and mechanism of injury. It establishes the overall condition of the patient and if immediate interventions are needed. Does the patient appear stable, potentially unstable, or unstable?<br>• The primary assessment should be completed in 60 - 90 seconds<br>• Manage life-threatening situations when found. |
| ♦ Establish patient rapport:<br>• Obtain Consent<br>• Name<br>• Age<br>• Sex<br>• Determine chief complaint<br>• **Medical or Trauma?** | • Situation and patient condition determines the level of rapport that is possible.<br>• Asking what the problem is assists is in determining the preliminary chief complaint and patient symptoms. Ask questions such as, “What happened? How may I help you? Tell me what hurts?<br>• Responding with empathy develops trust and encourages essential patient communication.<br>• All patients have the right to be treated with respect and should receive non-judgmental and impartial treatment.<br>• Body language (non-verbal communication) refers to facial expressions, gestures and body movements that |

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| | communicate a variety of messages to the patient regarding impressions of the healthcare provider; i.e. caring, helpful, dismissive, hostile, confident, incompetent, etc. |
| **PRIMARY ASSESSMENT – Cont.** | |
| ♦ Assess mental status (AVPU Scale)<br>• Alert<br>• Verbal Stimulus<br>• Painful Stimulus<br>• Unresponsive | This is NOT the time to obtain a comprehensive orientation level.<br>• Use Lowest level of stimuli to determine mental status<br>• If unresponsive begin assessment for CPR, Compression, Airway, Breathing (C-A-B) |
| **Airway**<br>♦ Assess and manage airways<br>• Patent<br>• Obstructed<br><br>**Manage life-threatening situations<br>• Open and clear/suction airway - if indicated<br>• Utilize basic airway adjuncts - if indicated<br>• Initiate immediate EMS call - if patient is unresponsive or unable to maintain patent airway | • Noisy respirations indicate an obstructed airway and airway positioning or maneuvers must be instituted to provide a patent airway.<br>• Assess for foreign body such as food, gum, etc.<br>• Use a nasopharyngeal airway (NP) airway for patients with altered mental status, unresponsive patients, or patients with a gag reflex.<br>• Avoid NP airway if patient had a severe head injury or history of fractured nasal bone<br>• Use an oropharyngeal airway for the unresponsive patient with no gag reflex.<br>• Immediate EMS call should be initiated if unable to establish or maintain an adequate airway. |
| **Breathing**<br>♦ Assess and manage breathing:<br>• Rate - (fast, slow, normal or absent)<br>• Rhythm - (regular, irregular)<br>• Quality - (air movement, chest expansion)<br>• Depth - (tidal volume)<br>• Rapid chest auscultation - if difficulty breathing or shortness of breath<br>♦Manage life-threatening situations<br>• Initiate appropriate delivery method for supplemental O2<br>• Utilize basic airway adjuncts - if indicated<br>Initiate immediate EMS call - if abnormal ventilations | • Visualize chest and signs of inadequate breathing<br>• The initial respiratory rate should not be counted at this time, but only observed if it is too fast, too slow or in the normal range<br>• Slow, shallow breathing or fast, shallow breathing may not provide adequate ventilations or tidal volume. Consider using BVM to increase tidal volume or rate, if necessary, especially if LOC is decreased<br>• Rapid chest auscultation for presence and equality is performed on **2 locations only** ($5^{th}$ - $6^{th}$ intercostal space, mid-axillary line) bilaterally |
| **Circulation**<br>♦ Assess and manage circulation:<br>• Capillary refill - if appropriate<br>• Uncontrolled external bleeding<br>• Pulse- normal, too fast, too slow or absent<br>• Skin - color, temperature, moisture)<br>•<br>♦Manage life-threatening situations<br>• Control life-threatening external bleeding | • Check the carotid pulses in critical situations. Check the femoral pulse if unable to obtain a carotid pulse. The radial pulse may be absent due to decreased blood pressure. A carotid pulse will be more prevalent during decreased blood pressure.<br>• Capillary refill is most accurate in pediatric patients. It is not always accurate in adult patients due to chronically poor peripheral circulation. It is not accurate in cold environments. |

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| Place in shock position - <u>if signs of hypo perfusion</u> Initiate immediate EMS call - <u>if uncontrolled external bleeding</u> | |
| ♦Priority Patient?<br>• EMS Contact | • Altered, unresponsive, sudden illness, uncontrolled severe bleeding or broken bones is IMMEDIATE EMS CALL |
| **NOTE:** During the Primary Assessment, begin treatment of obvious conditions. Sample History and Baseline Vitals can be taken while caring for the injury. | |

| **BASELINE VITALS** | |
|---|---|
| **Skill Component** | **Comments** |
| **<u>BLOOD PRESSURE</u>** | |
| ♦ Select appropriate size blood pressure cuff | • Appropriate size must be selected or an inaccurate reading will be obtained. Cuff width should cover 2/3 of the upper portion of the limb. Cuff bladder should encircle 2/3 the circumference of the limb. |
| ♦ Select appropriate site | • Constriction of the arm or limb held in a tense position may result in inaccurate readings, discomfort, blood clots, injury to the vein or damage to the device. |
| ♦ Position the extremity at appropriate level | • The extremity should be at the level of the heart and in a relaxed position or reading will be inaccurate:<br>o Above heart level - false low reading<br>o Below heart level - false high reading |
| ♦ Place cuff snugly around arm: | • Arm should be approximately at the level of the heart for the best sound to be heard.<br>• Center of the bladder must be placed over brachial artery in order to registry sounds clearly |
| ♦ Locate the brachial artery and palpate pulse | • Purpose for locating brachial artery is to find the best site for sound reproduction |
| ♦ Insert the stethoscope earpieces into ears | • Make sure earpieces are facing forward. |
| ♦ Place the bell over the brachial artery | • Listen for pulse |
| ♦ Inflate the cuff rapidly 20-30mmHg above the level where the pulse sound is obliterated | • Over inflation of the cuff causes vasospasms or pain and results in false high reading |
| ♦ Deflate cuff 2-4 mmhg/second and note where the first sound is heard (systolic pressure)<br>♦ Listen for the last sound (diastolic pressure) | • Slow cuff deflation causes venous congestion and results in a false high reading<br>• If the first sound is missed, deflate the cuff completely and wait 30 seconds before re-inflation to prevent venous congestion |
| Consider palpation for a systolic blood pressure reading by feeling radial artery. Record as #/P | • Blood pressure readying by palpation should only be done in cases where the environment presents a noise level that does not allow you to hear a pulse<br>• If a third attempt is needed, switch arms |
| **<u>EYE</u>** | |
| **<u>EYES</u>**<br>♦ Assess pupils for equal reaction to light | • Make sure to completely cover the eye to obtain a good assessment |
| **<u>LUNG SOUNDS</u>** | |
| ♦ Listen to a minimum of 3 bilateral anterior fields:<br>• Apices - 1” below the clavicle at mid-clavicular line | <u>Describe what you hear!</u><br><u>Sounds</u>:<br>• Rhonchi- rattling sounds that resemble snoring<br>• Rales – gurgling; indicates fluid in lungs |

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| • Mid-lung fields - 3rd - 4th ICS at mid-clavicular line<br>• Bases - 6th ICS and mid-axillary line | • Wheezing – whistling sound indicates narrowed airways<br>• Stridor – crowing sound on inhalation; upper airway obstruction |
| ♦ Listen to a minimum of 3 bilateral posterior fields:<br>• Apices - vertebral border at level of 3rd rib<br>• Mid-lung fields - inferior angle of the scapula<br>• Bases - 3 finger below the inferior angle of the scapula at the level of the diaphragm | • Flex shoulders anteriorly to spread scapulae in order to hear breath sounds |

| **BASELINE VITALS continued** | |
|---|---|
| **LEVEL OF CONSCIOUSNESS** | |
| ♦ Alert and Oriented to:<br>• To name<br>• To place<br>• To time | Assessment can be verbalized as patient being Alert and Orientated times the number of questions, they are able to answer (example: Patient is A & O times 3) |
| **SKIN SIGNS** | |
| ♦ **Assess for:**<br>• Color<br>• Temperature<br>• Moisture | Can often be assessed concurrently with respirations and pulse. Pale – poor perfusion; cyanotic (bluish) – poor perfusion/inadequate $O^2$; flushed – heat or CO; jaundiced (yellow) – liver problems |
| **RESPIRATIONS** | |
| ♦ Assess for:<br>• Rate<br>• Quality<br>• Tidal Volume | Respiratory rates:<br>Adult 12-20/minute<br>Child 15-30/minute<br>Infant 25-50/minute<br>• Rate can be calculated by counting for 30 seconds and multiplying by 2. Abnormal pattern should be counted for 1 full minute<br>Quality: (Normal, shallow, labored, noisy)<br>• Evaluated by the use of accessory muscles, patient position. Sounds clear or diminished are equal, labored, noisy, absent and the ability to speak in words, sentences or unable due to shortness of breath<br>Tidal Volume (How much effort vs work needed to breath)<br>• Determine if normal, increased or decreased |
| **PULSE** | |
| ♦ Assess for:<br>• Rate<br>• Rhythm: regular or irregular<br>• Quality: strong or weak | Pulse rates:<br>Infant 100-190/minute<br>Child 60-140/minute<br>Adult 60-80/minute<br>• Rate can be calculated by counting for 30 seconds and multiplying by 2. Irregular pulse should be counted for 1 full minute<br>Rhythm: (regular or irregular)<br>• Regular rhythm - consistent interval between beats<br>• Irregular rhythm - a beat may be early, late or missed |

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| | • **ALL IRREGULAR RHYTHMS ARE ABNORMAL**<br>Quality: (strong or weak) |

| **PULSE OXIMETRY** | |
|---|---|
| ♦ Pulse Oximetry<br>• Turn on device<br>• Apply probe to patients' finger<br>• Allow device to self-test<br>• Record reading and time<br><br>♦ Pediatric Considerations<br>• Turn on device<br>• Apply probe to patients' foot<br>• Allow device to self-test<br>• Record reading and time<br><br>♦ Special Note<br>Pulse oximetry **SHOULD NOT** prevent oxygen being administered to patients who require it, nor should it influence treatment without doing a through patient assessment. | Pulse Oximetry Range:<br>Normal 95-100 percent<br>Mild hypoxia 91-94 percent<br>Moderate hypoxia 86-90 percent<br>Severe hypoxia less than 85 percent<br><br>A READING BELOW 94% INDICATES A NEED FOR O2.<br>A reading should be taken and recorded with vital signs<br>If stable monitor every 15 unstable every 5 minutes.<br><br>Limitations / Faulty readings:<br>• Device will not read through nail polish. Clean patients finger nail with acetone to assist with a accurate reading.<br>• Hypo perfusion/ Poor Perfusion/ Shock<br>• Cardiac Arrest<br>• Excessive motion of patient during reading<br>• Carbon monoxide poison<br>• Hypothermia<br>• Sickle cell disease or anemia<br>• Edema (swelling)<br>• Time lag in detection of respiratory insufficiency. (The pulse oximeter could warn too late of a decrease in respiratory function based on the amount of oxygen in circulation.) |

# MEDICAL HISTORY

SAMPLE

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

## MEDICAL PATIENT CARE

## See Medical Care Chart

# Medical Care Chart

| Sudden Illness | Signs and Symptoms | General Care |
|---|---|---|
| **Shock –<br>Hypo perfusion** | • Extreme thirst<br>• Restlessness, anxiety<br>• Rapid, weak pulse<br>• Rapid, Shallow respirations<br>• Mental Status Changes<br>• Pale, cool, moist skin | • Keep patient calm, in position of comfort.<br>• Keep patient warm – attempt to maintain normal body temperature.<br>• Do Not Give Food or Drink<br>• Lay patient in supine position |
| **Anaphylactic Shock**<br>Can occur when people come into contact with a substance to which they are allergic | • Burning, itching, or "breaking out" (Such as hives or rash)<br>• Difficult and rapid breathing, with possible chest pain and wheezing.<br>• Rapid, very weak or not detected pulse<br>• Restlessness, often followed by fainting or unconsciousness | • SAMPLE History and Vitals<br>• Consider assist with inhaler or Epi Pen<br>• Treat for shock<br>• Make sure EMS has been called |
| **Respiratory Distress** | • Labored or difficult breathing, a feeling of suffocation<br>• Unusual breathing sounds<br>• Rapid or slow breathing<br>• Unusual pulse rate and character<br>• Changes in color of lips, skin, and nail bed: usually, color will change to blue or gray<br>• Confusion or hallucinations | • Monitor ABC<br>• Consider o2<br>• Comfort and reassure<br>• SAMPLE history & Vitals<br>• Keep patient at rest<br>• Place in sitting position, allowing proper drainage from mouth<br>• Reassess |
| **Stroke**<br>Blocking or bursting of vessels that supplies blood to the brain. | • Looking or feeling ill<br>• Changes in LOC<br>• Numbness of face, arm, leg<br>• Difficulty talking or understanding<br>• Blurred or dimmed vision, unequal pupil size<br>• Severe headache, dizziness, confusion<br>• F.A.S.T. (facial drooping, arm movement, slurred speech, time to call EMS) | • Check Pronator Drift – Arms out in front, close eyes (if there is stroke usually once side drifts)<br>• Call 911<br><br>• Monitor ABC<br>• Comfort and reassure<br>• SAMPLE History & Vitals<br>• Reassess |
| **Heart Attack**<br>Failure of circulation to the heart muscle that damages or kills portion of the heart | • Chest or upper abdominal sensation of pressure or burning, often mistaken for indigestion.<br>• Pain may localize behind sternum and radiate to either arm or shoulder. Pain may extend to hand, neck, jaw, teeth, upper back, upper and middle abdomen<br>• Shortness of breath, nausea, and sweating.<br>• Increased pulse rate, irregular pulse | • Call 911<br>• Monitor ABC's<br>• Comfort and reassure<br>• SAMPLE history & Vitals<br>• Call EMS<br>• Get AED/BVM Prepare to preform CPR<br>• Reassess |

# Medical Care Chart

| | | |
|---|---|---|
| **Diabetic Emergency** | • **Hyperglycemia:** Insulin level too low and sugar level to high<br>• **Hypoglycemia:** Insulin level to high and sugar level to low. | • SAMPLE History<br>• Look for medical tag<br>• Sugar if conscious |
| **Fainting**<br>Can happen when not enough oxygen flows through your blood into your brain | • Standing up to fast<br>• Vigorous exercise<br>• Hyperventilating<br>• Getting very upset<br>• Lung Buster | • Call 911, if patient has history of fainting, or other medical history<br>• Rest and “catch” breath<br>• Breath at normal rate<br>• Calm and Reassure |
| **Seizure**<br>Can result from altered or irregular electrical activity in the brain caused by: fever, infection, chronic epilepsy | • **Aura:** unusual sensation or feeling prior to onset.<br>• Drooling, body may become rigid<br>• Eyes roll upward, may urinate or defecate<br>• May experience sudden, uncontrollable, muscular contractions | • Do not restrain, protect from injury<br>• Maintain airway, place in recovery position after convulsion<br>• SAMPLE history and Physical exam |

# Medical Care Chart

| Hot & Cold Emergencies | Signs and Symptoms | General Care |
|---|---|---|
| **Heat Exhaustion** | • Muscle cramps in legs and abdomen<br>• Warm, moist flushed skin<br>• Headache, nausea, weakness, dizziness<br>• Loss of consciousness<br>• Weak, pulse and rapid shallow breathing<br>• Heavy perspiration | • Move patient to cool area<br>• Loosen or remove clothing<br>• Provide fluids<br>• Treat for shock & monitor ABC's<br>• Apply moist towels over cramped muscle<br>• Apply gentle, but firm pressure on cramped muscle |
| **Heat Stroke** | • Rapid Shallow breathing<br>• Rapid pulse<br>• Weakness, loss of consciousness<br>• No Perspiration<br>• Large (Dilated) Pupils<br>• Seizures, muscular twitching, or coma | • Move patient to cool area<br>• Rapidly cool patient<br>• Keep skin wet by applying wet towels<br>• Fan the patient, to increase heat loss<br>• Place cold packs on neck, armpits, wrists, ankles, and groin<br>• Monitor ABC & make sure EMS is called |
| **Hypothermia** | • Shivering<br>• Delayed capillary refill<br>• Altered Level of Consciousness<br>• Large (Dilated) Pupil | • Remove patient from cold<br>• Gradually re-warm<br>• Monitor vitals<br>• Make sure EMS has been called |
| **Frostbite** | • White, cold skin<br>• Painful or painless extremities<br>• Delayed capillary refill<br>• Occurs deep in affected tissue | • Remove patient from cold<br>• Limit movement of injured part<br>• Cover affected area w/dressing and bandage loosely.<br>• Treat for shock<br>• Make sure EMS has been called |

# Drug Abuse and Misuse

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|---|---|
| **Narcotic** | Stupor, euphoria, similar signs to depressants |
| **Stimulant** | Moist skin, sweating, chills, nausea, vomiting, fever, dizziness, rapid pulse and breathing, chest pain, excited, restlessness, talkative, irritable |
| **Hallucinogen** | Sudden mood changes, flushed face, hallucinations, anxious, and frightened |
| **Depressant** | Drowsiness, confusion, slurred speech, slow pulse and breathing, poor coordination |

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| **General Care for Drug Abuse and Misuse** | • Monitor personal safety<br>• Monitor ABC's – Be alert for respiratory arrest<br>• Gain patient confidence/maintain LOC's<br>• Protect from further harm<br>• Care for shock and continue to reassure |

# Poisons

## Routes:

**Ingestion – T**aken into the body by way of mouth
**Absorption – A**bsorbed through the skin and body tissue
**Inhalation – T**aken in by breathing
**Injection –** Enters directly into the bloodstream

| | |
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| **General Care for Poisoning** | • Monitor ABC's<br>• SAMPLE History<br>• Make sure EMS has been called |

# EMERGENCY CHILDBIRTH

## Stages of Labor

| | | |
|---|---|---|
| 1st stage (Dilation)<br>Regular uterine contractions to full dilation of the cervix | 2nd stage (Expulsion)<br>Full dilation of the cervix to the delivery of the infant | 3rd stage (Placenta)<br>Delivery of infant to the delivery of the placenta, 30 mins after childbirth |

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|---|---|
| **History of Pregnancy**<br>Pertinent questions asked to provide adequate care) | #of pregnancies**,** Total # of live births, Prenatal care**,** Expected Due date, Broken water, Last menstrual cycle**,** Expected complications |
| **Imminent Delivery** | Contractions increasing in intensity and frequency (2 mins. Apart 60-90 sec. intervals), Urge to Push**,** Sensation to move bowels**,** Crowning |
| **Crowning** | Infant's head is at the vaginal opening |
| **Delivery of the infant** | Support the infant's head Check for the umbilical cord and that it's not wrapped around the infant's neck Delivery of the upper shoulders Suction of the mouth and nose with bulb emptying it before inserting it into the mouth or nose. Umbilical cord; double camp cord 6" or greater from infant 3 inches between clamps. 11/7/2025cut after pulsating, use clean scissors or scalpel |
| **Care for Newborn** | If newborn is not actively crying, stimulate by rubbing the baby's back and flicking the feet.<br>If the heart rate is less than 100 or respirations < 30-2, |

# EMERGENCY CHILDBIRTH

| Special Situations | |
|---|---|
| **Nuchal Cord**<br>(When the umbilical **cord** becomes wrapped around the fetal neck 360 degrees) | If unable to slip cord overhead, clamp the cord in two places three inches apart and cut between the clamps in the middle. |
| **Prolapsed Cord**<br>(umbilical cord presents first) | Elevate hips with pillows or put the patient in a “knee chest” position Cover the cord with a dressing moistened with sterile saline |
| **Breech Presentation**<br>(Limb presentation) | Left lateral Trendelenburg position If baby’s body delivers and head fails to deliver in one to two minutes, create an airway by placing a gloved hand into the vagina and making space for the infant until the head delivers. Be sure to explain the procedure to the mother. |
| **Limb Presentation** | Left-lateral Trendelenburg position |
| **Meconium Stains**<br>(A sign of fetal or maternal distress Results from the fetus defecating Stains the amniotic fluid greenish or brownish-yellow in color) | Reduce the risk of aspiration by not stimulating the infant before suctioning the airway Suction the mouth and nose |
| **Post Delivery Care** | Fundal massage**,** Allow infant to breast feed Treat mother for shock |

# TRAUMA CARE

All trauma care patient should receive high flow $O_2$

| Skill Component | Comments |
|---|---|
| **Dressing:** A clean or sterile pad placed directly over a wound to absorb infection<br>**Bandage:** Material used to apply pressure to a wound or support an injured body part. | |
| **BLEEDING CONTROL**<br>♦ Remove enough clothing to expose entire wound | . |
| ♦ Manage bleeding by applying direct pressure with dressing and elevate the wound | • Direct pressure may involve just the finger tips or may require hand pressure |
| ♦ Apply roller bandage | • Apply roller bandage whether or not bleeding has stopped. DO NOT remove original dressings. |
| **Last-Resort Attempt**<br>♦ Apply a commercial tourniquet as distal as possible on the extremity, at least 2 inches above the wound<br>• inflated blood pressure cuff<br>**OR**<br>• constricting band and dowel Control continued bleeding | • Application of a tourniquet is a last resort. All other possibilities must be exhausted prior to the application of a commercial device.<br>• Note time tourniquet was applied in bold notes<br>• Administer high flow O2 |
| **Hemostatic Dressing application**<br>♦ Apply a commercial Hemostatic dressing at the site of the bleeding. and need to<br>♦ Must be packed deep inside the wound along with direct pressure.<br>♦ In order to be effective, hemostatic dressings require continuous direct pressure at the source of the bleeding until controlled.<br>♦ Anytime a hemostatic dressing is applied, the person needs to be evaluated by a healthcare professional.<br>♦ Use manufacturer's recommendations should be followed for proper<br>♦ Application of the hemostatic dressing according to local protocols | • A hemostatic dressing is a dressing treated with an agent or chemical that speeds clot formation. Chemical composition varies depending on the product.<br>• As is the case with tourniquets, hemostatic dressings are used when severe life-<br>• Typically, hemostatic dressings are used on parts of the body where a tourniquet cannot be applied, such as the neck or torso and are likely of greatest use for severe external bleeding:<br>• in locations where standard bleeding control is not effective,<br>• When a tourniquet cannot be applied (trunk or junctional areas such as the abdomen or groin,<br>• When a tourniquet is not available, or<br>• When a tourniquet is not effective to stop bleeding.<br>• Hemostatic dressing needs to be applied at the site of the bleeding and need to be packed deep inside the wound along with direct pressure.<br>• In order to be effective, hemostatic dressings require continuous direct pressure at the<br>• source of the bleeding until controlled. |
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# TRAUMA CARE

All trauma care patient should receive high flow $O_2$

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| **MUSCULOSKELETAL INJURIES**<br>♦ Stabilize and expose the injured extremity:<br>• Cut clothes away<br>• Remove shoes and socks<br>• Remove jewelry | • Shoes must be removed to assess for pulse and sensation<br>• Some extremities may be readily exposed and do not require that clothes are cut<br>• Jewelry must be removed |
| ♦ Assess the injury | • Do not move if painful |
| ♦ Assess extremity distal to injury for:<br>• Circulation<br>• Motor function<br>• Sensation | • Circulation - check for present pulse<br>• Motor function - have patient wiggle fingers<br>• Sensation - pinch digits |
| ♦ Select and prepare proper splint for stabilization and immobilization: | • The splint should achieve the goal of stabilization and immobilization of the joint above and below the fracture site.<br>• The splint should achieve the goal of stabilization and immobilization of the bone above and below the fracture site.<br>• Shimming involves padding the extremity in the splint to decrease movement of the extremity. Make sure there is even pressure and contact. |
| ♦ Re-assess extremity distal to injury for<br>• Circulation<br>• Motor function<br>• Sensation | • Every 5 to 15 minutes and make adjustments as necessary |

## TRAUMA CARE CHART

| Skin injuries | Signs and Symptoms | General Care |
|---|---|---|
| **Contusion** (Internal Bleeding – Closed Wound) | Discolored, tender swollen hard tissue, Increased respiratory and pulse rate, Pale, cool skin Nausea and vomiting. Thirst Mental Status Changes | Apply direct pressure, Rest immobilizes, cold |
| **Abrasion** | Scrapping or rubbing of skin | Apply Direct Pressure w/dressing Pressure Bandage, Apply additional dressing & bandage |
| **Laceration** | Cut Skin | Apply Direct Pressure w/dressing Pressure Bandage, Apply additional dressing & bandage, tourniquet |
| **Puncture - Penetration** | Impaled Object | Expose wound<br>Apply bulky dressing around object<br>Bandage the bulking dressing |

| | | |
|---|---|---|
| **Protruding Organs** | Usually around abdomen | Cover the wound and/or organs with moist, clean dressing. |
| **Amputation** | Complete loss of extremity or digit | Wrap completely in sterile dressing<br>Place in plastic bag and seal<br>Place bag on ice |
| **Chest Injuries** | **Signs and Symptoms** | **General Care** |
| **Sucking chest wound**<br>**Flail Chest** | Crushing injury<br>Two or more ribs broken in 2 or more places May cause difficulty breathing | Lessens pain, dress any open injuries with sterile gauze, prevents further damage. Keep patient in most comfortable position calm and reassure. |
| **Tension Pneumothorax** | complete collapse of lungs | Lessens pain, dress any open injuries with sterile gauze, prevents further damage. Keep patient in most comfortable position calm and reassure |

# Musculoskeletal Injuries

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

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

# Burn Care

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

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

# DETAILED PHYSICAL EXAMINATION

**NOTE:** Physical Examination is injury specific; once injured area is examined the rest of the examination can occur after caring for the injury.

| Skill Component | Comments |
|---|---|
| ♦ **Assess for:**<br>• Deformities<br>• Open Injuries<br>• Tenderness<br>• Swelling | • Adults - head to toe examination works best<br>• Children - toe to head examination works best to gain child's confidence. |
| ♦ **Assess the scalp/head**<br>• Inspect and palpate the scalp and ear<br>• Assess the eyes<br>• Assess the facial areas including oral and nasal area | • Asymmetry of head and face may be due to trauma or medical problem such as stroke or Bell's palsy (unilateral facial paralysis of sudden onset and unknown cause)<br>• Battle signs present with is bruising over the mastoid process and indicates basilar skull fracture or fracture of the temporal bone.<br>• Raccoon eyes present with is the bruising of one or both orbits and indicates fracture of the sphenoid sinus.<br>• Battle sign and raccoon eyes develop some time after the injury and generally are not seen upon EMS arrival, if noted, this may be due to a previous injury<br>Fluid from the ear or nose (Cerebral Spinal Fluid or CSF) also may indicate leakage of spinal fluid resulting from a basilar skull fracture |
| ♦ **Assess the neck**<br>• Inspects and palpates the neck<br>• Assess for Jugular Vein Distention (JVD)<br>• Assess for tracheal deviation (TD) | • JVD presents with enlarged jugular veins protruding from under the skin<br>• TD presets with the trachea off to the left or right of center<br>• If suspected, Lifeguards shall perform spinal immobilization based on mechanism of injury |
| ♦ **Assess the shoulder**<br>• Inspects<br>• Palpates | |
| ♦ **Assess the chest/ribs**<br>• Equal rise and fall of the chest<br>• Stability of the sternum<br>• Equal expansion of the chest | • Maintain patient modesty and perform chest palpation in a manner as to avoid any inference of impropriety.<br>• If not completed, complete breath sounds should be assessed in either anterior or posterior locations and auscultate for 2 breaths in all 3 fields |
| ♦ **Assess the abdomen/pelvis**<br>• Assess the abdomen<br>• Assess the pelvis | • DO NOT PALPATE pulsating masses - this may rupture an aneurysm.<br>• Palpate each of the 4 quadrants bilaterally one time only to assess for rigidity and guarding.<br>• Use finger pads DO NOT use finger tips<br>• Pelvic injuries are critical and have the potential for major blood loss. DO NOT palpate if there are obvious pelvic injuries or patient complains of pelvic pain, **IMMEDIATE EMS CALL SHOULD BE INITIATED** |

| | |
|---|---|
| ♦ **Assess the extremities - lower**<br>• Inspects and palpates each extremity<br>• Assess CMS | • Compare bilateral pulses, motor function and sensation<br>• Abnormal sensations may be tingling, burning or numbness. |
| ♦ **Assess the extremities – upper**<br>• Inspects and palpates each extremity<br>• Assess CMS | • Compare bilateral pulses, motor function and sensation<br>• Abnormal sensations may be tingling, burning or numbness. |
| ♦ **Assess the back**<br>• Inspects and palpates | • Visually inspect the back |

| **ONGOING ASSESSMENT** | |
|---|---|
| (Φ) **Repeat initial assessment as needed**<br>(Φ) **Comfort and reassure**<br>(Φ) **Evaluate response to treatment**<br>(Φ) **Transfer care and (rescues card) information to EMS** | • Priority patients are patients who have abnormal vital signs, S/S or poor perfusion, if there is a suspicion that the patient's condition may deteriorate, or when the patient's condition changes<br>• Re-evaluate at least every 5 minutes if any treatment was initiated or medication administered<br>• Evaluating and comparing results assists in recognizing if the patient is improving, responding to treatment or condition is deteriorating.<br>• Communication is important when dealing with the patient, family or caregiver. This is a very critical and frightening time for all involved and providing information helps in decreasing the stress they are experiencing.<br>• Report should consist of all pertinent information regarding the assessment findings, treatment rendered and patients' response to care provided. |

# LOS ANGELES CITY
# LIFEGUARD RECERTIFICATION
## BASIC LIFE SUPPORT SKILLS

**BLEEDING**

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

| If bleeding becomes unmanageable | | | |
|---|---|---|---|
| ♦ Add additional dressing and bandage<br>♦ Apply direct pressure<br>♦ Continue until paramedics arrive and take over or until bleeding become manageable. | | | |
| ♦ Properly position the patient and continue to care | | | |
| After proper management of injury, obtain vitals, SAMPLE history, begin detailed physical exam. | | | |

# LOS ANGELES CITY
# LIFEGUARD RECERTIFCATION
## BASIC LIFE SUPPORT SKILLS

**RIGID SPLINT/SLING**

| Procedure | | | |
|---|---|---|---|
| **Skill Component** | **Yes** | **No** | **Comments** |
| **Check Circulation, Sensation, and Motor Function before and after splinting** | | | |
| ♦ Assess Circulation | | | |
| ♦ Assess Motor Function | | | |
| ♦ Assess Sensory Function | | | |
| ♦ Applies SAM Splint to Extremity<br>o Properly measure, form, & places the splint | | | |
| **NOTE: THE EXAMINER GIVES CONDITIONS OF "CMS".** | | | |
| ♦ Immobilizes Above and Below Injury Site | | | |
| ♦ Applies Sling and Swathe | | | |
| ♦ Assess Circulation | | | |
| ♦ Assess Motor Function | | | |
| ♦ Assess Sensory Function | | | |
| **NOTE: THE EXAMINER GIVE CONDITION OF "CMS".** | | | |
| *- If indicated*<br>♦ Corrects intervention to obtain initial CMS | | | |
| ♦ Properly position the patient and continue to care | | | |
| After proper management of injury, obtain vitals, begin detailed physical exam and obtain SAMPLE history. | | | |