THE RALEIGH POLICE DEPARTMENT

1108-06

FIRST AID

PURPOSE

To provide general guidelines to officers who arrive on the scenes of severe injuries prior to the arrival of emergency medical personnel.

VALUES REFLECTED

This directive reflects our values of *Service and Compassion*. Our highest priority in the cases of severe injury is to offer comfort and aid to the victim, to protect them from further injury, and to save lives.

UNITS AFFECTED

All Divisions/All Personnel

REFERENCES/FORMS

G.S. 20-166(d) "Aid at Collision Scenes"
G.S. 90-21.14 "Good Samaritan Law"
G.S. 15A-503 "Police Assistance to Unconscious Arrestee"
G.S. 90-12.7 "Treatment of Overdose with Opioid Antagonist; Immunity"
DOI 1106-08 "Communicable Disease/Bloodborne Pathogens"

GENERAL POLICIES

The first officer arriving on a scene must determine whether an ambulance is needed and should then apply reasonable first aid pending arrival of emergency medical personnel. Personnel should not attempt to transport injured persons unless no other reasonable alternative is available (see DOI 1106-5 "Operation of Police Vehicles").

In cases of severe injury, the officer should check for breathing and control severe bleeding unless life threatening hazards necessitate immediately moving the victim to a safe location.

LEGAL IMPLICATIONS

Consent

In cases where the victim is conscious and coherent, officers should try to obtain consent prior to rendering first aid.

If a victim is unconscious or incoherent, consent is implied. However, if a parent or next of kin is present, consent should be obtained from that person.

Unauthorized Practice of Medicine

All personnel should be careful not to exceed the scope of their training or responsibility. They should not attempt techniques for which they have not received instruction or certification. If the assistance of a third party is requested by an officer, the level of assistance should be within the assisting person's level of competence.

Abandonment

If an officer responds to a medical emergency, the officer should not leave the patient until relieved by other competent personnel.

EFFECTING A PROMPT RESCUE

Where a life-threatening hazard exists, such as a fire or poisonous gases, the victim shall be moved to safety. Otherwise, the victim should not be moved.

Moving the Victim

If a victim must be moved, dragged, or pulled to safety, the victim should be pulled in the direction of the long axis of the body, preferably by the shoulders. If possible, pulling the victim sideways should be avoided.

Temporary Stretchers

At times, blankets, sturdy chairs, or other items may be available for use to move a victim . Use of such temporary stretchers is generally more preferable than dragging victims by their clothing.

CHECKING FOR PULSE AND BREATHING

Quick Check

Personnel should check for signs of life including consciousness, effective breathing, pulse, along with life threatening bleeding. The purpose of a quick check is to immediately identify life threatening conditions. Officers should feel for a pulse at the wrist or throat artery.

Cardiopulmonary Resuscitation (CPR)

Unresponsive victims with no pulse should be administered CPR. This is done by pushing hard and fast on the lower half of the sternum while the victim is on a hard surface. Allow the chest to return to its normal position before compressing again.

The current recommendations from the American Heart Association are to do compressions at a rate of 120 compressions per minute. Compressions of a depth of at least 2 inches is recommended for adults but less than 2.4 inches of depth. For children approximately 2-inch compressions and infants 1 ½ inch compressions are recommended. Children and infants' compressions can be estimated as 1/3 the depth of the chest.

Automated External Defibrillators (AED's) are simple and easy to use. AED's are commonly located at businesses, churches, and other large buildings. An AED can detect and reverse a fatal heart arrhythmia. The first step in using an AED is turning it on. Then simply follow the prompts given by the machine. Officers are encouraged to use an AED if available when performing CPR.

The officer should attempt to dislodge any obstruction of the mouth or throat if this can be done without risk of pushing the obstruction further down the throat. If appropriate, the officer can perform rescue breathing or CPR using a bag valve mask if available.

Trauma Care

Direct Pressure

Placing a dressing over the wound and applying direct pressure is the preferred method of controlling bleeding. A pressure bandage may be used to hold the compress in place, so that the officer's hands may be freed. If a dressing is not available, a gloved hand or fingers may be used, but only until a compress can be applied.

Use of a Tourniquet

A tourniquet should be used for life threatening bleeding of an extremity When an injury to a extremity is exposed and can be evaluated a tourniquet should be applied on affected extremity at least 2 inches closer to the center of the body (proximal) than the life threatening bleeding. The tourniquet should be applied over a long bone and not directly over joints such as the elbow or knee. The location of the tourniquet and the time it was applied must be noted by the officer. Once a tourniquet is applied, it should not be loosened by officers except on the advice of a physician.

Indications for use of a tourniquet include severe arterial bleeding, blood-soaked clothing, pooling of blood, or if all other bleeding control efforts have failed. If the source of life-threatening bleeding is not known due to multiple injuries on an extremity such as a blast injury, the placement of a

tourniquet should be placed high on the extremity. For victims with traumatic partial and complete amputations of an extremity the tourniquet placement is recommended high on the extremity regardless of bleeding.

Manufactured tourniquets approved for use include SOFT-T, CAT, and SAM XT. The SAM Junctional Tourniquet is approved for use by units receiving additional training including but not limited to Special Operations personnel and Training Staff.

Sucking Chest Wounds

A HyFin vent is a chest seal specifically designed for penetrating chest trauma. A HyFin vent is indicated for use on a victim of penetrating trauma to the torso. The HyFin vent is adhesive and is applied over entry and exit wounds on the chest, back, or side of the victim. Only HyFin vents are authorized for use by officers. Use of other manufactured chest seals is prohibited. If a HyFin vent is not available, the officer can apply an airtight dressing and secure it with overlapping strips of tape. It is recommended to place injured person on their affected side in the recovery position unless head, neck, or spine injury is suspected.

Three Phases of Casualty Care

Each of the three recognized phases of casualty care is defined below including the care recommended by the Committee for Tactical Emergency Causality Care. It is not necessary to go through each phase of care. The phase of care is determined by the threat or potential threat of violence.

Care Under Fire / Direct Threat Care

Care under fire or direct threat care is when there is current active violence or a likely risk of further injury. During this phase of care severe extremity bleeding control can be controlled by the application of a tourniquet placed high and tight above the wound over clothing. All other care should be delayed until the tactical field care phase.

Tactical Field Care / Indirect Threat Care

Tactical field care also known as indirect threat care is performed when there is a lesser potential of violence or additional injury to the care provider or injured person such as when behind cover. Other indications of tactical field care include when the threat of violence has been stopped, contained, secured, or retreated. During tactical field care officers should evaluate and treat injuries by using the mnemonic MARCH (massive hemorrhage, airway, respirations, circulation, head injury and hypothermia).

Evacuation Care / Cold Zone Care

Medical care provided to the injured away from the threat of violence is included in evacuation care. The care may be provided in the cold zone due to the distance away from an active scene. This care may be provided when moving the injured to a treatment area or to awaiting EMS personnel. This phase of care is often completed by EMS providers.

POISONING

If the victim is unconscious and poisoning is suspected, the officer should check for stains or burns about the victim's mouth. The officer should check the area for a source of the poisoning. Useful information including recommended first aid actions and ingredients may be located on the poison container. This information should be relayed to responding medical personnel.

Vomiting must not be induced if corrosives or petroleum distillates are involved.

If the victim is unconscious or having convulsions the officer should maintain an open airway and treat him/her for shock. In this instance, the officer should not attempt to administer liquids.

BURN VICTIMS

Thermal Burns

Burns should be covered as quickly as possible with a clean, sterile dressing. In emergencies, a clean sheet may be used. The officer should not remove adherent particles of charred clothing.

The officer should have victims with face burns sit up or they should be propped up. Burn victims should be kept under continuous observation for breathing difficulty. Burns to the face are always considered serious. Burns covering large areas of the body that appear leathery or charred can be life threatening.

Minor burns cover a small area of the body and are red or blistered. Minor burns do not include the head or face. A cold pack may be applied to areas of minor burns to reduce pain. Cool running water can be used to relieve pain of minor burns. Officers should not immerse or apply ice water over extensively burned areas, since this may induce shock or hypothermia.

Chemical Burns

Chemical or acid burns should be flushed with water for at least five minutes. Clothing contaminated with chemicals or acids should be removed. Dry powder causing burns should be brushed away prior to applying copious amounts of water to the affected area.

EPILEPSY AND SEIZURE VICTIMS

Preventing Injury

Officers should keep a seizure victim lying down and push away nearby objects. Efforts should be made to prevent the victim from banging their head, but other restraint should be avoided. A victim may injure themselves by tensing against the restraint.

Maintaining an Airway

The officer should not force blunt objects between the victim's teeth. The officer should prevent the victim from aspirating by placing the victim on their side in the recovery position. If breathing stops, and no pulse is detected the officer should provide CPR.

STABBINGS OR IMPALINGS

Impaled Objects

If a person is impaled by a knife, ice pick, etc., the foreign object should not be removed. Bulk dressings should be placed on either side of the object to stabilize it to prevent movement of the object. If the cheek is impaled, the victim should be positioned seated and leaning forward to allow drainage away from the throat.

Eviscerations

At times, organs or intestines may be protruding from the wound. The officer should cover the wounded area with a non-adhering dressing, such as aluminum foil or plastic wrap. The officer should then cover the non-adhering dressing with a sheet or towel. If the proper dressing is unavailable, no action should be taken.

STABILIZING VICTIMS

Once emergency measures have been taken, efforts should be made to reduce the traumatic shock associated with serious injuries.

Avoid Moving the Victim

Rough handling of the victim and should be avoided. The victim should not be moved unless necessary for safety reasons. The officer should keep the victim in a position best suited to the victim's condition, they should not be allowed to get up or walk about. The officer should loosen constrictive clothing, but the officer should not pull on the victim's belt in case spinal injuries are present.

Recovery Position

The recovery position is often the best position to place an ill or injured person absent a potential head, neck, or spine injury. The recovery position includes putting a person on their side while monitoring beathing and pulse. One hand can be used to monitor pulse and the other hand to monitor breathing. Placing the person on their side can maintain an open airway and reduce the risk of aspiration while waiting on medical personnel.

Keeping the Victim Warm

Personnel should maintain the victim's body temperature by placing blankets, emergency blankets, or additional clothing over the victim. If the victim is exposed to cold or dampness, additional blankets or clothing should be placed under the victim. Maintaining body heat is a very important action that can greatly improve the survivability of an injured victim.

RESPONDING TO AN OPIATE OVERDOSE / NALOXONE USE AND DEPLOYMENT

Calling for Medical Assistance

If an employee has reason to believe that a person is suffering from exposure to an opiate, the employee should immediately notify Raleigh-Wake Emergency Communications Center that they have a possible opiate overdose and request Fire and EMS.

Indications of Opiate Overdose

- Ineffective breathing (less than 10 breaths per minute)
- Purple or blue skin color, especially around lips and/or fingernails.
- Making loud, uneven snoring or gurgling noises
- Loss of responsiveness
- Loss of consciousness
- No pulse
- Presence of opioid-based narcotics and/or paraphernalia

Precautions

Sudden opiate overdose reversal can lead to vomiting. All personnel should use universal precautions to include gloves and a face mask if available. The on scene personnel should also be aware that the subject who overdosed may awaken and be confused and unpredictable in their behavior.

Training

No personnel will be provided Naloxone for use by the Department unless they have completed the mandated training. The training course will cover patient assessment, signs/symptomology of overdose, universal precautions, G.S. 90-12.7 and instruction on the use of intra-nasal Naloxone. After receiving the initial training, employees will be required to attend annual refresher training.

Naloxone Use and Continuing Care

Naloxone administration is indicated for use on suspected opiate overdoses to improve ineffective breathing. To administer Naloxone the cartridge should be placed into the nostril and the plunger depressed completely and left in place for several seconds. Once the dose is administered the victim should be rolled on their side facing away from the employee into the recovery position and monitored closely for beathing and pulse. A second dose may be required if breathing does not improve. If breathing stops and a pulse is present rescue breathing using a bag valve mask may be performed. If breathing stops and no pulse is detected CPR should be administered to the victim.

The employee administering Naloxone should remain with the patient until relieved by EMS or Fire personnel. Responding medical personnel should be told that Naloxone was administered and how many dosage units were delivered.

Scene Decontamination / Evidence Handling

If an opiate exposure occurs that results in medical care being required for involved police personnel, the area of exposure should be evacuated and secured. The Drugs and Vice Lieutenant will be notified

and will contact personnel who have completed and maintain current certification for dealing with clandestine labs so that they may respond and coordinate further scene/evidence processing.

Any evidence recovered at the scene of an overdose will be properly secured, documented, and placed into RPD evidence. Officers should refer to General Statute 90-96.2 prior to making any drug charges related to an overdose call for service. In general, persons experiencing or reporting an overdose are immune from prosecution if they possess less than 1 gram of cocaine or heroin.

Follow-up Reporting

Upon completing a medical assist, the assisting officer will complete an incident report detailing the nature of the incident, the care the patient received and the details surrounding the administration of Naloxone. The report will be forwarded to the Department Naloxone Coordinator who will then forward the data to North Carolina Harm Reduction's Overdose Prevention Program Coordinator.

Naloxone Storage

All personnel that are assigned to administer Naloxone will be responsible for its proper storage. Naloxone should be kept at normal room temperatures and should not be exposed to extreme temperatures for any extended period. For this reason, Naloxone should not be stored in vehicles during extreme temperatures or that may become susceptible to extreme temperatures for any extended period of time.

Maintenance / Replacement

Naloxone assigned to personnel should be checked during routine monthly inspections. Supervisors will ensure that the kits are in good condition and have not reached their expiration date.

Missing, damaged, used, or expired Naloxone kits will be reported to the Police Quartermaster for replacement. An Equipment Request Form will be filled out, signed by the appropriate supervisors and submitted to the Quartermaster at the time of replacement.

Naloxone Coordinator

The Drugs & Vice Lieutenant will be designated as the Naloxone Coordinator for the Department. The coordinator will keep statistics on usage and effectiveness of the Naloxone program. The Police Quartermaster will dispense and track Naloxone kit deployment.

GATHERING INFORMATION

Once the victim's condition is stabilized, officers should obtain information about the victim and the accident which may be useful to medical personnel.

Medical Alerts

If a victim is unconscious, personnel should check for any medical alert bracelets or necklaces that might be worn by the victim. Other identification carried by the victim may provide clues to the victim's condition or may provide the names of relatives. If possible, have a witness present prior to searching a person's wallet or purse.

Information Concerning Injuries

Officers should attempt to determine from the victim or witnesses, precisely what happened. Any medicines or chemicals that might be involved should be collected. The officer should try to determine how long the victim was unconscious or in the present condition.

NOTIFYING NEXT-OF-KIN

Officers should gather whatever information is available so that next-of-kin can be notified. In most cases, notification should be left to hospital personnel. Officers, though, are responsible for identifying unknown victims and should assist hospital personnel when requested in difficult notifications. In making notifications, officers should not try to diagnose illnesses or the extent of injuries. They should simply indicate that contact with the hospital is requested.

REQUIRED REPORTS

A case report is required if an officer attempts a life-saving procedure on a victim. Life-saving procedures include but are not limited to: cardiopulmonary resuscitation (CPR), the Heimlich maneuver, the administration of an automated external defibrillator (AED), the application of a tourniquet, the application of a chest seal, the administration of Naloxone, and direct pressure to control serious bleeding.