



# QUEENSLAND

**2017/2018 Season**

## **Skills Maintenance Bulletin**



The SLSQ 2017/2018 Season Skills Maintenance Bulletin provides all members with information regarding changes which will take effect for the upcoming season. It also contains reminders where common issues or important reminders have been identified. Please ensure you have read the information contained within before attempting the Skills Maintenance Theory Paper.

## **Wearing of Patrol Uniform When Not on Patrol**

In accordance with Section LS0009 in the Patrol Operations Manual, a member is only permitted to wear their patrol uniform components whilst performing their patrol duties or their patrol uniform when performing approved activities (e.g. Surf Club fundraising activity). This means that members are not to travel to or from their club wearing their uniform or to go swimming in their shorts when they are not part of the on duty patrol.

## **Advanced Resuscitation Techniques Award Holders – 2017/2018 Skills Maintenance Requirements**

Since the 1<sup>st</sup> July 2016, any member who holds the old Advanced Resuscitation Techniques Certificate (ARTC) which was aligned to HLTA404 version units of competency and had completed an SLSA ARTC skills maintenance/proficiency since 1 July 2015 has been encouraged to upgrade to the new award via a short 2 ½ hour assessment only process.

For those eligible and interested in upgrading, the assessment only RPL process requires candidates to answer theory questions (multiple choice and short answer) as well as complete practical scenarios incorporating the use of suction, OP airways, defibrillation and oxygen whilst working as part of a team performing CPR. This assessment will need to be completed with endorsed Emergency Care Facilitators so please check with your Chief Training Officer (CTO) that you meet eligibility criteria and for available sessions. As the sessions are RPL Assessment Only, no training is provided, just assessment. If the facilitator identifies that you do not have the required skills and knowledge to pass, you will need to attend a full course. Please note, if you successfully complete either the upgrade or a full course after 1<sup>st</sup> July 2017, this will count as your ART Proficiency for the 2017/2018 Season.

Members who already hold the new award (and HLTAID007 unit of competency) from previous seasons will be able to maintain their SLS award proficiency by completing skills maintenance through their club under the endorsed delegate system. The endorsed delegate will need to be proficient in the new Advanced Resuscitation Techniques [AID] award as well as hold the HLTAID007 unit of competency. Members who do not wish to upgrade at this point in time are still able to complete skills maintenance on the old ARTC award for this 2017/2018 Season via the endorsed delegate system.

## **Tropical Marine Stingers Heading South**

The previous season saw an increase in the number of reported cases of suspected tropical stings (Box Jellyfish and Irukandji) in areas further south than have been previously experienced. Gaining particular attention by the media were cases around Fraser Island. As a result of these cases occurring further south, it is important that members in the southern regions become more familiar with the recognition and treatment of Box Jellyfish (*Chironex Fleckeri* and Irukandji) as well as those which result in various degrees of Irukandji Syndrome.

Throughout a rescue, a rescuer must remain calm, make sound judgments, and above all not expose themselves, their casualties, or others to unnecessary risk. The essential parts of a surf rescue are:

- Casualty recognition
- Call for back-up (if available)
- Deciding on a course of action
- Approaching, securing and retrieving the casualty
- Returning the casualty to the beach or signaling for support craft as soon as practicable
- Follow - up emergency care

Rescue of sting casualties of *Chironex* Box Jellyfish includes the following considerations:

- Equipment (vinegar, oxygen and Defibrillators) should be kept close at hand.
- The unconscious casualty who has been stung should be removed from the water by their arms gripped and dragged up the beach, thus minimising contact with the rescuers and leaving the stung area exposed for vinegar to be poured over.
- The conscious casualty should be restrained from running around, reassured and persuaded to rest from physical activity to minimise absorption of venom from the stung area.
- Immediate first aid treatment as required.

Rescue of sting casualties of *Irukandji* includes the following considerations:

- Equipment (vinegar, oxygen and Defibrillators) should be kept close at hand.
- Typically, *Irukandji* sting casualties will present to lifesaving personnel either with a mild sting (before the syndrome begins) or with severe cramping and possibly additional symptoms (once the syndrome has begun).
- Immediately upon presentation, the sting should be thoroughly doused in vinegar, whether it appears severe or not (it will usually appear as a few reddened goose-pimples and possibly localized sweating), and whether syndrome symptoms have onset or not.
- Casualties should be kept calm, discouraged from re-entering the water, and closely monitored for 30-45 minutes for shock or other complications.
- Immediate first aid treatment as required.
- Advise Lifeguard Supervisor/Lifesaving Services Coordinator/Surfcorn of incident, monitor casualty for any initial signs of Irukandji syndrome, and call 000 for ambulance.

***“If in doubt, treat it as Irukandji”***

For further information refer to SLSQ Patrol Operations Manual Section LS0020 – Dangerous Marine Creatures.

## **Administering EpiPen™ (adrenaline auto-injectors) Procedure Changed**

The Australian Society of Clinical Immunology and Allergy (ASCIA) released a statement on the 13<sup>th</sup> June 2017 advising that there is a change to the instructions on how to administer EpiPen™ and EpiPen™ Jr adrenaline auto-injectors. It is now advised that the injection time should be for a period of 3 seconds instead of the 10 seconds which was previously used. Massage had been found to increase the risk of tissue irritation so is no longer part of the recommended treatment. New EpiPen™ and EpiPen™ Jr will have the updated instructions regarding inject for 3 seconds and no massage on them. In the meantime, all EpiPen™s should now be held in place for 3 seconds regardless of the instructions on the device. Updated posters can be accessed and downloaded from the ASCIA website (<https://allergy.org.au>)

## **Australian Resuscitation Council (ARC) Guideline Changes**

In November 2016 Guideline 9.2.5 - First Aid for Asthma had a minor update. The update now includes information which reflects the difference in first aid treatment recommended in Australia versus New Zealand. Within Australia the recommended Asthma First Aid Plan remains the same which is 4 x 4 x 4.

Asthma First Aid Plan for Australia (taken from ARC Guideline 9.2.5 dated Nov 2016)

**If a casualty has any signs of a severe asthma attack, call an ambulance straight away and follow the Asthma First Aid Plan while waiting for the ambulance to arrive.**

**Step 1** Sit the person comfortably upright. Be calm and reassuring. Do not leave the person alone.

**Step 2** Without delay give four separate puffs of a “reliever”. The medication is best given one puff at a time via a spacer device. Ask the person to take four breaths from the spacer after each puff of medication.

If a spacer is not available, simply use the inhaler. Use the casualty’s own inhaler if possible. If not, use the first aid kit inhaler if available or borrow one from someone else.

**Step 3** Wait four minutes. If there is little or no improvement give another four puffs.

**Step 4** If there is still no improvement, call an ambulance immediately.

Keep giving four puffs every four minutes until the ambulance arrives.

For further information on asthma please refer to your First Aid manual, Public Safety and Aquatic Rescue 34<sup>th</sup> Ed revised July 2016 manual or the National Asthma Council Australia website ([www.nationalasthma.org.au](http://www.nationalasthma.org.au)).

## INHALO Cylinders Approved for Use

Now approved for use by Surf Life Saving, the revolutionary INHALO design integrates cylinder, valve, regulator and flow meter into a single, robust, lightweight and reliable unit.

### INHALO Design and Specifications



#### INHALO specifications

Gas code	400CD
Gas type	Medical Oxygen E.P. Grade
Gas volume	630 litres
Empty weight	3.5 kg
Full weight	4.4 kg
Height	555 mm
Diameter	105 mm
Outlets	400 kPa outlet pressure (g)
- Firtree	Also known as 'barbed tail' Tubing diameters 6-8 mm
	Flow rates 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 15 lpm
- Diameter	Also known as Sleeve Index System (S.I.S.)
Indexed Outlet (D.I.O.)	refer AS2896

#### Higher Gas Content

INHALO's high capacity cylinder delivers significantly more gas than a standard C sized cylinder

#### Comparison of cylinder duration in hours (h) and minutes (m)\*

Cylinder size	400CD	400C
Contents*	630 litres	490 litres
Consumption rate	(h:m)	(h:m)
1 lpm	10:30	8:10
2 lpm	5:15	4:05
5 lpm	2:06	1:38
7 lpm	1:30	1:10
8 lpm	1:18	1:01
10 lpm	1:03	0:49
15 lpm	0:42	0:32

## **INHALO Features and Benefits**

The INHALO features a high volume gas package which is light, easy to use and versatile.

It eliminates the need for regulators, and with its plug-and-go functionality will make cylinder changeovers quicker, safer and easier – allowing you to concentrate on patient care.

### **Integral valve**

- Integrated valve/regulator/flowmeter
- Enables simple multi-functional use and eliminates the need for external regulators and flow meters
- Enables easier, safer and faster cylinder changeovers saving precious time
- Inhalo is completely maintained by BOC saving you costly equipment inventory & maintenance
- A wide selection of accurate flow settings (1-15 lpm) provides for a wide range of oxygen therapies
- Live contents gauge
- Easy to read gauge instantly provides a clear indication of gas level at all times
- Prevents waste as cylinder doesn't need to be opened to determine contents

### **Design**

- Ergonomic carry handle is designed to provide a balanced and safe carry point
- Robust design ensures a secure supply of oxygen
- Fibre-wrapped cylinder provides high capacity but light weight making handling easy
- Tamper evident seal provides assurance of quality and safety
- Ease of use simplifies training

### **High capacity package**

- The high gas capacity (630 litres) of the INHALO means less cylinder changes saving you time
- With significantly more gas than a standard C sized cylinder the INHALO saves you space, and cost on stock holdings and delivery

### **Multiple oxygen outlets**

- The 'plug & go' functionality make the INHALO versatile & easy to use
- Allows multiple therapies from the same cylinder, eg. oxygen supply &/or suction device (from DIO connection)
- The multiple outlets mean the INHALO acts like a cylinder & a wall outlet at the same time

### **Appearance**

- The INHALO has a smart, clinical look that reassures patients and enhances compliance
- Clear plastic finish allows easy cleaning and provides for better hygiene

### **Registration**

- The INHALO is a registered medical device, refer AUST R 135358, 187646
- BOC medical oxygen is a registered therapeutic good

We take this opportunity to also remind you about the ARC Guideline changes SLSA implemented with last season's (2016/2017) skills maintenance.

### Compression Rate

The latest ARC Guidelines now recommend that compressions should be performed at a rate of 100 – 120 compressions per minute (or almost 2 per second). This is an increase from the previous recommendation of a rate of approximately 100 compressions per minute. It is important to remember that the recommended rate is based on continuous compressions being delivered. By the time a rescuer stops, delivers two rescue breaths and recommences compressions, the casualty will not have physically received the full 100-120 compressions.

### Shock

It is now recommended that casualties showing signs and symptoms of shock be positioned in the supine (laying on their back with face up) position with no elevation of the legs or if unconscious, position them on their side but once again without elevating the legs. Controlling bleeding, calling an ambulance, administering oxygen (if trained to do so), maintaining body temperature and constant monitoring whilst managing the casualty remain unchanged.

### Bleeding

Previous guidelines had recommended elevation of the limb as part of the management for casualties with external bleeding. The new guidelines have removed elevation as part of the management techniques. There is no evidence that elevation of a bleeding part aids control of bleeding and there is the potential to cause more pain or injury. The ARC Guideline for bleeding now refers only to applying sustained direct pressure on or indirect pressure near the wound and if the casualty has bleeding from the lower limb or severe bleeding to lie them down. Where severe/life threatening bleeding has not been controlled by the above measures, use of a tourniquet above the bleeding point if available and trained in its use may be used as a last resort.

The full ARC Guidelines can be accessed at [www.resus.org.au](http://www.resus.org.au) if you are interested in reading further.

## **SLSA Clarification - Treatment of an Unconscious Casualty in the Water**

SLSA has provided the following clarification as part of the ARC Guidelines Change Management process:

As per ARC Guidelines, maintaining a casualty's airway must take precedence over all other injuries, including spinal injury. All casualties—not just those found in the water—must be treated as per DRsABCD.

In practice, this means that lifesavers, upon seeing a casualty in the water should:

- Check for **DANGER**: to self, bystanders and casualties
- Assess **RESPONSE**: is the casualty conscious or unconscious?
- **SEND** for help: signal or radio for assistance
- Clear the **AIRWAY**: A conscious casualty will be struggling to keep their head above water to breath and will require flotation assistance to do so. An unconscious casualty will need to be immediately removed from the water for further assessment on the beach. We do not routinely use in-water rescue breathing anymore. It is difficult to perform and delays time to compressions.
- Assess **BREATHING**: The casualty should be laid flat on their back to speed up the assessment process.
- Begin **COMPRESSIONS**: Effective compressions are a vital part of cardio-pulmonary resuscitation. It is via compressions to the sternum that blood is able to be circulated through the body and stave off tissue death until a normal heart rhythm can be resumed.
- Attach a **DEFIBRILLATOR**: Time to defibrillation has been shown to be closely linked to survival outcomes of casualties in cardiac arrest. It should be noted that the AED often does not detect a shockable rhythm in drowning casualties due to the mechanism of cardiac arrest in these cases.

## Spinal Management

The latest ARC Guideline recommends that the use of semi rigid (SR) cervical collars (such as Stiffneck found in club's gear and equipment) by first aid providers is not recommended. The potential adverse effects of SR cervical collars increase with the duration of use and include:

- unnecessary movement of the head and neck with the sizing and fitting of the collar
- discomfort and pain
- restricted mouth opening and difficulty swallowing
- airway compromise should the casualty vomit
- pressure on the neck veins raising intra-cranial pressure (harmful to head injury casualty)
- hiding potential life-threatening conditions

The ARC Guidelines recommend that the initial management for suspected spinal injuries should be manual support of the head in a natural, neutral position, limiting angular movement.

Rigid backboards placed under the casualty can be used by first aiders should it be necessary to move the casualty. The benefits of stabilizing the head will be limited unless the motion of the trunk is also controlled effectively during transport. Casualties should not be left on rigid spinal boards. Healthy casualties left on spine boards develop pain in the neck, back of the head, shoulder blades and lower back. The same areas are at risk of pressure necrosis. Conscious casualties may attempt to move around in an effort to improve comfort, potentially worsening their injury. Paralysed or unconscious casualties are at higher risks of development of pressure necrosis due to their lack of pain sensation. Additionally, strapping has been shown to restrict breathing and should be loosened if compromising the casualty.

For Lifesavers, our only immediate change is to not use the semi rigid cervical collars. Please continue to manage suspected spinal injuries using inline manual stabilisation as per the 34<sup>th</sup> Edition/34<sup>th</sup> Edition revised July 2016 of the Public Safety and Aquatic Education manual.



## **IRB Operations**

### **The following points shall be adhered to during the operation of all IRB's for Training:**

- Only members who hold the IRB Crew award or are listed as a candidate for the IRB Crew course can be utilised as an IRB casualty.
- No IRB award training can be conducted for a member while a member is signed onto patrol under any circumstances.
- A member's name must be registered on a course in Surfguard for new IRB course prior to the commencement of the course. If a member's name is not entered in Surfguard for an IRB course they are not permitted to take part in the course under any circumstances.
- That if a member does not complete an IRB assessment for a new award and the course is completed; the member must be put on a new assessment request form through Surfguard.
- Surfcom/LIMSOC is advised with the training activity signed on, an additional IRB/s is set up in the allocated training area, relevant paperwork (risk assessment) must be completed and an IRB trainer must be present and on the beach at the time of training.
- The IRB TACO and EDC/LDO must be notified of any additional training as per the step by step process.

### **The following points shall be adhered to for all IRB operations:**

As an IRB is launched from the beach (for all IRB activities including competition) the crew person is to adopt the lock-in position through the break to secure themselves in the IRB or remain seated on the starboard pontoon through the break. Once through the break the crew person can then adopt the most appropriate position in order to prevent themselves from becoming dislodged which could result in an injury.

### **Marine Incident Reporting, Patrol Logs and Reporting:**

All Powercraft injuries (major/minor) must have an SLSA incident report log completed. This form will be required to be submitted as part of the evidence when making a claim to WorkCover Queensland.

### **Solo Driving**

Solo driving is to be used in an emergency only and is not classed as a common practice for IRB operations. All IRBs must have the configuration of a qualified IRB Driver and a qualified IRB Crew person at all times.