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SITUATION PRACTICAL W – 1

SUBUNGUAL HEMATOMA (Lvl 3)

Worker: I hit my finger with a hammer
Worker: No
Worker: No
Worker: I was nailing floor boards and missed the nail

Worker’s skin is normal; worker is not anxious or agitated.

- Palpate bones of hand and fingers
- Check circ/nerve function of injured finger and compare to uninjured side
- Check ROM (range of motion)

- Systems review – no numbness, tingling dizziness or nausea; didn’t fall or hit head? Doesn’t hurt anywhere else?
- Findings – no tenderness along bone
- Good circulation and nerve function
- Normal

RTW – No Transport required

TREATMENT

-apply ice to help throbbing/swelling/pain
-start paperwork to allow ice to work (5-10 min)
-clean fingernail with anti-bacterial soap
-apply eye protection (face shield)
-have patient protect self with gauze
-have patient place finger on hard flat surface and push
-reassure patient that it won’t hurt and will feel relief
-drill hole or apply red-hot open end of a paper clip in injured nail. (use pliers/locking forceps to hold paperclip while heating and during treatment)
-have patient milk blood by continued pressing
-re-clean and reassess then apply gauze/tube gauze
-finish paperwork

FORMS

FA Record

ADVICE

Return if pain reoccurs and reopened to relieve pain.
Review and give patient copy of small wounds handout.
SPRAINED ANKLE (Lvl 3)

Worker: I twisted my ankle stepping off a stair
Worker: No
Worker: No
Worker: I slipped on the stair when I was coming to work, about 3 hours ago.

Worker’s skin is normal, not anxious or agitated

This is a Range Of Motion (ROM) check of the back

Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?)

Finding – slight swelling and redness noted when compared to uninjured limb. Circ/neuro good x’s 2
Patient winces on inversion of lateral aspect of foot. Other findings are normal.

RTW – patient was able to bear weight

Not required

- Apply ice after ROM (reduces swelling/pain)
- do paperwork, allowing ice to work (10 min)
- after 10 min, recheck ROM, asking if it seems better; (it does, swelling appears reduced, greater ROM)
- apply elastic bandage, (spica formation lower foot) ensuring pulling up on injured side.
- re-check circulation
- have patient sit up, re-assess for nausea/dizziness
- assess ability to bear weight.
- finish FA Record

FA Record

Read and give patient handout. (Appendix C)
SITUATION PRACTICAL W – 3

SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: Why is your wrist sore?

TENDONITIS (Lvl 3)
Worker: My wrist is sore.
Worker: No.
Worker: No.
Worker: I’ve been painting the warehouse for 2 days. Last night my wrist was sore but it didn’t feel too bad later. I painted a few hours today and it started to hurt again.

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Support injury
Wash hands and apply gloves
Expose both wrists and forearms/compare
Modified RBS

Workers skin is normal, worker not anxious or agitated.

No obvious deformity noted
Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?)

Palpate forearms, wrists and hand
PPQRRST – modified – (QRS)
Assess Range of Motion
(extension/flexion/invert/evert)

Findings – tenderness along tendon on thumb side of the wrist and forearm. No crepitus or swelling (but may have) Circ/neuro good x’s 2
Increased pain when painting motion is simulated. Side to side flexion minimal pain. All other findings are normal.

TRANSPORT DECISION

RTW – Transport not required

SECONDARY

not required (based on preliminary and subsequent observations)

TREATMENT

-ice for 10 minutes
-start paperwork/make working splint
-re-examine for swelling and ROM. Slight improvement
-apply working splint
-recheck circ/neuro function
-finish FA Record

FORMS

FA Record

ADVICE

Review and give handout (Appendix C) to patient
SITUATION PRACTICAL W - 4

LOOSE FOREIGN OBJECT IN EYE (Lvl 3)

Worker: I got some dust in my eye
Worker: No
Worker: No
Worker: I was sweeping the loading dock when the wind picked up and I swirled some dust into my eye.

PRIMARY SURVEY
ABC's - verbal/visual

Worker's skin is normal, worker is not anxious or agitated

Sit patient down
Cover eye with gauze; gather equipment
Wash hands thoroughly
Put on gloves (optional)
Modified RBS

TRANSPORT DECISION

RTW - no transport required

SECONDARY

Not required

TREATMENT
Ask patient if they're wearing contacts

-brush away loose surface dust; remove makeup
-if wearing contacts, ask patient to remove
-assess vision (verbal)
-instruct patient to flush eye (x2) examine cup
-ask if object can still be felt
-ask if object feels sharp or scratchy? If no...
-instruct patient to pull upper lid over lower lid or vice/versa if patient feels object in under lower lid.
-examine all surface of the eye using penlight
-if not located, evert eyelid and examine under lid - 2 attempts -if located, remove object with moistened cotton-tipped applicator
-flush eye ((x2) if necessary
-assess vision and eye movement

FORMS

FA Record

ADVICE

Caution worker to use eye protection. Return to FA if discomfort re-occurs
**SITUATION PRACTICAL W – 5**

**SCENE ASSESSMENT**
- FAA: What happened?
- FAA: Did you fall/hit your head?
- FAA: Anyone else hurt?
- FAA: How did this happen?

**PRIMARY SURVEY**
- ABC’s – verbal/visual
- Sit patient down
- Support the injury/sterile field under
- Modified RBS

- Visually inspect the cut.

- Cover wound with gauze and instruct patient to apply direct pressure/elevate
- Wash hands and put on gloves.

**TRANSPORT DECISION**

**SECONDARY SURVEY**
- Vitals – required
- History

- PPQRRST – modified – (QRS)
- Modified Head to Toe

- ROM

**TREATMENT**
- Leave gauze already in place on, due clotting. Apply tube gauze over gauze held on injury.
- Apply tape to stabilize finger (from wrist, over knuckle, around finger, on each side of injury. Clean other fingers.
- Re-check circ: apply cold, tube sling and transverse
- Set of vitals before patient leaves FA room

**FORMS**
- Patient Assessment Form - FA Record

**METHOD OF TRANSPORT**
- Taxi or Co-worker drives

**FINGER LACERATION (Lvl 3)**
- Worker: I cut my finger
- Worker: No
- Worker: No
- Worker: I was opening a box of freight when the box-cutter knife slipped and cut my finger.

- Worker’s skin is normal, worker is not anxious or agitated

- Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?).
- 3 inch gaping cut on lateral surface of right/left index finger; extends over two (2) joints

- Non –RTC - Transport to Medical Aid (3”, 2 joints)

- As found
- Allergies – patients own
- Medications – patients own
- Px Hx (Drs. care relevant to situation?) patients own
- Chief Complaint – pain in right/left index finger.
- Mechanism – cut right/left index finger with exacto knife
- Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. Cut is 3” long, deep, extends over 2 joints. Circ/neuro good x-2, minimal bleeding. Hurts to move finger. No other injuries found.
MINOR BURN TO FOREARM  (Lvl 3)

Worker: I burned my arm
Worker: No
Worker: No
Worker: I burned my arm on a motor I was working on.

Worker’s skin is normal, worker is not anxious or agitated

There is a reddened area of first degree burn about the size of a Looney and 3 small blisters starting to form.

Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?)

There is a reddened area of first degree burn and 3 small blisters, nothing else found. Circ/neuro good x’s 2. Normal

RTW – no transport required

Not required

-clean around area with anti-bacterial soap solution
-flush with saline and pat dry
-cover with non-adherent sterile gauze and moisten.
-secure dressing (lightly) with conforming roller gauze.
-start distal - wrap to proximal - (aids blood return).
-re-check circulation.
-finish paperwork

FA Record

Review and give handout to patient (Appendix C). May require burn to be cooled again if pain returns. Patient is allowed to apply non-petroleum based burn ointment if available and not going to medical aid
SPLINTER THROUGH 2 FINGERS (Lvl 3)

Worker: I got a splinter in my fingers
Worker: No
Worker: No
Worker: I was stacking lumber and wasn’t wearing gloves

Worker’s skin is normal, worker is not anxious or agitated

A 4” sliver has pierced the middle and index finger near the joints. There is minimal bleeding at the entrance and exit wounds of the fingers.

Medical Aid - Non RTC

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – sliver penetrating middle and index fingers of left hand (Q-sharp, R-no, S 5/10)
Mechanism – stacking lumber, not wearing gloves
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. Point tenderness at injury site, minimal bleeding. Circ/neuro good x’s 2.
Patient is unable to move fingers due pain.

-apply cold
-prepare a short arm splint (elbow to fingertips); may have to make side piece to support sliver if it’s too long.
-along with ABD, place arm on splint, insert position of function pad; extra support may be required under sliver and secure arm to splint.
-re-check circulation
-support arm in a large arm sling
-set of vitals before transport

Patient Assessment Form – FA Record

Taxi or Co-worker drives
SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: How did this happen?

CUT TO FOOT (Lvl 3)
Worker: I hurt my foot, I think it's bleeding
Worker: No
Worker: No
Worker: I dropped a 10 lb. box of canned soup on my foot

PRIMARY SURVEY
ABC’s – verbal/visual
Worker’s skin is normal, worker is not anxious or agitated

Sit patient down, support injury
Wash hands, apply gloves
Expose both feet; compare

Visually inspect the cut
2 cm superficial cut on top of the foot, not bleeding

Cover with gauze

Modified RBS
Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?).

Palpate leg and injury
There is no point tenderness; the cut is 2 cm long and is superficial. Circ/neuro good x’s 2.

PPQRRST – modified – (QRS)
Normal

ROM

TRANSPORT DECISION
RTW – no transport required

SECONDARY

TREATMENT
- clean area with anti-bacterial soap solution
- flush with saline and pat dry
- examine, then apply bandage (not bleeding) (butterfly closures required if bleeding), cover with sterile gauze and secure dressing with conforming roller gauze, starting distally and wrapping to proximal or use adhesive bandage, depending on worker activity
- re-check circulation.

FORMS
FA Record

ADVICE
Review and give handout to patient (Appendix C)
SITUATION PRACTICAL W – 9

SUPERFICIAL SLIVER (Lvl 3)
Worker: I got a sliver in my hand
Worker: No
Worker: No
Worker: I stacking lumber and forgot to wear my gloves

PRIMARY SURVEY
ABC’s – verbal/visual
Worker’s skin is normal, worker is not anxious or agitated

Sit patient down
Support injury on sterile field on table
Wash hands, apply gloves

Visually inspect injury
Superficial sliver in palm of left hand

Cover wound site with gauze

Modified RBS
Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?).

Palpate hand, compare
There is superficial tenderness at the site of the entrance wound. Circ/neuro good x’s 2. Normal

ROM

TRANSPORT DECISION
RTW – no transport required

SECONDARY
Not required

TREATMENT
-clean area with anti-bacterial soap solution
-flush with saline and pat dry
-determine the direction of entry
-remove sliver with forceps
-clean entry wound with saline
-apply an adhesive strip bandage

FORMS
FA Record

ADVICE
Review and give handout to patient (Appendix C)
SITUATION PRACTICAL W – 10

TORN EAR (Lvl 3)

Worker: My ear is bleeding
Worker: No
Worker: No
Worker: A piece of brick flew off the grinding wheel and it struck me on the ear

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Wash hands, apply gloves
Visually inspect injury

Place soaker on shoulder for drips
Cover wound with gauze and instruct patient to apply direct pressure

Modified RBS
Palpate side of head

TRANSPORT DECISION

TRANSPORT DECISION

SECONDARY SURVEY
Vitals – required
History

PPQRRST – modified – (QRS)

Modified Head to Toe

TREATMENT
Ensure ABC’s every 10 min

- place a pad of sterile gauze behind the ear to support ear in its’ natural position.
- secure dressings with elastic gauze roller bandage
- apply cold
- retrieve and preserve any avulsed parts
- set of vitals before patient leaves FA room

FORMS

Patient Assessment Form – FA Record

METHOD OF TRANSPORT

Taxi or Co-worker drives
SITUATION PRACTICAL W – 11

BROKEN FINGER (Lvl 3)

Worker: I think I broke my finger
Worker: No
Worker: No
Worker: I dropped a 50 lb. carton on it

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Support injury on sterile field on table
Wash hands, apply gloves
Modified RBS
Palpate arm and compare to other

Worker’s skin is normal, worker is not anxious or agitated
Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?).
Slight swelling and redness; no open wounds

TRANSPORT DECISION
Medical Aid - Non RTC

SECONDARY SURVEY
Vitals – required
History

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. Care relevant to situation?) patients own
Chief Complaint – pain in left/right finger
Mechanism – dropped 50 lb. box on hand
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. There is point tenderness over entire finger. Circ/neuro good x’s 2.
Worker can’t move injured finger due pain.

PPQRRST – modified – (QRS)
Modified Head to Toe

TREATMENT
- apply cold
- place gauze over finger and secure with tube gauze
- secure tube gauze with 1” tape. Start at wrist, over knuckle and wrap over/under finger from both sides.
- re-check cire, re-apply cold
- apply tubular sling and transverse
- vitals before patient leaves FA room

Ensure ABC’s every 10 min

FORMS
Patient Assessment Form – FA Record

METHOD OF TRANSPORT
Taxi or Co-worker drives
SITUATION PRACTICAL W – 12

CRUSHED HAND (Lvl 3)

Worker: I hurt my hand
Worker: No
Worker: No
Worker: The fire door slammed on my hand

PRIMARY SURVEY
Assess patient visually

Worker looks pale, anxious and agitated. Open crush injuries to right/left hand and fingers; bleeding is minimal

Lay patient down
Support injury on sterile field and cover
Wash hands, apply gloves
ABC’s (complete)
Apply oxygen at 10 LPM
Modified RBS

All findings normal except for pale, cool skin

TRANSPORT DECISION

Systems review: didn’t fall, hit head, no nausea, dizziness, numbness or tingling? Arm is warm on injured arm

Medical Aid - Non RTC

SECONDARY SURVEY
Vitals – required
History

As found – patients skin now normal (due to oxygen)
Allergies – patients own
Medications – patients own
Px Hx (Drs. Care relevant to situation?) patients own
Chief Complaint – pain in left/right fingers and hand
Mechanism – fire door slammed on hand
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. There’s obvious open fractures of the hand and fingers. Bleeding’s minimal and point tenderness is present. Circ/neuro good x’s 2.
Patient won’t move hand due to pain

PPQRRST – modified – (QRS)
Modified Head to Toe
Assess injured limb and compare
Do not remove clotted ABD pad
ROM

TREATMENT

-apply cold if patient can bear weight on fingers.
-prepare a short arm splint extending from the elbow to just beyond the fingertips.
-take sterile field under hand, secure arm to splint
-recheck circulation and nerve function
-sit patient up and ask if feels dizzy/nauseous
-support arm in large arm sling and broad transverse
-vitals before patient leaves FA room

Ensure ABC’s every 10 min
Vitals every 30 min

FORMS

Patient Assessment Form – FA Record

METHOD OF TRANSPORT

Taxi or Co-worker drives
SITUATION PRACTICAL W – 13

CHEMICAL SPLASHED IN EYE (Lvl 3)  
(Ambulance arrives in 10 min.)

Worker: Acid splashed into my eyes, they’re burning
Worker: No
Worker: No
Worker: It was Hydrochloric acid

SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: Do you know what chemical was?

CRITICAL INTERVENTION
Take patient to sink and immediately flush the eyes. If possible, lay patient down while flushing. Continue flushing for 30 minutes.

Send someone to clean-up if needed
Wash hands and apply gloves
Instruct helper to locate MSDS sheet for Hydrochloric acid

PRIMARY (while flushing if possible)
ABC’s – full primary survey required
Conduct primary survey while flushing

RBC’s – all findings are normal, patient is anxious
RBS – nothing else found

TRANSPORT DECISION

RTC – call for ETV/Ambulance
Flushing must continue en-route to medical aid; use saline IV bags and nasal canulae to flush eye if available.

SECONDARY (en route or while waiting)
Vitals – required
History

PPQRRST
Modified Head to Toe
(if ambulance is delayed)

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – my eyes
After 30 min of flushing, examine the eyes and remove any remaining particles from behind the eyelids with a moist cotton-tipped applicator

TREATMENTS

-ensure ETV/Ambulance attendants continue flushing en route using saline IV bags and tubing. (If only one eye ensure acid doesn’t flow into good eye)

FORMS

Patient Assessment Form – FA Record

METHOD OF TRANSPORT

ETV or Ambulance (if available)
SITUATION PRACTICAL W – 14

SCENE ASSESSMENT
FAQ: What happened?
FAQ: Did you fall/hit your head?
FAQ: Anyone else hurt?
FAQ: How did this happen?

PRIMARY SURVEY
Assess patient visually
Lie patient down
Give patient sterile gauze and instruct patient to apply direct pressure & elevate
Wash hands and put on gloves
Full ABC’s
RBS (complete)
Give patient oxygen at 10 LPM
Ask where is finger tip
Have assistant retrieve finger

TRANSPORT DECISION

SECONDARY SURVEY
Vitals – required
History

PPQRRST - modified - (QRS)
Modified Head to Toe
Assess injured limb and compare
Do not remove clotted gauze
ROM

TREATMENT
Reassess ABC’s every 10 min

FINGERTIP AVULSION (Lvl 3)

Worker: I cut the end of my finger off
Worker: No
Worker: No
Worker: I cut it off on the table saw

Patient’s skin is pale and looks anxious, there is arterial bleeding from the finger
Airway - clear; breathing - normal; skin - pale, cool, dry
Nothing else found
At saw
wrap with moist gauze, into bag, into bag of ice, label
Medical Aid - Non RTC

As found – patients skin now normal (due to oxygen)
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – cut off finger tip
Mechanism – table saw
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. There is tingling at end of finger. Bleeding is controlled. Circ/neuro good x’s 2.
Patient is able to move finger
-apply cold
-apply tube gauze over gauze controlling bleed
-apply tape from wrist, over knuckle and around finger, on each side of hand
-support hand with tube sling and secure with transverse
-set of vitals before patient leaves for medical aid

FORMS
Patient Assessment Form – FA Record

METHOD OF TRANSPORT
Taxi or Co-worker drive
SITUATION PRACTICAL W – 15

BROKEN WRIST (Lvl 3)

Worker: I think I broke my wrist
Worker: No
Worker: No
Worker: I slipped on the stairs and stuck my arm out to break my fall.

PRIMARY SURVEY
ABC’s – verbal/visual

Worker’s skin is normal, worker is not anxious or agitated

Sit patient down
Support injury on sterile field on lap
Wash hands, apply gloves
Modified RBS

TRANSPORT DECISION

Medical Aid - Non RTC

SECONDARY SURVEY
Vitals – required
History

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – broken wrist
Mechanism – slipped on stairs, used arm to break fall.
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. There’s no numbness or tingling. There is point tenderness, swelling and discolouration on the anterior surface of the wrist. No bleeding, circ/neuro good x’s 2.
Patient is able to move uninjured fingers

PPQRRST – modified – (QRS)
Modified Head to Toe

TREATMENT

-apply cold
-prepare long arm splint extending from armpit to fingertip
-secure arm to splint, fingertips exposed (ensure position of function under palm of hand)
-re-check circulation and nerve function
-support arm in large arm sling and secure with transverse
-set of vitals before sending patient to medical aid.

ROM

FORMS

Patient Assessment Form – FA Record

METHOD OF TRANSPORT

Taxi or Co-worker drive
SITUATION PRACTICAL W – 16

SHOULDER DISLOCATION (Lvl 3)

Worker: I think I broke my shoulder
Worker: No
Worker: No
Worker: A 20 lb. box of water bottles fell on my shoulder

Worker’s skin is normal, worker is anxious

Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?). Check and compare arms, shoulder hurts, nothing else found.

Medical Aid - Non RTC

TRANSPORT DECISION

SECONDARY SURVEY

As found
Allergies – patients own
Medications – patients own
PxAHx (Drs. care relevant to situation?) patients own
Chief Complaint – the shoulder
Mechanism – 20 lb. box fell on shoulder
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. The shoulder is obviously deformed with point tenderness at shoulder joint. Circ/neuro good x’s 2.
Patient is unable move shoulder.

PPQRRST – modified – (QRS)

Reassess ABC’s every 10 min

Modified Head to Toe – examine shoulder (scapula/clavicle), as well the limbs & compare

ROM

-apply cold
-patient no longer anxious
-apply large arm sling, padding under shoulder, at elbow
-apply transverse bandage
-reassess circulation and nerve function
-vitals before sending patient to medical aid

TREATMENT

Reassess ABC’s every 10 min

FORMS

Patient Assessment Form – FA Record

METHOD OF TRANSPORT

Taxi or Co-worker drive
SITUATION PRACTICAL W – 17

ELBOW FRACTURE (Lvl 3)

SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: How did this happen?

Worker: I think I broke my elbow, I can’t move it
Worker: No, I only hurt my elbow
Worker: No
Worker: I was in a rush and was running up the stairs 2 at a time when I tripped

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Support injury
Wash hands, apply gloves
Modified RBS

Worker's skin is normal, worker is anxious

Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?), check and compare both arms, arms are warm, elbow is deformed, nothing else found.

TRANSPORT DECISION

Medical Aid - Non RTC

SECONDARY SURVEY
Vitals – required
History

As found

Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – the elbow
Mechanism – fell down stair and banged elbow on stair
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. Patient says only that there is numbness in forearm; nothing else found. Circ neuro good x’s 2.
Patient is unable to move the joint.

PPQRRST – modified – (QRS)
Modified Head to Toe
Examine injured limb and compare to uninjured limb
ROM

TREATMENT
- apply cold
- prepare long arm splint, extending from armpit to finger-tip (ensure px of functions).
- secure arm to splint, fingertips exposed
- patient no longer anxious
- re-check circulation and nerve function
- support arm in large arm sling and secure with transverse
- set of vitals before sending patient to medical aid.

FORMS
Patient Assessment Form – FA Record

METHOD OF TRANSPORT
Taxi or Co-worker drive
SITUATION PRACTICAL W – 18

HEAD INJURY (Lvl 3)

Worker: I hit my head on a low overhead steel beam; I’m still seeing stars. Not feeling too good.
Worker: No
Worker: Yes
Worker: No

FAA: What happened?
FAA: Did you lose consciousness
FAA: Are you feeling dizzy/nauseated?
FAA: Was anyone else hurt?

FAA: Don’t move your head or neck; we need to support your head and neck and lay you down.
Apply gloves;
Position worker supine with C-spine control
Hand off C-spine control to helper

PRIMARY SURVEY
Complete full Primary Survey

Apply cold with pressure to control goose egg developing on forehead
apply oxygen at 10 LPM (head injury)

TRANSPORT DECISION

SECONDARY SURVEY
Vitals – required

History

PPQRST
Head to Toe - focusing on the head examination/upper limbs

TREATMENT
Reassess ABC’s every 10 min
Vital signs every 30 min
Do not rule out C-Spine

-apply (cold if not done so prior and) hard collar
-use multi-person lift
-reassess vitals before sending patient to medical aid
-secure patient to spine board in supine position

FORMS

METHOD OF TRANSPORT

ABC’s normal; the worker is a bit anxious and confused
RBS: goose egg developing on forehead; no other injuries

Medical Aid - Non RTC (eyes open to speech or confused)

As found except GCS: patient’s eyes are closed but open to speech or confused
Allergies – patient's own
Medications – patient's own
Px Hx (Drs. care relevant to situation?) patient's own
Chief Complaint – my head, seeing stars
Mechanism – hit head on steel beam
Systems review: didn’t fall down, don’t hurt anywhere else. Patient feels dizzy, nauseated; neck feels stiff and sore; patient says they feel sleepy. There is a goose egg on forehead, no bleeding, Circ/Neuro good x’s 4.

Patient Assessment Form – FA Record

ETV - BC Ambulance (if available)
SITUATION PRACTICAL W – 19

FAA: What happened?
FAA: How did it happen?

FAA: Don’t move your head or neck; we need to lay you down. If the metal has penetrated your eye, we want to prevent loss of fluid from your eye. Apply gloves; have patient sit carefully. Position worker supine with C-spine control. Hand off C-spine to helper or use sandbags.

PRIMARY SURVEY
Cover both eyes, support object if required. Complete full Primary Survey.

TRANSPORT DECISION
-apply oxygen at 10 LPM (blanket?)
-dress and bandage eyes
-secure patient to spine board
(no collar due no trauma)

ABC’s and eye every 5 minutes

SECONDARY SURVEY (en route)
Vitals – required
History

PQRRST – modified – (QRS)
Head to Toe
Entire head examination/upper limbs

TREATMENT
Reassess ABC’s and eye every 5 min
Vital signs every 10 min

FORMS

METHOD OF TRANSPORT

PENETRATING EYE INJURY (Lvl 3)

Worker: I have something in my eye
Worker: I was grinding a blade and a piece of metal flew into my eye.

ABC’s normal; the worker is anxious
RBS; eyes covered, no other injuries found

RTC – Transport (penetrating eye injury)
(do reassessment of ABC’s after dressing eye)

No change. Keep talking to patient.

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – something in my eye
Mechanism – piece of metal flew off grinder
Systems review: didn’t fall down, don’t hurt anywhere else. Patient has headache and feels nauseated. Circ/neuro good x’s 2.

Patient Assessment Form – FA Record

ETV - BC Ambulance (if available)
INFECTED WOUND  (Lvl 3)
Worker: I have a cut that’s infected
Worker: I cut my hand 3 days ago and came to FA. The attendant assessed, cleaned and bandaged the cut.
Worker: No
Workder’s skin is normal, worker is not anxious or agitated
Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?). There is a small cut on the palm of the right/left hand. Area around wound is red and swollen; pus is visible in wound; there are red streaks halfway up the arm.
Medical Aid - Non RTC

SITUATION PRACTICAL W – 20
FAA: What happened?
FAA: When did you hurt yourself?
FAA: Are you feeling dizzy/nauseated?

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Support injury on sterile field on table
Wash hands, apply gloves
Modified RBS
Expose and inspect the cut

TRANSPORT DECISION

SECONDARY SURVEY
Vitals – required
History

PPQRRTST – modified _ (QRS)
Modified Head to Toe

ROM

TREATMENT
ABC’s every 10 min

FORMS

METHOD OF TRANSPORT
Patient Assessment Form – FA Record
Taxi or Co-worker drive
SITUATION PRACTICAL W – 21

SHOULDER INJURY (Lvl 3)

Worker: I hurt my shoulder
Worker: No
Worker: No
Worker: A 20 lb. box of screws fell on my shoulder when I was stocking shelves in the warehouse

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down
Support injured limb
Wash hands, apply gloves
Modified RBS

Worker’s skin is normal, worker is calm

Systems review (didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?). Visually inspect injured shoulder. There is bruising, redness and deformity mid right clavicle. Arms are warm, no tingling

TRANSPORT DECISION
Medical Aid - Non RTC

SECONDARY SURVEY
Vitals – required
History

As found
Allergies – patients own
Medications – patients own
Px Hx (Drs. care relevant to situation?) patients own
Chief Complaint – my shoulder hurts
Mechanism – 20 lb. box fell on shoulder.
Systems review: didn’t hit head, fall down, not dizzy, nauseous or was hurt anywhere else. There’s no numbness or tingling. There is point tenderness, swelling, discoloration and deformity mid 1/3 of shoulder. No bleeding. Circ/neuro good x’s 2.
Patient is unable move shoulder due to pain

PQRRST – modified – (QRS)
Modified Head to Toe
-examine shoulder (clavicle/scapula) as well as compare arms
ROM

TREATMENT
-apply cold
-support arm with tubular sling, tensioning the sling from behind. (pull up and back on back side of sling)
-pad under the elbow and armpit as required
-secure with broad transverse sling.
-reassess circulation and nerve function of injured arm
-set of vitals before sending patient to medical aid.

FORMS
Patient Assessment Form – FA Record

METHOD OF TRANSPORT
Taxi or Co-worker drive
SITUATION PRACTICAL W – 22

NOSE BLEED  (Lvl 3) (Epistaxis)

SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Are you feeling dizzy/nauseated?
FAA: How did this happen?
FAA: How heavy was the box?
FAA: How far did box fall?
FAA: Did your head snap back?
FAA: How long has it been bleeding?

Worker: I have a nose bleed
Worker: No
Worker: No
Worker: A box fell off the cupboard and hit me on the nose
Worker: not very
Worker: Couple of feet
Worker: No
Worker: 4 or 5 minutes (more than 30 min, goes to MA)

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down, instruct patient to hold gauze under nose (lap), lean forward, not to swallow blood; gauze on nose, pinch soft part of nose for 10 – 15 minutes
Wash hands, apply gloves
Visually inspect facial area of patient

Doesn’t appear to be broken (check with patient). When looking at patient, nose is straight.
Systems review: didn’t fall, hit head, no nausea, dizziness or headache.
There is no point tenderness. Patient has no problem swallowing. There is minimal bleeding or pain.

Modified RBS

Palpate facial area around nose

TRANSPORT DECISION

RTW – no transport required

SECONDARY

TREATMENT

- have patient hold ice on bridge of nose.
- start form work (allow ice to help stop bleeding)
- after 10 – 15 min, reassess for bleeding
- if bleeding has stopped, finish forms, give patient advice and allow patient to clean up. (If bleeding hasn’t stopped, re-apply pressure for another 10 – 15 min, with ice. Recheck, if stopped, see above; if not, send to MA – now more than 30 min.)
- finish paperwork.

FORMS

FA Record

ADVICE

Advise worker not to blow nose (at least 4 hours), keep hands away from face - no picking, no lifting heavy weight, no foreign objects in nose. Return if bleeding reoccurs. We will go talk to the supervisor about alternate work for you.
SITUATION PRACTICAL W – 23

CUT TO SHOULDER (Lvl 3)

SCENE ASSESSMENT
FAQ: What happened?
FAQ: Did you fall/hit your head?
FAQ: Anyone else hurt?
FAQ: How did this happen?

Worker: I cut my shoulder
Worker: No
Worker: No
Worker: I bumped into the side of a door frame that had a nail sticking out of it

PRIMARY SURVEY
ABC's – verbal/visual

Worker’s skin is normal, worker is not anxious or agitated

Sit patient down, support injured arm
Wash hands, apply gloves
Expose the injury
Visually inspect the cut

2 cm superficial cut on top of the shoulder, minimal bleeding

Cover with gauze

Modified RBS

Systems review: didn’t fall, hit head, no nausea, dizziness, numbness, tingling or hurt anywhere else?

Palpate shoulder area

There is no point tenderness; the cut is 2 cm long and is superficial. Circ/neuro good x’s 2.
Normal

ROM

TRANSPORT DECISION

RTW – no transport required

SECONDARY

Not required

TREATMENT

-wash around cut with anti-bacterial soap solution
-flush cut with saline and pat dry
-apply skin closures
-apply sterile gauze
-secure dressing.
-re-check circulation.

FORMS

FA Record

ADVICE

Review and give handout to patient (Appendix C)
Discuss Tetanus
**NEEDLE STICK INJURY (Lvl 3)**

Worker: A needle punctured my hand  
Worker: No  
Worker: No  
Worker: I was cleaning up debris in the parking lot when I grabbed a bag with a needle and a syringe in it.  
(Patient may say the feel 'dirty or disgusted')

**SITUATION PRACTICAL W – 24**

**SCENE ASSESSMENT**
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: How did this happen?

If patient has needle in hand for evidence, have patient put needle in covered bio-hazardous container (if not??)

**PRIMARY SURVEY**
ABC’s – verbal/visual  
Have patient wash hand with antibacterial soap if possible (makes blood flow)  
Sit patient & support injured limb  
Wash hands, apply gloves  
Modified RBS

**TRANSPORT DECISION**
Medical Aid - Non RTC (within 2 hours)

**SECONDARY SURVEY**
Vitals – required  
History

Modified Head to Toe  
Examine injured hand and compare  
ROM

**TREATMENT**
- clean around puncture with antibacterial wipe  
- flush with saline and pat dry  
- cover with gauze and secure with conforming roller gauze  
- reassess circulation and nerve function of injured hand  
- set of vitals before patient leaves for medical aid

**FORMS**
Patient Assessment Form – FA Record

**METHOD OF TRANSPORT**
Taxi or Co-worker drive – Call ahead (Cocktail shot)
SITUATION PRACTICAL W - 25

SCENE ASSESSMENT
FAA: What happened?
FAA: Did you fall/hit your head?
FAA: Anyone else hurt?
FAA: How did this happen?

PRIMARY SURVEY
ABC’s – verbal/visual
Sit patient down. Ask pt to remove shoes & sock. Support injury
Wash hands, apply gloves
Modified RBS
Visually inspect the cut

TRANSPORT DECISION
RTW - no transport required

SECONDARY SURVEY
Not required

TREATMENT
Examine injured limb and injury
Check CMS

small puncture, minimal bleeding center of left heel
Good circ/neuro, movement does not increase pain
-soak wound in antibacterial soap solution for 15-20 min.
-flush with water and pat dry
-apply a bandage
-re-check CMS

FORMS
FA Record

ADVICE
Review and give handout to patient (Appendix C)
Discuss Tetanus