EMERGENCY FIRST AID
AND
INJURY PREVENTION

"A TRAINING PROGRAM FOR THE CHILD CARE PROVIDER"

GEORGIA
EMERGENCY MEDICAL SERVICES
FOR CHILDREN

The Georgia Emergency Medical Services for Children Program would like to acknowledge the following for the development of Emergency First Care and Injury Prevention: "A Training Program for the Child Care Provider" and collaboration with the Ohio EMSC Program:

Christy Beeghly, M.P.H.,Project Coordinator
Alan Boster, Project Coordinator
Carol Ankrom and other ODHS Licensing specialists/staff at the Ohio Department of Human Services
Jamie McArdle Blair,RN,CS,CPN,MS,Chief,Bureau of Community Health Services & Systems Development, Ohio Department of Health
Frank Bright, Chief, Bureau of Health Promotion and Risk Reduction, Ohio Department of Health
Charlene Buckner, Bureau of Health Promotion and Risk Reduction, Ohio Department of Health
Irene Butler, Bureau for Children with Medical Handicaps, Ohio Department of Health
Ginny Carey, Early Childhood Development, Columbus State Community College
Shannon Cole, Bureau of Oral Health Services, Ohio Department of Health
Sharon Devine, EMT-B Coordinator & Paramedic Instructor, NW Ohio Paramedic Program
Michi Durkop, RN, Graduate student, Ohio State University
Donna Goeb, Administrator, Jolly Tots II, Inc.
Christie Holmes, Ohio Chapter, American College of Emergency Physicians & Past President, Ohio SAFE KIDS Coalition
Pauline Hosenfeld, Chief, Child Day Care Licensing Section, Ohio Department of Human Services
Shulamit Lewin, MHS, State Outreach Coordinator, EMSC National Resource Center
Wayne Neal, RN, MAT, Children with Special Health Care Needs Specialist, EMSC National Resource Ctr.
Angela Norton, Health Planning Administrator, Ohio Department of Health
Ron Phillips, Columbus Health Department
Brenda Sager, Ohio Child Care Resource and Referral Association
Jean Searson, EMT-B & I Instructor
Melody Sexton, Ohio Department of Education
Ruth Shrock, Ohio Department of Health
Judith Upton, Bureau for Children with Medical Handicaps, Ohio Department of Health
Members of the Day Care Advisory Council

We would also like to thank the following Central Ohio Day Care Centers for their participation in a pilot training of the curriculum.
Children First, Inc.
Hilltop Educare Center
Meadow Park Children's Center
Mother's Helper
North Broadway Children's Center
A special thanks to the following individuals for their many contributions to the project:
Medical Reviewer - William Cotton, M.D., Columbus Children's Hospital, EMSC Grant Principal Investigator
Brian Pio, EMT-P, University of Cincinnati Hospital
Tom LeMaster, RN, REMT-P, Children's Hospital Medical Center of Cincinnati Curriculum Consultant
Don Wagner, HSD, CHES, University of Cincinnati, Program of Health Promotion

This educational material is being distributed through the Georgia Emergency Medical Services for Children Program sponsored by project MCH6H33MC00008-02 from the Emergency Medical Services for Children Program, Health Resources and Services Administration, U.S. Department of Health and Human Services, Maternal Child Health Bureau and National Highway Traffic Safety Administration.

April 2003

The recommendations in this publication are not intended to indicate an exclusive course of treatment or to serve as a standard of medical care. Individual circumstances may require variations on these recommendations. The Georgia EMSC Program disclaims any liability or responsibility for the consequences of any action taken in reliance on the statements or opinions contained herein.

Manual Outline

PowerPoint presentations available on CD, or you may download them from the website at:

http://health.state.ga.us/programs/ems/emsc

Forward

Everyday, millions of our young children leave home to spend part or most of their day in some type of child-care setting. Children participate in child-care in a variety of settings, such as child-care centers, family child-care homes, or in-home care, at various hours of the day. In just 20 years, the percentage of children enrolled in child-care has soared from 30 percent (1970) to 70 percent (1993). By the year 2000, 75 percent of women with children under 5 years of age will be employed and in need of child-care. According to the 1999 population estimates approximately 580,150* children in Georgia are under 5 years of age. Currently there are 111,016* licensed childcare centers providing services for our children. Additionally, 30,783* children are enrolled in Georgia's Pre-K program.

Regulations in Georgia were updated in 1991 to encompass some of the areas of concern for the health and safety of children in childcare. Regulations were put in place to include injury prevention and day care provider training.

Training of child-care personnel is a key factor in assuring the quality of care and safety for Georgia's children. Families, child-care providers, health professionals and communities must work together to create child care settings that are healthful, safe, and nurturing environments for all children.

Emergency First Aid and Injury Prevention was developed to meet the needs of child care providers in Georgia. By providing a program that was developed by emergency professionals, child care professionals, and educators, and by making the program affordable and accessible, "First Care" has met this need.

This manual has been published in response to the need for a healthier, safer environment for all the children of Georgia who participate in a day care environment. Georgia Emergency Medical Services for Children remains committed to providing education and training to all the individuals who provide care to the infants and children in our State.

*The 2000 Georgia County Guide ISSN#1044-0976

Dear First-Aid Trainer,

We, at Georgia's Emergency Medical Services for Children (EMSC) program, would like to thank you for taking the steps to become a trainer for the *First Aid for Child Care Personnel* course.

Every day, millions of our young children leave home to spend part or most of their day in some type of child care setting, such as child care centers, family child care homes, or in-home care. In just 20 years, the percentage of children enrolled in child care has soared from 30 percent (1970) to 70 percent (1993). By the year 2000, 75 percent of women with children under 5 years of age will be employed and in need of some kind of child care assistance from the State of Georgia. Based on the Georgia Department of Regulatory Services, Daycare Section, approximately 149,454 children currently receive child care services from approximately 1680 facilities in Georgia. *This accounts for only the children receiving child care services in centers licensed by the State of Georgia.*

An estimated 240 to 320 children lose their lives in centers across the country each year (*U.S. News* & *World Report,* 1997). In Georgia, there were 109 serious injuries reported in child care in 2001. Child day care providers would have made a difference to these children if they were aware that injuries can be prevented and had the knowledge and skills of how to prevent them; and were prepared for emergency situations and possessed basic emergency response and first-aid skills. Training of child care providers is a key factor in assuring the quality of care and the safety of Georgia's children.

This is how you will play a significant role. There is a great need for up-to-date and affordable first-aid training as child care centers have limited amounts of money and staff turnover is high. Licensed centers in Georgia are *required* to have at least 50 percent of employees certified in an approved safety and first-aid training course, as well as CPR.

Please keep us informed of your activities within the child care community, your use of this course and success or problems you experience. You may reach the EMSC program at 404-679-0547.

Sincerely

Kelly Buddenhagen, EMSC Program Coordinator
Office of Emergency Medical Services

Trainer Instructions

Target Audience: Providers of child care to infants, children and adolescents in child care centers.

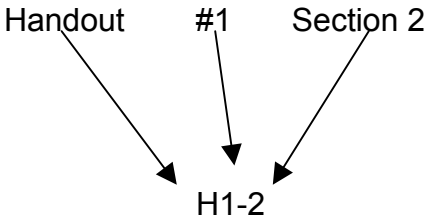
Group Size: Limit class size to 20 or less.

Trainer Qualifications: Qualified Healthcare Provider/Trainer
(Contact Regional EMS Office for more information on approval for continuing education credit.)

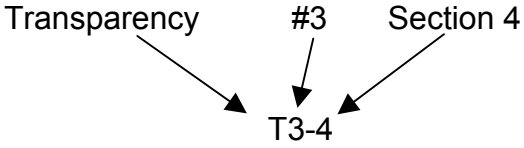
Length of Module: Entire course is 6 hours.

The 6 hour training is divided into 6 separate parts which can be presented separately or all at once. Each section contains an overview indicating the general topics covered as well as the additional resources that are available. The overview is followed by a training outline formatted in two columns. The right column contains trainer notes. The left column contains handouts, transparencies and activities in their suggested order and placement. Activities for section 2 and 6 are listed in the outline but the actual instructions are found in the activity section following the outline.

Each handout, transparency, and activity is labeled with its own unique number so that you can match the outline to the correct resource. They are coded by type, number and section. For instance the first handout in section 2 is labeled H1-2.



The third transparency of section 4 is labeled T3-4.



The following symbols will be found in the trainer notes to cue you as to when to use the resource.

H = Use Handout
T = Use Transparency
A = Use Activity

Important: This program was designed to be used in conjunction with the **participant handouts**. The handout masters can be found in your manual in the order that matches that curriculum outline. We STRONGLY urge you to copy and distribute a set of all handouts to each participant. Without the handouts, the participants will not be able to participate in some of the activities and they will not leave with the information that was intended.
Handouts can also be requested by contacting the EMSC Program Coordinator at 404-679-0547.

Training Tips

Before the Program

- ***Contact your Regional EMS Office for information on continuing education credit for this course.***
- **Limit your class size to less than 20.** This program is designed to be interactive and it cannot be effectively facilitated with a very large group.
- If you have the opportunity, co-facilitate the program with another instructor. This will make your job easier and is usually enjoyed by the participants.
- Arrange for enough copies of the handouts for each participant. Try to arrange for the handouts to be distributed in a booklet instead of loose leaf.
- Arrive early to set up. Test your audiovisual equipment and arrange your slides or transparencies Arrange handouts on an information table or on the participants' chairs. Greet people as they enter.
- Be prepared. Make sure that you are prepared and know the content of the program well. Refer to your trainer manual and notes as necessary, but do NOT read from your manual. Having notes on cards may be helpful and convenient.

During the Program

General Tips

- Explain in your program introduction that you encourage questions and comments, but there is a great deal of information to cover and you don't want to run over on time.
- Allow time for several breaks and for evaluating the participants at the conclusion of the training.
- Use simple language whenever possible. Try to avoid medical terminology as the participants do not have medical backgrounds. If you must use a medical term, define the term alt the same time. The trainer notes in your manual use lay person language.
- Keep it simple. Information that is brief and simply stated is more likely to be remembered. Don't provide a lot of technical information unless it is in response to a question.
- Pause after important points to let participants formulate questions. Individuals process information at different rates. Be sure to allow for these differences.
- Demonstrate as much as possible. Use gloves, props if available. It helps to make the information more "real" to the participants. If you have access to them, use mannequins/dolls. You can use them to demonstrate repositioning an injured child safely, controlling bleeding, immobilizing the neck (C-spine), rescue breathing, etc. They can be very useful.

Training Tips - continued

- Watch for non-verbal cues from the group. These provide you with feedback on the clarity and effectiveness of your delivery. If you notice people looking puzzled or frustrated, stop and ask if anyone has questions. If people are yawning or looking around the room, take a break or use an activity to involve the participants more.
- Be sure you understand a question before you respond to it. Ask for further clarification if necessary before jumping in with an answer.
- Be specific in referring the participants to a handout. Allow time to find the handout before proceeding.
- Encourage participants to share experiences and ideas if relevant, but keep the group on track. Ask someone to hold off introducing a new topic or idea while another is being discussed. For example, "Could you hold that thought for a while? We will be talking about burns later in the program and I will be sure to address your question at that time."

Time-saving tips:

- You will not be able to thoroughly review every overhead and complete the program in 6 hours. Much of the information is contained in the handouts. Cover the main points using the trainer notes and then refer participants to their handouts for further information or as a reminder of the information.
- If you find that you are far behind schedule or are running out of time, you may have to eliminate certain topics or activities from your agenda. You may feel that your group is comfortable with basic first-aid principles and would like the opportunity to rehearse their skills in the presence of a trained instructor. Or you may feel that this group has specific first-aid questions that need to be addressed. Your group will be your best compass for determining what information can comfortably be eliminated. During the introduction, ask the group to share one thing they want to learn in the course.
- Keep on track. Don't allow yourself to be side-tracked by one question or specific issue unless you feel that it is a critical point to be made. If a participant has a very specific example or question that will take you some time to answer/explain, ask to come back to it at the end of the program or ask to speak to the participant individually at the end of the program. Try to be available for questions for a few minutes after the program. Some participants may feel more comfortable asking questions individually.

Involving Participants

- Try to increase participation as much as possible. Ask questions to allow the participants to interact. This will help to hold their attention. Use as many of the activities as time will allow.

- When misinformation is offered by a participant, validate the person whenever possible by showing understanding of how s/he acquired the misinformation. Be sure to then provide the correct information.

Day Care Rules

- A complete listing of rules for centers licensed by the Georgia Office of Regulatory Services can be found on the State of Georgia web site: www2.state.ga.us/Departments/DHR/ORS/.
- If you are asked a question about licensing rules and you do not know the answer or do not feel comfortable answering, remind the participants that you are not an expert on the rules. If they have specific questions, encourage them to call their licensing specialist or district coordinator.

Difficult Situations

- Lack of Participation

Much of the first-aid curriculum is designed to be interactive. It may feel very uncomfortable to you if you ask a question and no one answers. When asking questions, give the participants time to answer. This may feel awkward but keep in mind that people process verbal information at different rates. Try to rephrase the question. If you still don't get a response, keep in mind the information that you want the group to leave with. You may have to switch into lecture mode to get the information out.

- Domination by one Participant

Try to get participation from everybody present. It's important that there is an opportunity for each group member to be heard. Don't let one or two people dominate the discussion. Don't be afraid to make a comment such as: "I really appreciate your participation but I'd really like to hear what others have to say at this point."

- You Don't Know the Answer to a Question

Don't be afraid to admit that you don't know the answer to a question. Don't give an answer that you are not sure of. You can tell people that you will find out the answer and get them the information at a later time or you can give them resources where they can find out the answer for themselves.

- You Disagree with a Comment Made by Another Participant

Don't get into an argument. You will probably not be able to change that person's mind. Just try to convey the accurate information to the rest of the group. Try one of the following and then move on:

"You have a point, however based on my experiences, I would disagree."

"What I've come to understand through my training and experiences is..."

Co-Facilitation

There may be times when you are presenting this program with another trainer.

Following are Some Tips on Co-facilitation:

- The key to successful co-facilitation is preparing for the presentation together. It is a good idea to actually practice the program and especially the activities together. This will help you to understand how your co-facilitator feels about the issue.

- When planning the agenda, be aware of each other's style. Some people like a lot of structure and will want to divide the sections up very precisely; planning everything ahead of time. Others are more comfortable with a looser structure.

- As you discuss your stylistic differences and similarities, you may also want to talk about a decision-making process to use during the session itself. This may mean having the exercises prioritized so that you and your co-facilitator have agreed ahead of time what can be dropped if time is running out. It may mean that you will consult with the group about what they want to do. Having a system of communication during the session is very helpful. You might want to develop some signals to communicate messages such as "time is running out", or "we need to slow down," etc.

Planning Checklist

- Do you have appropriate room and A/V equipment? Libraries, churches and community organizations often reserve space and A/V equipment for community programs.
- Are the physical arrangements comfortable and attractive?
  - Are there enough chairs for everyone?
  - Is the lighting adequate?
  - Is the room temperature comfortable?
- Have you limited the number of participants to 20 or less? (This program is interactive and large groups will not be effective.)
- Have you confirmed with a contact person, the number of participants to expect?
- Have you prepared and tested the equipment you are using ahead of time? Be conscious of the fact that equipment may vary from site to site. Ask the person in charge of the equipment to demonstrate its use. When using slides, make certain that they are loaded properly and in the correct order.
- Do you have the following supplies:
  - Extra light bulbs if using a slide projector or transparency overhead projector?
  - Extension cord?
  - Easel with paper, dry erase board or chalk board for recording participant responses?
- Have you secured/copied enough handout packets for each participant?
- Have you copied enough Certificates of Completion, tests (if needed) and evaluation forms for each participant.
- Are you offering refreshments?
- Are nametags available?
- Have you allowed time for breaks and evaluations?

The following additional equipment/supplies are recommended for demonstration purposes, if available:

- Latex gloves
- Gauze or a cloth compress to demonstrate bleeding control
- CPR mannequins or baby doll
- Pocket masks or rescue breathing barriers
- Choke tubes/small object testers (available for under $2.00)

Evaluation Instructions

Evaluating the Participants
As an instructor, it will be your responsibility to evaluate the participants in your course. There are two primary options available to you depending on time restrictions and the size of your group. Whichever option you choose, it is important that you as an instructor are able to judge whether the group seemed to absorb the information that was intended. If not, you may need to alter your presentation for the next group or further assess the reasons why this did not occur.

Option 1

Use Section 6 of the program, First-Aid Roleplays (Activity A2-6) and evaluate the participants as they practice their new first-aid skills. Pay particular attention to the following:

- Is the proper care being given and the correct action being taken for the situation (e.g. check ABC's, call EMS, control bleeding, etc.)?
- Is the participant referring to their handouts for needed information?

This type of evaluation will be impossible if you have a large group. But if your group is relatively small and/or there is more than 1 instructor available to facilitate, this may be a good option because you will be able to observe strengths and weaknesses and provide feedback at the same time. Make certain that you have the opportunity to observe every person in the caregiving role.

Option 2

Ask each participant to complete the written Training Post-test. The post-test is included. Encourage the participants to refer to their handouts for assistance in completing the test. If you choose this option, make certain that you give the participants the right answers before they leave. An answer key is included that can be copied and distributed to participants when they return their completed tests or you can provide the correct answers verbally and allow opportunity for discussion.

Participants Evaluate the Program

Regardless of which option you choose to evaluate the participants, always allow the participants to evaluate the program. Use the enclosed "Participant Evaluation" forms. These forms will also provide you with important information about the participants' understanding of the information and their enjoyment of the program. There is also a "Trainer Evaluation" for you to complete.

Please mail a copy of the “Trainer Evaluation” forms to:

Georgia Office of EMS
EMSC Program
2600 Skyland Drive
Lower Level
Atlanta, GA 30319

This information will enable the EMSC program to learn how those using the curriculum feel about it and make changes or updates as needed.

Participant Training Evaluation

1. Compared to other trainings, how would you rate this session? (Circle One)

   Excellent Good Satisfactory Unsatisfactory

   Comments:

2. How would you rate the trainer? (Circle One)

   Excellent Good Satisfactory Unsatisfactory

   Comments:

3. How would you rate the handouts? (Circle One)

   Excellent Good Satisfactory Unsatisfactory

   Comments:

4. How would you rate the visual aids? (Circle One)

   Excellent Good Satisfactory Unsatisfactory

   Comments:

5. What do you find to be the most useful part of this training? Why?

6. What would you do differently in this training? Why?

7. What changes will you be able to make in your child care activities because of what you learned in this training?

8. Would you recommend this training to other child care providers? O **Yes** O **No**
If NO, why not?

Thank you for your time. Please feel free to write any additional comments below.

Trainer Evaluation

This form is to be completed by the trainer(s). Information included will be used to improve the training curriculum.

Location of training: (city, county)		Date of training
Trainer Name	Title	
Agency		
Address	City	Zip
Telephone Number Area code ( )		

1. Trainer Credentials (Circle One)

   Registered Nurse
   EMS Instructor
   Certified Instructor in First-Aid
   Licensed Physician

2. Class attendance (number) _____

3. Was the course easy to teach? YES or NO
   If no, what should be changed?

4. Were there any questions you felt you could not respond to? YES or NO
   If yes, please describe.

5. How much did you charge each participant for the course? Indicate the range. (Circle One)

   $0
   up to $5
   $5.01 to $10
   $10.01 to $15
   $15.01 to $20
   $20.01 to $25
   more than $25

6. How much did it cost to conduct the training? Indicate the range. (circle One)

$0 -$10
$10.01 to $25
$25.01 to $50
More than $50, specify _____

7. What were the expenses for? List or describe.

8. Did any of the following present difficulties for you?

a) Finding audiovisual equipment YES or NO

b) Arranging a meeting space YES or NO

c) Finding materials needed for the class such as:
handouts/CPR mannequins, etc. YES or NO

If yes, please describe:

d) Other, specify:

9. Were there any other barriers or obstacles to teaching the session? If so, please describe.

10. What characteristics of the course do you believe were the most beneficial?

Please mail a copy of this evaluation form to:

Office of EMS
EMSC Program
2600 Skyland Drive
Lower Level
Atlanta, GA 30319

First-aid for Child Day Care Personnel
Training Post-test

Please read and answer all the questions. For multiple choice questions, circle the best answer. Circle ONLY one answer. You may use your handout packet for assistance if needed.

1) First Aid/CPR training may mean the difference between
   a) Life and death
   b) Temporary and permanent disability
   c) Rapid recovery or prolonged hospitalization
   d) All of the above

2) What are the steps of the Emergency Action Principles?

   a) _____

   b) _____

   c) _____

   d) _____

3) The very first thing that you should do when you discover that a child has been injured is:
   a) Pick the child up and move them to a table/couch where you can further assess them
   b) Perform a toe-to-head exam to look for specific injuries
   c) Survey the scene for dangers to yourself
   d) Call EMS

4) Injuries in child care settings are:
   a) Unpredictable and random
   b) Predictable and preventable

5) Which of the following is NOT a true characteristic which makes children more vulnerable to injury?
   a) Children are curious explorers of their environment
   b) They cannot accurately judge speed and direction of sound and movement
   c) Their airways are smaller leading to a greater risk for choking
   d) The proportion of their head to body size is the same as adults

6) Incident reports must be completed and given to the parent/guardian in which of the following circumstances:
   a) Anytime a child is injured
   b) Anytime a child is transported by EMS
   c) All of the above

7) Preparation is an important part of first aid management. Which of the following are examples of good preparation for emergencies:
   a) Emergency telephone numbers are posted by each phone.
   b) Emergency fire and evacuation plans are posted.
   c) A physician and dentist are designated to act as consultants to day care workers with questions about various injuries and illnesses.
   d) First aid boxes are available for field trips.
   e) The center has communicated with local EMS about their available services and how to contact them in an emergency.
   f) All of the above

8) The ABC's of first aid refer to:
   a) Airway, Bleeding and Circulation
   b) Airway, Breathing and Circulation
   c) Assess: Breathing and Circulation
   d) Airway, Breathing and Carotid

9) Which of the following is NOT true of the first aid box? It should be:
   a) Checked periodically and outdated or missing items replaced.
   b) Maintained in a safe place and out of the reach of children
   c) Readily accessible to staff
   d) Locked at all times
   e) None of the above

10) Four year old Sally has fallen head first off the playground equipment from a distance 2 times her height. She is lying flat on the ground and tells you that her "neck hurts a lot". The most appropriate action in this situation would be to:
   a) Ask her if she can move her neck. If she can, help her to her feet and allow her to continue playing.
   b) Perform a thorough check of her ABC's.
   c) Suspect possible head/neck injury, send someone to call EMS and immobilize her neck.

11) Five year old Johnny fell on the playground and has knocked out his permanent tooth. The first thing you do is calm him down. What is the next step you should take?

a) Scrub the dirt off the tooth
b) Rush him to the dentist
c) Give him aspirin
d) Find the tooth and place it in Hanks Balanced Salt Solution (HBSS) or milk

12) Sherry, 3 years old, fell off the jungle gym during morning play period and after a few minutes of crying resumes play. At lunch, you notice that she is using her fork awkwardly. As you continue to observe her, you realize that she is not using the left hand she usually eats with. What should you do next?
a) Tell her to use her left arm.
b) Carefully examine her left arm for bruises, swelling and the presence of pain with movement.
c) Call EMS.
d) Help her eat her lunch and make a note to notify her parents at the end of the day.

13) Stephanie, a 2-1/2 year old, trips over an electrical extension cord and bumps her forehead on the linoleum tiled cement floor. While calming and comforting her, you apply a cool compress gently to her bruises. Which of the following is the most appropriate action?
a) Bandage her head securely.
b) Call EMS.
c) Observe closely for vomiting, confusion, unequal pupils, and uncoordinated movements.
d) All of the above

14) Michael, aged 4, walks up to you in the lunchroom with a bloody nose. What should you do?
a) Ask him to sit down with his head tilted back.
b) Wear gloves, position him with head tilted forward and pinch his nostrils together.
c) Place ice on the back of his neck.
d) Have him blow his nose to see if bleeding stops

15) What is the most effective way to prevent the spread of infection in the child day care setting?
a) Wearing cloth gloves when exposed to blood or other body fluids
b) Good handwashing practices

16) Signs of shock from blood and/or fluid loss include:
   a) Cool, clammy skin
   b) Agitation or restlessness
   c) Weakness
   d) All of the above

17) Carrie is a child in your center with a history of diabetes. One day, she becomes irritable and upset. She seems confused and says that she doesn't feel well. You can see that her hands are shaking slightly. She does NOT have a blood sugar monitor available. What is the first thing you should do?
   a) Call EMS.
   b) Check her emergency care plan for instructions.
   c) Give her sugar.
   d) Wait for 10 minutes to see if her symptoms go away.
   e) Give her a glass of water.

18) The primary objective of first aid for a child who is having a seizure is to protect the child from further harm. This is best accomplished by:
   a) Restraining the child
   b) Removing surrounding objects which may cause the child harm
   c) Positioning child on his/her side to prevent choking
   d) All of the above
   e) b & c

19) The first action to control bleeding should be:
   a) Apply a tourniquet to the affected part
   b) Apply direct pressure and elevate
   c) Remove penetrating objects
   d) Push on pressure points

20) Even serious neck injuries may not be obvious at first. If you suspect that a child may have a neck injury , which of the following actions should you take?
   a) Ask the child to move his/her neck so you can check it.
   b) Immobilize the neck by sitting at the child's head and placing one of your hands on each side of the child's head. Hold the head perfectly still.
   c) Pick up the child and comfort him/her.
   d) None of the above.

21) If a child tells you that he/she is being abused in any way, the most important thing to do is:
   a) Call the parents and confront them about the abuse.
   b) Promise the child that everything is going to be okay.
   c) Believe the child and report the abuse to the children services agency in your county.
   d) Ask the child if they are telling the truth because what they are saying could get the person in trouble.

22) One of Ebony's fingers is severed when a staff person unintentionally shuts the van door on her hand. You would do all of the following EXCEPT?
   a) Wear gloves.
   b) Place the severed finger directly on ice.
   c) Call EMS.
   d) Control the bleeding with direct pressure.
   e) Have Ebony lie down and elevate her feet 8-12 inches to prevent shock.

23) Which of the following statements is true about the first-aid management of frostbite?
   a) Leave wet clothing on to minimize cooling effect on the skin.
   b) Rewarm body parts suffering from frostbite with heat that is no warmer than body temperature.
   c) Rub frostbitten areas vigorously to re-establish circulation.
   d) Rewarm the body parts by dunking them in very warm water.

24) The signs/symptoms of poisoning are always the same.
   a) True
   b) False

25) If you suspect that a child has eaten something poisonous, the FIRST thing you should do is:
   a) Give the child Syrup of Ipecac to induce vomiting
   b) Call the Poison Control Center for instructions
   c) Give the antidote identified on the container
   d) Take the child to the hospital

26) Harry is stung by a bee and is crying. He begins to cough and scratch his belly and arms. You notice that he is breathing rapidly and is now beginning to wheeze. You suspect that he is having a severe allergic reaction to the bee sting. You would do all of the following EXCEPT.
   a) Call EMS.
   b) Give Harry something to drink to try to clear his throat.
   c) Locate Harry's emergency care plan.
   d) Give rescue breathing if necessary.

27) EMS should be called anytime a child:
   a) is unconscious or semi-conscious.
   b) is not breathing or is having difficulty breathing.
   c) has bleeding that won't stop.
   d) has injuries to the head, neck or back.
   e) All of the above

28) Kevin is burned on the arm by brushing against a hot pot in the kitchen. The burned area is forming blisters. Which is NOT an appropriate action to take?
   a) Call EMS.
   b) Put ice on the burned area and then apply burn ointment.
   c) Apply a cool, clean cloth to the burned area.
   d) Notify Kevin's parents and urge immediate medical care.

29) When performing rescue breathing on a child with a pulse, give 1 slow breath every:
   a) 2 seconds
   b) 3 seconds
   c) 4 seconds
   d) 5 seconds

30) First-aid treatment for an infant under 1 year with an obstructed airway includes:
   a) Opening the mouth and probing the throat with your fingers to look for the obstruction.
   b) Providing 5 chest thrusts and 5 back blows.
   c) Providing 5 abdominal thrusts.
   d) Sitting the infant upright on your knee.

31) Which of the following are signs of breathing difficulty?
   a) Wheezing
   b) Rapid breathing
   c) Bluish color around mouth or nail beds
   d) Excessive coughing
   e) All of the above

32) We know that a child has an open airway if he/she is able to talk.
   a) True
   b) False

33) If a child in your care has repeated evidence of injuries in unusual places and offers you an unlikely explanation for the injuries or refuses to say how the injuries occurred, what might you suspect?
   a) The child is clumsy and injury-prone
   b) The child is being abused
   c) The child is a trouble maker and is probably fighting with other children
   d) None of the above

34) Daniel releases the hand of the day care worker, darts into the street and is hit by a car. When you reach him, he is unconscious. Which of the following first-aid steps are in the correct order?
   a) Check pulse, breathing & look for broken bones.
   b) Move Daniel only if he is in immediate physical danger, assess his ABC's and send someone to call for help.
   c) Phone for help, keep Daniel warm and provide him a drink of water.
   d) Put Daniel in your car and rush him to the hospital.

35) First-aid knowledge and skills can often contribute to the speedy recovery of a seriously ill or injured child. Which of the following principles are true about providing first-aid in an emergency situation?
   a) Attend to the least serious injuries first and the most serious injures last. This allows you to take care of simple things quickly before moving on to more complicated conditions.
   b) Remain calm, assess the situation and think before you act.
   c) Start CPR whenever you find an unconscious child.

SECTION 1. OVERVIEW
INJURY PREVENTION

Objectives for General Injury Prevention Section; Participants will be able to:

- Explain the difference between an accident and an injury.
- List the most common types of injuries occurring in child care settings.
- Apply the Injury Triangle to realistic situations.
- Perform a safety assessment of their child care environment on their own time.
- Identify relevant injury problems in their respective child care agency and brainstorm solutions.
- Describe abuse and neglect reporting responsibilities and requirements.
- Identify personal barriers to injury prevention and brainstorm solutions.
- Access resources to develop an injury prevention action plan on their own time for their center.

Topics:

A. Injuries are Preventable (35 minutes)
B. Intentional Injuries (5 minutes)
C. Day Care Rules Pertaining to Safety (7 minutes)
D. Barriers to Injury Prevention and the Injury Prevention Action Plan (13 minutes)

Handouts Available

H1-1 = Was this an Accident?
H2-1 = Injury Facts
H3-1 = Injury Triangle
H4-1 = Safety Checklists
H5-1 = Safety Inspection Checklists
H6-1 = Child Development Chart
H7-1 = Warning Signs of Child Abuse/Neglect
H8-1 = Regional EMS Offices
H9-1 = Incident Report Form
H10-1 = Injury Prevention Plan
H11-1 = Action Plan Sheets
H12-1 = Safety Resources

Transparencies/Slides Available:

T1-INT = First Aid for Child Day Care Personnel
T1-INT = Partnership Triangle
T3-INT = Smiling Child
T4-INT = Program Overview
T1-1 = Is this an Accident?
T2-1 = Questions for Story
T3-1 = Injuries are NOT Accidents!

Transparencies/Slides Available (continued):

T4-1 = Injury Facts
T5-1 = Common & Serious Injuries to Children
T6-1 = Children are vulnerable to injury because:
T7-1 = Children are vulnerable to injury because:
T8-1 = Injury Triangle
T9-1 = Injury Prevention Strategies
T10-1 = Change the Environment
T11-1 = Supervision is Important
T12-1 = Change the Behavior
T13-1 = Prevention Tips
T14-1 = Injury Triangle Example
T15-1 = Why talk about abuse in this course?
T16-1 = Recognizing Abuse
T17-1 = Steps to Take
T18-1 = Completing the Incident Form
T19-1 = Suggestions
T20-1 = The Injury Prevention Plan

SECTION 1. INJURY PREVENTION (1 HOUR)

Topics & Training Strategies	Trainer Notes
A. Topic: Injuries are Preventable (35 minutes)	**Introduction** The first section of the program focuses on preventing injuries. Injury prevention is a formal name for many informal activities; some of which you may already be doing. For example, not allowing young children to play with marbles because they may choke and supervising children on the playground are injury prevention activities. Injury prevention doesn't have to be difficult or time- consuming and it will certainly make your center appealing to parents who are concerned about safety issues. I will begin this section by providing you with a situation that may help you think about accidents differently.
H1-1: Is this an accident?	**Is this an Accident?** • I would like you to listen to the following story and try to take in as many details as possible. • Make yourself comfortable. • Try to visualize the situation happening. • Close your eyes if you would like. • You may also follow along with **handout H1-1**.
T1-1: Is this an Accident? (Picture)	**Use T1-1 Now** **Note to Instructor:** Read the following aloud to class. Read slowly to allow the participants to "see" the story happening. **Scenario:** Jessica, a 4-year old, eagerly runs outside for playtime at Sunshine Day Care Center. She is not quite big enough to play on the jungle gym but she is determined to try the monkey bars today. She struggles to reach from one bar to the next but keeps trying, unnoticed to center staff. The surface underneath the monkey bars is concrete and all the wood chips have been kicked away. There are also sharp sticks lying underneath. The staff person who is supervising the children is seated where she cannot see Jessica. Although Jessica is determined her little arms become tired and slip off the bars. She falls and lands on her wrist, while hitting her head on the hard ground surface. She also lands on a sharp stick, which punctures her arm. Jessica's wrist is fractured and she also suffers from head, neck and back injuries.

	Note to Instructor: Ask the participants the following questions. Allow them to respond but offer suggestions if they do not come up with appropriate answers.
T2-1 Questions for Story • Was this an accident? • What could have been done to prevent this from happening?	**Use T2-1 Now** • **Was this an ACCIDENT?** **Desirable Participant Response:** Even though, it was not intentional (no one wanted this to happen or directly contributed to it happening), there are very clear points where interventions could have taken place to prevent the injuries from happening. • **What might have been done to prevent this injury from happening?** *(Record responses on the board/overhead)* **Desirable responses:** 1. Improving supervision. 2. Not allowing her to play on equipment which is too big for her and redirecting her attention to a piece of play equipment she can safely climb on. 3. Positioning yourself where you can see all children or moving around to supervise more effectively. 4. Adding more appropriately sized equipment for young children. 5. Removing concrete from play areas. 6. Making sure that an adequate covering of wood chips is covering the ground underneath play equipment at all times. 7. Clearing sticks and other sharp objects away from beneath the play equipment. Some of these interventions such as concrete removal and purchasing new equipment can be quite expensive and may not be possible for your center. However, the majority of suggestions, such as supervising closely, clearing sticks and sharp objects, adding more wood chips are easy and inexpensive to carry out. They just take a little bit of thought and effort.
T3-1 Injuries are not Accidents • **Accidents = Random and unpredictable** • **Injuries = Predictable and Preventable**	**Injuries are Not Accidents** **Use T3-1 Now** The word ACCIDENTS suggests something random, and unpredictable- not preventable. Most INJURIES are predictable and preventable. We have a great deal of information about when, where, how, why and to whom

	injuries occur. This information can be used to predict patterns of injuries and to prevent them from occurring. Using the word "accident" leads us to believe that nothing could have been done. Therefore, injuries are not accidents! I now want to show you a few facts about child injuries so that you can see what a large problem it is. Then we will discuss steps that we can each take to do something about the problem.
T4-1 Injury Facts • Leading cause of death and disability among children ages 14 and under in U.S. • Half of these deaths occur to children 4 and under. • 1 in 4 children require medical attention each year for injuries. • Estimated that 9 out of 10 injuries can be prevented.	**Injury Facts** **Use T4-1 Now and refer participants to H2-1** • Unintentional injury is the leading cause of death and disability among children ages 14 and under in the US. • Children ages 4 and under are at greater risk of unintentional injury-related death and disability and account for nearly half of these deaths among children ages 14 and under. • 1 in 4 children (or more than 14 million children ages 14 and under) sustains injuries that are serious enough to require medical attention each year. As former Surgeon General C. Everett Koop said on the subject of childhood injury, "If some infectious disease came along that affected one out of every four children in the United States, there would be a huge public outcry and we would be told to spare no expense to find the cure--and be quick about it." But often child injuries are thought of only as tragic accidents.
H2-1 Injury Facts	• It is estimated that as many as 90% (9 out of 10) of unintentional injuries can be prevented.
T5-1 Common & Serious Injuries to Children: • Falls • Burns • Poisonings • Motor Vehicle Crashes • Pedestrian-motor vehicle crashes • Drowning • Choking	**Common and Serious Injuries to Children** **Use T5-1 Now** The most common and serious injuries to young children are from • Falls • Burns • Poisonings • Motor Vehicle Crashes • Pedestrian-motor vehicle crashes • Drowning • Choking

T6-1 Children are vulnerable to injury because: • heads are larger in proportion to their bodies • internal organs are not mature • large body surface area for their size • small fingers • small airways • immature swallowing mechanism • bones are still growing	I'm now going to discuss some of the physical and developmental reasons why children are at a greater risk for injury than adults. **Physical Characteristics which make infants and/or children more vulnerable to injury: Use T6-1 Now** • Children's heads are larger in proportion to the rest of their bodies than adults by about 30%. The neck muscles and spine which support the head are not as strong as those of adults. This increases the risk of severe head or neck injury. • Their internal organs are not mature and are not well protected by their rib cage and pelvis bones. • They have a large body surface area for their size and thus are more susceptible to temperature extremes (e.g. frostbite, heat exhaustion), burns and fluid loss. • They have small fingers that fit into small, dangerous spaces, such as electrical outlets. • They have small airways that allow for easy choking. • They have an immature swallowing mechanism which also may allow for easy choking. • Their bones are still growing and break more easily.
T7-1 Children are vulnerable to injury because: • Natural explorers of their environment. • May not understand "NO". • Fearless. • Put things in their mouths. • Can't judge speed and direction of sound. • Lack balance and coordination. • Imitate adult behaviors.	**Developmental characteristics which make infants and children vulnerable to injury:** **Use T7-1 Now** • They are natural explorers of their environment. • They may not understand the word "NO". • They are fearless and may not be afraid of dangerous situations. • They naturally put things in their mouths to learn about them, thus increasing the risk of choking, poisoning, or electrical shock. • They can not accurately judge speed and direction of sound and movement (e.g. an oncoming car). • They lack balance and coordination to avoid injuries from events such as falls or hot liquid spills. • They imitate adult behaviors such as taking medicines or using tools, thus increasing their chances of poisoning, choking, electrical shock or severe wounds.

	The Injury Triangle (10 minutes) There are many different approaches to predicting and preventing injuries. We are going to explore one of these ways today: The Injury Triangle.
T8-1 Injury Triangle Child, Environment, Agent **H3-1 Injury Triangle**	**Use T8-1 & H3-1 Now** As I mentioned before, injuries often follow predictable patterns. These patterns can be identified by looking at the child, the environment and some injury-causing agent(s). These are the 3 corners of the triangle. The agent can be almost anything --a toy, a piece of furniture, a wading pool, a food item, another child. In the picture here, we see that the injury-causing agent is the baby walker (which is **NOT** recommended for use at any time). The stairs are part of the injury-causing environment and the child rolling toward the stairs unsupervised is the injury-causing behavior. We want to train ourselves to avoid harmful situations by recognizing the injury triangle and problem environments, agents, or behaviors.
T9-1 Prevention Strategies: • Change the Environment • Change the Behavior	**Use T9-1 Now** There are two main ways to control harmful situation and injuries: • Change the Environment • Change the Behavior Changing the environment is the easiest, but changing behaviors may have the longest lasting effect. A good injury prevention program uses both methods.

T10-1 Change the Environment • Train yourself to look at the center the way a child might. • Use Safety Checklist to perform safety check of center. • Ongoing Job **H4-1 Safety Checklist** **H5-1 Safety Inspection Checklist**	**Changing the Environment** **Use T10-1 Now** • In general a good way to change the environment is to train yourself to look at your center as a child might. Get down on your hands and knees to take a child's perspective. Bright colors, shiny objects, wires, cords, water, things that look good to eat are things that might attract a young child. Rusty surfaces, sharp edges and furniture can also create hazards. • Handout H4-1 provides some other guidance in thinking about a safe child care environment. I (we) hope that you will use this check list in your center to perform a safety check. • Handout H5-1 may help you keep track of inspections; which areas, when they were inspected, what was found and what steps are being taken to correct the situation. • Remember that changing the environment to promote safety and protect the children in your care is an ongoing job, because the environment is ever-changing. Every time a new child enters, a new toy appears, or a new activity is taught, changes are produced that need to be assessed for safety and health risks.
T11-1 Supervision is Important! (Picture)	**Supervision is Important!** **Use T11-1 Now** Remember that childproofing can NEVER replace good supervision. Children can get into a lot of trouble when we are not looking. Good supervision is a key ingredient to controlling injuries. If we are paying attention and watching the children in our care, we will be prepared to act quickly to potentially dangerous situations. A child who is supervised will not have the opportunity to find pills in a purse, find bleach under the sink, wander out the door or fight with another child.
T12-1 Change the Behavior Learn about injury risks at each stage of a child's development so that you can prevent injuries from occurring	**Changing Behavior** **Use T12-1 Now** Changing behaviors can be a more difficult task but it: can produce lasting results. At each stage of a child's development, the potential for harm from certain injuries changes. Children learn by exploring their environment. We know that infants place objects in their mouths, while the 2 year-old is in the "age of mobility". Being aware of the developmental stages helps us foresee the risks and prevent injuries. We can teach the 2 year-old how to climb stairs safely, and the 5 year old how to walk instead of run. We can teach children age 3 and up how to stop, drop & roll if they catch on fire.

H6-1 Child Development Chart

We do not have time to review risks for each developmental period but a child development chart has been included in your handouts. **(*Refer participants to H6-1).*** I also strongly recommend that you take a child growth and development course. The more familiar you are with the developmental periods and their related risks, the better equipped you will be to predict injuries and prevent them from occurring.

T13-1 Prevention Tips

1. Perform a Safety Check of your center regularly.
2. Maintain good supervision of children.
3. Learn about injury risks at each developmental stage.

Review General Injury Prevention Tips Use T13-1 Now

For now, I want to quickly review 3 general steps you can take to help prevent injuries from occurring.

1. Perform a Safety Check of your center regularly. Use the enclosed handout that we enclosed.
2. Maintain good supervision of children.
3. Learn about injury risks at each developmental stage.

Applying the Injury Triangle

I now want to hear about some of the safety problems and/or injury situations that you have witnessed in your own centers or with your own children? What are the injuries you have seen?

Note to Instructor: List participants' responses of the safety problems that they identify in their own centers on a blank overhead or board. Limit time and discourage participants form telling long stories. After you have a short list (4-7) of incidents, pick one incident on which to focus. Once you have selected your incident, ask the group to apply the injury triangle. Ask the questions which follow below. If the group does not respond with any incidents of their own, use the Injuries are NOT Accidents example or choose an example from one of the scenarios.

T14-1 Injury Triangle Example

- What factors contributed to this injury? Think of the behavior, environment & injury-causing agent.
- What could have been done to possibly prevent the injury?
- What are some of the barriers?
- What strategies would be best for this situation?

Use T14-1 Now

- What factors contributed to this injury? Think about the 3 corners of the Injury Triangle: environment, behavior and injury-causing agent (5).
- What could have been done to prevent the injury?
- What are some barriers to changing the corners of the triangle in this situation?
- What strategies would be best for this situation (i.e. changing the behavior, environment or injury-causing agent)? What are some of the pros and cons for intervening at each stage?

	Note to Instructor: Point out that it's not always possible to affect all areas. You need to think about the best strategy for a given situation. The easier the strategy is to carry out, the more likely it will be carried out.
B. Topic: Intentional Injuries **(5 minutes)** **T15-1 Why talk about abuse in this course?** 1. Abuse/neglect can cause injury and illness to children. 2. They happen often enough that most will see these problems at some time. 3. Under Georgia law, you are required to report suspected abuse/neglect.	**Introduction** **Not all injuries which happen to children are unintentional.** Children can also be physically and emotionally injured by violence and abuse. This next section of the program is briefly devoted to the subject of abuse and neglect. There is a 2-hour abuse and neglect course that is required for center staff to take. Resources are provided in your reference section. We will touch briefly on the issue in this course for several reasons. **Use T15-1 Now** 1. Abuse/neglect can cause injury and illness to children. 2. Abuse/neglect are widespread enough that most child day care providers will see these problems at some time. 3. Under Georgia law, child day care providers are required to report suspected child abuse or neglect. **Have any of you taken a child abuse/neglect course?** If you haven't taken the course, I recommend taking it when it is next offered in your area. A child's caregiver can be his/her best line of defense against the damage caused by abuse or neglect. **Note to Instructor:** If a number of participants have completed the child abuse course, you may want to make this section more interactive by asking the participants questions instead of just presenting the information. Either way, limit time to 5 minutes. **Definitions** • **Abuse** is an act done to a child by another which inflicts pain, injury or emotional trauma. It can be physical, emotional or sexual. • **Neglect** is an act of omission: it is something that a child needs for survival and well-being that is withheld or withdrawn, such as adequate food, clothing, shelter, and medical care.

T16-1 Recognizing Abuse • Accept that it happens! • Train yourself to ask: "Could this be abuse?" whenever a child has an unusual or suspicious injury. • Become familiar with the warning signs. **H7-1 Abuse Checklist & Steps to Take** **T17-1 Steps to Take** • Report the abuse/neglect to the Department of Family and Children Services in your county. • It is your legal responsibility even if you just suspect it. • Become familiar with how to assist a child who discloses abuse.	**Warning Signs** **Use T16-1 Now** • IMPORTANT: The first step in recognizing abuse or neglect is to accept that they exist. Child abuse is a big problem. There are about 650,000 confirmed cases of child abuse per year in the U.S. Whenever a child comes to your center with an unusual or suspicious injury, train yourself to assess, "Could this be abuse?" • The next step in recognizing abuse is being familiar with some of the physical and behavioral warning signs. We do not have time to review all of the warning signs of abuse or neglect but some of the most common are listed in Handout H7-1. **Steps to Take** **Use T17-1 Now** As a child care provider, you see children on a daily basis. In this situation, you may be the first to suspect abuse or neglect. Quick action can be critical to breaking the cycle of abuse and neglect by helping parents and children receive needed treatment and preventing further injury or harm to abused children. • If you suspect child abuse or neglect, report the abuse to the Children's Services Agency in your county. • As a child care provider, this is your legal responsibility - even if you just suspect it! • H7-1 also provides some tips for assisting a child who discloses abuse to you. Please become familiar with these as you may be the first and only person whom the child speaks to about the abuse. **Your reaction will be critical**. Please keep this issue in mind as we examine different types of injuries later in the program.
C. Day Care Rules (7 minutes)	**Introduction** If you are not already familiar with day care licensing rules concerning the health and safety of children, I strongly encourage you to become familiar with them on your own. The rules are designed to help keep children safe in centers. They can be used to child-proof your center and design injury prevention activities. ***Cont.***

	I am not an expert on the rules. If you have specific questions about the rules, please call your licensing specialist. Also, check in your center. A licensing report can be made available to you. The report will provide you with an excellent opportunity to see what you can do to improve safety in your center. **Documenting Injuries** As I am sure everyone in the room would agree, caring for children requires a great deal of time. Having an understanding of your time constraints, I (we) ask one more important task of you: documentation. Documenting injuries means that you record: • what type of injury occurred • when it occurred • how it happened • where it happened and • what steps were taken to care for the child. Licensed centers are required by the Georgia Department of Human Services to complete an incident report when a child is injured or is transported by EMS. **Importance of Documentation** Why do you think that documentation might be important? **Note to Instructor:** List participants' responses on the board. If the participants do not respond, highlight the following point. <u>Main Points:</u> Documentation allows you to see patterns of injuries occurring in your center. It provides important information about the Injury Triangle and allows you to design an appropriate injury prevention plan and injury prevention activities. Documentation helps protect your center from liability. By not documenting and reporting injuries, your center becomes vulnerable to formal complaints and lawsuits.

Use T18-1 Example of Incident Report Form	**Completing an Incident Form** • Fill out soon after incident so details will be fresh. • Be specific. Include factual detail. • Be objective. Give the facts not your opinion. • Write clearly. • Give a copy to child's parent and keep a copy on file. **Review of Incident Report Form** **Use T18-1 now** Incident Report Forms vary among daycare centers. Look at an Incident Report Form from your daycare. The important point is that the incidents are being documented in an appropriate way. I want to make sure that each of you feels comfortable in completing an incident form before we leave today. **Note to Instructor:** Briefly review the incident report form by referring to the notes below. Ask the participants if they have any questions about their forms or the example form used. Fill the form out as soon as possible after the incident so that the details will be fresh in your mind. Keep a supply of the forms in each classroom so they will be available when you need them. Try to be specific in answering each question. Include as much factual detail as you remember. Be objective. Give the facts of what happened, not your opinion of what happened. Write clearly so others may understand what you have written. ***TIME PERMITTING:*** Let's take our example from (use either "Injuries are Not Accidents" situation or example from Injury Triangle) and document the injury. Always remember to give a copy of the form to the child's parent/guardian or whoever picks up the child on the day of the incident. Keep a copy on file in your center. We are now going to be discussing how you can use injury prevention activities in your own center and what barriers might exist to carrying out those activities.

D. Topic: Barriers to	**Introduction**

Injury Prevention & the Action Plan (13 minutes)	As we have been talking about, caring for children can be one of the most challenging jobs that there is. **Barriers to Injury Prevention** What are some issues or barriers that you face on a day to day basis that might inhibit safety in your center? • Children demand much attention and need constant supervision. • Time and resources are limited. • It is difficult enough just doing your job. • There is always something that needs to be done. • If it weren't for all the other rules, I might have time. **Problem-solving the barriers** Now, let's take a few moments to think of some tips or solutions to these barriers. Does anyone have any suggestions or ideas of things that have worked in their own center?
T19-1 Suggestions • Use the "Safety Checklist" to scan for hazards as you clean. • Rotate roles with staff each week. • Use injury prevention activities with children. • Organize a safety event that includes one of the day care rules.	**Suggestions:** **Use T19-1 Now** • Incorporate injury prevention activities into clean-up time. Use the "Safety Checklist" included in your handouts to scan for hazards as you clean. • Share or rotate roles each week. One staff person could be responsible for a safety check once a day. • Use injury prevention activities with children. This will provide a learning opportunity while children are being supervised and it will help to improve safety at the same time. Use age-appropriate methods to help children think about injuries as preventable. There are injury prevention resources available to assist you in working with children. Some are listed in your handouts. Cont. • Organize a safety event which includes one of the day

	care rules. For example, hold a fire drill and practice your emergency evacuation plan. Invite a local firefighter to speak to your center about fire prevention. This could be targeted to staff or children.
H10-1 Injury Prevention Action Plan	**The Injury Prevention Action Plan** Our final topic in part one of the program is the Injury Prevention plan. We don't have time to develop an individual plan for everyone, but I would like to point out some information in your handbook that may be helpful. Turn to **Handout H10-1**, the Injury Prevention Action Plan.
H11-1 Action Plan - **Planning Sheet** **H12-1 Safety Resources**	In developing a plan, try not to overwhelm yourself. Take small steps but do SOMETHING now. Write down one thing that you will be able to do the next time you are in your center. Take a moment now. **Handout H11-1** may be helpful to you as you develop your own plan. **Handout H12-1** contains a list of many state and national safety resources.
T20-1 Injury Prevention Plan • Involve all staff. • Review incident reports. • Use the injury triangle. • Plan a safety activity each month. • Write down important dates in a calendar. • Develop a schedule for safety activities. • Use your resources.	**Developing a Plan** **Use T20-1 Now** To develop your injury prevention plan, sit down with other staff and develop a plan for the year. Some ideas to get you started are: • Look at incident reports from the previous year. What are the major injuries occurring in the center. What changes could be made to the environment or to behavior to make the center safer. Remember the injury triangle. • Plan a safety activity each month for staff or children. Most months have an awareness topic. For example, October is Sudden Infant Death Syndrome (SIDS) awareness month. You could invite a speaker to talk to staff about preventing SIDS. Or you could invite a local firefighter to speak to the children about fire safety during Fire Prevention Week. • Write important dates down in your calendar. For example, check the batteries in smoke detectors on the same day of every month. In that way, you won't forget. • Use safety resources such as the safety checklist. Develop a schedule for safety activities. For example, rotate staff roles so that each week a different person is responsible for safety checks. Cont. • Use your available resources. Many areas have local

	SAFE KIDS Coalitions that are available to speak about safety or provide injury prevention materials. Some groups can assist with bicycle helmet fittings and child safety seat fitting. Other local volunteer groups also work on child safety issues. As we proceed through the program, we will be returning to the concepts of injury prevention and applying them to more specific situations. But no matter how safe we are, sometimes injuries happen even in the best of situations. We will now turn our attention to responding to emergencies.

SECTION 2. OVERVIEW
EMERGENCY PREPAREDNESS & THE EMERGENCY ACTION PRINCIPLES

Objectives for General Emergency Response Section: Participants will be able to:

- Identify important steps to take to prepare for emergencies.
- List situations when EMS should be called.
- Assess the severity of an emergency situation.
- Explain and perform the four Emergency Action Principles.
- List important infection control precautions

Topics:

A. The Emergency Plan; Is your Center prepared? (5 minutes)
B. What is an Emergency (20 minutes)
C. Emergency Action Principles (45 minutes)
    1. Survey the Scene (5 minutes)
    2. Primary Survey (15 minutes)
    3. Access EMS (15 minutes)
    4. Practice steps in secondary survey - head to toe examination (10 minutes)
D. Assessment (3 minutes)
E. Infection Control/Universal Precautions (5 minutes)

Handouts Available:

H1-2 = Emergency Preparedness Checklist
H2-2 = Required First-aid supplies
H3-2 = Emergency Phone numbers
H4-2 = When to call EMS?
H5-2 = Is this an Emergency?
H6-2 = Emergency Procedures for an Injury or Illness
H7-2 = Approach to an Ill or Injured Child
H8-2 = Emergency Action Principles -Overview and Survey the Scene
H9-2 = Emergency Action Principle #2 -Primary Survey
H10-2 = Emergency Action Principle #3- Accessing EMS
H11-2 = Emergency Action Principles #4 -Secondary Survey
H12-2 = Infection Control
H13-2 = How to Wash Hands

Transparencies/Slides Available:

T1-1 = Children are NOT Small Adults
T2-2 = Emergency Preparedness
T3-2 = Emergency Procedures
T4-2 = Life Threatening Conditions
T5-2 = Injury Severity
T6a-2 = When to call EMS
T6b-2 = When to call EMS (continued)
T7 -2 = Emergency Action Principles Overview
T8-2 = Survey the Scene
T9-2 = Primary Survey -ABC's
T10-2 = Loss of Consciousness: Common Causes
T11-2 = Recognition of Loss of Consciousness
T12a-2 = Comparison of Adult & Child Airway
T12b-2 = Anatomy of the Airway
T13-2 = Opening Airway: Head Tilt/Chin Lift Picture
T14-2 = Opening Airway: Jaw Thrust Picture
T15-2 = Checking Breathing
T16-2 = Checking Circulation
T17a-2 = ABC's
T17b-2 = Monitoring the ABC's in a Conscious Child/Infant
T18-2 = When you Call EMS?
T19-2 = Secondary Survey: Overall Impression
T20-2 = Secondary Survey: Head-to-toe Examination
T21-2 = Daily Assessment
T22-2 = Infection Control

Activities Available:
A1-2 = Calling EMS
A2-2 = Severity Activity

SECTION 2. EMERGENCY PREPAREDNESS & THE EMERGENCY ACTION PRINCIPLES (1 HOUR & 30 MINUTES)

Topics & Training Strategies	Trainer Notes
Introduction to Part 2 (2 minutes) **T1-2 Children are *NOT* Small Adults** Suddenly Ill & Seriously Injured Children Can't Wait. (Picture of children in adult's clothes)	**Introduction to Emergency Response** **Use T1-2 Now** ▪ As we've said, sometimes injuries and illness happen even when we've tried to create the safest environment for children. As an (EMT/nurse/etc.), I know that when I am called to care for an ill or injured child, it will be a different situation. Children are NOT small adults. They have their own special emergency needs. It is important for me to have special training for children because the more comfortable I am, the better able I will be to help the child. ▪ This course was specially designed for people caring for children. Obviously, you don't want the children in your care to be injured. It can be a very frightening experience for all involved. But injuries and illnesses do happen. You need to be prepared because it is your responsibility to help the child. **SUDDENLY ILL AND SERIOUSLY INJURED CHILDREN CAN'T WAIT** until their parents/guardians pick them up at the end of the day. They need help immediately. ▪ This next section of the program will begin our coverage of first- aid skills. First-aid is the immediate care for children who become injured or suddenly ill until further medical care, if necessary can be obtained. First-aid knowledge and skills can often mean: 1. The difference between the life and death of a child. 2. The difference between temporary and permanent disability. 3. The difference between rapid recovery and long hospitalizations.

A. Topic: The Emergency Plan: Is your center prepared? (5 minutes) **H1-2 Emergency Preparedness** **T2-2 Emergency Preparedness** ▪ Caregivers have roles and responsibilities. ▪ Caregivers certified in first- aid & CPR are present. ▪ A file is in order for each child. ▪ First-aid kit is stocked and readily available. ▪ First-aid kit and staff trained in first-aid go on all outings. ▪ Smoke detectors and other alarms work. ▪ Physician/nurse & dentist act as consultants. ▪ Providers have communicated with EMS. ▪ Emergency phone numbers are accessible. **H2-2 Required First-aid Supplies** **H3-2 Emergency Phone Numbers**	**Introduction** Being prepared for an emergency before it happens is an important part of first-aid. This section of the program will focus on emergency preparedness. **Emergency Preparedness** **Use T2-2 Now** Handout H1-2 summarizes this information for you. I hope you will use this information to assess how prepared your center is for an emergency and to become better prepared in the future. ▪ All caregivers have roles and responsibilities in the event of a fire, tornado, injury or other incident. ▪ One or more caregivers certified in infant and child first-aid and CPR are always present. ▪ A file is in order for each child. Handout H1-2 lists the most important information to keep in each child's file. This information needs to be available in the event of an emergency. ▪ All first aid kits have the required supplies. Handout H2-2 lists these. The kits are stored in a location where they are readily available in an emergency. The kit is checked at **least 4 times a year.** Staff are familiar with the contents and their function. ▪ The first-aid kit and trained staff accompany all field trips. Smoke detectors and other alarms work. ▪ A physician/nurse and a dentist are designated to act as consultants to providers with questions about various injuries and illnesses. ▪ Center providers have communicated with local EMS regarding: ⇨ services available to the center. ⇨ important information about the center that would be helpful in an emergency. ⇨ children with special health care or emergency needs, etc. ▪ Emergency phone numbers are posted by all phones. A list of necessary phone numbers is available in Handout H3-2.

T3-2: Emergency procedures are near each phone & include: ▪ How to phone EMS ▪ Directions to your center ▪ Transportation to an emergency facility ▪ Notification of parents ▪ Evacuation and fire plans ▪ Plans to care for other children while a caregiver stays with injured child ▪ Plans for missing children	**Emergency procedures are posted near each phone.** **Use T3-2 Now** These procedures include: ▪ how to phone EMS ▪ written directions to find your center ▪ transportation to an emergency facility ▪ notification of parents ▪ where to meet if the child care setting is evacuated ▪ plans for an adult to care for children while a caregiver stays with injured child or escorts injured child to emergency care ▪ plans if a child is missing from the center. These plans, especially evacuation and fire plans, should be practiced.
B. Topic: What is an Emergency? (20 minutes) **T4-2 Life Threatening Conditions** ▪ Not breathing ▪ No pulse (heart stopped) ▪ Severe bleeding ▪ Unconsciousness **H4-2 When to call EMS?** **T5-2 Injury Severity** 1) Life Threatening Conditions -Call EMS 2) Needs medical attention NOW 3) Needs medical attention but can wait for parent/guardian 4) Can be managed with 1st- aid *Quick Action can prevent a more serious condition.*	**Injury Severity** **Use T4-2 Now** Injuries and illness may fall along a range of seriousness from not at all serious to life-threatening. They can also include everything in between. Anytime someone is severely bleeding, unable to breathe, or can't be woken up (unconscious), this is a life-threatening emergency. **Introduction to EMS** Anytime a condition is life-threatening, Emergency Medical Services (EMS) should be called. EMS is a generic term used to describe the emergency service in a particular area. This may be a fire department, rescue squad, ambulance company or police station. The type of service should by known by all staff who may be in a position to call EMS. Most areas dial 911 to access EMS but other areas use a 7-digit phone number. Know the emergency number for your area and post it near all phones. Handout H4-2 lists some signs which indicate when to call EMS. **Use T5-2 Now** ▪ Other conditions may not be life-threatening but may require emergency care (e.g. knocked out teeth, eye injuries, & fractures). Some conditions require medical treatment but may not need immediate attention (e.g. infected wounds and some rashes).

T6a-2 When to call EMS? ▪ Unconscious, semi-conscious or confused. ▪ Not breathing, difficulty breathing or choking. ▪ No pulse. ▪ Bleeding that won't stop. ▪ Coughing/vomiting blood. ▪ Poisoning. ▪ Seizure for the first time. ▪ Seizure > than 5 minutes. ▪ Head, neck or back injuries. **T6b-2 When to call EMS?** ▪ Sudden, severe pain. ▪ Injuries that may leave the child permanently disabled ▪ Condition could worsen or become life-threatening. ▪ Moving child could cause further injury.	▪ Others, such as minor cuts, scrapes and bruises may be managed with basic first-aid care by trained day care center staff. **Importance of Quick Action** Another factor to keep in mind is that some situations may worsen over time. A condition that seemed somewhat minor at first may become life-threatening if untreated. For example, a child with heat exhaustion may be managed with first aid in the early stages. If left untreated, the child may suffer from heat stroke, which is a life- threatening condition. This is why it is so important to react quickly when children are ill or injured. Quick action may help to prevent a more serious condition. **Call EMS anytime a child: Use T6a-2 Now** ▪ is unconscious, semi-conscious or unusually confused. ▪ is choking, not breathing, having difficulty breathing or having shortness of breath. ▪ has no pulse (child's heart has stopped). ▪ has bleeding that can not be stopped with direct pressure or is spurting/pulsing or flowing freely from the body. ▪ is coughing up or vomiting blood. ▪ has been poisoned. ▪ has a seizure for the first time or one lasting more than 5 minutes. ▪ has injuries to the head, neck or back. **Call EMS if: Use T6b-2 Now** ▪ the child has sudden, severe pain anywhere in the body. ▪ the child's condition is limb-threatening (for example, severe eye injuries, amputations or other injuries that may leave the child permanently disabled unless he/she receives immediate care.) ▪ the child's condition could worsen or become life-threatening. ▪ moving the child could cause further injury . ▪ the child needs the skills or equipment of paramedics or EMTs. ▪ distance or traffic would delay getting the child to the hospital.

▪ Needs skills/equipment of EMS. ▪ Conditions could delay getting to the hospital.	**If any of the above conditions exist, or if you are not sure, call EMS.** Keep in mind that the list just provides guidelines for when to call EMS. You must use your best judgment based on the condition of the child and situational factors such as the distance to a hospital to determine if EMS should be called.
	Note to Instructor: Time permitting, complete Activity A1-2: Severity Activity. If you are running behind on time, skip this activity or save for the end of the program.
A1-2 Severity Activity H5-2 Is this an Emergency?	**Severity Activity (15 minutes)** You will now have the opportunity to examine several situations and decide how serious it is. Some situations will be obvious whereas others will require more thought. It will be up to you to decide what is the best action to take. [EJ] Handout H5-2 lists the emergency situations we will be using. **Use A1-2 Now**
C. Topic: Emergency Action Principles Overview **H6-2 Emergency Procedures for an Injury or Illness** H7-2 Approach to an Ill or Injured Child	**Introduction to Emergency Action Principles** An important part of first aid is feeling confident about what to do in an emergency situation. It is essential to have some tools for emergency response. We are going to look at some of these tools now. Handout H6-2 lists general procedures for an emergency. You can read this information on your own. Handout H702 offers tips for approaching a suddenly ill or injured child. You can read information on your own.
T7-2 Emergency Action Principles Overview 1. Survey the Scene – What's going on? Is it safe for me to approach? 2. Primary Survey 3. Access EMS – How to be prepared when you call 4. Secondary Survey	Now we will be turning to a very important set of emergency response tools: the *Emergency Action Principles.* First, I (we) will present an overview of the steps. Then, we will look at each of the steps individually. You can follow along with Handout H8-2 – H11-2. **Use T7-2 Now** 1. Survey the Scene – What's going on? Is it safe for me to approach? 2. Primary Survey – ABC's 3. Access EMS – How to be prepared when you call 4. Secondary Survey – Head-to-toe examination

H8-2 Emergency Action Principles **#1-Survey the scene (5 minutes)** **T8-2 Survey the Scene** ▪ Stay calm. ▪ Is the scene safe? ▪ What happened? ▪ How serious does the injury or illness appear to be? ▪ How many people are injured? ▪ Are there bystanders who can help?	The Emergency Action Principles are numbered in the order that they should initially be performed. However, if there are other adults nearby who can assist, then some of the steps can be performed at the same time. Also, accessing EMS (step 3) may be done at any time if the situation is obviously life or limb threatening, there are several victims who need immediate attention, the child's condition worsens or the secondary survey reveals a serious condition. **#1 Survey the Scene** **Use T8-2 Now** Surveying the scene is a formal way to say, "What's going on here?" Handout H8-2 provides a checklist of some of the questions you may want to ask yourself as you are surveying the scene. ▪ The first and most important thing to keep in mind is to REMAIN CALM. Take a moment to stop, clear your head, and think before you act. ▪ The next most important thing is to determine whether the scene is safe for you to approach. What are the potential dangers to you? Always remember not to create another victim by helping. You can only be helpful if you are not injured yourself. Things like traffic, electric wires, fire, smoke, gas, chemicals and violence can be dangerous and require caution. If there is no way that you can assist the child without putting yourself in danger, call for help immediately. **<u>Other important information to gather includes:</u>** ▪ What happened to the child? How was the injury caused? ▪ How serious does the injury or illness appear to be? Is it obvious that EMS should be called? ▪ How many people are injured? ▪ Are there others who can help? If possible, gather information from bystanders about what happened. **IMPORTANT CAUTION!** A very important rule that I want you to remember about providing first-aid for injuries before we go any further is **DO NOT MOVE AN INJURED CHILD UNLESS IT IS ABSOLUTELY NECESSARY IN ORDER TO PREVENT FURTHER INJURY OR TO SAVE THE CHILD'S LIFE.** You may further injure the child by moving him/her.

#2-Primary Survey (15 minutes)

T9-2 Primary Survey

1. Is the child conscious?
2. Does child have a clear airway?
3. Is the child breathing?
4. Does the child have a pulse?
5. Is the child bleeding severely?

T10-2: Common Causes Injuries, especially head injuries

- Illness or severe infection Blood loss and shock
- Poisoning
- Severe allergic reaction
- Diabetic reaction
- Heat exhaustion
- Fatigue
- Stress
  - Not eating

Introduction

The purpose of the primary survey is to make contact with the child and to find out how serious the condition is. It should take no more than **45 seconds** to complete. The primary survey is an assessment step. It is about discovering what is wrong -NOT necessary fixing it.

Questions for the Primary Survey Use T9-2 Now

In the primary survey, you will be looking for answers to these questions. This information will immediately tell you if the child is suffering from a life-threatening condition. I (we) will demonstrate these steps in a moment.

1. Is the child conscious?
2. Does child have a clear airway?
3. Is the child breathing?
4. Does the child have a pulse?
5. Is the child bleeding severely?

We will now discuss each of these individually.

Loss of Consciousness: Use T10-2 Now

You may or may not know the cause of unconsciousness if you discover an unconscious child. Unconsciousness can have many causes including:

- Injuries, especially head injuries
- Illness or severe infection
- Blood loss and shock
- Poisoning
- Severe allergic reaction
- Diabetic reaction
- Heat exhaustion
- Fatigue
- Stress
- Not eating

T11-2: Recognition of Loss of Consciousness ▪ Extreme weakness ▪ Dizziness or light-headedness ▪ Extreme sleepiness ▪ Nausea ▪ Pale, sweaty skin If you recognize the signs of loss of consciousness, lay the child down to prevent further injury from falls. **H9-2 Emergency Action Principle #2: Primary Survey** **T12a-2 Comparison of Adult & Child Airway** ▪ Child (picture) ▪ Adult (picture) **T12b-2 Anatomy of Airway** ▪ Airway Open (picture) ▪ Airway Closed (picture)	**Recognition of Loss of Consciousness: Use T11-2 Now** ▪ Extreme weakness ▪ Dizziness or light-headedness ▪ Extreme sleepiness ▪ Nausea ▪ Pale, sweaty skin If at any time you recognize the early signs of loss-of-consciousness, lay the child down to prevent further injury from falls. **Checking Level of Consciousness** **Refer participants to H9-2.** ▪ There is a difference between fainting and unconsciousness. Both conditions can have the same causes, however fainting is usually much LESS serious than a state of unconsciousness. Most people who faint recover quickly when lying down. If a child does not regain consciousness quickly, call EMS. ▪ If a child appears unconscious, tap him/her gently but firmly on the shoulder and ask, "Are you okay?" If you do not get a response, then your next step will be to check the child's Airway, Breathing and Circulation (pulse). We call this step the ABC's. ▪ It is important to check airway and breathing whenever you find an unconscious child. This is because a blocked airway or no breathing will cause a child to become unconscious due to the child not getting needed oxygen into the body. ▪ To check the ABC's, the child should be lying on his/her back, on a firm, flat surface. If the child is lying crumpled or face down, you will need to re-position the child onto his/her back. We will cover this procedure later. Since "not breathing" is life-threatening, moving the child may be necessary in order to save a life.

T13-2 Head Tilt/Chin Lift

- Place hand on forehead & apply gentle, firm pressure to tilt head back.
- Place **1-2** fingers under bony part of jaw and lift chin forward.

(picture)

Explain & Demonstrate ABCs:

Note to Instructor: Demonstrate the ABCs on a volunteer or mannequin (if available) while you explain the steps using the following notes. After you have explained and demonstrated the ABCs, ask the participants to practice with a partner.

A = Airway Use T12a-2 Now

- Your first step is A -the airway. The airway is the passage through which air (& oxygen) travels to the lungs when we breathe, If a child's airway is blocked, oxygen cannot reach the lungs and death will soon follow. If a child is talking, crying and/or coughing, then he/she is getting SOME air through the airway-
- As we discussed before, children's airways are different than adults. They are smaller and the structures are proportioned differently. For example, a child's tongue takes up more space in the mouth than an adult's tongue. A child's windpipe is narrower than an adult's which can lead to choking. These differences cause children to experience more airway and breathing problems when they are ill or injured.

Use T12b-2 Now

An airway can be blocked by the tongue when a child is lying on his/her back. In fact, the tongue is the most common cause of a blocked airway in an unconscious person. When you encounter an unconscious child, it is critical that you open the airway. There are 2 methods which you can use. Either method will lift the tongue away from the back of the throat and make breathing possible again.

a. <u>The Head Tilt/Chin Lift</u> **Use T13-2 Now**

(demonstrate technique on a volunteer or mannequin if available)

1. Place one hand on the child's forehead and apply firm (but gentle), backward pressure with the palm to tilt the head back.
2. Place one or two fingers of the other hand (use one finger for an infant) under the bony part of the lower jaw near the chin and lift to bring the chin forward.
3. Do **<u>NOT</u>** press the fingers into the soft tissue under the chin. This may block the airway.
4. Do **<u>NOT</u>** use the thumb for lifting the chin.
5. Do **NOT** close the child's/infant's mouth completely.

T14-2 Jaw Thrust (picture)
1. Use if head/neck injury is suspected.
2. Sit at child's head facing length of body.
3. Rest elbows on ground.
4. Grasp bony part of jaw and lift with both hands.

b. <u>Jaw Thrust Technique</u>: ***Use T14-2 Now***
(demonstrate technique on a volunteer or mannequin if available)

1. Use this technique if head *or* neck injury is suspected.
2. Sit at the child's head facing the length of the body.
3. Rest your elbows on the same surface on which the victim is lying.
4. Grasp the bony part of the child's lower jaw and lift with both hands, one on each side.

After you open the airway using one of the methods, look in the mouth. In an injured or suddenly ill child, the airway can be blocked by mucous, blood, vomit or a foreign object like a small toy or a piece of food.

- If you see blood or vomit in the mouth, wear gloves, and try to wipe the mouth clear with a tissue or piece of cloth.
- If a foreign object is clearly seen in the mouth, remove it. We will cover what to do if a child is choking in Section 3 of the program.

B = Breathing **Use T15-2 Now**

T15-2 Checking Breathing
1) Look *for* chest to rise and fall.
2) Listen *for* breath.
3) Feel *for* air coming from nose and mouth.

After you open the airway, check for breathing. Sometimes opening the airway will help the child to start breathing again. Look, listen & feel for breath.

1. **Look** for the chest to rise and fall.
2. **Listen** for breath with your face close to child's nose and mouth.
3. **Feel** for air coming out of the child's mouth and nose with your face close to child's nose and mouth.

Chest movement alone does not mean that the child is breathing. Do not rely on anyone sign. Remember to keep the airway open.

<u>If child is breathing,</u> check the quality of the breathing. Does breathing seem normal for this child or is it rapid, shallow or labored? Is the child gasping for air or wheezing etc.? Abnormal breathing tells you that something is wrong.

T16-2 Circulation 1) Pulse ▪ Infant (< 1 year)-arm ▪ Child (> 1 year)-neck 2) Bleeding	***Protecting the Airway*** ▪ If the child is unconscious due to an illness or medical condition (i.e. he child has not been injured) and you see, hear and feel that the child is breathing, you may roll the child onto his/her side. This will help to protect the airway from the tongue or in case the child vomits. **NOTE: ONLY TURN THE CHILD ONTO THE SIDE IF THE CHILD HAS NOT BEEN INJURED AND IS INJURED.** ▪ If the child is unconscious due to injury, and IS breathing, do NOT move the child. Continue to perform the jaw thrust to keep the airway open until help arrives. ***C = Circulation*** ***Use T16-2 Now*** For C = Circulation, there are two steps: checking the pulse to see if the child's heart is beating and checking for severe bleeding. **a. <u>Pulse</u>** You only need to check the pulse if the child is not breathing. If the child is breathing, then the heart must be beating. If the child is not breathing, check the pulse. There are two methods that you can use to check. Which method you use depends on the age of the child. 1. ***If the child is less than one year old,*** check the pulse by placing 2 fingers ***(NOT** the* thumb) on the inside of the infant's arm between the elbow and the shoulder (brachial pulse). 2. ***If the child is one year old or older,*** check the pulse by placing two fingers on either side of the neck, below the jaw (carotid pulse). Do ***NOT*** use your thumb. *~* ***Note to Instructor:*** *Ask the participants to locate and feel their own carotid pulse now. Allow about* 1-2 *minutes for this.* Feel for a pulse for ***about*** **10** seconds. While checking the pulse, remember to keep the airway open by keeping gentle pressure on the child's forehead. **b. <u>Bleeding</u>** Is the child bleeding severely? Without moving the child, check the child's body quickly for blood. Look for blood soaked clothing or pools of blood near the child. Bleeding is severe if blood is spurting or flowing freely from a wound or if you cannot stop it. We will cover how to control bleeding

	if you cannot stop it. We will cover how to control bleeding later. If you find that the child is not breathing and/or is bleeding severely, CALL EMS!
T17a-2 ABC's ▪ With any serious illness or injury, always start with ABCs ▪ Continue to monitor because they can change.	***Importance of the ABC's*** ***Use T17a-2 Now*** ▪ Whenever you have an unconscious child or a child with altered consciousness, check the ABC's first. DO NOT start any other first aid until you have checked them. By checking them, you will be able to identify the conditions most in need of immediate care. ▪ It is also important to keep checking the ABC's because they can change.
T17b-2 Monitoring the ABC's in a Conscious Child/Infant. Look for: A = <u>Threats to Airway</u> • Vomiting (could block airway) • Severe congestion in the nose/throat B = <u>Breathing Difficulties</u> • Wheezing (high-pitched sound) • Increased use of stomach/chest muscles • Short, rapid or shallow breaths • Flaring (widening) nostrils • Excessive coughing • Turning blue around the mouth or nail beds C = <u>Circulation Problems</u> Severe bleeding	***Monitoring the ABC's in* a *Conscious Child/Infant*** ***Use T17b-2 Now*** ▪ If the child is not seriously injured or is awake, alert and talking or crying, check the ABC's by simply watching and talking with him/her. Ask yourself: A. Is the airway in danger of being blocked by anything such as vomit, blood, severe congestion/mucous? Is something partially blocking the airway? B. Does breathing seem normal or are breaths rapid, short and shallow or labored? Is child wheezing or turning blue? Basically, does breathing seem ABNORMAL ? C. Is child bleeding severely? ▪ If you feel that any of the ABC's may be at risk, call EMS. ▪ If the child becomes unconscious or has any loss of consciousness, closer observation and monitoring of the ABCs, as we discussed a moment ago, will be necessary. **Practicing the Primary Survey (Time Permitting)** Please practice the primary survey skills with a partner and I will walk around to see how you are doing and answer any questions. Later we will discuss what to do if a child is not breathing, but for now I just want you to practice checking the ABC's. I encourage you to use Handouts H8-2 – H11-2 as a reminder of the information.

#3-Accessing EMS (15 minutes) **H10-2 Emergency Action Principle #3: Accessing EMS**	**Introduction** ▪ Earlier, we discussed when a situation is serious enough that you should call for emergency help. Your first two Emergency Action Principles (EAP), "Survey the Scene" and "Primary Survey" will give you information you need to decide if the situation if life-threatening and EMS should be called. EAP #3 is about accessing EMS. You will be given information about what to expect when you call and what types of questions may be asked. ▪ Hopefully, in most situations, there will be other trained adults who can provide assistance. If there are other adults nearby, shout for help and send one of them to call EMS. If you are alone, you may have to call EMS yourself. In either case, it is important to have answers to the necessary questions that may be asked by EMS. **When you call EMS…** As we discussed a few moments ago, having the emergency phone number and directions to your center near all phones, are essential parts of an emergency plans. I will now provide you with some information that will prepare you for calling EMS. Please see Handout H10-2. Calling EMS may seem like a very easy task. But think about how you might be feeling in a true emergency. Your adrenaline will be pumping and your heart racing. You may be very nervous and possibly emotional. This is all normal. It may seem difficult to think clearly. If you find yourself feeling really nervous: ▪ Take a deep breath. ▪ Try to stay in control and remember what you have learned. ▪ Help the child. Action can have a calming effect. I am now going to provide a demonstration of what is likely to happen if you call EMS. The two most important things to remember are: ▪ Speak calmly and clearly. ▪ DON'T HANG-UP until the dispatcher tells you to. She may need additional information or need to give you instructions.

T18-2 When you call EMS…

- Speak calmly and clearly.
- DON'T HANG-UP until the dispatcher tells you to.

Expect the following:

- What is the emergency?
- What is your name and where are you calling from?
- Where is the emergency?
- How old is the victim?

You may also be asked:

- How many victims are there?
- Is the victim awake?
- Is the victim breathing?
- Is there severe bleeding?
- What are the injuries?

Use T18-2 Now

Note to Instructor:

- **Ask for a volunteer to simulate with you a caller and EMS dispatcher in an emergency situation. You will be the dispatcher and the volunteer will be the caller.**
- **Display T18-2 while the simulation occurs.**
- **You will ask the following "Dispatcher" questions while the volunteer will have the caller information to answer your questions. Do not allow the caller to hang-up until you have obtained all the information that the dispatcher may need.**
- **You may wish to stand back-to-back to simulate the call.**
- **Distribute A2-2 to the volunteer caller.**

A2-2 Calling EMS	**EMS Dispatcher:** 1. What's the emergency? 2. What is your name and where are you calling from? 3. Where is the emergency (i.e. where can the child be found?) 4. How old is the victim? 5. Is the victim conscious? 6. Is the victim breathing? 7. Does the child have a history of allergy to stings? Is there any medication available? 8. What has been done or is being done for the victim? 9. Do you know how to perform rescue breathing? **Caller:** ⇒ You are at the center on a summer day (use your center's address). ⇒ Dave, a 5 year-old, approaches you after playtime one day. He appears to be acting strange. As he approaches, you see that his face is swollen and hives are forming all over his body. He is starting to wheeze (make a high-pitched sound during breathing out). ⇒ He tells you that he has been stung by a bee. You think that he is having a severe allergic reaction to a bee sting. You do not know Dave to have a history of allergy but his symptoms are very concerning as they are affecting his breathing. ⇒ You have no medication for Dave's condition. ⇒ You have completed a first-aid and a CPR course and are prepared to give rescue breathing and CPR if necessary. ⇒ You take Dave with you and call EMS. **Note to Instructor:** ▪ **Once you have the essential information, end the call by stating that EMS is on the way.** ▪ **After completing the simulation, ask the participants if they have any comments or questions about accessing EMS.** ▪ **Conclude by highlighting the following points.** As a person trained in first-aid, you should continue to provide care to the child and send another prepared adult to call EMS. You will want to make sure that the person you send has answers to the questions listed in H10-2. Also, send an adult to find the child's file. The file should contain parent/guardian contact information and physician phone numbers and may contain information about the child's condition which will be important for the EMS personnel to know.

#4-Secondary Survey (10 minutes)

H11-2 Emergency Action Principle #4: Secondary Survey

T19-2: Secondary Survey Overall Impression

- Find out what is wrong.
- Talk to the child and bystanders.
- Does breathing seem normal?
- Does the color of the skin look normal?

T20-2 Secondary Survey Toe-to-Head Exam

- Tell the child what you are doing.
- Move from Toe-to-Head looking for anything unusual.
- Look for bleeding, cuts, swelling, bruises, etc.
- Check the legs and feet.
- Check the arms and hands.
- Check the shoulders, chest & stomach.
- Check the face, ears, nose and mouth.
- Write down what you find.

Introduction

- Our last emergency response step is called the secondary survey. This step, like the primary survey, is an assessment step. It will help tell you what is wrong. The steps are listed in Handout H11-2.
- If the child has a life-threatening condition, for example, the child is not breathing or is bleeding severely, do NOT perform a secondary survey. Call EMS and care for the life-threatening condition instead.

Secondary Survey

Note to Instructor: Demonstrate the secondary survey with a volunteer or mannequin (if available) while you explain the steps using the following notes.

a. Overall Impression — Use T19-2 Now

- Talk to the child and/or any bystanders. Find out what is wrong.
- An injured child or infant may be frightened. Try to stay calm and reassure the child. Tell the child that you are there to help. Ask the child "What happened?", "Where does it hurt?" or say, "Point to where it hurts."
- As the child talks, pay attention to breathing. Does it seem normal OR is the child gasping for air or breathing very quickly?
- Does the color of the child's skin look normal OR does it seem pale, bluish or flushed? Is the child sweating a lot?

b. The Toe-to-Head Examination

- Tell the child what you are going to do. Say something like, "I'm going to see where you are hurt now so I can help you."
- Start at the feet and move to the head, looking for anything which feels or looks unusual to you or causes the child pain. Calmly talk to the child as you are examining him/her.
- Look for bleeding, cuts, bruises, swelling and deformities.
- Ask if the child can bend his/her leg and wiggle the toes to check the child's legs and feet. Check one leg at a time.
- Ask if the child can bend his/her arm and wiggle the fingers to check the child's arms and hands. Check one arm at a time.
- Ask the child to take a deep breath and blow it out slowly to check the stomach and chest.
- Ask the child to shrug his/her shoulders.
- Check the child's head, face, ears, nose and mouth. Look for blood or other fluid in the child's ears, nose or mouth.

D. Topic: **Assessment (3 minutes)**	**Write down any information the child gives you as well as anything unusual that you find during your exam** so that you can give the information to EMS personnel or the parents. If you find injuries, give first-aid and call EMS, if needed. If you are not sure how serious the condition is, call EMS. <u>Things to keep in mind before examining:</u> 1. Call EMS if you think the child has a head, neck, or back injury. 2. Do **NOT** ask the child to move any area that is painful. 3. Do **NOT** press on any area that the child says is painful. **Practicing the Secondary Survey (Time Permitting)** Please practice the secondary survey with a partner. I will be available to answer any questions. Use Handout H11-2 as a reference. **Daily Assessment** **Use T21-2 Now** ▪ The assessment steps of the Emergency Action Principles – in particular the secondary survey, can be applied to any injury – even injuries which occurred at home. When children arrive at the center, assess their general condition. Look for: 1. Behavior changes – Is the child acting "normal" for this child? 2. New injuries – document any new injuries which occurred at home. This is important as you may need to provide first-aid or monitor conditions throughout the day. It will also help to protect the center from liability, as you will be able to document that the injury was present when the child arrived and did not occur at the center. 3. Anything else which seems abnormal for that child. ▪ This assessment may help you recognize problems occurring at home. It may give you clues about whether a child is being abused or neglected. It will help you determine if the parent needs some injury prevention information. ▪ Discuss your concerns and/or questions with the parent/guardian. If you believe it to be in the best interest of the child and/or parent, recommend the parent meet with the center administrator before departing that day. These actions help to promote the child/parent/center partnership in meeting the child's needs.

E. Topic: Infection Control
(5 minutes)

H22-2 Infection Control

T22-2 Infection Control

- Wash hands thoroughly.
- Wear gloves.
- Wear protective eyewear if possible.
- Wipe-up any blood or body fluid spills.
- Send soiled clothing home in a double-bagged plastic bag.
- Do not eat, or touch your mouth or eyes while giving first-aid.
- Have children wash hands often & avoid other's blood or body fluids.

H13-2 How to Wash Hands

Introduction to Infection Control

Some people do not want to help an injured person because they fear infection from a contagious disease. This portion of the program will cover precautions you can take to protect yourself from infection.

Use Infection Control Precautions with Everyone

In order to be infected with anything, you must be exposed to someone who is carrying an infection, like a virus or bacteria. Most times, you can't tell by looking if someone is carrying an infection. Therefore, it is important to use precautions when providing first-aid to anyone. This idea is called universal precautions. Universal precautions will help protect you and the children in your care.

Be Prepared

Protecting yourself from infection can be easy. In fact, proper hand washing is the #1 way to prevent the spread of infections. Using latex gloves when providing first-aid is another effective way to protect yourself. Gloves can be purchased in bulk. *Avoid using latex if staff or children have latex allergies. Gloves are sold in other materials.*

Use T22-2 Now and refer participants to H12-2

- Wash hands thoroughly:
  1. after physical contact with any body fluids (even if gloves have been worn).
  2. before and after eating or handling food.
  3. after cleaning.
  4. after using the restroom.
  5. after changing diapers.
- Wear latex gloves or use another type of barrier such as a plastic bag when in contact with blood and other body fluids.
- If possible, wear protective eyewear when body fluids may come in contact with eyes (e.g. squirting blood).
- Wipe-up blood or body fluid spills as soon as possible (wear gloves). Bag the trash in a plastic bag and dispose of immediately. Clean area with a bleach solution or approved disinfectant (1 part liquid bleach to 10 parts water).
- Send all soiled clothing (i.e. clothing with blood, stool, or vomit) home with the child in a plastic bag.
- Do not eat, or touch your mouth or eyes, while giving any first aid.

<u>Infection Control Guidelines for Children</u>

- Remind children to wash hands after coming in contact with their own blood or body secretions.
- Remind children to avoid contact with another person's blood or body fluids.

Please refer to Handout H13-2 for information on correct hand washing.

Activities:
Section 2

- A1-2 = Assessing the Severity of the Situation – Is this an Emergency?
- A2-2 = Calling EMS

Activity A2-2: Calling EMS

Severe Allergic Reaction

- ***Caller:***
  - ⇒ You are at your center on a summer day (use your center's address).
  - ⇒ Dave, a 5-year-old, approaches you after playtime one day. He appears to be acting strange. As he approaches, you see that his face is swollen and hives are forming all over his body. He is starting to wheeze (make high-pitched sound during breathing out).
  - ⇒ He tells you that he has been stung by a bee. You think that he is having a severe allergic reaction to a bee sting. You do not know Dave to have a history of allergy but his symptoms are very concerning as they are affecting his breathing.
  - ⇒ You have no medication for Dave's condition.
  - ⇒ You have completed a first-aid and a CPR course and are prepared to give rescue breathing and CPR if necessary.
  - ⇒ You take Dave with you and call EMS.

- ***EMS Dispatcher:***
  1. What's the emergency?
  2. What is your name and where are you calling from?
  3. Where is the emergency?
  4. Is the victim conscious now?
  5. Is the victim breathing?
  6. Does the victim have a history of allergy to stings? Is there any medication available?
  7. How old is the victim?
  8. What has been done or is being done for the victim?

Call EMS and provide first aid until they arrive.

Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible.

Provide first-aid and monitor the child's condition. Notify parents when they pick up the child at the end of the day.

No first-aid needed. Allow child to return to normal activities.

Activity A1-2 ASSESSING SEVERITY OF SITUATION – IS THIS AN EMERGENCY?

This activity allows participants to assess the severity of different injury and illness situations. Read the following directions to participants.

Instructor:

- I am going to read (or ask for a volunteer to read) injury and illness stories. Once the story has been read, I would like you to stand next to the sign on the wall which best indicates what you would do in that situation. Your opinions are:
    1. Call EMS and provide first aid until they arrive.
    2. Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible (child needs care within 1-4 hours).
    3. Provide first-aid and monitor the child's condition. Notify parents.
    4. No first-aid needed. Allow child to return to normal activities.
- Please try to make your decision quickly – no more than 30 seconds. Then I will ask for volunteers to discuss why they chose that action. Finally, I will give you physicians' recommendations for these situations. Feel free to ask any clarifying questions at that point. Keep in mind that these are only guidelines and you must use your best judgment given your knowledge, experience, and the situation.
- I don't want you to feel like you must have all the right answers or know exactly what to do now. You will be receiving more specific first-aid instructions later in the program. For now, I just want you to think about what your first reaction would be to the situations.
- Try not to read more into the stories than the information with which you are provided. Assume that you have been given all of the important information about the incident.
- Do you have any questions now about the instructions?

Injury Scenarios

1. Several children are playing with a ball and they kick it into an overhead light. The light shatters, sending glass into one child's eye. The child starts screaming in pain and finds it difficult to open his eye. You find glass in the child's eye. What would you do?

Physician Recommendation	***Reason:***
Call EMS and provide first-aid until help arrives.	Injury is limb-threatening (i.e. Sight is jeopardized.)

2. Two children are playing and one throws a wooden block at the other. The block cuts his lip and the side of his face. Upon examining the injuries, you see that the wound is gaping and the edges will not stay together easily. What would you do?

Physician Recommendation	***Reason:***
Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible.	Not life or limb threatening but requires immediate medical care to prevent further problems.

3. While playing outside, a child you are watching falls on the asphalt. After you comfort the child and examine her wounds, you see that she has some surface cuts, scrapes and bruises, but not a lot of bleeding. What would you do?

Physician Recommendation	***Reason:***
Provide first-aid and monitor the child's condition. Notify parents when they pick up child at the end of the day.	Injury is not life-threatening. It does not affect airway, breathing or circulation, there is no heavy bleeding and no limbs are in danger.

4. A 12-month-old's thumb was severed when staff accidentally shut the door on her finger. What would you do?

Physician Recommendation	***Reason:***
Call EMS and provide first-aid until help arrives.	Limb-threatening injury – could be severe bleeding, traumatic to child.

5. You find a 3-month-old face down in her crib. When you turn her over, you see that she has turned blue and appears to have stopped breathing. What would you do?

Physician Recommendation	***Reason:***
Call EMS and provide first-aid until help arrives.	Life-threatening – affecting airway.

6. Ben, a child with diabetes, comes to you and says that he feels "shaky". He is pale and seems a little irritable. What would you do?

Physician Recommendation	***Reason:***
Provide firs-aid and monitor the child's condition. Notify parents.	Child's condition is not affecting ABC's. He does not seem confused – just irritable. If child is given something to eat and shows improvement, then there is no emergency. If no improvement within 10-15 minutes, seek medical attention.

7. Two children get into an argument over a toy. One child bites the other child and breaks the skin. The wound bleeds slightly. What would you do?

Physician Recommendation	***Reason:***
Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible.	Not an emergency because it does not affect ABC's, no heavy bleeding, not limb-threatening, not affecting the child's level of consciousness. It does require immediate medical care because of the exposure to body fluids of another child. In this case, the parents/guardians of both children should be notified of the exposure and urged to seek immediate medical care.

8. A child trips and falls while running. He lands on a stick. The stick punctures his arm. Bleeding is minimal but the stick is stuck in the wound. What would you do?

Physician Recommendation	***Reason:***
Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible.	The injury is not life-threatening as it is not affecting the airway, breathing or circulation. The bleeding is minimal and there is no risk of loss of limb. However, when the puncturing object is still left in the wound, you should **NOT** remove it on your own. The object may be helping to contain heavy bleeding. This type of wound needs immediate medical attention.

9. Shawn is knocked to the ground when the wooden seat of a swing hits him under the chin. When you look at Shawn, you notice that two of his teeth are chipped and one side of his face looks different that the other. You suspect that he may have a broken jaw.

Physician Recommendation	***Reason:***
Provide first-aid and notify parents to take the child to a doctor or dentist as soon as possible.	Any chipped, displaced, or knocked-out teeth require immediate dental care in order to save the teeth, but the parent/guardian should be notified to take the child to the dentist. The suspected broken jaw also requires immediate medical care. If you suspect Shawn has any other type of head injury or is bleeding severely, you should call EMS. You should also call EMS if you feel that Shawn's airway is blocked or may become blocked in any way by blood, vomit or a foreign object.

10. Mike, a 5 year old, who is taking antibiotics for his ear infection, complains of a rash on his chest but has no other signs or symptoms.

Physician Recommendation	***Reason:***
Provide first-aid and monitor the child's condition. Notify parents.	Not life-threatening or limb-threatening. Child has no other symptoms than a rash. There is not much first-aid that can be done for this type of rash. Best action is to closely monitor the child's condition and watch for other signs. Make certain to notify parents to watch for other reaction. If you are administering the medication at the center, contact Mike's parents or doctor regarding what to do about giving the next dose. If the condition gets worse, contact parents and urge them to seek medical attention.

11. Ryan takes a hard fall off a spinning playground ride and complains of tingling in his left arm that has lasted 5 minutes.

Physician Recommendation	***Reason:***
Provide first-aid and notify parents to take the child to a doctor as soon as possible.	Child could have a fracture in his arm since he fell hard from a spinning ride. Since you suspect a fracture, but not a limb-threatening situation, urgent medical care is the best action.

Mention to the participants that in none of the situations is it recommended to do nothing. In most cases first-aid can be of value even with seemingly minor situations and children's conditions following any incident should always be closely monitored.

Instructor:

The most important points to remember are to:

- Call EMS for the following conditions:
    - Affecting Airway, Breathing or Circulation
    - Heavy bleeding
    - Affecting the child's level of consciousness
    - Head, neck & back injuries and other situations when you cannot move the child.
    - Limb-threatening conditions such as amputations, severe eye injuries.
- **Always** notify the parents/legal guardians of any injury or illness incident. They have a right to know and this will allow the parent to continue to monitor the child's condition and to take whatever steps they see as necessary. It is required to fill out incident report forms after any injury.

SECTION 3. OVERVIEW
RESPONDING TO BREATHING EMERGENCIES, BLEEDING & SHOCK

Objectives: Participants will be able to:

- Explain and perform shock first-aid
- Explain and perform the steps of controlling bleeding
- Describe the steps involved with first-aid for infant and child choking and practice the motions
- Describe the steps involved with infant and child rescue breathing and practice the motions

Topics

A. Shock & Bleeding (10 minutes)

B. Breathing Emergencies (50 minutes)

Handouts Available:

H1-3 = Shock First-aid
H2-3 = Controlling Bleeding
H3-3 = Nosebleeds
H4-3 = Prevention of Breathing Emergencies
H5-3 = CPR for Children
H6-3 = CPR for Infants
H7-3 = Choking (Conscious)
H8-3 = SIDS in Child Care Setting

Transparencies/Slides Available:

T1-3 = Causes of Shock
T2-3 = Shock prevention
T3-3 = Shock Signs/Symptoms
T4-3 = First-aid for Shock
T5-3 = Controlling Bleeding
T6-3 = Nosebleeds
T7-3 = CPR is important!
T8-3 = Causes of Breathing Emergencies
T9-3 = Choking/Suffocation Hazards
T10-3 = Obstructed Airway
T11-3 = Examples of Choking Hazards
T12-3 = Examples of Choking Hazards
T13a-3 = Prevention of Breathing Emergencies
T13b-3 = Prevention of Breathing Emergencies (Continued)
T14-3 = Signs of Breathing Emergencies
T15-3 = First-aid when victim is getting SOME air
T16-3 = Rescue Breathing

T17-3 = Differences for Infants
T18-3 = Differences for Adults
T19-3 = Choking: Conscious Child or Adult
T20-3 = Choking: Unconscious Child or Adult
T21-3 = Choking: Conscious and Unconscious Infant
T22-3 = Sudden Infant Death Syndrome (SIDS) Background
T23-3 = SIDS Risk Reduction

SECTION 3. RESPONDING TO BREATHING EMERGENCIES, BLEEDING & SHOCK (1 HOUR)

Topics & Training Strategies	Trainer Notes
A. Topic: Shock & Bleeding (10 minutes)	**Introduction to Section 3.** In the next hour, we will be focusing on more specific situations of emergency response. A large portion of this hour will be devoted to breathing/respiratory emergencies. We will start this part of the program by talking about shock and bleeding. **Background Information:** Shock is the loss of enough blood and fluid that parts of the body become deprived of needed nutrition and oxygen. Shock has many causes but it is the final result of many severe illnesses and injuries. **SHOCK IS A LIFE THREATENING PROBLEM IF UNTREATED**. It is a frequent cause of death in children. Learning to recognize the early warning signs of shock could help you save a life.
T1-3 Causes of Shock Most common causes: • Internal and external blood loss. • Fluid loss from vomiting, sweating, diarrhea or burns. Call EMS if you suspect shock.	**Common Causes** **Use T1-3 Now** <u>The most common causes of shock are</u>: • Blood loss (internal and external) -even if you don't see bleeding, a child could have internal injuries. • Fluid loss from severe vomiting, diarrhea, sweating, or burns <u>Other causes include:</u> • Severe allergic reaction. Severe infection • Poisoning or drug overdose We will discuss first-aid recommendations for these conditions later.
T2-3 Shock prevention should be started with: • Broken bones • Serious burns • Bleeding • Head, neck or back injuries	**Use T2-3 Now** <u>Shock prevention steps should be started with the following injuries:</u> • Broken bones • Serious burns • Bleeding • Head, neck or back injuries

T3-3 Signs & Symptoms

- Confused or light-headed
- Agitated or restless
- Sleepy or losing consciousness
- Large amount of bleeding
- Severe pain or swelling
- Pale, cool, or clammy skin
- Rapid, weak pulse
- Weakness
- Nausea and vomiting

T4-3 First-aid for Shock

- Wear gloves when exposed to blood or body fluids
- Perform the Emergency Action Principles. Check ABC's.
- DO NOT MOVE child if neck or head injury is suspected.
- Have child lie down and elevate feet 8-12 inches.
- Keep child warm, but not hot.
- Loosen tight clothing.
- Call EMS.
- Contact parents/guardians
- If you know cause of shock, see first-aid recommendations for that condition.
- DO NOT give anything by mouth.

H1-3 Shock

Signs and Symptoms of Shock **Use T3-3 Now**

- Confusion or light-headedness
- Agitation or restlessness
- Sleepiness or loss of consciousness
- Sudden or large amount of bleeding
- Severe pain or swelling of trunk, arm or leg
- Pale, cool, or clammy skin
- Rapid, weak pulse
- Weakness
- Nausea and vomiting

Note to Instructor: Demonstrate first-aid for shock with a volunteer or mannequin if available. Display **T4-3** as you demonstrate.

First-Aid for Shock **Use T4-3 and H1-3 Now**

- Wear gloves when exposed to blood or body fluids.
- Perform the Emergency Action Principles. Check ABC's.
- DO NOT MOVE child if neck or head injury is suspected.
- Allow child to find a position of comfort, preferably lying down with feet elevated 8-12 inches.
- Keep child warm, but not hot. Cover child with a light blanket.
- Loosen tight clothing.
- Call EMS. Shock is life-threatening.
- Contact parents/guardians immediately.
- If you know the cause of the shock, refer to first-aid guidelines for that condition. For example, if child has a severe cut which is bleeding a lot, control the bleeding (more on bleeding shortly).
- DO NOT give anything by mouth.

Note to Instructor: Demonstrate how to control bleeding with a volunteer. Use gauze pads and gloves to make demonstration more realistic. Display **T5-3** as you demonstrate.

H2-3 Bleeding

T5-3 Bleeding First-aid

- Wear gloves
- Perform the EAPs.
- Apply firm, direct pressure with palm of hand using gauze pads. If bleeding continues, add more pads to wound. DO NOT remove used compresses.
- Elevate injured area, if possible, unless it will cause further injury-
- Uncontrollable bleeding can lead to shock. Call EMS.
- DO NOT USE A TOURNIQUET.
- Bandage the wound firmly but do not cut off circulation after bleeding is controlled.

H3-3 Nosebleeds

T6-3 First-aid for Nosebleeds

- Wear gloves
- Place child sitting down with head leaning slightly forward.
- Do NOT lean child backward or tilt head backward.
- Do NOT have the child blow, wipe or rub the nose.
- Ask child to breathe through mouth.
- If blood is flowing, pinch nostrils shut for 10-15 minutes. Apply ice to nose.
- If bleeding does not stop

Controlling Bleeding **Use T5-3 and H2-3 Now**

- Wear gloves whenever exposed to blood or body fluids.
- Perform the Emergency Action Principles. Check the ABCs.
- Apply firm, direct pressure on the wound with palm of hand using a compress of gauze pads. If wound continues to bleed, add more pads to wound. Do not remove compress already in place. EMS personnel may remove compress when they arrive but you should try to leave them in place until EMS arrives.
- Gently support and elevate injured area, if possible, unless it will cause further injury.
- In most cases, bleeding can be controlled with direct pressure. If you are unable to control the bleeding (e.g. it is spurting, pulsing or flowing freely) or if the wound is excessively deep or wide or has foreign objects imbedded, call EMS. These wounds should be seen by a doctor immediately.
- Remember that uncontrollable/severe bleeding can lead to shock which is a life-threatening condition. Call EMS. DO NOT USE A TOURNIQUET.
- Bandage the wound firmly but do not cut off circulation after bleeding is controlled.

If an amputation has occurred:

- Call EMS
- Wear gloves and control bleeding with direct pressure as described before.
- Place detached part in a plastic bag and tie the bag. Put the bag in a container of ice water. Send bag to the hospital with child.
- DO NOT PUT AMPUTATED PART DIRECTLY ON ICE.

First-aid for Nosebleeds **Use T6-3 and H3-3 Now**

- Wear gloves
- Place child sitting down with head leaning slightly forward.
- Do not have the child tilt her head backward.
- Do NOT have the child blow, wipe or rub the nose.
- Ask the child to breathe through the mouth.
- If blood is flowing freely from the nose, pinch both nostrils shut with thumb and forefinger. Provide constant pressure for about 10-15 minutes. Apply ice to nose.
- If bleeding does not stop within 15 minutes or if nosebleeds are frequent, contact parents/guardians and seek medical attention.

in 15 minutes, contact parents and seek medical attention.	• If child has suffered a head injury, do NOT move child and follow recommendations for head injuries. Use the jaw thrust to open the child's airway.
B. Topic: Breathing Emergencies (50 minutes) **T7-3 CPR is important!** **T8-3 Causes of Breathing Emergencies** • Choking • Electric shock • Near drowning • Head injuries • Poisoning • Asthma • Severe allergic reactions	**Background Information:** • At this point in the program we will be focusing on problems affecting the breathing system of infants and children. • Breathing emergencies are common in children. If a child or infant is having difficulty breathing or is not breathing, this is a breathing emergency. A breathing emergency is life-threatening. • Children are likely to suffer from breathing emergencies much more often than adults. If a child's heart stops (cardiac arrest), it is usually the result of a breathing emergency. That is, the breathing emergency usually causes the heart stoppage. Therefore, it is so important to know what to do for a child who is having difficulty breathing or who has stopped breathing. By knowing what to do, you could very well save a child's life. • Earlier in the program, we learned about how to open an airway and look, listen and feel for breathing. We will now talk about what to do if you find that a child has stopped breathing or is choking. **Use T7-3 Now.** **Note to Instructor:** Read the following statement aloud. **I (we) strongly recommend that all day care personnel successfully complete a course in CPR (Cardiopulmonary Resuscitation). This course will in no way take the place of a formal CPR course. It will try to familiarize the day care provider with the recognition and emergency management of breathing difficulty, choking and cardiopulmonary arrest in infants and children.** **Use T8-3 Now** Common causes of breathing emergencies in infants and children • **Choking**-Children's airways -the path which air travels from the nose or mouth, through the windpipe (or trachea), and into the lungs -are smaller than adults. This means that objects are more likely to lodge in the airway, causing choking. A child's tongue also takes up more space in the mouth and throat. This is why it is so important to open a child's airway to lift the tongue away from the back of the throat. • **Serious injuries** such as electric shock, near drowning, poisoning or injuries from a car crash.

T9-3 Choking & Suffocation Hazards • Left in their high chairs unsupervised. • Drawstrings on coats. • Rattles around neck. • Ribbons/strings on pacifiers. • Drapery and appliance cords near infants. • Toys small enough to lodge in child's airway. • Toy boxes with a drop lid. • Space between slats of cribs, play equipment or banisters. • Large pieces of food. • Water, even small amount. • Diaper bags/plastic bags near cribs or within reach of child.	• **Illness and medical conditions** such as asthma or severe allergies. **Choking and suffocation hazards:** • Choking or suffocation hazards in child care occur most frequently in those children under one year of age. The crucial time for concern is the first 3 years of a child's life. During these years the child is less able to move himself/herself from a suffocation hazard (such as an infant on a pillow) and their teeth, mouth and throat muscles are not fully developed to prevent choking hazards. While we typically think of choking as being a mealtime hazard, there are other high risk areas and times. • Let's take a moment to think about some of the hazards that exist in a child care setting that might lead to choking, strangulation or suffocation. Think about your own center. What could be hazardous to a child? **Use T9-3 Now** <u>Children have also been suffocated, strangled or choked by:</u> • Being left in their high chairs unsupervised. A child can attempt to slide out of the chair and become caught between the tray and chair which can lead to strangulation. • Drawstrings on coats, jackets or sport clothing. • Rattles tied around the neck. • Ribbons or strings on pacifiers. • Drapery and appliance cords near infants. • Toys small enough to lodge in a child's airway. • Toy boxes with a drop lid. • Space between slats of play equipment, banisters, fences • Pieces of food that are large enough to lodge in a child's airway. (pieces of hot dog have caused choking in children) • Water, even a small amount such as a bucket. • Diaper bags or plastic bags near cribs or within reach of children.

T10-3 Obstructed Airway (Choking) (picture)	**Use T10-3 Now** As I (we) mentioned a moment ago, children's airways are smaller than adults. This picture shows what happens when a small item becomes lodged in a child's airway. The obstruction is preventing air from entering the child's lungs.
T11-3 Examples of Choking Hazards (picture)	**Use T11-3 Now** The small items (hot dogs, bubble gum, hard candy, marbles, grapes, small toys, etc.) in the picture present choking hazards to children who are 3 years of age and younger. Take a look at the items in the picture. Can these or similar objects be found in your center?
112-3 Examples of Choking Hazards (picture)	**Use T12-3 Now** This picture presents more choking hazards study the picture. Take a moment to study the picture **Prevention of Choking and Suffocation:** Based on your experiences with your own children or the children in your care, what are some tips that you could recommend to help prevent choking, suffocation or strangulation? Think about the injury triangle and remember the problem behaviors and environments. **Note to Instructor:** Allow participants to respond and list responses on the board/overhead. After participants have responded, use T13a-3 and T13b-3 to present any prevention recommendations that were not mentioned by participants. This will help to reinforce their positive responses and fill-in gaps.
T13a-3 Prevention • **SUPERVISION!** • Supervise children when eating and in high chairs. • Check floor regularly for objects that may cause choking. • Don't prop bottles. • Dispose of any plastic bags in child-proof containers. • Have only age-appropriate toys within children's reach.	The following list presents additional prevention recommendations **Use T13a-3 Now** • Adequate supervision is probably the most effective prevention tip for breathing emergencies. • Always supervise children when they are eating and in high chairs. • Check the floor regularly for small toys or objects. • Don't prop bottles. • Dispose of any plastic bags in child-proof containers. • Allow only age-appropriate toys. If you have children of varying ages in your center, you will need to supervise the young children very closely to ensure that they are not playing with small toys or game pieces, etc. The best prevention is to make

	certain that choking hazards are nowhere to be found by children 3 and under. Products such as choke tubes/small object testers can be purchased for less than $2.00. These items can help you determine if an object is too small for a child 3 years and under to have.
	Note to Instructor: If possible and time permitting, bring a small object tester and demonstrate its use with various objects.
T13b-3 Prevention • Give age-appropriate foods. • Avoid feeding round foods such as hot dogs and hard candy. • Encourage children to eat slowly and to chew and swallow before drinking beverages. • No strings or ribbons around children's necks. • NEVER leave young children alone with water.	**Use T13b-3 Now** • Give children age-appropriate foods and cut foods into small pieces for young children. • Avoid feeding round foods such as hot dogs and hard candy. • Encourage children to eat slowly and to chew and swallow completely before drinking beverages. • Do not allow strings or ribbons to be tied around children's necks. • NEVER leave young children alone with water. This includes buckets, toilets, bathtubs, swimming pools, fountains, etc.
H4-3 Preventing Breathing Emergencies	Much of the information on preventing breathing emergencies which we just discussed is summarized for you in **handout H4-3.**
T14-3: Signs of breathing emergencies • Wheezing. • Coughing w/small toy or food • Can't speak/ cough/breathe • Flaring nostrils • Clutching throat or wild gestures • Blueness around the face • Excessive drooling • Agitation • Loss of consciousness (late sign) • Sitting up, leaning forward • Head bobbing with each breath	**Signs of breathing emergencies in infants and children** **A child needs help if you observe these signs:** **Use T14-3 Now** • Making a "wheezing" (high pitched) sound. • Coughing while eating or playing with small toy. • Inability to speak, cough, or breathe • Flaring nostrils • Clutching throat, or gesturing wildly • Blueness around the face • Excessive drooling • Agitation • Unexplained loss of consciousness (late sign) • Sitting up, leaning forward • Head bobbing with each breath **First aid for an infant or child who is experiencing breathing difficulty or choking:** When a child is having a breathing emergency, you will first need to determine how serious the condition is. The severity of the situation will tell you what type of first aid you need to give.

T15-3 First-aid when child is getting SOME air: • Shout for help and send someone to call EMS. • Stay calm and calm child. • Allow child to choose position of comfort. • Stay and watch child closely for worsening of symptoms.	**When Child is Getting SOME Air** **Use T15-3 Now** When a child is having difficulty breathing for whatever reason, BUT is getting SOME air, first aid will differ from the situation when a child is not able to get any air. If a child is crying, coughing or speaking, the child is able to get SOME air. The most important things to do in this situation are to: • Shout for help and send someone to call EMS. If no one is available, call EMS yourself. • Stay calm. Try to calm the child. Tell child that you will get help. • Allow the child to choose the position in which he/she is most comfortable. He/she will do this naturally. • Stay or have another adult stay with the child until help arrives. Watch the child closely for worsening of symptoms. • If you know the cause of the breathing difficulty, for example the child is having a severe allergic reaction or the child has asthma, then follow the first-aid recommendations for those conditions. **When Child is NOT Getting Any Air** When a child is unable to breathe at all or stops breathing on his/her own, rescue breathing is the first-aid which should be given. To do rescue breathing, you will breathe air from your own lungs into the child's lungs. This air contains more than enough oxygen to keep the child alive. In essence, you will be breathing for the child. I will now provide you with instructions and a demonstration of rescue breathing. Then, I will ask you to practice these skills with a partner. You will not actually be breathing into your partner; you will just practice the motions. I will show you as I explain the steps.
T16-3 Rescue Breathing (Child) Open Airway. Look, listen & feel for Breath. If child is not breathing: • Send someone to call EMS. • If child is not breathing, pinch nose shut, give 2 slow breaths. • If air does not go in, re-tilt head. Give 2 more breaths. • Check pulse. If pulse, but no breathing, begin rescue breathing, 1 every 3 seconds.	**Note to Instructor:** Ask for a volunteer and demonstrate rescue breathing and first aid for choking with the volunteer (motions only). Explain what you are doing using the following notes as you demonstrate. Show and explain techniques for children. Then show the important differences in technique for infants and adults Perform the Emergency Action Principles. **Use T16-3 Now** • Always survey the scene and perform a primary survey (Check level of consciousness and the ABC's.) • Tap child on the shoulder and ask, "Are you okay?" to determine unresponsiveness.

• Check breathing & pulse every minute. • Continue as long as child is not breathing or until help arrives. • If no pulse, give CPR. **H5-3 CPR for Children Over 1 Year**	• Shout for help and send someone to call EMS. • Position the child on his/her back (be careful if you suspect neck or back injury). We will cover this later. • Open airway with the head-tilt chin lift or jaw thrust. Check breathing. (look listen and feel for breath). **Rescue Breathing** **Refer participants to H5-3** • If child is not breathing, you will give 2 slow, small breaths (1 to 1-1/2 seconds/breath). • Look for the child's chest to rise and fall. Listen and feel for air coming out of the child's nose and mouth. • If air doesn't go into lungs, gently re-tilt head farther back. Give 2 more breaths. If air still doesn't go in, then you will follow procedures for choking. We will talk about this in a moment. • If air does go in, then you will check the child's pulse by placing 2 or 3 fingers at the side of the neck for 5 to 10 seconds. If there is a pulse, but no breathing, begin rescue breathing. Give 1 breath every 3 seconds. You want to be giving breaths at a rate of about 20 per minute. • After one minute, check breathing again by looking, listening and feeling. Call EMS unless someone has already done so. • Check the pulse for about 3-5 seconds. If no breathing, but there is a pulse, continue rescue breathing at about 1 breath every 3 seconds. Check pulse and breathing every minute (about every 20 breaths). • If breathing starts, keep the airway open. Keep checking breathing and pulse closely. Keep the child warm and as quiet as possible until EMS arrives.

H6-3 CPR for Infants Under 1 Year

T17-3 Differences with Infants

- Open airway using only one finger to lift the chin.
- Check pulse by placing 2 or 3 fingers on the inside of the infant's upper arm, between the elbow and the shoulder.
- Seal your lips tightly around the mouth AND NOSE to make sure that you form a seal.
- Blow less to make the chest rise and fall. Blow slowly and watch for the chest to rise.

T18-3 Differences with Adults

- Give 1 breath every 5 seconds (about 12 per minute).
- May need to blow more air to make chest rise and fall. Blow slowly and watch for the chest to rise.

H7-3 Choking

Rescue Breathing - continued

Infant **Use T17-3 and refer participants to H6-3 Now**

The main differences in providing rescue breathing to an infant are:

- Open the infant's airway by using only one finger to lift the chin. Lift bony part of the chin. Do not push on the soft parts under chin.
- Check the pulse by placing 2 or 3 fingers on the inside of the infant's upper arm, between the elbow and the shoulder.
- Seal your lips tightly around the infant's mouth AND NOSE to make sure that you form a seal and air will not escape.
- You will need to blow less air into the infant to make the chest rise and fall. This is because an infant's lungs are smaller and the infant does not require as much air. Blow slowly and watch for the chest to rise.

Adult **Use T18-3 Now**

For adults, use the same procedure as you would use for children. The only differences are that:

- You give one breath every 5 seconds (about 12 per minute).
- You may need to blow more air into an adult to make the chest rise and fall. Again, blow slowly and watch for the chest to rise.

Participants Practice Rescue Breathing Skills with a Partner (time permitting)

You will now have the opportunity to practice rescue breathing with a partner. You will not breathe into your partner. You will just practice the motions as I did when I demonstrated. I will be here to answer questions.

Note to Instructor: Try to observe all the pairs if possible. Offer feedback to improve skills and reinforce correct technique.

Choking

A choking person will usually be conscious at first. If the airway is blocked for too long, the person will become unconscious as the brain is deprived of needed oxygen. Because of this, we will talk about choking first-aid for both conscious and unconscious victims. We will also cover infant and child procedures as they differ slightly.

Handout H7-3 reviews the steps for you.

- If someone is conscious and showing warning signs of choking as we discussed earlier: unable to speak, cough or cry, grabbing throat, face turning blue, or drooling; you will perform the following steps. We will talk about what to do for a child or an adult, as the steps are the same. Then we will discuss what to do for an infant.

T19-3 Conscious Child or Adult

- Ask, "Are you choking?" If child can't make any sound, continue.
- Stand behind child & place your fist against stomach above navel. Grasp fist with other hand.
- Give 5 quick upward thrusts.
- Continue until object is coughed up or until child becomes unconscious.
- If unconscious, follow the recommendations for an unconscious child.

T20-3 Unconscious Child or Adult

- Open the airway.
- Check breathing. If child is not breathing, give 2 slow breaths.
- If air will not go in, re-tilt head & try to give 2 breaths again.
- If air still won't go in, give 5 abdominal thrusts.
- If object is seen in mouth, sweep it out with finger.
- Re-tilt head and give 2 breaths.
- If air goes in, give rescue breathing. Recheck breathing and pulse every minute.
- Continue to do abdominal thrusts and check child's mouth until air goes in.

Choking -continued

- Remember, do NOT do anything except call for help and stay with the child if the child is getting SOME air (can talk, cough effectively, cry) OR if the obstruction is due to infection or a medical condition such as croup, asthma, an allergic reaction, etc. You may make the situation worse. With serious conditions, it is very important to gather information about the situation by surveying the scene and doing a primary survey before actually giving first-aid.

Conscious Child or Adult **Use T19-3 Now**

- Ask the child: "Are you choking?" If the child is unable to make any sound, then continue.
- Perform the Heimlich maneuver: Stand behind the child and place the thumb-side of your fist against the middle of the stomach just above the navel. Grasp the fist with other hand.
- Give up to 5 quick upward thrusts.
- Continue until object is coughed up or child loses consciousness.
- If child becomes unconscious, follow the recommendations for an unconscious child. We will discuss these in a moment.

Unconscious Child or Adult **Use T20-3 Now**

If you discover an unconscious victim, you may not immediately know why the person is unconscious. There could be many reasons. It will not be obvious that the person is choking unless you saw him/her actually start to choke and become unconscious. In order to find out if an unconscious person is choking, you will need to perform the Emergency Action Principles. You will:

- Open the airway.
- Check for breathing. If the child is not breathing, you will give two slow breaths until chest rises.
- If air will not go in (chest will not rise), re-tilt the head back again to open the airway and try to give two breaths again.
- If air still won't go in, place the heel of 1 hand on the child's stomach above the middle of the navel and below the rib cage. Place the second hand on top of the first.
- Give up to 5 abdominal thrusts in an inward and upward motion. Lift the jaw and tongue. If a foreign object is seen, sweep it out with your finger. Do NOT perform a blind sweep of the mouth.
- Re-tilt the head and try to give two more breaths.
- If air goes in, give rescue breathing for a minute. Re-check

T21-3 Conscious and Unconscious Infant

- Position infant face down on your arm, supporting the head.
- Give 5 back blows with heel of your hand between the infant's shoulder blades.
- Put infant face up on forearm.
- Using 2-3 fingers, give 5 chest thrusts on center of breastbone.
- Lift jaw and tongue. Sweep out object with finger if you see it.
- Tilt head. Try to give 2 breaths.
- Continue until object is coughed up, breaths go in, infant breathes on own.

breathing and pulse about once a minute.

- Continue to breathe for the child as long as child is not breathing & pulse is present or until help arrives.
- Continue to perform abdominal thrusts and to check the child's mouth until you are able to make air go into the child's lungs. You will know that the obstruction has been cleared when the chest rises and falls with your breath.

Conscious & Unconscious Infant **Use T21-3 Now**

- Position infant face down on your arm, supporting the head.
- Give up to 5 back blows with the heel of your hand between the infant's shoulder blades.
- Position infant face up on your forearm.
- Using 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone. (Make sure that fingers are NOT over the very bottom of the breastbone).
- Lift jaw and tongue. If you see foreign object, sweep if out with your finger.
- Tilt head back. Try to give 2 breaths.
- Continue these steps until object is coughed up, breaths go in, infant starts to breathe on his own or help arrives.
- The steps for an unconscious infant are about the same as for a conscious infant. The main difference is that with an unconscious infant, you will perform the Emergency Action Principles before attempting to clear the airway.

Participants Demonstrate Choking First Aid Skills with a Partner (Time Permitting)

You will now practice choking first-aid in the same manner that you practiced rescue breathing. With your chest thrusts, practice the motions only. Do **NOT** use force or you could cause injury to your partner. I will be here to observe and answer questions.

T22-3 Sudden Infant Death Syndrome (SIDS) Background

- Sudden and unexplained death of infant under one year. Death usually occurs during sleep.
- Strikes about 5,000 babies each year in U.S.
- NOT the same as infant choking or suffocating on an object.
- Baby may seem healthy.

T23-3 SIDS Risk Reduction and Response

- Place infants on their backs in cribs. Do not place on stomach for sleep, unless baby's doctor says to.
- Use firm mattresses in cribs. Do NOT place soft or fluffy material under infant or near head.
- Keep baby room comfortably warm, but NOT HOT.
- Don't smoke around children.
- If infant stops breathing, perform rescue breathing and call EMS.

H8-3 Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS)

Note to Instructor: Time permitting, continue with discussion of SIDS. If time is short, refer participants to **H8-3** to read on their own.

Background **Use T22-3 Now**

- SIDS is the sudden and unexplained death of an infant under one year of age. Death occurs quickly, usually during sleep time.
- SIDS strikes about 5,000 babies each year in the U.S.
- Usually the baby stops breathing for an unexplained reason. It is NOT the same thing as an infant choking or suffocating on an object. With SIDS, the cause of the breathing failure is unknown and the baby often seems healthy.

SIDS Risk Reduction **Use T23-3 Now**

- The American Academy of Pediatrics (MP) recommends placing infants on their backs in cribs. Babies 1 year and under should NOT be placed on their stomachs when placed in their cribs to sleep, UNLESS the baby's doctor has recommended this due to the baby's unique condition such as gastro-esophageal (acid) reflux or certain upper airway problems.
- Use firm mattresses in cribs. Don't use fluffy blankets, foam pads, comforters, pillows, sheepskin or other soft surfaces under the baby. **NEVER** place a baby on a waterbed to sleep.
- Babies should be kept warm, but not TOO warm. Keep the temperature in the babies' room so that it feels comfortable to you.
- Never smoke around children of any age, especially children under 1 year of age.

First-Aid

- If you discover an infant who has stopped breathing, follow the recommended steps for rescue breathing which we just covered and as with any life-threatening situation, send someone to call EMS

This information on SIDS is summarized in **handout H8-3**.

	Use of Rescue Breathing Barriers There are many inexpensive products available which serve as breathing barriers when one is providing rescue breathing. These barriers allow your breath to enter the victim's body but air will not pass the other way. These barriers help to prevent infections that may occur from direct mouth-to-mouth contact. If you have a barrier, keep it in your first-aid kit with other supplies. Use the same rescue breathing techniques that you would if you did not have a barrier. **Note to Instructor:** Demonstrate use of breathing barrier if available and time permits.

SECTION 4. OVERVIEW
RESPONDING TO SPECIFIC INJURIES

Objectives for General Emergency Response Section:
Participants will be able to:

- Describe how to use and practice using the emergency guideline handouts.
- Describe general prevention tips for passenger safety, falls, dental injuries, poisoning, burns and heat/cold emergencies.
- Use the emergency guidelines to describe important first-aid considerations for head, neck & back injuries, muscle & bone injuries, bites & stings, eye injuries, dental injuries, poisoning and burns.
- List the conditions under which it is absolutely necessary to move an injured child and describe how to safely move an injured child.

Topics

A. Overview of Emergency Guidelines
B. Passenger Safety
C. Falls
D. Head, Neck & Back Injuries
E. Muscle & Bone Injuries
F. Bites & Stings
G. Eye Injuries
H. Dental Injuries
I. Poisoning & Over-medication
J. Burns, including electric shock
K. Heat & Cold Emergencies

Handouts Available:

H1a-4 = American Academy of Pediatrics Child Restraint Recommendations
H1b-4 = Rules for Transportation
H2-4 = To Move or Not to Move an Injured Child
H3-4 = Neck & Back Injuries
H4-4 = Head Injuries
H5-4 = Muscle and Bone Injuries
H6-4 = Eye Problems
H7 -4 = Bites
H8-4 = Tick Removal
H9-4 = Stings
H10-4 = Shedding Baby Teeth & Preventing Oral Injuries
H11-4 = Dental First-aid Chart
H12a-4 = Poison Prevention
H12b-4 = Toxic Plants
H12c-4 = Arts & Crafts Materials
H12d-4 = Medication Administration
H13-4 = Poisoning & Overdose

H14-4 = Preventing Burns
H15-4 = Burns
H16-4 = Heat Emergencies
H17 -4 = Hypothermia
H18-4 = Frostbite
H19-4 = Preventing Heat & Cold Emergencies
H2O-4 = Blisters
H21-4 = Bruises
H22-4 = Cuts/Scrapes
H23-4 = Diarrhea
H24-4 = Ears
H25-4 = Electric Shock
H26-4 = Fainting
H27-4 = Fever
H28-4 = Headache
H29-4 = Rashes
H3O-4 = Puncture Wounds
H31-4 = Splinters
H32-4 = Stomach Aches
H33-4 = Tetanus
H34-4 = Vomit
H35-4 = Unconsciousness

Transparencies/Slides Available:

T1-4 = Review of Emergency Procedures
T2-4 = Child Safety Seats
T3-4 = Preventing Injuries from Falls
T4-4 = Causes of Serious Head and Neck Injuries
T5-4 = Signs of Head and Neck Injuries
T6-4 = Immobilizing the Head and Neck
T7-4 = When to move ...
T8-4 = Repositioning an Injured Child
T9-4 = Neck Injury
T10-4 = Common Causes of Muscle/Bone Injuries
T11-4 = Prevention
T12-4 = Signs/Symptoms of Muscle/Bone Injuries
T13-4 = Crushed Leg
T14-4 = Eye Injury
T15-4 = Snake Bite
T16-4 = Sting
T17-4 = Prevention of Dental Injuries
T18-4 = Mouth/jaw Injury
T19-4 = Poisons may be ...
T20-4 = Common Poisons
T21-4 = Poison Prevention
T22-4 = Poison Prevention

(Continued)
T23-4 = Medication Administration
T24-4 = Signs/Symptoms of poisoning
T25-4 = Poisoning
T26-4 = Preventing Scald/Heat Burns
T27 -4 = Food Heating Precautions
T28-4 = Stop, Drop, Roll and Cool
T29-4 = Preventing Sun Burn
T30-4 = Severity of Burns
T31-4 = Scald Burn Example
T32-4 = Prevention of Heat Emergencies

SECTION 4. RESONDING TO SPECIFIC INJURIES (1 HOUR)

Topics & Training Strategies	Trainer Notes
A. Overview of Emergency Guidelines- how they can be used. (5 minutes)	**Introduction to the Emergency Guideline handouts** At this point in the program, we will be exploring some specific injury situations, prevention tips and first-aid recommendations. As there is a great deal of information contained in this section, we do not expect you to remember every detail. Included in your handout packet is a group of handouts which can be used as emergency guidelines. These guidelines contain recommended first-aid procedures and can be used as a quick reference when injuries present themselves. It will be helpful if you are familiar with how to use them before an emergency situation occurs. You have already seen 3 of these guidelines in the shock and bleeding section. **Note to Instructor:** You may wish to remind the participants midway through this section that they do not have to memorize all of this information. They can always refer to the emergency guidelines.
T1-4 Review of Emergency Procedures • Stay calm. • Wear gloves when exposed to blood. • Do NOT move child unless absolutely necessary. • Perform Emergency Action Principles. • Give rescue breaths if needed. • Control bleeding if needed.	**Review Emergency Procedures** **Use T1-4 Now** There are a few important emergency procedures for any injury that I want to review before we talk about specifics. They are as follows: • Try to stay calm. • Wear gloves when exposed to blood and other body fluids. • Do NOT move the child unless it is absolutely necessary. • Perform the Emergency Action Principles. Can anyone tell me what the four steps of the EAP's are? 1. Survey the Scene 2. Primary Survey (ABC's) 3. Access EMS 4. Secondary Survey (Head-to-toe exam) • Give rescue breaths if needed. • Control severe bleeding if needed. With serious injuries, the above assessment should be completed before giving first-aid for specific conditions. Remember to always assess and tend to the most serious injuries first.

	Instructions for Section 4 1. For this section, I will first present the injury or condition that we will be discussing. 2. Then we will discuss prevention. 3. Next I will briefly give you some background information such as signs and symptoms. 4. Then I will read a story which will contain the injury that we have been talking about. 5. I will ask you to determine what to do for the child in the story. You should use your emergency guidelines at that time. Later in the program, you will have the opportunity to practice using the guidelines on your own. **Note to Instructor**: After you read each injury/illness example, ask the participants to refer to their emergency guidelines to help them decide what they would do for the child in each situation. As the participants give their responses, make certain to correct any inappropriate answers. Provide any steps that have been left out of the participants' responses. Refer to the trainer notes that follow each example for guidance. **As time permits, use as many of the examples as possible.** Does anyone have any questions now?
B. Passenger Safety **T2-4 Child Safety Seats** - **pictures** **H1a-4 Georgia's Child Restraint Law** **H1b-4 Rules for Transportation**	**Prevention Use T2-4 Now** Anytime you transport children in a car, even for very short distances, they must be secured in an age/size appropriate safety seat which follows Georgia's Child Restraint Law. Information is included in **handout H1a-4** about the appropriate seats for children and **handout H1b-4** offers some additional safety rules for transporting children. There are many resources available to assist you. Securing children properly in an appropriate child safety seat is very important. Please seek additional information on this issue. Your local SAFE KIDS Coalition is a great resource for information on child safety seats. A list of local coalitions is included **handout H12-1**. Car crashes can lead to a number of different injuries. Always remember to follow the EAPs if you have children who have been injured in a car crash.

C. Falls & Collisions with Objects (3 minutes) **T3-4 Preventing Injuries from Falls & Collisions** • Use soft surfaces for play areas. • Equipment, materials and furniture shall be sturdy, safe, easy to clean and maintain, and free of sharp points, rough edges or rusty parts. • Use age-appropriate play equipment . • Don't allow running inside. • Supervise closely around swings. • Do not allow children to go down slides head first. • Follow OEMS rules.	**Prevention** **Use T3-4 Now** Recommendations for preventing injuries due to falls include: • Use soft surfaces for play area (place wood chips, mulch or sand underneath equipment). • Equipment, materials and furniture shall be sturdy and safe, easy to clean and maintain, and free of sharp points or corners, splinters, protruding nails, loose or rusty parts, or paint which contains lead or other poisonous materials. • Use age-appropriate play equipment. • Do not allow running inside. • Supervise children closely around swings. Do not allow children to twist swings, swing the empty seats or walk in front of moving swings. Teach children not to walk within an imaginary boundary while someone is swinging. • Do not allow children to go down slides head first. • Follow OEMS rules regarding safety for children. Falls can also lead to many different types of injuries including head, neck and back, muscle, bone, cuts/wounds, and dental injuries. When performing your head-to-toe exam, you will determine if there are injuries, where they are and how serious they may be. We will now look at some specific types of injuries and present first-aid recommendations. Please follow along with your emergency guideline handouts.
D. Head, Neck & Back Injuries (10 minutes)	**Description/Background** • **Head injuries** range from minor bumps and bruises to severe injuries causing brain damage. • **Neck injuries** range from mild strains to broken bones and possible nerve damage/paralysis. • Young children & infants are prone to head injuries because their heads are larger in proportion to their body than adults. Head injuries may occur frequently in day care centers but are generally of a less serious nature. Most will occur due to short falls and collisions with equipment and other children. Occasionally, a more serious head injury will occur.

T4-4: Causes of Serious Head & Neck Injury If any of the following occur, do NOT move child: • Falling from a height or down stairs. • Being forcefully struck in the head, neck or spine. • Being in a car crash. • Being hit by a car. • Being thrown from a bike. • Violent shaking from abuse.	**Common Causes of Serious Head & Neck Injury** **Use T4-4 Now** If any of the following occur, do NOT move the child: • Falling from a height such as falling off play equipment. • Falling down stairs. • Being forcefully struck in the head, neck or spine. • Being in a car crash. • Being hit by a car. • Being thrown from a bike. • Violent shaking, such as from child abuse.
T5-4: Signs of Head & Neck Injuries: • Unconsciousness • Seizure in a child without a history of seizures • Confusion • Sleepiness • Severe bleeding from the head • Blood or watery fluid in the ears • Unequal pupils • Child can't feel arms or legs or has a numb/tingling feeling in arms or legs • Neck pain • Vomiting • Headache	**Signs of Head & Neck Injuries Use T5-4 Now** Sometimes head and neck injuries may not be obvious immediately. Signs and symptoms may develop over 24-48 hours and may mimic other illnesses. Check hurt or unusually behaving children carefully. The child may have had an unwitnessed injury. The following could be signs of head/neck injury and indications that EMS should be called: • Unconsciousness • Seizure in a child without a history of seizures • Confusion • Sleepiness • Severe bleeding from the head • Blood or watery fluid in the ears • Unequal pupils • Child can't feel or has a numb/tingling feeling in arms/legs • Neck pain • Vomiting • Headache What is the first rule that we talked about with regard to head, neck and back injuries? (Do NOT move the child.)

Immobilizing the Head

Note to Instructor: Demonstrate how to immobilize the head with a volunteer or mannequin if available. Display T6-4 while you are demonstrating and explaining.

T6-4 Immobilizing the Head

1. With child lying on back, hold the head still.
2. Kneel at head and brace your forearms on the surface that child is lying upon.
3. With hands on each side, gently hold head still.
4. Don't move head or neck while holding it. Support neck until help arrives.

Use T6-4 Now

With suspected head, neck and back injuries, you also want to immobilize the neck so the child cannot move it and cause further injury.

1. With the child lying on his/her back, hold the head still.
2. Kneel at the head and brace your forearms on the same surface that the child is lying upon.
3. With one hand on each side, gently hold the head still.
4. Make certain not to move the head or neck while holding it. Support the neck until help arrives.
5. OR, place rolled up towels/clothing on both sides of head.

17-4: When to move

- If there is gas, fire or smoke
- If there is traffic that might further injure the child
- Any other immediate danger
- The child must be moved in order to provide needed rescue breathing or CPR

When to move a victim **Use T7-4 Now**

- If there is gas, fire or smoke
- If there is traffic that might further injure the child
- Child is in water (e.g. diving accident)
- Any other immediate danger
- Child must be moved to give rescue breathing or CPR

Moving a seriously injured child quickly:

If you absolutely must move a seriously injured child quickly to prevent further harm, move the child as "one piece" so that there is no twisting of the head, shoulders, neck or back. Support the child's head and neck and pull the child in the direction of head without bending the neck or back.
Do NOT drag the child sideways.
If possible, have another adult help to move the child as a unit.

How to re-position a child safely

If a seriously injured child is unconscious and lying crumpled or face down, you may need to reposition the body so that you can provide needed rescue breathing or CPR. You will want the child to be lying flat on his or her back. To do this, roll the child as "one piece" so that the head, shoulders and body (torso) move at the same time with NO twisting. Twisting the head or neck may cause further injury.

	Note to Instructor: Demonstrate how to reposition a child safely with a volunteer or mannequin if available. Stress that they do this only if absolutely necessary. Display **T8-4** while you demonstrate and explain.
T8-4: Repositioning 1. Kneel beside child at a distance equal to width of child's body and at child's shoulders. 2. Raise child's arm closest to you over child's head. Legs should be straight or slightly bent. 3. Place one hand behind child's head and neck for support. 4. Place other hand under child's arm to brace shoulder and torso. 5. Roll child toward you by pulling steadily and evenly at shoulder while controlling head and neck. Body should be moved as a unit. 6. Once on his/her back, position arms alongside body.	**Use T8-4 Now** 1. Kneel beside the child at a distance about equal to the width of the child's body and at the level of the child's shoulders. This allows space to roll the child while you support the neck. 2. Raise the child's arm closest to yourself over the child's head. The child's legs should be straight or slightly bent. 3. Place one hand behind the child's head and neck for support. 4. Place other hand under child's arm to brace the shoulder & torso. 5. Roll the child toward you by pulling steadily and evenly at the shoulder while controlling the head and neck. The head and neck should remain in line with the torso, and the body should be moved as a unit. 6. Once on his/her back, position child's arms alongside the body.
H2-4: To Move or Not to Move an Injured Child	All of the previous information about moving/repositioning an injured child can be found in **handout H2-4.**
T9-4: Neck injury example Darla falls from the top of the playground equipment. She lands hard on the ground and hits her head. When you approach her, she is lying crumpled on the ground and she tells you that her "head hurts a lot".	**Emergency Guideline Example -Neck Injury Use T9-4 Now** Darla falls from the top of the playground equipment. She lands hard on the ground and hits her head. When you approach her, she is lying crumpled on the ground and she tells you that her "head hurts a lot".

H3-4 Neck & Back Injuries **H4-4 Head Injuries**	**Emergency Response based on the Emergency Guideline handouts:** What would you do in this situation? Please look at your Emergency Guideline **handout H3-4 and H4-4** for help. **Note to Instructor:** Allow the participants to respond. If they leave out essential information or provide inaccurate information, see the notes below and highlight the appropriate information. **Please follow these instructions for the remainder of Part 3.** Use as many of the examples as time permits. • Do not move Darla. There are no immediate hazards around and she is able to talk so she is conscious and breathing. • Look for any bleeding. Wear gloves and provide direct pressure if bleeding. • Keep Darla warm and quiet. • Support her neck by placing rolled-up towels or your hands gently on both sides of her head. • Send someone to call EMS and notify her parents/guardians. • Watch for loss of consciousness or stopped breathing. • Look for other injuries and provide first-aid until help arrives. • Document the incident on the Incident Report Form.
E. Muscle & Bone Injuries **T10-4: Common Causes**: • Falls • Car crashes • An object, such as a car or bicycle striking a child • Overuse • Abuse/rough handling of children **T11-4 Prevention**	**Background** Children may have minor falls and bumps throughout the day. The majority will result in minor bruises and strains. However, children will tend to break their bones before they pull or sprain a muscle or ligament. It is important to be able to recognize serious injuries such as broken bones (fractures). **Common Causes: Use T10-4 Now** • Falls • Car crashes • An object, such as a car or bicycle striking a child • Overuse • Abuse/rough handling of children. Always remember to keep in mind the possibility of abuse with these types of injuries. **Prevention** **Use T11-4 Now**

• Don't pick children up by the arms. Pick-up a child gently by supporting the child underneath the armpits. • Maintain good supervision • Preventing falls and car crashes will help to prevent these types of injuries.	• Sometimes, we don't realize how much bigger and stronger we are than children. We can injure children by picking them up in certain ways. One cause of injury to children is picking them up by their arms. Children should NOT be picked up by their arms as this can result in dislocation of the elbow. Children need to be handled very carefully. Pick-up a child gently by supporting the child underneath the armpits. • As always, good supervision is an important prevention strategy. • As falls and car crashes are common causes, preventing those types of situations will also help.
T12-4: Signs/Symptoms: • severe pain • swelling • feeling heat in the injured area • discolorations • deformities - bone bent wrong way or sticking through skin. • child cradling or not using part	**Signs/Symptoms** **Use T12-4 Now** Signs of an injury in need of medical care are: • severe pain • swelling • feeling heat in the injured area • discolorations • deformities - bone is bent the wrong way or bone is sticking through the skin. • a child who is cradling or not using a part of the body such as her arm or wrist.
T13-4: Crushed Leg Amanda, a 9 year old in the after school program, suffers a crushed leg as she walks between two cars in the day care center parking, when a parent unintentionally backs up his car and hits the other car's bumper. When you arrive at the scene, Amanda is lying on the ground. Her leg is deformed and something is sticking out of an open wound on her leg. **H5-4: Muscle and Bone Injuries**	**Emergency Guideline Example -Crushed leg** **Use T13-4 Now** Amanda, a 9 year old in the after school program, suffers a crushed leg as she walks between two cars in the day care center parking, when a parent unintentionally backs up his car and hits the other car's bumper. When you arrive at the scene, Amanda is lying on the ground. Her leg is deformed and something is sticking out of an open wound on her leg. **Emergency Response Refer participants to H5-4 Now** • Wear gloves. Perform the Emergency Action Principles - be sure to assess for any other injuries that may not be immediately obvious. • Send someone to call EMS and notify her parents/guardians. • Cover Amanda's open fracture with a dry sterile dressing. • Stay with her and help quiet her until help arrives. • Do NOT move injured part. Immobilize by supporting gently. • Document the incident on the Incident Report Form.

F. Eye Injuries

Background:
Always call EMS if the injury looks severe, if there is a change in vision, if an object has penetrated the eye or if the eye has been burned by a chemical. It is always best to call EMS if there is any doubt as to how serious an eye injury is.

T14-4 Eye Injury

Mark and Adrian (both 4-years old) are playing eye doctor. Adrian finds a pen and decides to examine Mark's eye with it. He punctures Mark's eye with the pen. Mark begins screaming and clutches his eye protectively.

Emergency Guideline Example - Eye Injury
Use T14-4 Now

Mark and Adrian (both 4-years old) are playing eye doctor. Adrian finds a pen and decides to examine Mark's eye with it. He punctures Mark's eye with the pen. Mark begins screaming and clutches his eye protectively.

Emergency Response **Refer participants to H6-4 Now**

- Have Mark sit upright.
- Cover Mark's eye with a paper cup or similar object so that Mark will not touch his eye. Be careful not to apply any pressure to the eye or bump the pen.
- Send someone to call EMS and notify his parents/guardians.
- Stay with Mark and try to calm him.
- Document the incident on the Incident Report Form.

H6-4 Eye Injury

Chemical in Eye

> **Note to Instructor:** Quickly demonstrate how to correctly flush an eye by placing the affected eye below the unaffected eye and rinsing from the nose outward to the side of the face. Refer -participants to **H6-4** for additional first-aid steps.

G. Bites & Stings	**Background:** • Bites and stings can be minor or life-threatening depending on the severity of the wound, allergies, etc. • Stings from bees, wasps hornets, etc. and spider bites can be serious if a child has a severe allergy. These can be life-threatening situations. We will discuss these in the next section.
H7-4: Bites **H8-4: Tick Removal**	• Human and animal bites can be found in **handout H7-4**. **First-Aid Recommendations for other bites/stings** • Ticks - Always thoroughly inspect child after time in woods. Ticks may carry serious diseases and must be completely removed. Notify parent if tick is found. Procedures for removing a tick can be found in H8-4.
T15-4 Snake Bites Treat as a possible poisoning.	**Use T15-4 Now** • Snake bites - treat as a possible poisoning. We will cover this later.
T16-4 Stings During outdoor playtime, Dell is stung by a bee. He does not appear to be having any difficulty breathing and you do not notice a large amount of redness or swelling. **H9-4: Stings**	**Emergency Guideline Example - Bee Sting** **Use T16-4 Now** During outdoor playtime, Dell is stung by a bee. He does not appear to be having any difficulty breathing and you do not notice a large amount of redness or swelling. **First-Aid Recommendations for Stings** **Refer participants to H9-4** • Scrape area with a card. • Do NOT squeeze. • Apply cold compress. • Observe Dell during normal activities for about 2 hours. Watch for any allergic reaction (covered in next section) • Document the incident on the Incident Report Form.

H. Dental Injuries & Problems

H10-4: Shedding Baby Teeth & Preventing Oral Injuries

T17-4: Preventing Dental Injuries:

Do **NOT** allow children to:

- stand on swings or walk under a moving swing
- go down slides head first
- jump off moving merry-go-rounds
- run alongside of or push playmates into a pool
- hit, push or throw things at other children when they are drinking from a container or fountain.
- play on or near stairs
- trip or push their playmates.

T18-4 Mouth/Jaw Injury

Dana, a seven-year old, walks behind another child who is swinging on a swing. The seat of the swing hits her in the mouth. She begins crying immediately. You look in her mouth and see that one of her front teeth has been knocked out and several others seem loose. You are able to locate the tooth on the ground. Dana has already lost her front baby teeth so you know this tooth is one of her permanent teeth.

Background

Many different types of injuries and problems can occur in the teeth and mouth. Teeth can be knocked-out, chipped, or displaced. The lip, tongue, jaw and cheeks can be injured as well. Children can also have bleeding gums and toothaches. Young children will shed their baby teeth. This is normal although it may cause the child to become upset. We will not cover all of these conditions but first-aid recommendations can be found in your handouts **H10-4** - **H11-4.** Feel free to ask questions about any specific problem.

Prevention of Dental Injuries Use T17-4 Now

General injury prevention steps will help to prevent dental injuries.

Do **NOT** allow children to:

- stand on swings or walk under a moving swing.
- go down slides head first.
- jump off moving merry-go-rounds.
- run alongside of or push playmates into a pool.
- hit, push or throw things at other children when they are drinking from a container or fountain.
- play on or near stairs.
- trip or push their playmates.
- walk around with a toy or object in their mouth.

Emergency Guideline Example Use T18-4 Now

Dana, a seven-year old, walks behind another child who is swinging on a swing. The seat of the swing hits her in the mouth. She begins crying immediately. You look in her mouth and see that one of her front teeth has been knocked out and several others seem loose. You are able to locate the tooth on the ground. Dana has already lost her front baby teeth so you know this tooth is one of her permanent teeth.

H11-4 Dental first-aid chart	**Emergency Response Refer participants to H11-4 Now** • Try to calm Dana down. Send a staff person to call her parents or guardians and arrange to take her to the dentist immediately. • Observe her for any signs of head injury (see **H4-5**). • Wear gloves. Apply pressure with clean gauze to control any bleeding. • Gently rinse the tooth in Hank's Balanced Salt Solution (HBSS), saline or water. Don't scrub. • If Dana is calm enough that you think she will NOT choke, place the tooth back in the socket and have her hold it in place. OR, place the tooth in HBSS/milk. • Document the incident on the Incident Report Form.
I. Poisoning & Over-Medication **T19-4: Poisons may be:** • Swallowed • Inhaled • Absorbed through the skin or eyes • Injected **T20-4: Common Poisons** • Medicines • Insect bites and stings • Snake bites • Plants/wild berries • Chemicals/cleaners • Drugs/alcohol • Spoiled or contaminated food **T21-4: Poison Prevention** **Poison proof your center. Ask:** • Is it a "pretty poison"? Products that, through the eyes of a child, look like something good to eat/drink. • Things that glitter, pretty colored pills, bottles and containers of all kinds can	**Background** Poisons are substances which may cause injury or death when introduced into the body. It is impossible to list all possible poisons because the list would be too long. Almost any substance can be poisonous if used improperly. Poisons may be: **Use T19-4 Now** • Swallowed • Inhaled • Absorbed through the skin or eyes • Injected **Common Poisons** **Use T20-4 Now** • Medicines • Insect bites and stings • Snake bites • Plants/wild berries • Chemicals/cleaners • Drugs/alcohol • Spoiled or contaminated food **Prevention Use T21-4 & H12a-4 Now** Poison proof your center. With any product that is brought into your center, ask the following questions: 1. Is it a “pretty poison"? - Products that, through the eyes of a child, look like something good to eat or drink. Children are curious -things that glitter, pretty colored pills, bottles and containers of all kinds can attract a child. For example: • Palmolive dish detergent is the same green color as a Sprite soda bottle.

attract a child. Medicine is a frequent cause of poisoning	• Blue mouthwash, antifreeze, glass cleaner look like blue punch. • Raid Spray insecticide works like a spray can of cooking oil. • White plastic containers of ammonia or bleach look like milk containers. • Never store paint thinner, turpentine, gasoline or other chemicals in cups or soft-drink bottles.
T22-4: Poison Prevention • Does it contain alcohol or gasoline (mouthwash)? • Is it an insecticide or pesticide? • Is it a cleaning agent? **If the answer to any of the above is yes, store it out of sight and locked up.** • Keep Syrup of Ipecac in 1st- aid kit. • Keep Poison control number available. **H12a-4 Poison Prevention** **H12b-4 Toxic Plants** **H12c-4 Arts & Crafts Materials**	**Poison Prevention – Continued Use T22-4 Now** 1. Does it contain alcohol or gasoline (mouthwash)? Even small amounts can be harmful to a child. 2. Is it an insecticide or pesticide? 3. Is it a cleaning agent? For example cleaners, such as toilet, drain, and oven cleaners 4. Is it a medication of any kind? Medicines can look like candy. Don't call medicine "candy". This can be confusing to children. When left alone, they may find the bottle and eat/drink its contents. <u>If the answer to any of the above questions is yes, store it out of sight and locked up.</u> • Make certain that any plants in your center are non-poisonous. **Handout H12b-4** lists Toxic and Non-toxic plants. Keep in mind that this is not a complete list and the best precaution is to keep ALL plants out of the reach of children. • Make certain that all toys, furniture, art supplies and equipment are made of non-toxic materials as young children may taste or chew anything. Please see handout **H12c-4** for guidelines on selecting safe arts & crafts materials. • Keep Poison control number with other emergency phone numbers readily available. **Special Considerations for Medication** Medications taken or given improperly can be poisonous. In fact, they are a common cause of childhood poisonings. There are important considerations to keep in mind when giving medications. We do not have time to review all issues involved in administering medications, as this could be a separate course all by itself.

T23-4: Medication Administration

- Take a medication administration course.
- If you ever are in doubt, contact the parent and/or physician before giving it.
- If you witness an unexpected reaction after giving medication, call the physician and/or the Poison Control Center for additional information.
- If child takes wrong medication, call Poison Control.

Use T23-4 Now

- **If you are in a position to administer medication to children on a regular basis, I strongly encourage you to take a course specializing in this issue.** Check with your regional Resource and Referral Center for ongoing training.
- There are a few recommendations that I want to leave you with concerning medication administration:

  1. If you ever are in doubt about giving a medication, contact the child's parent and/or physician before giving it.

  2. If you witness an unexpected reaction after giving medication, call the child's doctor and/or the Poison Control Center for additional information.

  3. If a child takes or is unintentionally given the wrong medication, call Poison Control for more information.

H12d-4 Medication Administration

Handout H12d-4 contains more information on this subject.

Signs and Symptoms of Poisoning

It can be difficult to recognize unless you directly witness the poisoning. Many poisons cause symptoms that are similar to diseases or other injuries. Symptoms can also vary depending on the amount of poison ingested, the length of time it has been in the system and the size or weight of the child. This type of situation highlights the importance of surveying the scene with any emergency. The scene may provide you with clues about what happened. Other children or staff may be able to provide answers. Clues may be lying on the ground. An important step is to gather as much information as you can find about the poison.

T24-4: Signs/Symptoms of Poisoning:

- Pills, berries or unknown substance in child's mouth
- Burns around mouth or on skin.
- Strange odor on breath.
- Pain
- Difficulty breathing
- Sweating
- Upset stomach or vomiting
- Dizziness, fainting or unconsciousness
- Confusion
- Seizures

<u>Some signs and symptoms of poisoning follow</u> **Use T24-4 Now**

- Pills, berries, leaves or unknown substance in child's mouth
- Burns around mouth or on skin.
- Strange odor on breath.
- Pain
- Difficulty breathing
- Sweating
- Upset stomach or vomiting
- Dizziness, fainting or unconsciousness
- Confusion
- Seizures

T25-4: Poisoning You discover Kevin, a curious 2- year old, putting pills in his mouth from the purse of one of the staff. **H13-4 Poisoning & Overdose**	**Emergency Guideline Example** **Use T25-4 Now** You discover Kevin, a curious 2-year old, putting pills in his mouth from the purse of one of the staff. **Emergency Response** **Refer participants to H13-4 Now** • Find the staff person to whom the purse belongs to find out more information such as: what type of pills, what strength, and how many were in the bottle before. • Save the remainder of the bottle and its container. It may need to accompany Kevin to the hospital. • Take Kevin and the bottle to the phone with you. • Call Poison Control Center and follow their instructions. Be prepared to give Kevin's age, weight, and all relevant information about the poison. • Do NOT give anything by mouth unless instructed by Poison Control. • Keep the airway open and check breathing and pulse. Observe any changes in Kevin's level of consciousness or breathing. • Call EMS if necessary and notify Kevin's parents/guardians. • Document the incident on the Incident Report Form.
J. Burns, including electric shock	**Background** Burns can be caused by contact with heat, electricity, chemicals or extreme cold. Always keep your own and the other children's safety in mind in case of a fire or electric shock. In the event of fire, evacuate the children from your facility or the area, call the fire department and get help. Only attempt to put out the fire yourself if it is small and easy to contain. ALWAYS remove the children first. <u>Suspect child abuse if:</u> • a child comes to your center with a burn which seems suspicious 1. "stocking" or "glove" scald burns without splash marks 2. burns on genitals or buttocks 3. burn appears to have been made by a manufactured object such as a cigarette or iron • explanation for how the burn occurred does not match the injury • child tells you that someone burned him/her.

T26-4 Scald and heat burn prevention • Keep matches/lighters out of children's reach. • Set water heater temperature to 120 degrees Fahrenheit or less. • Practice fire drills regularly. • Do not allow children to be in cooking areas or: • Turn all pot handles in and away from edge. • Turn off cooking appliances after use. • Keep coffee maker and its electrical cord out of reach. • SUPERVISE! SUPERVISE!	***Prevention*** Prevention Heat Burns & Scalds ***Use T26-4 Now*** • Keep matches and lighters out of children's reach. • Set water heater temperature to 120 degrees Fahrenheit or less. • Practice fire drills regularly • Keep children out of cooking areas or: a) Keep children away from cooking and heating appliances. Turn all pot handles in toward stove and away from edge where they could be grabbed by a child. b) Turn off cooking appliances after use. c) Keep coffee maker and its electrical cord out of reach.
T27-4 Food Heating precautions • Never heat baby bottles or other liquids in a microwave. • Regardless of how you heated the bottle, shake to distribute the warmed liquid. • Test temperature of formula on your arm before feeding. • Stir semi-solids well and test temperature before feeding. • Open heated containers carefully to avoid steam burns	Heating Precautions **Use T27-4 Now** 1) Never heat baby bottles or other liquids in a microwave. Due to their uneven heating, single food item may have both cold and very hot spots. Explosion of formula bottles has been known to occur even after having been removed for a period of time. The liquid may be hot enough to cause severe burns of the infant's mouth and throat, even though the external surface of the container may be comfortable to the touch. 2) Regardless of how the bottle is heated, shake to distribute the warmed liquid. 3) Carefully test temperature of formula on the inside of your lower arm before feeding it to an infant. This part of your arm is more sensitive than your hand. 4) Stir semi-solids or other foods well and test its temperature before feeding it to infant or child. 5) Open heated containers carefully to avoid steam burns. Know and follow the administrative regulations on fire safety and the Licensure Rules to which reference has been made in this unit.

T28-4 Stop, Drop & Roll Teach children 3 and older to do the following if they catch on fire: 1. **Stop.** Stop where you are - do NOT run. 2. **Drop.** Drop to ground or to floor and cover your face with your hands. 3. **Roll.** Roll to put out flames 4. **Cool.** Cool burns right away with water only. 5. **Call EMS.**	<u>Stop, Drop & Roll</u> **Use T28-4 Now** Children age 3 and older can save their own lives by dropping and rolling when their clothes catch fire. Teach them to: 1. **Stop.** Stop where you are -do NOT run. 2. **Drop.** Drop to the ground or to the floor and cover your face with your hands. 3. **Roll.** Roll to put out flames 4. **Cool.** Cool the burn right away with water only. 5. **Call EMS.**
T29-4: Preventing Sun Burn • Avoid hottest sun (11 :00 - 2:00). Plan outdoor time for early morning or late afternoon; if not, make sure there is adequate shade. • Use sunscreen (SPF 15 or higher) with parent's permission. Be mindful of allergies- • Encourage parents to bring hats and other protective clothing for children when in sun. • Be a role model. Use sunscreen and protection yourself.	<u>Preventing Sun Burn</u> **Use T29-4 Now** • Avoid children's exposure during the hottest sun (11:00 - 2:00). Try to plan outdoor play times for early in the morning or late in the afternoon; if not, make sure there is adequate shade. • Block the sun with sunscreen with parent's permission. Use a sunscreen and lip balm with a sun protection factor (SPF) of 15 or higher. Apply sunscreen according to directions 30 minutes before going into sun. Choose a flavored lip balm that children will want to wear. Try to avoid heavily scented sunscreens that may bother some children. Be mindful of any specific allergies. • Encourage parents to have children wear hats and other protective clothing when in sun. • Be a role model. Use sunscreen and protection yourself. Show parents and staff how and when to apply sunscreen.
H14-4 Preventing Burns	<u>Preventing Electrical Burns</u> • Cover electrical outlets with protective covers. • Keep electrical cords out of the reach of children. Children have been severely burned and electrocuted after chewing through electrical cords. Burn prevention information can be found in **handout H14-4.**

T30-4: Severity of Burns • Redness, No blisters, small area Give first-aid • Blisters, broken skin, large area -needs medical attention. • White or Charred Skin, Burns to the face & neck, electric or chemical -Call EMS	**Severity of Burns** **Use T30-4 Now** Burns are another type of injury that can be relatively minor, serious or life threatening. Anytime a burn is worse than a reddened area without blisters or covers a large part of the body, get medical attention immediately. The slide/transparency offers some general guides as to a recommended course of action: • Redness, No blisters, small area -Give first-aid • Blisters, broken skin, large area -Needs medical attention. • White or Charred Skin, burns to the face & neck, electric or chemical -Call EMS
T31-4 Scald Burn Example Cara, 2 years old, knocks a cup of hot coffee off a table. Her arm is scalded by the hot liquid. Her lower arm looks red and slightly swollen. **H15-4 Burns**	**Emergency Guidelines Example** **Use T31-4 Now** Cara, 2 years old, has made her way into the kitchen area of her center. She knocks a caregiver's thermos filled with hot soup off the table. Her hand is scalded by the hot liquid. Her hand looks red and slightly swollen. **Emergency Response** **Refer participants to H15-4** • Flush the burn with cool running water. Don't use ice. • Bandage loosely. • Contact the parent/guardian. • Document the incident on an Incident Report Form.
L. Heat & Cold Emergencies **H16-4 Heat Emergencies**	**Background** Heat and cold emergencies are caused by exposure to extreme weather conditions. These conditions are very easy to prevent but they can be life or limb threatening if untreated. Caring for these conditions is covered in your emergency guidelines **H16-4 -H18-4.** <u>Heat Emergencies</u> Heat emergencies occur from a loss of fluid without adequate water replacement. Usually this is caused by spending too much time or performing strenuous activity in the heat. A child of any age may suffer from a heat emergency, but children ages 2-5 are most at risk because they have endless amounts of energy and are not able to distinguish between different levels of fatigue.

H17-4 Hypothermia	Hypothermia Hypothermia, also known as exposure to cold, results when the body reaches a state where it is no longer capable of warming itself. Young children are particularly susceptible to hypothermia due to their large surface area to body size proportions. It can be a life-threatening condition if left untreated for too long.
H18-4 Frostbite	Frostbite Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention.
H19-4 Prevention of Heat & Cold Emergencies **T32-4 Prevention** 1. Be aware of the weather. Do not allow children outside without appropriate clothing. 2. Plan outdoor activities that limit exposure in extreme weather 3. Never leave children unsupervised in vehicles. 4. Make sure children drink plenty of fluids. 5. Take EARLY action. Don't wait until symptoms worsen to remove child.	**Prevention** **Use T32-4 & H19-4 Now** 1. Be aware of weather conditions & do not allow children outside without appropriate clothing. 2. Plan outdoor activities limiting exposure in extreme temperatures. 3. NEVER leave children alone in vehicles -even with windows cracked or when the temperature doesn't seem that hot. Temperatures can rise very quickly inside vehicles. Many children have died from heat exhaustion in locked cars. 4. Make sure children are offered & have access to fluids. **5.** Take EARLY action. Be aware of the early warning signs. It is much easier to prevent a serious complication than to wait until the child's life is in danger to intervene.
H20-4 Blisters **H21-4 Bruises** **H22-4 Cuts/Scrapes** **H23-4 Diarrhea** **H24-4 Ears** **H25-4 Electric Shock** **H26-4 Fainting** **H27-4 Fever** **H28-4 Headache** **H29-4 Rashes** **H30-4 Puncture Wounds** **H31-4 Splinters** **H32-4 Stomach Aches** **H33-4 Tetanus** **H34-4 Vomit** **H35-4 Unconsciousness**	**Additional Emergency Guidelines:** In your handouts, we have included additional emergency guidelines (**H20-4 – H35-4**), which are intended for use in an emergency situation. They cover topics such as bites, cuts/scrapes, electric shock, rashes, puncture wounds, splinters, ear and nose problems, etc. We do not have time to cover these topics in this program. I encourage you to review the guidelines on your own as they will be more effective if you are familiar with them before an emergency occurs. You may find it to be helpful to go through your handout pack and copy all of the emergency guideline handouts, alphabetize them, and keep them near the first-aid kit, emergency telephone numbers, etc. In that way, they will be ready and easy to use in an emergency situation.

SECTION 5. OVERVIEW
CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Objectives:

Participants will be able to:

- Describe psychological concerns of children with special health care needs. Identify elements in an individual emergency care plan.
- Describe the importance of planning for children with special health care needs.
- Describe prevention tips for life-threatening allergies, asthma, diabetes and seizures.
- Describe and demonstrate first-aid skills for life-threatening allergies, asthma, diabetes and seizures.
- Identify additional resources for seeking information about children with special health care needs.

Topics:

A. Introduction to Children with Special Health Care Needs (10 minutes)
B. Allergies/Breathing Difficulties (5 minutes)
C. Asthma (5 minutes)
D. Diabetes (5 minutes)
E. Seizures (5 minutes)

Handouts Available:

H1a-5 = Children with Special Needs
H1 b-5 = Emergency Care Plans for Children with Special Needs
H2-5 = Allergies Information
H3-5 = Allergic Reaction
H4-5 = Asthma Information
H5-5 = Asthma/Wheezing, Breathing Difficulty
H6-5 = Diabetes Information
H7-5 = Diabetes
H8-5 = Seizures Information
H9-5 = Seizures

Transparencies/Slides Available:

T1-5 = Psychological Concerns of Children with Special Health Care Needs
T2-5 = Emergency Care Plans for Children with Special Needs
T3-5 = Assessing Condition of CSHCN
T4-5 = Allergic Agents
T5-5 = Signs/Symptoms of Allergies
T6-5 = Prevention of Asthma
T7-5 = Signs/Symptoms of Asthma
T8-5 = Diabetic Emergencies
T9-5 = Signs/Symptoms of Diabetic Emergencies
T10-5 = Causes of Seizures
T11-5 = Signs/Symptoms of Seizures

SECTION 5. CHILDREN WITH SPECIAL HEALTH CARE NEEDS (30 MINUTES)

Topics & Training Strategies	Trainer Notes
A. Topic: Introduction to CSHCN (10 minutes)	**Introduction** This next section focuses on a special group of children -those living with a chronic or life-long health condition. Between 10-15% of American children have a chronic health condition such as diabetes, asthma, a heart condition, etc. These children's conditions may make them more vulnerable to serious illness and injury.
T1-5: Psychological Concerns • With parent's permission, allow child to participate in group activities unrestricted. • Offer support without being overly protective. • Don't be afraid. **BE AWARE!** • Use the child and parent to learn about condition	**Psychological Concerns** **Use T1-5 Now** • Children with Special Health Care Needs (CSHCN) usually do not want to be singled out. In most cases, CSHCN can and should participate unrestricted in group activities unless the parent and/or physician has indicated otherwise. It is important for the adults in the child's life to give support without being overly protective. • Do not be afraid of these children or overly concerned about accepting them into your center. Simply be aware of their unique needs and be prepared. CSHCN often know a great deal about their own conditions. Use the child and the parent to learn about the condition. Handout H1a-5 provides additional background information about CSHCN.
H1a-5: Children with Special Needs	**Day Care Center Issues** The center should have a policy regarding children with special health care needs. This policy should include: 1. asking parents/guardians about any special conditions that a child has at the time of enrollment. 2. setting clear guidelines about the center's role (e.g. special prevention guidelines or medication administration, etc.) and the parent/guardian's role in managing the child's condition.
	Other Concerns of CSHCN • Be aware that CSHCN may be at increased risk for certain injuries due to their medical condition. Your handouts offer some special prevention tips based on these unique conditions. We will look at these further as we talk about specific conditions.

H1b-5 CSHCN Emergency Care Plan

T2-5 CSHCN Emergency Care Plans

- Allergies
- Medications, side-effects
- Baseline findings
- Summary of the child's medical condition
- Child's "normal" emergency symptoms
- Emergency procedures for this child's unique needs
- Parent/guardian and emergency contact info.
- Insurance information
- Physician phone numbers
- Special equipment or supplies the child may require

T3-5: Assessing Condition of CSHCN

- Need to know child's "NORMAL" behavior and physical condition in order to recognize an emergency.
- Signs/Symptoms can be individual.

- Keep in mind that young children may have special needs that have not yet emerged or been diagnosed. Becoming familiar with the "normal" behavior and health status of all children in your care is an important step in recognizing health issues that may develop. Watch for any unexpected changes. Report these changes to the parent/guardian as soon as possible. Since children may spend the majority of their day at the center, you may be the first person to observe changes and recognize a problem.

Individual Emergency Care Plan

- As symptoms and effective treatments can be as individual as the children who are living with these special conditions, it is necessary to have the parent/guardian, along with the child's physician, design an emergency care plan.
- It will be important to keep a copy of the plan readily available to appropriate staff at all times the child is under the center's care. You may find it easiest to keep a copy of the plan in each room in which the child will be. A copy of the plan should also be taken along on field trips and other outings.
- The plan should be shared with local EMS providers so they are aware of this child's unique needs before an emergency arises.

Handout **H1 b-5** lists the essential items to be included in the emergency care plan.

<u>The plan should contain</u> **Use T2-5 Now**

- Allergies
- Medications, related side-effects and specific medications the child should not have
- Baseline findings (age, pulse, respiratory rates, blood pressure)
- Brief summary of the child's medical condition
- Child's "normal" emergency symptoms history. What are the usual symptoms that this child experiences?
- Emergency intervention strategies (emergency procedures that best address this child's unique needs)
- Parent/guardian and emergency contact information (full names, phone numbers, addresses, etc.,)
- Insurance information
- Name and phone number of primary care physician & specialists
- Special equipment or supplies the child may require

B. Topic: Allergic Reactions (5 minutes)

T4-5 Allergic Agents

A severe allergic reaction is most likely to occur in response to:

- Medication (e.g. Penicillin)
- Foods (e.g. shellfish, nuts, peanut butter, chocolate, milk)
- Insect Stings (e.g. wasp, bee, ants)
- Environmental Allergens (e.g. Latex)

H2-5 Allergies Information

T5-5 Signs of Allergic Reaction.

Sudden onset of:

- Pale skin
- Hives all over body
- Confusion
- Weakness
- Coughing and wheezing
- Difficulty breathing
- Loss of consciousness
- Blueness or swelling around the mouth & eyes

Assessing Condition **Use T3-5 Now**

- In assessing the condition of a child with special health care needs, one of the most important things to know is the child's "NORMAL" behavior and physical condition.
- As stated before, signs and symptoms for CSHCN can be individual. Knowing how a child normally feels and acts will provide the background information that you need to know if the child is in any sort of danger.

As time is a limiting factor in this program, we will not be able to cover all the special health care needs of children. We will focus briefly on the most common and provide some guidance on how to manage an emergency situation. Again, the emergency guidelines contain information about each of these conditions.

Georgia's STARKids program is designed to prepare individual emergency plans for all children with special needs. Contact your regional coordinator for more information.

Background

- Children may be allergic to many things in their environment.
- Most often allergic reactions are mild and can be controlled by removing what the child is allergic to from the child's diet or environment. Sometimes, however, a reaction can be severe and require immediate medical attention. These reactions can be fatal if not reversed within a few minutes after the reaction begins.

Use T 4-5 Now

- A Severe allergic reaction is most likely to occur in response to
  1. Medication (e.g. Penicillin)
  2. Foods (e.g. shellfish, nuts, peanut butter, chocolate, milk)
  3. Insect Stings (e.g. wasp, bee, ants)
  4. Environmental Allergens (e.g. Latex)
- Often the emergency care plan will include keeping an epinephrine kit for injection along with other first-aid supplies. This is not a supply that is available with first-aid kits but it is a prescription drug written specifically for an individual child.
- It is important to check with the parent on a routine basis (every 6 months or so) to find out if the order has changed as children grow rapidly and the prescription for a toddler may not be effective when the child is 4 years old.
- It is also important to check for the expiration date of the drug on a routine basis.

H3-5 Allergic Reaction **C. Topic: Asthma (5 minutes)** **H4-5 Asthma Information** **T6-5 Prevention of Asthma Attacks** • Be aware of child's triggers and help child to avoid them. • Maintain a smoke-free environment. • Keep an emergency plan on file and educate staff about child's condition & first-aid steps • Keep parent-approved medication available.	**Handout H2-5** contains other important information, such as prevention recommendations about children with severe and life- threatening allergic reactions. **Signs and Symptoms** **Use T5-5 Now** Please turn to **handout H3-5** now. A severe allergic reaction is characterized by a SUDDEN ONSET of symptoms. Call EMS if child experiences: • Pale skin • Hives allover body • Confusion • Weakness • Coughing and wheezing • Difficulty breathing • Loss of consciousness • Blueness/Swelling around the mouth (lips, tongue, throat) & eyes This guideline contains the essential first-aid recommendations for a child who is experiencing a life-threatening allergic reaction. Do you have any questions about the recommendations? **Background:** • Close to 5 million children in the U.S. have asthma. Children account for about 1 out of every 3 people who have asthma. (Source: Asthma Information Center- JAMA) According to the Centers for Disease Control and Prevention, asthma is the most common chronic illness in childhood. Most children are under age 5 when they have their first attack. • Asthma is a chronic lung disease in which airflow in and out of the lungs may be blocked. Children with asthma may respond to certain factors in the environment, called triggers, which do not affect non-asthmatics. In response to a trigger, the airway of a child with asthma may become narrowed and inflamed, resulting in wheezing and coughing symptoms. • For some people, asthma causes only mild symptoms once in a while. For others, every day can be a struggle to breathe. **Handout H4-5** provides some background information and prevention tips for asthma.

H5-5 Asthma/Wheezing...

T7-5 Asthma Signs & Symptoms

- Wheezing.
- Rapid breathing or shortness of breath.
- Flaring of nostrils.
- Increased use of stomach or chest muscles.
- Tightness in chest.
- Excessive coughing.

Prevention Tips for Asthma Attacks **Use T6-5 Now**

- A child with asthma may have allergic and non-allergic triggers. If you are aware of a child's triggers, you will be able to help the child avoid them.
  1. **Allergic triggers:** Some allergic triggers include molds, animal dander, dust mite particles, cockroach particles, food additives, and certain medications. Keeping your center as clean as possible and regularly vacuuming dust and dirt can help prevent asthma attacks.
  2. **Non-allergic triggers:** Some non-allergic triggers include exercise, cold air or sudden changes in temperature, respiratory infections such as colds, flus or sinus infections, materials in the air that you breathe such as tobacco smoke, wood smoke, room deodorizers, fresh paint, household cleaning products, and perfumes.

Other prevention tips include:

- Maintain a smoke-free environment.
- Have an emergency care plan on file and educate all staff about the proper steps to take in the event of an attack.
- Keep any guardian-approved medications readily available at all times including on field trips and outings. When children are old enough, encourage them to carry their guardian-approved medication and use it when they experience initial signs/symptoms of an attack.
- Keep in mind that some children may have asthma that has not yet been diagnosed.

Signs/Symptoms **Use T7-5 Now**

Please turn to **handout H5-5 now**. A child with asthma/wheezing may have breathing difficulties which include:

- Wheezing -high-pitched sound during breathing out.
- Rapid breathing or shortness of breath. Flaring (widening) of nostrils.
- Increased use of stomach or chest muscles during breathing.
- Tightness in chest.
- Excessive coughing.

Keep in mind that if a child without a history of asthma experiences the above symptoms, it could be asthma. This could be the first attack. Seek medical attention and contact parents/legal guardian any time a child experiences breathing difficulties.

	Do you have any questions about the first-aid recommendations for caring for a child who is experiencing signs/symptoms of an asthma attack?
D. Topic: Diabetes (5 minutes) **T8-5 Diabetic Emergencies can be triggered by:** • Too little food • A delayed meal • Strenuous exercise without extra food • Too much sugar **H6-5 Diabetes Information** **H7-5 Diabetes** **T9-5: Signs & Symptoms** • Sudden changes in hunger • Irritability and feeling upset • Inability to concentrate • Sweating • Feeling "shaky" or trembling • Dizziness/No coordination • Paleness • Cramping • Confusion • Seizures & unconsciousness (late stage symptoms)	**Background Information** Diabetes can be a life-long condition resulting from an inability of the body to balance the amount of sugar that is maintained in the blood. When this balance is not maintained, that is when there is too much or too little blood sugar, children can suffer an emergency condition. **Use T8-5 Now** **Factors that can lead to an emergency in known diabetes include:** • too little food • a delayed meal • strenuous exercise without extra food • too much sugar **Prevention Tips** **Handout H6-5** contains some tips for preventing diabetic emergencies and related injuries for which a child with diabetes could be at increased risk. Please turn to **Handout H7-5** as we discuss signs and symptoms of diabetic emergencies. **Signs & Symptoms** **Use T9-5 Now** • Sudden changes in hunger • Irritability and feeling upset • Inability to concentrate • Sweating • Feeling "shaky" or trembling • Lack of coordination or dizziness • Paleness • Cramping • Confusion • Untreated symptoms may progress to seizures and unconsciousness **First-aid Recommendations** • As the recommended course of action for children with diabetes can depend on a number of factors, you will want to have an emergency care plan on file for the child.

	• Your emergency guidelines offer some general advice for a child who is experiencing symptoms of a diabetic reaction. • Does anyone have any questions about the recommendations?
E. Topic: Seizures (5 minutes) **H8-5 Seizures Information** **T10-5 Causes of Seizures** **1. Illness & Injury such as:** • High Fever-typically ages 6 months – 5 years with a fever of 103 F or higher. • Head Injury • Poisoning • Diabetes • Dehydration • Heat Exhaustion **2. Epilepsy** - a chronic condition characterized by recurring seizures.	**Background and Common Causes of Seizures:** Seizures are not a disease. They are a symptom of some other condition or disturbance. Seizures can have a number of causes which generally fit into two categories: **Use T10-5 and refer participants to H8-5 Now** **1. <u>Illness & Injury such as:</u>** • High Fever- tends to occur in children aged 6 months -5 years with a fever of 103 F or higher but some have seizures with lower fevers. This is probably the most common type of seizure that you will witness in a child care center. • Head Injury • Poisoning • Diabetes or low blood sugar • Dehydration • Heat Exhaustion **2. <u>Epilepsy</u> -** a chronic condition in which the brain becomes overloaded with electrical charges and produces a set of uncontrollable movements. Epilepsy is characterized by recurring seizures and often a loss of consciousness. When a seizure occurs due to illness or injury, it may be a one-time occurrence. In this case, a child will not have a known history of seizures and may never have another seizure. Any time a child without a known history of seizures has a seizure, call EMS. If you know the cause of the seizure, refer to the first-aid recommendations for that condition for more guidance. When seizures occur in children with epilepsy, they are usually recurring. These children fit into our category of children with special health care needs. An emergency care plan should be developed for these children.

H9-5 Seizures **T11-5 Signs/Symptoms** **Seizures may be any of the following:** • Staring with loss of eye contact. • Staring with twitching of arms and legs. • General jerking movements of the arms and legs. • Unusual behavior such as physical movements, hostility, strange noises. • It is not unusual for a child to be sleepy after a seizure.	**Prevention Tips** For children with a history of seizures, an emergency care plan should be developed and all staff should be educated about the proper first-aid to give in the event of a seizure. Please turn to **Handout H9-5 Now** as we look at the signs and symptoms of seizures. **Signs & Symptoms** **Use T11-5 Now** **Seizures may be any of the following:** • Staring with loss of eye contact. • Staring involving twitching of the arm and leg muscles. • General, uncontrollable jerking movements of the arms and legs. • Unusual behavior for that person such as physical movements, hostility, making strange noises, etc. • It is not unusual for a child to be sleepy after a seizure. While it can be frightening for you to see a child having a seizure, most are not harmful to the child. **First-Aid Recommendations** Does anyone have questions about the first-aid recommendations for a child who is experiencing seizures?

SECTION 6. OVERVIEW
APPLYING INJURY PREVENTION & FIRST-AID

Objectives for General Emergency Response Section:

Participants will be able to:
- Practice applying the injury triangle to injury situations in small groups.
- Practice using their emergency guidelines and applying them to scenarios.
- Practice assessing a child and performing first-aid skills.

Topics:
A. Applying the Injury Triangle (15 minutes)
B. First-aid Role-plays (40 minutes)
C. Wrap-up (5 minutes)

Handouts Available
H1-6 = Injury Prevention Situations
All handouts from Sections 1-6 of Program

Transparencies/Slides Available:
T1-6 = Questions for "Applying the Injury Triangle"
T2-6 through T10-6 = Pictures of smiling children

Activities Available
A 1-6 = First-aid Role Plays

SECTION 6.
APPLYING INJURY PREVENTION & FIRST-AID (1 HOUR)

Topics & Training Strategies	Trainer Notes
	Introduction We are nearing the end of the program and hopefully you feel that you have more knowledge about responding to children's injuries and illness than you did when we started. Now you will have the opportunity to practice using your new knowledge and skills.
A. Applying the Injury Triangle (15 minutes)	**Introduction** I am going to ask you to participate in an activity that will allow you to practice applying the injury triangle to injury-causing situations. **Applying the Injury Triangle.** First I am going to break the large group into 4 smaller groups (or pairs depending on the number of participants}. **Note to Instructor:** Designate areas of the room for each group. Allow time for them to move into the smaller groups.
H1-6 Injury Prevention Situations 1. What was the major injury-causing agent in this case? 2. Are there environmental changes that could be made? 3. Are there behavioral changes that could be made? 4. What will probably make the biggest difference to child safety in this case?	Please turn to **handout H1-6.** I will assign 2 (or 1 depending on time) injury situations to your group. Read the situation and then discuss the following questions. **Use T1-6 now** 1. What was the major injury-causing agent in this case? 2. Are there environmental changes that could be made? 3. Are there behavioral changes that could be made? 3. What may make the biggest difference to safety in this case? • Find someone willing to write down responses. Use the injury triangle that was discussed in part 1 of the program. You can find the triangle on **handout H3-1.** Try to limit the amount of time that you spend on each situation to about 2-3 minutes. • When your group has discussed both situations, we will come together to hear each group's responses. Does anyone have questions at this time? **Note to Instructor:** Allow 6-8 minutes for each group to work. Then call them back to the large group. Ask the groups to read one of their scenarios and list their recommendations. Start with volunteers and move on as time permits. Allow each group to respond first. Time permitting, ask if there are any other recommendations. You may wish to add your own if they have not been mentioned. A few suggestions follow in the trainer notes. Allow 8-10 minutes for large group discussion.

Injury Scenarios:

1. Brad, a 3 month-old infant was found suffocated in his crib. A diaper bag was found over his face.

   Suggestions if participants do not respond with ideas.
   - **Behavior-** Check children frequently.
   - **Environment** -Clear crib area of any objects that are within the baby's reach.

2. Debbie, a 5 year old was sent home with severe (covering arms, legs and back & forming blisters) sun burns after spending a summer day outside.

   Suggestions if participants do not respond with ideas.
   - **Behavior-** Teach day care staff to apply sunscreen to children and re-apply it throughout the day.
   - **Environment** -Keep children out of the extreme sun part of the day 11:00- 2:00.

3. Terrance, an 8-year old child in a day summer camp was marked in his file a non-swimmer. Terrance was found floating face down in the swimming pool. EMS tried to save him but it was too late.

   Suggestions if participants do not respond with ideas.
   - **Behavior**- Staff need to check files before field trips, monitor non-swimmers carefully.
   - **Environment** -Swim only in pools with lifeguards, well monitored, etc.

4. Alan (5 years old) and Todd (6 years old) are playing with toy trucks when an argument erupts over a particularly desirable truck. Todd throws one of the trucks in Alan's direction and it hits Alan in the eye. Alan's eye has been cut by the toy and is bleeding.

   Suggestions if participants do not respond with ideas.
   - **Behavior-** Supervision, teach sharing skills, teach that throwing is not allowed.

5. Sam suffered a dislocated elbow when his day care center staff picked him off the ground in a rough manner.

   Suggestions if participants do not respond with ideas.
   - **Behavior-** Teach staff about muscular or bone injuries that children are susceptible to, teach staff proper techniques to lift a child without injury.
   - **Environment-** Screen staff carefully, fire or do not hire staff that handle children roughly or abuse children.

B. First-aid Role-plays (40 minutes)

First-Aid Role-play Instructions

- In our last activity, you will be able to use the first-aid information that you learned throughout the program. For the next 40 minutes, you will respond to injury and illness situations.
- You will be able to apply the emergency action principles, assess the severity of the situation and administer first-aid. I encourage you to refer to your handouts or emergency guidelines for help.
- There are stations set up around the room containing different emergencies. You will either be a victim in need of assistance or a caregiver ready to provide the needed first-aid.
- You will move from station to station and each station will contain the information that you need to play out your role. Read your role (and only your role) carefully first.
- For the first half of the activity, you will be either the victim or the caregiver. For the 2nd half, you will switch roles.

Note to Instructor: Set up the role-play stations before beginning part 6 or during a break period. Allow each participant the opportunity to be in the first-aid care-giving role for **at least** two scenarios. Set up the number of stations according to the number of participants you have. For example, if you have 12 participants, you will need 6 stations set up so that each pair has a station. Leave two scenarios at each station. Allow each group to work through both scenarios before moving on to a different station and switching roles. If time permits, allow the participants to continue with more than 2 scenarios.

- I will time each station and indicate when you will move and when you will switch roles. After each scenario, I will give you about 2-3 minutes to discuss the situation with your partner. Use each other as a source of information.
- This activity will be most effective if the "victims" take their roles seriously.
- At the end of the activity, you will have the opportunity to discuss how you felt about participating as a caregiver and victim and to have any specific questions answered which you did not have answered during the role-play.

A2-6 First-aid Role-plays

Note to Instructor: Make yourself available to be participants during the role-plays to answer any questions. Float from station to station to observe how they are performing. If you see any "mistakes", correct the participant gently. Remind them to refer to their handouts and emergency guidelines for assistance. Make certain that all the participants are clear on the appropriate first-aid for the condition before moving on. **Use A2-6 Now.**

	Processing the Role-play Activity **Note to Instructor:** Allow 10-12 minutes at the end to discuss the groups' reaction to this activity. Use the questions which follow as a guide. Try to reassure the participants if they are feeling anxious or upset about what happened. Remain mindful of time limitations, but allow them to vent their feelings. 1. What are your general reactions to this activity? 2. How did it feel to be in the caregiving role? 3. In your victim role, did your caregiver do or say anything that seemed to make a difference to you or put you at ease? 4. Does anyone have any questions about what is the appropriate first-aid to provide in their situation?
C. Conclusion (5-7 minutes) **T2-6 through T10-6** Smiling children	**Review of Questions from Program Introduction** **Note to Instructor:** Review the list of questions from the introduction section of the program. If there are specific questions that you did not cover within the program, answer them now or provide a resource where they can find the information. I know that you all care about children and want to do the right thing to help them stay safe and happy in your center. I encourage you to continue to learn about safety and first-aid for children. The handouts which you received contain most of the information covered in the program. They are yours to keep and refer to. I also strongly encourage you and all the staff in your center to seek training in CPR for children. Thank you all for your participation in this program. I'd like to leave you with a few of the best reasons why we are all here today. **Use T2-6 – T10-6 Now** **Note to Instructor:** Show the slides of the children, pausing about 5 seconds for each.

Activities:
Section 6

A1-6 = Injury Role-plays

- Prior to the program, copy the following examples and cut between each station and between each caregiver and victim role. Clip the roles together for each station.
- Set up the stations before beginning part 6 or during a break period. The number of stations needed will be determined by the number of participants in the class. For example, if you have 12 participants, you will need 6 stations set up so that each pair has a station.
- Leave two scenarios at each station. Allow each pair to work through both scenarios before rotating stations and switching roles. Allow each participant the opportunity to be in the first-aid care-giving role for at least two scenarios. If time permits allow the participants to continue with more than 2.
- Instruct the participants to read only their role and to not share information before the role-play.
- Refer to the "Trainer Notes" in the curriculum for further instructions.

Station 1

Victim: Tony, a 3 year old, is running on the playground. He trips and lands on a nail that was lying on the ground. He is found crying with the nail still stuck in his hand. It does not appear to be bleeding a great deal.

Caregiver: There are other adults nearby who can help call EMS, find the child's file or retrieve the first-aid kit. Ben, a child in your center with a known history of diabetes, approaches you. You notice that he looks very pale and is acting irritable.

Station 2

Victim: Your name is Mike and you are 6 years old. You just went down the slide head first. You were not able to get your arms free and you land on your face. One of your teeth is knocked out. Your mouth is bleeding and you are in a lot of pain.

Caregiver: Mike lands on his face after coming down the slide head first. When you examine him, you see blood in his mouth and a tooth is missing. You do not know if it is a permanent or primary (baby) tooth. You find the tooth on the ground.

Station 3

Victim: Your name is Tammy (5 years old) and you are being abused at home. You have not told anyone about what is happening to you but the abuse has been going on for a while. Last night, your father was angry about something and burned you with his cigarette on your arm. When the caregiver asks you about the burn, you don't really want to talk about it. You tell her that you burned it on an iron. When questioned more about it, you reluctantly tell her that your father burned you with his cigarette. This makes you upset.

Caregiver: Tammy (5 years old) is dropped off at day care and you notice a small round burn about the size of a cigarette on her arm. You know that Tammy has often come to day care with bumps, bruises and burns. Last year, she even had a fractured wrist. When you question her about the burn, she gives you an unlikely explanation. Suggestions: Gently say, "Tammy, the burn that you have doesn't look like it came from an iron. It looks like a cigarette burn. Did someone burn you with a cigarette?"

Station 4

Victim: Your name is Tim and you have just pinched a chunk of your finger off in the chain of the swing on the playground. It is bleeding a lot.

Caregiver: You see that Tim has been injured on the playground. His thumb is bleeding a lot and upon further examination, you see that a chunk is missing.

Station 5

Victim: Your name is Harry and you have a severe allergy to bees. You have an emergency care plan on file. Today, you are stung by a bee. You begin to cough and cry. Your stomach and arms itch and you scratch them. You start to breathe quick, shallow breaths as you are having difficulty getting air.

Caregiver: You notice Harry is coughing and looks unhappy. As you approach him, you see that he has a rash allover his neck and is scratching his arms and stomach. He is also breathing short, quick breaths and appears to be having difficulty breathing. You remember that Harry has an emergency care plan on file.

Station 6

Victim: Your name is Billy. You have a nosebleed.

Caregiver: You see Billy’s nose is bleeding.

Station 7

Victim: Your name is Nina. You have just been hit by a car. You are unconscious with severe injuries. Lie down and be unresponsive.

Caregiver: Today you have taken the children to the park. One particularly energetic child, Nina, darts into the road and is struck by a car. You rush to help her. The first-aid kit is in the van. There are other adults nearby who can help.

Station 8

Victim: You are on a field trip to the park on a warm summer day. You fell asleep in the back of the van and were left unnoticed. You are now suffering from heat exhaustion as the temperature in the van has risen a great deal. You wake up in the van and feel very tired, thirsty, weak and dizzy. You also have a headache. A staff person finds you in this state.

Caregiver: Your center is taking a field trip to the park on this warm summer day. After about an hour at the park, you discover that Rita, a child from your center, was sleeping in the van unnoticed. When you find her, you see that her skin looks very flushed and she seems a little dizzy. She tells you that she feels very tired and is thirsty.

Station 9

Victim: Your name is Sam. It is lunchtime and you are eating very quickly and taking large bites of food. Suddenly, you can't breathe. You are choking and are not able to make any sound. You grab your throat.

Caregiver: At lunchtime, you see that something is wrong with Sam. He is grabbing his throat. When you approach him, you ask if he is OK. He can't make any sound. You see that his lips are starting to turn blue.

Station 10

Victim: Your name is Sherry. You are 3 years old and you fell off of the jungle gym during morning play. Your right arm has been hurting a lot ever since. You have been cradling your arm and not using it. You are right-handed so it is unusual that you should be using your left hand and arm.

Caregiver: You notice Sherry is holding her right arm in an awkward way. She is cradling it and not using it as she normally would. She is using her left hand to pick things up. This is strange since she is right-handed. You ask her what happened.

Station 11

Victim: Your name is David and you have just been bitten on the arm by Kenny. Kenny and you were arguing over a toy. The bite wound is bleeding.

Caregiver: Kenny and David get into an argument over a toy. Kenny bites David on the arm and breaks the skin. The wound is bleeding slightly.

Station 12

Victim: Your name is Stephanie (2-1/2 years old). You were running through the Center when you tripped on an extension cord and bumped your head on the linoleum tiled cement floor. Your head "hurts" and a bump is forming on your head.

Caregiver: Stephanie, a 2-1/2 year old child was running through the center when she tripped and fell. She bumped her head on the linoleum tiled cement floor. She tells you that her head "hurts". When you examine it, you feel a bump.

Station 13

Victim: Your name is Ryan and you are a very curious little boy. One day, while on a field trip to the park, you find a bush with pretty red berries. They look good to eat so you start eating them. You eat about 12 berries. In a few minutes, your stomach starts to hurt and you do not feel good.

Caregiver: One day on a field trip to the park, you see Ryan sitting on the ground holding his stomach. He looks like he does not feel very well.

Station 14

Victim: Your name is Joe. You are two years old and you have been knocked to the ground by an older child on a bicycle. You are lying on the ground. You feel cold and your side hurts.

Caregiver: Joe, a 2 year old, is knocked to the ground by an older child on a bicycle. He becomes pale, cool and sweaty. You notice that he has a large, dark bruise on his right side.

Station 15

Victim: Your name is Darnel. You are 7 years old and you have a history of asthma. Today, you are having some difficulty breathing. You begin to wheeze while taking shallow, rapid breaths.

Caregiver: Darnel is a 7 year-old child with a history of asthma. Today, he is experiencing some difficulty breathing. He seems to be taking rapid, shallow breaths and is making a wheezing sound. You know that Darnel has an emergency care plan on file and he also has prescribed, guardian-approved medication. His breathing difficulty didn't appear to start quickly and his symptoms are staying about the same.

Station 16

Victim: Your name is Sam. You are six years old and are bitten when you reach out to pet a stray dog pacing near the fence during outdoor playtime. Your hand is gaping open and bleeding quite a bit. You become very upset when you see all the blood.

Caregiver: Six year-old Sam is bitten when he reaches out to pet a stray dog that was pacing near the fence during outdoor playtime. Upon examining the wound, you see that there is an open, gaping wound and blood is flowing from the wound.

Station 17

Victim: Your name is Rita and you have a known history of seizures. Today, you have a seizure causing jerking of your arms and legs. It lasts for about 2 minutes. This is a "normal" seizure for you.

Caregiver: Rita is child with a history of seizures. She is found one day having a seizure that is causing a jerking motion of her arms and legs. The seizure lasts about 2 minutes.