

# Circular 011:07:16



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**To:** Chief Instructors  
Club Captains  
LSOC Executive  
Club Secretaries  
LSO Council  
Trainers & Assessors

**Cc:** All Members

**From:** Dean Hemburrow – Manager Member Training

**Date:** 20 July 2016

**Subject:** **Important Training Changes to note for the 2016/17 Season**

**Action:** Take note of important changes in the first aid and spinal treatments

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For additional details on this Circular please contact:

Volunteer Training on 03 9676 6950 (option 2) or email [volunteertraining@lsv.com.au](mailto:volunteertraining@lsv.com.au)

**Circulars are available at** [www.lsv.com.au/circulars](http://www.lsv.com.au/circulars)

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Following an international review of a number of treatment protocols in first aid and resuscitation, the Australian Resuscitation Council (ARC) released a number of revised guidelines in January 2016. Dr. Natalie Hood, the SLSA National Medical Adviser, made a number of recommendations to the National Lifesaving and Education Committees based on these revised guidelines. Following extensive discussions, it was determined that the changes listed below are implemented for the coming season:

## 1. Spinal Management

- a. International research has proven that rigid spinal collars are ineffective in treating victims with a suspected or an actual neck injury. For lifesavers in a first-aid setting, manual in-line stabilisation is sufficient.
- b. Studies of car accident victims have shown that the individual victim is better at protecting their own injured neck than rescuers. For lifesavers, this means that walk-up spinal victims are in the best position to guard their injury and should be instructed to lie down on their own, keeping their head still. Where a victim requires more than minor assistance in getting to the ground, lifesavers may use the spinal board in lowering them to the ground.
- c. Spinal boards are uncomfortable for victims. Victims should not be left on the spinal board for any length of time. This piece of equipment should really only be used for extrication.
- d. Given the change in technique, SLSA wishes to remind lifesavers that a good handover to ambulance personnel is essential in ensuring that a victim with a suspected spinal injury is given appropriate treatment. Always communicate clearly with ambulance personnel what you have observed and what treatment you have given. Ambulance personnel may elect to put some kind of spinal collar on victims as part of their treatment procedures e.g. a soft collar.
- e. Please note: Further information regarding equipment requirements will be circulated.

## 2. Heart attack

Aspirin has been shown to have a positive effect in preventing arterial blockages in victims with heart disease. The ARC has determined that as aspirin is generally low risk and therefore is acceptable to give a victim presenting with a suspected heart attack a standard dose of aspirin, if it is available. You must first check that the victim is not allergic to aspirin or has any other reasons for not wanting to take aspirin. Due to Work Health and Safety regulations however, aspirin cannot be routinely stocked in first aid kits, so this is not a necessary requirement for our first aid kits on the beach.



### **3. Heat exhaustion**

There is evidence to suggest that victims suffering from heat exhaustion recover more quickly when they are given a drink containing sugar and electrolytes. If you have one available, you may offer a victim suffering heat exhaustion any commercially available *sports drink*. There is no need to stock these in your first aid kit. Water is an acceptable rehydration solution too.

### **4. External bleeding**

There is no evidence to support the belief that raising a bleeding limb has any impact on the treatment of the wound. It is therefore not necessary to raise a bleeding limb.

### **5. Shock**

Raising a victim's legs in cases of shock has been shown to have only a very small and transient effect on their recovery. Given that raising a victim's legs takes time and resources and may involve exposure of the victim, it is no longer recommended to waste time and resources in performing this task. Victims may simply be made comfortable and monitored.

### **6. CPR compression rates**

There has been much research into the most effective number of compressions in CPR. This has been confirmed to be no less than 100, but not more than 120 compressions per minute. Any faster than 120 compressions per minute and the effectiveness of compressions is lost.

## **Training Outcomes**

- The Public Safety and Aquatic Rescue training manual, 34th edition, has also been slightly revised to reflect all of these changes. Version 2 of the manual will be available for purchase from the SLSA shop prior to the 2016/2017 season.
- Training resources available from LSV will be updated and released prior to the season commencement 2016.
- Further information will be provided at both the Club Conference and Regional Workshops.

