

Outdoor Action Medical Protocols**DRAFT STATUS – 2/2/99**

The following protocols are under review with McCosh Health Center. They are not to be used until a final issue is announced.

**CARDIC-RESPIRATORY ARREST:
NORMOTHERMIC PATIENTS****DEFINITIONS**

1. cardiac arrest - the absence of functional cardiac activity.
2. respiratory arrest - the absence of effective spontaneous respiration.
3. Patients with core temperatures over 90°F (including mild hypothermia) are managed the same as normothermic patients regarding cardiorespiratory arrest.

ASSESSMENT

1. Cardiac arrest is determined in the field by the absence of a spontaneous pulse palpated at the carotid artery.
2. Respiratory arrest is determined in the field by the absence of effective spontaneous respiration.
3. Core temperature is determined in the field by the use of a rectal thermometer or by clinical signs and symptoms.

TREATMENT

1. Initiate treatment according to American Red Cross CPR or American Heart Association standards.
2. *Initiation of CPR is not required for* persons who appear dead as a result of obvious lethal injuries such as decapitation, or a severed trunk.

Discontinuation of CPR

American Red Cross CPR Standards allow for the rescuer to discontinue CPR in 4 situations:

1. A party with equal or higher medical training takes control of patient care from the rescuer.
 2. The rescuer is exhausted and unable to continue or continuation of treatment endangers the rescuer's safety.
 3. The scene becomes unsafe.
 4. The patient recovers; i.e. the patient regains a pulse.
3. *Follow evacuation procedures as detailed in the Evacuation Procedures/Protocols section*

**CARDIO-RESPIRATORY ARREST:
SEVERELY HYPOTHERMIC PATIENTS****DEFINITIONS**

1. severe hypothermia - core temperature below 90° F.
2. cardiac arrest - the absence of functional cardiac activity.
3. respiratory arrest - the absence of effective spontaneous respiration.

GENERAL PRINCIPLES

1. Because the severely hypothermic heart is irritable and ventricular fibrillation can be induced by physical stimuli, it is important to accurately determine that functional cardiac activity is absent before beginning chest compression. In severe hypothermia, functional cardiac activity can be present but the pulse might not be palpable under field conditions:

- a) pulse rate can be very slow and pulse pressure is usually reduced in severe hypothermia
- b) environmental conditions can make even a strong pulse difficult to feel

ASSESSMENT

1. In order to avoid the possibility of causing ventricular fibrillation in a cold but functioning heart, take 1-3 minutes to feel for the presence of a carotid pulse. If no other clinical signs of life are present, the absence of a palpable pulse indicates the absence of functional cardiac activity.

2. Even if a pulse is not palpable in the field, functional cardiac activity is always considered to be present in the severely hypothermic patient if any of the following clinical signs of life are present:

- a) spontaneous ventilation
- b) uncoiling response
- c) any spontaneous movement or sound

TREATMENT

1. Initiate treatment according to American Red Cross CPR standards (exceptions follow).

- a) You must always assume that the patient is alive. Initiate *non-aggressive* re-warming (see Hypothermia Protocols). “The person is not dead until they are warm & dead.”
- b) Initiate Positive Pressure Ventilations
- c) Place patient in a Hypothermia Wrap (see Hypothermia Protocols).

If there are no signs of life after an extensive assessment

- c) Initiate CPR

If the victim has been submersed in cold water for more than 1 hour

- a) Initiate treatment as above
- b) Do **NOT** begin any active rewarming that could send cold peripheral blood back into the core

2. Basic Life Support procedures in the field have no significant positive effect on normal recovery and should not be initiated in the field if:

- a) chest is frozen / non-compliant
- b) obvious lethal injury is present
- c) these procedures put rescuers at risk

3. Due to the sensitivity of the heart, and the possibility of inducing ventricular fibrillation, chest compression should never be done if any clinical sign of life (*see below*) (i.e. clinical sign of functional cardiac activity) is present **even if** a pulse is not palpable under field conditions. This includes:

- a) spontaneous ventilation
- b) uncoiling response
- d) any spontaneous movement or sound
- e) pulse

4. The “metabolic icebox” effect of severe hypothermia is protective and can result in normal recovery with or without field treatment if aggressive controlled rewarming by professional care is initiated soon enough. Chest compression during evacuation produces no certain additional benefit in severe hypothermia, and in order to avoid induced ventricular fibrillation and to avoid delay in transport, it should generally not be used during field evacuation. Use of ventilation is appropriate if it does not significantly delay transport to rewarming.

5. Basic Life Support procedures should be discontinued in the field if:

- a) rescuers are exhausted or these procedures put rescuers at risk

b) these procedures significantly delay evacuation to controlled rewarming. These procedures can be discontinued during a technically difficult or dangerous phase of an evacuation, and restarted when evacuation conditions permit.

6. Evacuate the patient following procedures outlined in Evacuation Procedures/Protocols.

DISLOCATIONS: GENERAL**DEFINITIONS**

1. CSM: Circulation, Sensation, and Movement. These are assessed, distal to the injury, in the sensory/motor exam.
2. direct injury: dislocation is caused by force applied directly to the joint.
3. indirect injury: dislocation is caused by lever force applied at a distance from the joint.
4. simple dislocation: indirect injury to:
 - a) patella
 - b) digits (*excluding the thumb*)

GENERAL PRINCIPLES FOR SIMPLE DISLOCATIONS

0a. Outdoor Action Leaders are not authorized to reduce shoulder dislocations.

0. In cases where a dislocation is not reducible (see below), treat the dislocation as an unstable injury: splint in a position of comfort.

1. Attempt reduction only if the mechanism of injury is the result of an indirect force.
2. In any treatment context, an attempt to reposition or reduce any dislocated joint into anatomical position should be made if distal CSM is impaired (*except in shoulder dislocations*).
3. An attempt to reduce a simple dislocation into anatomical position should be made if transport time is delayed or prolonged greater than 2 hours*—even if distal CSM is normal (*except in shoulder dislocations*).
4. Attempt reduction as soon as possible after injury. Muscle spasm increases over time, and reduction is more difficult the longer the joint remains dislocated.
5. Check distal CSM before and after any manipulation of any injured bone or joint.
6. Discontinue an attempt at reduction if:
 - 1) *pain* is significantly increased by manipulation
 - 2) *resistance* to movement is encountered In these cases, the joint should be immobilized as comfortably as possible in the position of injury for transport.
7. *Evacuate the patient following the guidelines in Evacuation Procedures/Protocols.*

* alternate: substitute time as determined by local medical director.

DISLOCATION: SHOULDER**ASSESSMENT**

1. Mechanism of injury is consistent with simple dislocation (indirect injury).
2. Patient is unable to reach hand across to touch the uninjured shoulder.
3. Injured shoulder generally shows a typical “hollow spot” deformity that is not present on the uninjured side.

TREATMENT**0. Do not attempt to reduce the dislocation.**

1. Check and record distal CSM and any associated injury to peripheral nerves.
2. Splint the shoulder in a position of comfort that requires the least movement, which often entails splinting the hand on the affected side to the head or hip.
3. **Evacuate the patient following the guidelines in Evacuation Procedures/Protocols.**

DISLOCATION: PATELLA**ASSESSMENT**

1. Mechanism of injury is consistent with simple dislocation.
2. Early exam (before swelling) clearly shows the patella dislocated laterally (toward the outside of the leg).

TREATMENT

1. Check and record distal CSM and any associated injury to peripheral nerves.
2. If definitive care will be delayed more than 2 hours*, make an attempt to reduce the dislocation.
3. Loosen the patellar tendon by flexing the hip and straightening the knee.
4. At the same time that the hip is being flexed and the knee straightened (i.e. in the same motion), firmly push the patella medially back into normal anatomic position.
5. Recheck and record distal CSM.
6. Immobilize the leg in full extension.
7. If during the attempt at reducing the dislocation, if the attempt at reduction is unsuccessful or if:
 - a) pain is significantly increased by manipulation or
 - b) resistance to positioning is encountered.Then immobilize as comfortably as possible in the position of injury.
8. **Follow evacuation procedures as detailed in the Evacuation Protocols/Procedures, regardless of whether or not the dislocation has been reduced.**

DISLOCATION: DIGITS (*Excluding the Thumb*)**GENERAL PRINCIPLES**

1. Simple dislocations occur when a force is applied to the shaft of the digit and the joint is “levered” apart (e.g. catching a ball on the fingertip). Dislocated digits can be angulated in a mediolateral plane (sideways), or they can override axially (bones stacked on over each other) with a typical “bayonet” deformity.
2. Fractures often occur with dislocated digits, but they do not change the initial field treatment.

ASSESSMENT

DRAFT

1. Mechanism of injury is consistent with simple dislocation.
2. Patient is unable to move the injured joint.
3. Early exam (before swelling) shows the digit locked and angulated at a joint or with a typical “bayonet” deformity.

TREATMENT

Thumb

1. Due to the complexities of the joint, no attempts should be made to reduce a thumb dislocation.

Other Digits

1. Check and record distal CSM and any associated injury to peripheral nerves.
2. If definitive care will be delayed more than 2 hours*, make an attempt to reduce the dislocation.
3. Apply firm traction to the distal segment and move it back into normal anatomic position.
4. Recheck and record distal CSM.
6. Immobilize by splinting or by taping injured digit to the adjacent uninjured digit.
7. Immobilize as comfortably as possible in the position of injury and transport if the attempt at reduction is unsuccessful or if:
 - a) pain is significantly increased by manipulation.
 - b) resistance to positioning is encountered.
8. Evacuate the patient, *following procedures as detailed in Evacuation Procedures/Protocols.*

SPINE INJURY

DEFINITIONS

1. positive mechanism: mechanism of injury with a reasonable potential to cause an unstable injury to the spine. Signs and symptoms include:

- Mechanism of injury (fall, sudden impact or other trauma)
- Paralysis
- Numbness or tingling in the extremities
- Weakness in extremities
- Pain, or tenderness anywhere along spine
- high-impact motor vehicle accidents
- high-impact explosions / blast injuries
- direct blunt or penetrating injuries near the spine
- other high velocity / high-impact injuries

TREATMENT

1. If a mechanism of injury exists, spinal injury is assumed and an assisted evacuation is required.
1. If there is an immediate danger to the patient, or if failure to move the patient will interfere with initial care, the rescuers may move the patient to a safe and appropriate location, without moving the patient's spine or changing his/her body posture (beaming). Rescuers will only move the patient if it is absolutely necessary to his/her safety.

2. The spine must be stabilized. One person should always be at the head of the patient, using Traction-in-position (TIP) to maintain the neck in a neutral position (the position the head normally sits in relation to the spine, neither bent forward or backward). A cervical collar can be improvised with a SAM splint, foam pad, or by filling a stuff sacks with sand or dirt to form a moldable but rigid cradle

3. Under no circumstances will Outdoor Action leaders, support staff, or participants evacuate a patient with a possible spinal injury unless under the supervision of professional rescuers. Evacuate the patient, *following procedures as detailed in Evacuation Procedures/Protocols*.

BURNS

DEFINITIONS

1. First Degree Burns (Superficial Burns):

Only the top layers of skin are affected. Tissue is red and painful (nerve sensation is intact). Sunburn is a typical first degree burn.

2. Second Degree Burns (Partial Thickness Burns):

Deeper layers of tissue are damaged. Tissue is red and very painful (nerve sensation is intact). Blisters may form.

3. Third Degree Burns (Full Thickness Burns):

The full thickness of tissue is affected which includes all layers of skin and may include muscle and bones. The burned area is white, black or leathery. There is often no pain at the deep site of the burn (due to nerve damage). Typically the tissue outside the third degree burn goes to second and then first degree as you move out from the center. These areas may be very painful.

Treatment:

First Degree Burns: First remove the source of the burn, then locally apply cold.

Second Degree Burns: Local application of cold. If blisters are present, they should be left intact. Clean the area gently and apply a sterile dressing. Non-stick pads such as Telfa™ are best for this, covered with roller gauze. Do **not** place antibiotic or other ointments on the non-stick pad.

Third Degree Burns:

- Local application of cold. If a third degree burn is large, over 5-10% of the body (the size of your stomach), and especially if the burn is on the trunk of the body, **do not apply cold**. At this point, the skin is burned away, and the body cannot properly regulate temperature, so there is a high risk of hypothermia. Burns to the face and neck should always be cooled to make sure the airway does not swell shut.
- If blisters are present, they should be left intact. Clean the area gently and apply a sterile dressing. Non-stick Telfa™ pads are best for this covered with cling gauze. Once it is dressed, leave the burn alone, unless you are out in the field for an extended period of time. In this case, you may want to immobilize the burned area, so that further tissue damage does not occur through moving around.
- Attempt to rehydrate the person, as volume loss does occur with burns. Do not force fluid if the person is unable to swallow.
- Monitor closely for infection.

- Be extra careful of hypothermia—a severely burned person no longer has the ability to properly thermoregulate.

Evacuation Guidelines:

Management of severe burns or burns to critical areas requires advanced medical care in a hospital setting. You need to evaluate the percentage of the body areas burned, the areas burned, and the depth of the burn. You should evacuate any patient who has burns of the following types:

- Burns greater than 10% of the body surface.
- Burns to the lungs.
- Second or Third Degree burns to sensitive areas such as the face and neck, hands, feet, or genitals

WOUND MANAGEMENT**DEFINITIONS**

1. open wounds - injury that extends through the full thickness of skin:
 - a) lacerations
 - b) avulsions
 - c) amputations
 - d) puncture wounds
2. shallow wounds - injury that disrupts skin but does not extend through full thickness:
 - a) abrasions
 - b) minor superficial burns
3. high-risk wounds - wounds with high potential for infection:
 - a) bite wounds
 - b) very dirty / contaminated wounds
 - c) crushing / contused / ragged wounds
 - d) wounds over injured bone, joint, or tendon
 - e) puncture wounds
 - f) full/partial thickness burns
 - g) Impaled objects
 - h) Open fractures
4. wound infection - increased bacterial growth and increased inflammation at the wound site
Anyone showing signs of a systemic infection from a wound should be evacuated immediately.
 - High fever that develops after a wound.
 - Red streaks on the skin moving away from wound and toward the heart.
5. impaled object - foreign body that extends through the skin into underlying tissues

GENERAL PRINCIPLES

1. Initial wound management in any context requires that bleeding be stopped by the use of direct pressure. Immobilization, elevation and cold compresses can also be helpful to control bleeding.
2. If bleeding is easily controlled, wounds should generally be cleansed in the field to help control infection if transport time is greater than 2 hours.
3. Wound closure in the field by sutures or adhesive strips is not allowed

4. Evacuate the patient if there:

- a) was a large initial blood loss
- b) is any sign of major infection
- c) appears to be a need for stitches; a gaping cut over ½ inch long.
- d) A laceration to the face, hands, or over a joint.
- e) Is any injury to a blood vessel, ligament, or tendon
- f) is a systemic reaction (streaking)

ASSESSMENT

1. Exercise universal precautions (see Universal Precautions)
2. Determine the type of wound.
3. Check distal CSM after applying dressings.

TREATMENT1. open wounds

- a) Stop initial bleeding.
 - 1) Direct pressure is effective if the wound is clearly seen and steady pressure is maintained for at least 15 minutes.
 - 2) Elevation and cold compresses can also be helpful to control initial bleeding.
 - 3) Immobilization helps protect the newly formed clot.
- b) If bleeding is easily controlled, cleanse the wound
 - 1) Remove foreign material.
 - 2) Wash the skin around the wound with soap and clean water, or a dilute povidone-iodine solution. To make the solution, add approximately one inch of iodine ointment (1% iodine) to one liter of water and allow to dissolve.
 - 3) Irrigate the wound with clean water.
 - 4) Cover the wound with a dry sterile dressing.

2. shallow wounds

- a) Cleanse the wound. Use the procedure that is used for open wounds, but wash the wound surface directly with soap and clean water.
- b) Apply an antibacterial dressing** directly to the wound surface after cleansing. Do not use antibacterial dressings if the patient is allergic to the medication.
- c) Cover the wound with a dry sterile dressing.

3. burns

- a) Cool immediate with water
- b) Flush with 0.5% dilute povidone-iodine solution (“tea-colored”)
- c) Cover the burn with a non-adherent dressing (Telfa pad)
- d) Wrap the are in sterile gauze

If the burn area also constitutes an open wound:

- a) Flush with 0.5% dilute povidone-iodine solution (“tea-colored”)
- b) Treat as a high-risk wound (see below)
- c) Do not place ointments on the wound (as it may trap heat)

3. high-risk wounds

- a) Control bleeding.
- b) Cleanse the wound as thoroughly as possible
- c) Use a 1.0% dilute povidone-iodine solution (“coke-colored”) to irrigate the wound if the patient is not allergic to the medication.

- d) Cover the wound with a triple antibiotic ointment and sterile dressing.
- e) Immobilize the wound site to help control further bleeding and infection.
- f) ***Evacuate following the guidelines in Evacuation Procedures/Protocols***

4. wound infection

- a) Remove all foreign material from the wound.
- b) Allow the wound to drain.
- c) Cleanse the wound daily and apply dilute povidone-iodine dressings using the same procedure that is used for high-risk wounds.
- d) Immobilize the wound site to prevent spread of infection.
- e) ***Evacuate following the guidelines in Evacuation Procedures/Protocols***

5. impaled objects

- a) Treat all impaled objects as high-risk wounds (see above).
- b) Impaled objects that prevent safe and effective patient packaging or transport should be removed if removal is simple, safe and easy.
- c) Any objects that impale the eye will be left in place and stabilized. Bandage both eyes if possible to prevent eye movement.
- e) Do not remove objects impaled in the head, neck, chest, or abdomen.
- f) If the impaled object prevents the evacuation (e.g. patient is impaled on a fence post), then call for emergency personnel to evacuate the patient. Do not attempt to remove the patient from the object.
- d) When possible, bring the impaled object along
- g) ***Evacuate following the guidelines in Evacuation Procedures/Protocols***

Allergic Reactions & Anaphylactic Shock [8/1/96]

DEFINITION

Anaphylactic shock is a form of neurogenic shock which results from a serious allergic reaction. It is usually caused by insect stings (bees, wasps, hornets, yellow jackets, etc.), but it also may be triggered by other insects (flies, mosquitoes), foods, (fish, shellfish, berries, nuts), drugs (antitoxins, penicillin), and pollens.

GENERAL PRINCIPLES

1. Anaphylactic reactions may be **mild to immediately life threatening**. Someone may have a reaction with no prior history. Be wary of people who are allergic to shellfish, but have never been stung by a bee. Anaphylactic reaction can set in anytime from almost immediately to hours later. Allergic reactions to ingested food take longer than injected substances (like bee stings) or contact allergies. If the person has not had any reaction after 6-8 hours, they will not have a reaction.

2. It is essential that you evaluate the patient's condition carefully. You need to ascertain whether the person is having a **localized reaction** or a **systemic reaction**. The allergic reaction releases histamine which dilates blood vessels. In a local reaction blood vessels around the allergy site dilate causing localized swelling. In a systemic reaction, blood vessels all over the body dilate. This massive vasodilation causes the person to go into shock. The most dangerous aspect of a systemic reaction is the potential for airway obstruction caused by swelling from the vasodilation. An obstructed airway can lead to death in minutes. Be most careful about stings around the face, neck, and mouth since these are most likely to create swelling around the airway. In this case even a local reaction can compromise the airway. Anyone showing swelling around the face or neck should be treated as described below for Systemic Reaction. The more immediate the reaction to the sting, the more likely the reaction will be severe.

3. For local reactions, treat with *diphenhydramine*. *Diphenhydramine* (Diphen or Benedryl) is an antihistamine which inactivates histamine in the blood to keep the vessels from dilating. *Diphenhydramine* will not constrict vessels. Epinephrine is a vasoconstrictor and reverses the vasodilation. However, Epinephrine will not deactivate histamine. That is why for a systemic reactions you must treat with both Epinephrine and *Diphenhydramine*.

ASSESSMENT: LOCAL REACTION

This is a normal reaction to a sting (See Insect and Spider Bites/Stings).

- Local pain
- Swelling
- Redness
- Itching

TREATMENT: LOCAL REACTION:

- 1) Monitor the person.
- 2) If you see any sign of the local reaction spreading give *diphenhydramine* (see Medication Profile) and watch for a systemic reaction.
- 3) If the reaction is caused by an injected substance (bee sting) you can also use the Extractor within the first 2-3 minutes of the sting to remove some of the venom and decrease the allergic response.

ASSESSMENT: SYSTEMIC REACTION

Mild

- Look for hives (red spots at other body locations away from the sting site),
- Itching and burning, especially of the face and chest,
- Discomfort, and anxiety.

Question for McCosh: Do we always give Epi with mild systemic reaction?

Moderate-Severe

- Difficulty breathing - this can be immediately life-threatening.
- Nausea
- Vomiting

- Pain (generalized/abdominal)
- Constricted feeling in the chest
- Wheezing
- Dizziness
- Weakness
- Hoarse speech

TREATMENT: ANY TYPE OF SYSTEMIC REACTION

1. Use the Anaguard for any patient showing any level of systemic reaction (mild to severe). The instructions are taped to the inside of the kit. Have someone read them out loud once and then again while you work. Inject into the deltoid muscle (upper arm), thigh, or butt. You want to get the dose into the person's system before they have more severe symptoms. Once the major vasodilation has occurred, it is difficult for the injected Epinephrine to be transported through the body. Be prepared to give a second dose after the initial Epinephrine dose wears off (within 5-10 minutes). If the person shows no improvement after 5 minutes, give the second dose. You may even have to give a third dose (**the maximum number of doses is 3**). After administration of Epinephrine the patient may feel fine, but s/he must be evacuated, no matter how good s/he may feel. The person can usually walk on his/her own power.

Contraindications for Giving Epinephrine:

- a) previous history of cardiac disease
- b) high blood pressure
- c) previous history of stroke

2. Begin preparations to evacuate your patient. Anyone having a systemic allergic reaction must be seen by medical personnel. Depending on the severity of the reaction, the patient may be able to walk out on their own after receiving the Epinephrine. If they are unable to walk out, you will need to make arrangements for a litter evacuation.

3. Give *Diphenhydramine* (see Medication Profile). Have the person continue to take *Diphenhydramine* (25 - 50 mg) every 4 hours for 3 additional doses over the next twelve hours.

4. If the reaction is caused by an injected substance (bee sting) you can also use the Extractor within the first 2-3 minutes of the sting to remove some of the venom and decrease the allergic response.

NOTE: Open your Anaguard before you go on a trip. Familiarize yourself with the instructions. Also, be aware that people with a history of anaphylactic reactions often carry their own Anaguards or Epi-pens. The patient may administer the Epi-pen to herself, however, the pens only have one dose, so if a second dose is needed, you will need to use the Anaguard.

Medications: Dosage

Medications Protocols: 9/12/97

- Leaders are not permitted to prescribe or administer medications. The one exception to this is Epinephrine and Benadryl in the event of anaphylactic shock (see the Anaphylaxis Protocol below).
- All medications are carried in the first aid kit, which is kept by one of the trip leaders.
- In cases where participants are over 18, Leaders can let participants know what medications are available in the first aid kit and can provide information about the purpose and dosage of medications from the Medications Profile. (What about people under 18?)
- Participants can elect to self-administer medications from the first aid kit by making a request to the leader.
- Leaders must check with the participant to see if there are any contraindications or allergies based on the participant's history and information in the Medications Profile before allowing the participant access to the medication.
- All medications must be signed out from the first aid kit to keep track of dosage and time of use. See the Medications Sign-out Form.

Universal Precautions:

What Precautions do I Take?

The following set of Universal precautions are used by hospitals and health care organizations around the world to protect people who are exposed to body fluids. The best way to protect yourself and others, is to assume that all body fluids (see above) are contaminated. This means **always** wear gloves and handle contaminated items carefully.

I. General Concerns:

- A variety of diseases can be transmitted from blood and bodily fluids through contact with open cuts and mucous membranes. Major concerns include HIV (the AIDS virus) and hepatitis.
- The basic principle of universal precautions is to keep a protective barrier between the individual (rescuer or patient) and external bodily fluids. Bodily fluids of concern include: blood, blister fluid (may contain blood), vaginal secretions, semen, vomit.
- All bodily fluids should be assumed to be contaminated, and treated appropriately.

II. Personal Precautions

- **Wear disposable gloves whenever you may come in contact with body fluids.** These should be bagged as described below.
- Anything contaminated with body fluids (bandages, clothing, medical instruments, etc.) should be rinsed with a chlorine bleach solution (1 part bleach:10 parts water)
- Any blood at the scene (on the ground, tarp etc.) should be sprayed with chlorine solution (see above)
- If you are changing a dressing, it should be considered to be contaminated. Dressings that have been contaminated by puss-like drainage should be handled with great care to avoid spreading infection.
- All bandages etc. used for cleaning a wound, halting bleeding, or dressing a wound must be double bagged in a plastic bag and carried out. Place a 1:10 bleach solution in the plastic bag. This will kill both HIV and hepatitis. Do not throw out any blood contaminated items that are sharp (e.g. Epinephrine syringes with needles). Due to the risk of someone sticking themselves, these items are considered medical waste. Sharp objects (needles, etc.) should be placed in a rigid container and labeled **Medical Waste**. Remember, we don't halt the spread of infectious diseases unless we also make sure that we don't put others like sanitation workers at risk.
 - Glasses / goggles should be worn where splashing or spurting blood is a concern.
 - Bandanna can be worn as a minimally protecting mask, when necessary.
 - CPR must be performed using a CPR mask equipped with a one-way valve .

III. Disposal of waste and body fluids:

All clothing, bandages, instruments, etc. that have contacted any bodily fluids are assumed to be contaminated.

- Anything contaminated must be rinsed in a chlorine bleach solution (1:10).
- Any blood at scene (on ground, tarp, etc.) must be sprayed with chlorine solution.
- All bandages must be disposed of in a double bagged plastic bag (with bleach solution in bag), placed in a red biohazard bag and carried out.
- Sharp, blood contaminated items (e.g. Epinephrine syringes,) must be kept in a rigid container marked biohazard waste.

Medical Waste Disposal:

- All medical waste should be placed in a red plastic bag marked Biohazard. Chlorine bleach should be sprinkled into the bag.
- Upon return the bag should be placed into the Medical Waste Box.
- When the box is full, Equipment Room staff will contact Building Services at 8-3490 to arrange for pickup.
- All sharps (Anaguard syringes) should have the needles cut off into the sharps container in the Equipment Room. The rest of the syringe should be placed in with the regular medical waste.

- Sharps containers will be replaced on at least an annual basis. _____Date