Mayday Medics

April 26-28, 2024

Chicago

Trainers Outline

Friday 6pm-9:30pm 210min Medic history, roles, Stop 12345				
Section	**Description**	**Duration**	**Time**	**Trainer**
Welcome	hopes/fears, logistics, security, intros	20	6:10-6:30	Eli
Medic History and roles	Inspiration, MCHR,	15	6:30-6:45	Scott and Harold
This Training	Doc, Eowyn, Rosehips, Grace. Goals. Ground rules.	15	6:45-7:00	Scott
Buddies	Includes PEARL practice	15	7:00-7:15	Jed
Consent	Permission; promoting autonomy	15	7:15-7:30	Ben
Legal		5	7:30-7:35	Scott
Break		15	7:35-7:50	
Intro to Patient Assessment Triangle		10	7:50-8:00	Ben
Scene Assessmet		25	8:00-8:25	Minku
MOI	trauma or medical; sick or not sick; MOI for spinal injury	10	8:25-8:35	Ben
Spreading Calm	Activity: two lines	20	8:35-8:55	Rock
EMS / getting help		15	8:55-9:10	Scott (Someone else?)
BSI	Gloves practice	10	9:10-9:20	Scott
Closing	Plan for tomorrow	5	9:20-9:25	Scott
Total		200		

Saturday Morning 9:00-12:30 (240min) **ABCDE**				
Welcome	“One thing you bring to this training”	15	9:00-9:15	
Initial Assessment Overview		10	9:15-9:25	Ben
LOR	AAAAVPU Mentioning that during disability we will fill in gaps for initial decision to control spine, which happens here	10	9:25-9:35	Scott
Airway / Breathing	head tilt-chin lift; rescue position/gutter, rescue breathing, tripod / position of comfort, pneumo/hemothorax	35	9:35-10:10	Ben
Circulation	check pulse, blood sweep, stop the bleed, shock	40	1010:10:50	Scott
Break		15	10:50-11:05	
Disability / Da Spine	Already decided Holding c-spine, rolling c-spine	15	11:05-11:20	Ben
Environment	Traffic, police, ops, privacy circle, warmth, Includes Carries	40	11:20-12:00	Scott
Triage	refer to “are there any more”	15	12:00-12:15	Eli
GSW	Review of ABC’s, scene safety, cover / concealment, death	15	12:15-12:30	Scott
Lunch		15	12:30-1:45	

Saturday Evening 1:45-6:00 **Focused Assessment, Specific Conditions**				
Head 2 Toe		15	1:45-2:00	Eli
SAMPLE		15	2:15-2:30	Ben
But Why?	determinants of health; nonmedical/preventative interventions	20	2:30-2:50	**Ben**
Head Trauma		20	2:50-3:10	Minku
Scenario	Shock / Head Trauma	20	3:10-3:30	
Scenario Debrief		10	3:30-3:40	
Wound Care		15	3:40-3:55	Scott
Psych First Aid		20	3:55-4:15	**Rusty**
Break		15	4:15-4:30	
Breaks / Sprains / Strains		30	4:30-5:00	Ben
Scenario	Major Trauma	20	5:00-5:20	
Debrief		15	5:20-5:35	
Burns and Blisters		15	5:35-5:50	Eli
Wrap-up		10	5:50-6:00	
Total				

Sunday Morning 10:00-1:00 (180min) Major Medical, Environmental				
Section	**Description**	**Duration**	**Time**	**Trainer**
Welcome		15	10:00-10:15	
Major Medical Intro		10 (90 total)	10:15-10:25	Scott
- Seizures	Shove a belt in their mouth, obviously	5	10:25-10:30	Eli
- SOB and Panic Attack	Position of comfort, albuterol	10	10:55-11:05	Scott
- Chest Pain	Nitro, red flags	10	11:25-11:35	Jed
- Anaphylaxis	Epi Pen	10	10:30-10:40	Zo
- Abdominal Pain	Box of mystery, N/V, red flags, pregnancy	10	10:45-10:55	Scott
- Diabetic Emergencies	Sugar	5	10:40-10:45	Jed
- Fainting	Red flags	10	11:15-11:25	Eli
- Headache / Stroke	Red flags, FAST exam	10	11:35-11:45	Zo
- Overdose	Narcan, we have nasal and IM to give out	10	11:05-11:15	Rusty
Break		15	11:45-12:00	
Major Medical Round Robin	Scenario	25	12:00-12:25	
Environmental (Bridge training joins)	too much heat, not enough, best dressed	35	12:25-1:00	Ben and ?
Lunch		60	1:00-2:00	

Sunday Afternoon 2:00-6:30 (270 min) Police Weapons and Tactics, Big Scenarios, Wrap				
Section	**Description**	**Duration**	**Time**	**Trainer**
Scenario	Environmental / heat	15	2:00-2:15	
Scenario Debrief		20	2:15-2:35	
Police Tactics and Weapons		45	2:35-3:20	Scott and ?
Eyeflush Practice		20	3:20-3:40	
Jail, Jail Support, Handcuff Injuries		10	3:40-3:50	ben?
Break		15	3:50-4:05	
Scenario	Jail Support?	15	4:05-4:20	
Debrief		15	4:20-4:35	
Gear Discussion		15	4:35-4:50	Ben and all trainers with kits
Mental Health Emergencies		15	4:50-5:05	Scott
Big Scenario		30	5:05-5:35	
Debrief		20	5:35-5:55	
Street Medic Org		10	5:55-6:05	Scott and Emissary?
Final Thoughts		15	6:05-6:20	Eli? Ben?
Eval		10	6:20-6:30	Ben

Friday Night

Medic Basics, Stop 12345

Welcome, Intros, Getting Started

Materials: hopes and fears newsprint sheets, goals newsprint sheet, ground rules handouts and newsprint sheets, agenda handout and newsprint sheets, what if? newsprint sheet, trainer info newsprint sheet, acronyms and medical terms newsprint sheet. Nametags.

* Security: Ask “Is there anyone from media, law enforcement, or other state surveillance/enforcement organizations in the room?” They are not welcome without explicit discussion with trainers and consent of all present. Explain why security is both important and imperfect. Mention that CAM has trained CPD in the past. If anyone is talking about “underground” activities prob just fragile ego, let a trainer know.

* Logistics: bathroom, water fountain, parking, other

* Hopes & Fears: As people come into the room, they get unlimited sticky notes. Encourage people to write at least one hope and one fear (one per sticky note) and place it on the “Hopes” and “Fears” chart papers which have been prepared beforehand and well placed in the room. Hopes and fears can reflect their expectations for the training, a coming action, or where they are at in their lives right now.

o Two volunteers: one reads hopes, one reads fears.

* Intros: name, preferred pronoun, where from, and in 10 words why you have come to the training

o note who is not in the room racial, economic, gender, age, political etc diversity
beware of assumptions

Medic History and Roles:

- Not exactly novel idea to care for each other amidst social struggle
- Medicine in support of and as an act of protest
- Draw inspiration from many sources:

o Ben Reitman
o Spanish Civil War, American Medical Bureau of Abraham Lincoln Battalion
o JANE collective
o Freedom House Ambulance

    - MCHR
- Howard speaks about 60's-70's
- Scott shouts out Dick Reilly and Kevin Clark

This Training

- Medics active in MCHR started training lay people in 60's and 70's
- Resurgence during anti-globalization era, Seattle 1999.
- CAM founded 2002, first action FTAA in Quebec City
- Evolved over years, shout out to Eowyn, Grace, Rosehips
- This training is not: any kind of official certification, or a CPR training
- Draws from conventional EMS, wilderness medicine, trauma combat casualty care,
- **Goals (On Sheet):**
    - volunteers to read
        - Train excellent street medics / affinity group medics who have a solid base of knowledge and skills, know their strengths and limits, and know when and how to get help.
        - Prepare trainees to care for themselves and their community on and off the streets.
        - Model street medic values - fight the power, do no harm, anti-authoritarian and anti-oppressive health care.
        - Become better trainers and build better trainings, feedback form at end of training.
        - Have fun
    - **Caveats**
        - We try to balance teaching worst-case scenarios with common problems.
        - We don't train for every situation you'll encounter - we try to prepare you to think on your feet so you can act responsibly in any situation.
        - Real learning happens in real emergencies with the support of a more experienced buddy. This training is just a foundation, if you don't use what you learn, you'll lose it.
- **Ground Rules- On Big Sheet**
    - Copy from Grace

Buddies

"360 Buddy Vision"

Facilitator says Buddies don't focus on the same things – you play dif- ferent roles. The most common and useful role split is for one buddy to do patient assessment and patient care, and the other buddy to do scene control and comms.
Trainer buddy pair mimes One buddy doing first aid, other doing scene control and comms.
Trainer buddy pair mimes Walking as a buddy pair.
Trainer buddy pair demonstrates Squeezing through a dense and surg-
ing crowd (holding space and looking over heads and through legs).

Dividing roles

Trainer buddy pair demonstrates deciding who will take patient assess- ment and who will take scene control before approaching an imaginary pa- tient.
Facilitator says The scene control buddy asks surrounding people to help and gives them helpful tasks to do. Scene control involves collect- ing info about what happened, making a privacy circle, calling for back-up, language interpretation, lifts and carries, de-escalation, clearing a path out of the area for your buddy team and patient to exit, look-out, etc. We'll practice doing scene control later this evening.

COOPERATIVE CARE

Facilitator says The patient assessment buddy is usually the “lead” buddy in crisis decision-making. Usually buddies discuss all decisions, but if some- thing has to be done fast, it’s the lead buddy’s call. If the lead buddy is wrong, you can sort it out during debrief.

CHOOSING A BUDDY

1. **Facilitator says** Choose your buddy before the action, either from home base or at pre-action meetings.
1. **Facilitator says** Things to consider:

- Someone who is calm, who you trust and feel safe with.
- Similar risk level in terms of police violence and arrest.
- Different experience levels; different training.
- Response to chaos: not great to have 2 hyped up folks.
- Gender presentation (important for patient care); gender on gov’t ID
- (important in jail).
- Language: if you speak same non-English language, might be best to
- buddy up with others who do not speak this language.

“Getting to know you” with the Pearl acronym

P for **Physical Vulnerabilities:** Relevant disabilities and impairments, medical issues, medication schedule, situations you must avoid.
E for **Emotional Vulnerabilities:** reasons you might be targeted, situations you must aviod, loved ones at action, etc.
A for **Arrestability:** Willingness to go to jail vs. magnitude of desire to stay out.
R for **Roles:** Patient care or scene control/comms? On street, in first aid station, on dispatch, organizing medical response, doing sexual assault response, available for aftercare?
L for **Loose Ends:** Languages spoken, special skills, interests, car keys, etc.

PRACTICE: BUDDY TIME!

Practice

Facilitator reminds students they’re welcome to opt out of practice ses- sions for any reason/at any time.
Students Get into pairs. They have 5 minutes to get to know each other.

Debrief

Facilitator asks Did you find PEARL useful?
Facilitator asks Are you and your buddy a good match? Why/why not?

Informed Consent

- "Reliable adult pt agrees to receive care after being informed of risks and benefits of each intervention".
- consent for everything we do - asking questions; performing interventions
- Consent is ongoing process; must be reaffirmed throughout; can be rescinded at any time
- Injury and illness can cause loss of control/autonomy
- narrate care
- Street medics support movement participants in recovering autonomy
- DEMONSTRATION (2 buddies, one patient - see p. 22 of 2014 trainer outline)
- Refusal
- Handout
- One's own motivation; how sick?; clarification of role; different medic; pt's definition of needs; language barriers; respect NO
- Oops
- pay attention to pt language, expressions
- be accountable (how?)
- apologize clearly
- use body language/distance to respect boundaries
- maintain consent standard moving forward
- Implied consent
- forgiveness v permission - if unresponsive, consent is implied
- narrate care/explain actions as if pt was responsive
- minors
- parental consent?
- assuming *wink*
- Summary
- be confident, medic face; ask permission to to each new thing; narrate; warn if will hurt or scary; pay attention to pt reponse

Legal:

Illinois Good Samaritan law does not cover untrained bystanders, however no known history of street medics getting sued for care provided, including in sketchy situations to sketchy people. Encourage people to get AHA or Red Cross certification to be protected under good sam.

- Without good sam possibility of negligence vs willful and wanton misconduct
- Negligence: duty to care, reasonable care (within scope of what you've been trained), cause actual harm
- Once care is initiated must stay with person until:
  - Treatment complete
  - They refuse further care
  - Scene becomes unsafe
  - Hand off care to someone with equal or greater training
- No duty to act in Illinois
- No known history of medical providers having action against their license due to street medic work, including for protest misdemeanors. "The risk is you get so drawn into movement work you forget to renew your license." Anne Hirshman
- Reinforce consent
- Duty to report child / elder abuse for liscenced healthcare workers, teachers, etc.
- Physicians and nurses have a duty to report:
  (1) any injury resulting from the discharge of a firearm; or
  (2) any injury sustained in the commission of or as a victim of a criminal offense

- Don’t do this.

Intro to PAT:

“Foundation of Care” (NOLS WMI); system of information-gathering, tx, changes in pt condition

- STOP 12345 (scene survey)
- I’m number one (scene assessment/safety)
- what happened to you (initial impression)
- don't get any on me (BSI)
- are there any more (triage)
- Now we arrive (spreading calm)
- ABCDE (stop and fix life threats)
- Airway (head tilt-chin lift; rescue position)
- Breathing (two rescue breaths?; find and cover entrance and exit wounds)
- Circulation (ID and stop life threatening bleed - blood sweep)
- Disability/da spine (review MOI and decide re: control of c-spine)
- environment (assess and manage environmental hazards)
- Focused assessment (can be reordered as appropriate)
- SAMPLE
- Signs/symptoms (OPQRST)
- Allergies
- medications (prescribed, OTC, herbal, around-the-corner)
- past pertinent hx
- Last ins and outs
- Events leading up to illness/injury
- Head to toe
- Look/listen/feel/expose
- don’t forget back/under bulky or plastic-y clothes
- Reassessment (run the clock, reassess for changes)

Scene Assessment:

- Minku’s powerpoint
- Key points:
    - Are you safe from harm?
    - Are others around you safe?
    - What is the weather?
    - Who around you is at heightened risk of illness injury?
    - Where (exactly) are your?
    - What are your escape routes?
    - What are possible treatment spaces?
    - What is the mood of the police?
    - Scene buddy vs treatment buddy
    - 360 vision

Mechanism of Injury

- Key Points:
    - MOI vs NOI
    - Walk up assessment
    - Ways we can determine MOI/NOI if someone unable to tell us
    - What if we don’t know?

-

Spreading Calm:

Stress as People providing First Aid, Stress as Medics
○ Being at a demo can be very very stressful, for a lot of reasons
○ Community medics can do a lot of good by simply being a kind, caring presence, and helping people calm down
○ But first, we must be calm.
○ We often forget this, because of the heat of the moment, because we think we are strong (and we are!!), because we are in a caretaker role
○ At a demonstration, the authorities want us to be panicked, upset, stressed: Fear is a weapon.

- * What things stress you out in first aid situations, at demonstrations, or in life? ○ *go round, feel free to pass*

- * What do you do to calm, center, focus yourself in an intensely stressful situation? ○ *go round, feel free to pass*
  ○ mention "faking calm"

- * How do people show their stress and emotional upset in an intense situation?
  ○ *brainstorm*

- * What are things that we can do to help you, or others, be calm? calm, comfort, reassure
  ask, is there one thing I can do to help you feel better?

- * 10/ *Parallel lines activity*
  Keep tightly to time limits. This activity can be done in 10 minutes if everyone gets ready quickly and limits are followed.

○ Have everyone line up in 2 parallel lines, with equal numbers in each line.
○ People in line #1 are upset, those in line #2 are responders, responders will try to calm people in line #1
○ Give situation: just saw a close friend get badly hurt in a car accident
○ You will have 2 – 3 minutes do calm, comfort and reassure the upset person. Just do your best.
○ Run for 2 – 3 minutes
○ Ask line #2 responders: BRIEFLY, How did this feel?
○ Ask line #1 upset people: BRIEFLY, What effective things did your responder do? ○ Switch responders and upset people and repeat.

EMS / Getting Help:

Key Points:

- Structure of EMS
- Closest hospital? Trauma center?
- EMS generally not going enter "unsafe" scene, often parks a couple blocks away
- Often need to get pt through police lines to get to EMS
- Paramedics generally competent but not compassionate
- Paramedic discretion to allow friend / family in ambo
- Police often ride with paramedics
- Demonstrate handoff to paramedics

Activity:

- 911 Call
- Brainstorm other ways to get help
    - Make sure to include:
        - More experienced street medic / street medic clinic
        - Driving to hospital / private vehicle
        - Trainer contact info board
        - Hotlines
        - Dr. DuckDuckGo
        - Remote areas / encampments

BSI:

- Key Points:
    - Wear gloves, use hand sanitizer
    - Disposing of gloves
    - Hep C, HIV, PEP
- Activity:
    - Practice putting on / taking off gloves

Closing

- Key points:
    - Be on time tomorrow
    - Dress like you're going to a protest / clothes you can get fake blood on
    - Go around: Favorite bit of trivia / surprising info / new thing. Optional: thing you already knew all about

Saturday Morning

9:00-12:30

Welcome

Key Points
- Nametags
- Announcements
- Review Agenda
- Activity
    - Go-around "What is one thing you bring to this training?"
        - Skills and experiences you have that might help others learn and grow EG: being calm, massage, lot of demo experience, etc.
    - Pantomime what you do to wake up

Initial Assessment Overview

- Definition:
    - A series of steps that you will complete at least once with every person you treat, to quickly identify life threatening problems and get help fast
    - Here we are identifying STOP AND FIX problems that, without intervention, will kill our patient within minutes or hours
- Note we aren't teaching CPR
- Consists of three closely related systems
    - Neurologic
    - Respiratory
    - Circulatory
- Environmental problems can also be immediately life threatening, so check on the following:
    - Disability
    - Environment
        - created safe space or move pt to safe space
- Demonstrate initial assessment on awake pt with a sprained ankle

Level of Responsiveness

- Upon "5 - now we arrive" we introduce ourselves too our patient
    - "My name is Scott and this is my buddy Minku, we know first aid, can we help you?"
    - ASK what's bugging them
        - identifies patient's chief complaint
        - begins the assessment of LOR
- Think of the brain as an onion, as we peel away layers a person gets more and more altered
- AAAAVPU
    - AEIOUTIPS on big paper, don't have to memorize
- AMS sign of very serious problem - get help!
- Unresponsive to pain - not protecting their airway.

Airway / Breathing

- Review airway anatomy on poster, unfortunate design flaw of food hole and air hole are the same.
- Airway / breathing assessment (Scott Pt)
    - Pt demonstrates severe resp distress
        - Key points:
        - Immediately get help
        - Scary! Ground yourself, calm, comfort, reassure the pt.
        - Assessment: 1-2 words vs sentences, rate, accessory muscles, look / feel chest wall, cyanosis.
        - We'll talk about asthma on Sunday
        - Position of comfort

- Head Tilt / Chin lift: (Ben Pt)
    - Unresponsive trainer on ground, breathing fine
    - Trainer gets help (tell someone to call 911)
    - Trainer checks pulse (will cover in next section)
    - Trainer demonstrates look / listen / feel
    - Sweeps gum out of patient's mouth
    - Unresponsive pt starts snoring
    - Trainer demonstrates Head Tilt / Chin lift, explains tongue is most common airway obstructions
    - Mention that jaw thrust is a thing - not training here

- Rescue breathing (Ben Pt)
    - Trainer discusses importance of continually reevaluating ABC's
    - Pt stops breathing
    - Trainer checks pulse - we will cover in next section
    - Trainer tries head tilt / chin lift again
    - Pt still not breathing
    - Trainer demonstrates rescue breathing, both using mask for real and fake puffs we use in this training.
    - Mention that at this point we would give naloxone if available - will cover on Sunday

- Rescue position (Ben Pt)
    - Unresponsive pt starts vomiting
    - Trainer demonstrates rolling the pt, placing in rescue position, and guttering.
    - Explains importance of rescue position if you ever have to leave unresponsive pt, or if your friend is drunk.

- Trainee's practice:
    - Assessing airway / breathing unresponsive pt
    - head tilt / chin lift
    - Rolling pt into rescue position
    - Guttering

- Choking (Scott Pt)
    - One trainer starts to choke
    - Other trainer encourages choker to cough
    - Choker goes silent, hands on throat
    - Trainer has someone call EMS
    - Trainer walks through 5 back blows, 5 abdominal thrusts
    - Choker goes unresponsive
    - Trainer starts chest compressions, looks in mouth
    - No blind sweep
    - Trainer demo's: preg / obese choking (chest thrusts)
    - Trainer demos's: Baby choking
    - Consider transport to hospital to monitor for airway edema

- Students practice:
  - back blows / abd compression

- Chest injuries: (Scott Pt)
  - Penetrating chest injuries, Hemo / pneumothorax
    - Review anatomy of pleural space
    - Entry / exit wound: expose and inspect! Wound can be small
    - Place gloved hand over wound
    - Occlusive dressing
    - Chest seal
    - Pt positioning - bad side down
  - Broken ribs / flail chest
    - Splint with soft object - get help

- Students practice:
  - Inspecting chest wall
  - taping plastic over chest (optional)

Circulation

- Review anatomy
    - Heart, pipes, blood
        - Problems can happen with all three
        - Heart: Heart attack (MI), irregular rhythm, heart failure
        - Pipes: relaxed, so blood pressure too low
        - Blood: Not enough from bleeding or dehydration
    - Shock
        - What we call a serious problem with one of the above
        - Different from emotional shock
        - Review types of shock on poster paper - no need to memorize
        - General signs of shock:
            - Confused, AMS -> unconscious
            - Weakness, dizziness, falling
            - Skin pale, cool, ashy
            - Shallow / rapid breathing
            - HR fast, sometimes slow
            - Vomiting
        - Treatment: keep pt warm, GET HELP
    - Pulses (Scott Pt - unresponsive on ground, agonal respirations)
        - Check responsiveness
        - Demonstrate radial and carotid pulse checks, mention femoral
        - No pulse or unsure pulse- start chest compressions 30:2 / get AED / find someone CPR certified
    - Students practice, finding their own pulse, finding buddy's radial and carotid pulse
        - Acknowledge this is sig more difficult in real world with heavier patients, sicker patients, medics own adrenaline.
    - Stop the bleed - what we've all been waiting for. (Ben pt, moaning on ground)
        - Life threatening vs non-life threatening bleed
        - Demonstrate blood sweep
        - Demonstrate 1cup of blood
        - Demonstrate direct pressure
        - Demonstrate tourniquet
        - Pass tourniquets around room - students practice on their own leg, on their own arm, don't need to crank it down but they can if they want.
            - Notes on tourniquets as students practice:
                - Correct hasty vs correct correct
                - Painful
                - Cops carry them
                - Warning about buying knockoffs
                - Once it's on leave it on! Unless…
                - Converting hasty to correct for >2hr to definitive care
        - Demonstrate wound packing for junctional wounds (youtube vid?)
            - quick clot vs regular gauze
        - Demonstrate pressure dressing for non-arterial wounds
            - Show combat bandage
    - Students practice:
        - Direct pressure, pressure dressing

- Other wounds:
    - Neck, abdomen (including evisceration)
- Internal bleeding
    - chest, abdomen, pelvis, thighs
    - Signs: pain, swelling, bruising (may not be present), shock

Disability

- Review c-spine anatomy, describe risks of c-spine injury
- Review MOI for c-spine
    - hit by car
    - high-energy car crash (>30mph, sig damage, airbags)
    - falls from more then twice persons height
    - other: falls on back of neck, falls onto head, elderly/frail higher risk
    - NOT: police batons, penetrating
- Signs / symptoms of c-spine injury
    - Neck pain, limited ROM
    - range from paralysis and no breathing to numbness or tingling in one extremity
- Treatment goal: neck as still as possible
- Demonstrate (scott patient, sitting in “driver seat” (chair))
    - have pt get out of car, lie down
    - hold c-spine
    - pt starts vomitting
    - demonstrate roll while holding c-spine
- Students practice:
    - c-spine hold, roll
- Will need backboard by paramedics
    - paramedics will do their own assessment and decide not necessary

Environment

- In unsafe scene blindness and inability to move well may become life threats
- Brainstorm: what could make a scene unsafe?
    - whatever missed from Friday
    - weather
    - crowds
    - ops
    - police
    - cars
- How can we modify environment?
    - shelter from sun / rain
    - keep pt warm - emergency blanket
    - blinded pepper spray - eyefuls
    - control traffic
    - privacy circle
- demonstrate privacy circle (if time)

- Carries!
    - If they can walk, let them walk, if they can limp, let them limp, if the can crawl poke them with a stick
    - Emphasize safety, participation optional
    - Demonstrate:
        - one person assist
        - two person assist
        - cradle
            - wrists locked, heel-clicking sidestep
        - clothing drag, standing drag, blanket drag
- Students practice:
    - all carries within their skill level.

Triage

- "To sort"
    - Principle of treating and evacuating most serious life / threatening injuries first
    - Especially important when more patients then buddy teams
    - Common in street medicine, especially chem weapons / police violence and environmental illness
    - GET HELP, create as safe / controlled a scene as possible to facilitate care by additional providers including EMS as they arrive
    - If many seriously injured protestor one experienced medic team may serve as "triage medic," determining severity and allocating other medic teams
- Triage system:
    - Red
        - Immediately life threatening ABC problem
    - Yellow
        - Potentially life or limb threatening if care delayed
        - Eg: compound fracture, large wound (non-arterial)
    - Green
        - "Walking wounded"
        - Clear from scene "If you can hear me follow my voice"
        - Will need medics to care, re-evaluate, and keep in safe location
    - Black
        - Dead or unsurvivable injury

GSW

- Scene safety!
    - Don’t create another patient!
    - Scene often chaotic, hard to tell where shooting is coming from
    - Cover vs concealment
    - Ground yourself before attempting aid
- Treatment principles:
    - already learned lifesaving interventions
    - search for multiple wounds
    - patients may not know immediately that they’ve been shot, or may think they have been shot but haven’t been
    - search for multiple wounds, expose chest
    - Bullets can take unpredictable path through body
    - high energy rifle vs low energy pistol
    - Not every GSW is scary! Graze wounds, ricochet, through muscle with minimal bleeding
- Other:
    - Bulletproof vests (different ratings)
    - Carrying gun incompatible with being marked medic, and displaying weapon at site of shooting dangerous (may be shot by police / other bystanders)
    - Consider carrying pepper spray for antifa demos
- Death and the humble medic
    - Most people shot with pistols live, most shot by rifles die
    - Most who die will die no matter what aid we provide, most who live will live no matter what aid we provide
    - Loss of agency creates trauma - will talk more this afternoon. Death ultimate loss of agency and inherently traumatic.
- If patient dies:
        - can do CPR if scene very safe and no other patients - unlikely to help in traumatic arrest
        - state moves in, controls scene
        - talking about psych first aid this afternoon
- Did you?
    - Keep yourself and your buddy safe?
    - Treat patient with as much dignity and respect as possible?
    - Care for patient as best you could?
        - Don’t judge yourself based off what an imaginary super-medic could or would do.
- Honor our martyrs
    - Michael Brown, Rekia Boyd, Laquan McDonald, George Floyd, Tortugita and countless other victims of police violence
    - 34,000 dead in Gaza including 685 Healthcare workers in Gaza, all those uncounted.
    - The surviving healthcare workers in Gaza continuing to provide care

Saturday Afternoon

Secondary Assessment, Specific Injuries

Secondary Assessment

- Addressing non-life threatening injuries
- Trauma -> head to toe, Medical -> SAMPLE
- Head to Toe
    - Just demonstrate
- SAMPLE
    - On board, do memorize
- Activity:
    - Buddy pairs take SAMPLE history on each other
        - Okay to lie! If you're a bad liar raise your hand.

But Why?

- Enter the Ben and Grace mind palace

Head Trauma

- Review anatomy including skull, brain, CSF, closed compartment
    - Major concerns:
        - Skull fracture
        - Internal Bleeding
        - Internal Swelling
- Common injury from CPD at protests
- Open wounds
    - Lots of bleeding, looks scary, usually isn't
    - RED FLAGS (pretty obvious):
        - Big ol' wound, bone exposed, skull fracture, grey matter
    - Feel for underlying unstable skull fracture
    - No direct pressure over a skull fracture!
        - Skip doughnut bandage - just get to hospital
- Internal Injury
    - Internal bleeding or swelling
    - MOI: falls, major trauma, car accidents, whiplash, strikes to head (especially if head on ground). Unusual from baton but possibility.
    - Consider C-Spine
    - RED FLAGS (may happen immediately or over next day):
        - Decreasing LOC
        - Patient on blood thinners
        - Increasing agitation / confusion
        - Problems with extremity strength, sensation, coordination
        - Vomiting more then once after injury
        - Intense / worst headache
        - Vision changes
        - Seizure

        - Don't teach late or hard to find signs:
            - Cushings triad
            - pupil changes
            - raccoon eyes / battle sign
            - CSF leak
- Concussion
    - Scrambling of connections inside brain without bleeding or swelling
    - May have brief loss of consciousness
        - What happened before you got injured? What's the next thing you remember?
    - May have brief blurred vision
    - Symptoms often last for days, sometimes weeks
        - Irritable, headache, difficulty concentrating, tired
    - Recovery:
        - Pt needs to rest, take time off of work, physical activity, avoid screen time
        - Stay in safe place with someone who can check on them
        - Do NOT need to wake people from sleeping (though reasonable to check on them after 6-8 hours)
        - Must avoid repeated head injury, no high risk sports or activities for next 2 months or until cleared by medical provider
        - Return to activity as symptoms allow, return of symptoms = too much activity
        - Evaluation by medical provider for severe symptoms or symptoms for more then 2-3 days
- Very reasonable to be evaluated in ER for any head injury even if no red flags

Scenario: Shock / Head Trauma

Fall from scaffolding, falling objects strike other people

Wound Care:

- General principles:
    - Our bodies are amazing, most wounds heal no matter what we do
    - Control bleeding with direct pressure
    - But don't use rubbing alcohol or peroxide
    - Triple antibiotic (neosporin) often causes allergic reaction
    - Clean: lots of water, strong water, soap and water / tweezers for heavily contaminated
    - Tetanus prophylaxis if last vaccine > 5 years ago
    - Wound beds like to be moist not wet, will heal faster if covered with salve or ointment
- Wound closure
    - Generally optional, speeds healing and reduce scarring
    - Must be clean + recent
    - steri strips + tincture of benzoin

- Special wounds:
    - Avulsions: clean under flap, replace
    - Amputations: Keep part dry and cold, transport to hospital
    - Punctures: Encourage bleeding, do not close
    - Impaled objects: Stabilize and transport
    - Eye injuries: Cover eye with shield, get to help
    - Lost tooth: Avoid touching root, rinse briefly if dirty, best place is right back where it came from, (alternatively in milk or spit) get to dentist.
    - Bloody nose: Pinch just below cartilage, lean forward
- Red flags:
    - Infection
    - Diabetic
    - Frail
    - Affecting joints, tendons
    - Exposed bone
    - Bites (needs antibiotics)

Mental Health First Aid

By Rusty

Introduce - 30 secs

Self Goals: To talk a bit about how common mental health needs re: Mass Cas / Trauma in the Street Medic role. Not the end-all-be all of MH, but an introduction.

Open ? - <5 mins

For those doing/preparing to do this work, what concerns/challenges come up for you in anticipation of navigating the mental health components of what you may encounter?

Clarification of Role/Posture - 1 min

We're not doing trauma processing therapy at curbside. We're not treating pathology. We're trying to promote resilience.

Easier said than done - how?

In short, establishing safety, and facilitating agency by addressing immediate needs. We're first and foremost trying to help people feel less helpless/overwhelmed in upending moments

Why? - 1-2 mins

1) Exhaustive (unprompted) trauma debriefing (where folks are asked to talk in-depth about their experiences of the event soon after) can be unhelpful, even harmful.

https://div12.org/treatment/psychological-debriefing-for-post-traumatic-stress-disorder/

2) Trauma often accompanies a loss of agency/safety, upend our sense of self, others, environment. In turn people can fixate on interpretations of what they could/should have done differently; guilt, shame: stuckness that disrupt recovery. In addition to addressing the immediate challenging emotions, we help people to take agency-promoting actions that can prevent those stuckness-inducing interpretations from taking hold.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689312/

3) By helping folks in this way, we're planting a small seed for / connecting them to a supportive social environment characterized by human connection, where they can later process thoughts, feelings, behavior, somatic sensations, and interpretations as needed.

What? - 3 mins

EVENT - More congruent w/event-based street medic role:

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.

POST EVENT - More congruent w/community-based street medic role:

- Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors cope effectively with the psychological impact of disasters.
- Be clear about your availability, and (when appropriate) link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public-sector services, and organizations.

https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230010/all/Introduction_and_Overview#0How?

How? - 10 mins

Before - ? - In your team/affinity group, etc. - how do you set the stage for action?

★ Designate a support person for the group or each person.
★ Tell the support person any risk factors for trauma such as:
  - History of mood disorders or personality disorders
  - History of previous trauma
  - Higher than normative (>90bpm) resting heart rate
  - Lacking social / family support, housing insecurity, etc.
★ Try to "pre-plan" for potentially traumatic outcomes
  - Cultivate a sense of optimism about life, the movement, the action; candor and connection
  - NARRATIVE: People often need to "make it make sense".
  - Mindfulness/candor/connection helps afterwards but must be cultivated beforehand.
  - Have participants make lists of the things / people that support them to facilitate connections post-event if needed - both practical and psychological benefits

During

- Stick with the group/buddy.
- Take breaks if you need to.
- Designate nearby safe area to meet up in case of emergency.
- Reminders of the narrative / meaning & solidarity.
- Identify at-risk groups

Immediately After

Triage by immediate safety needs

  - **Needing medical attention**. Some mechanisms of injury may cause physiological, neurological symptoms which mimic psychological ones.
  - If someone appears to have a **reduced level of situational awareness** due to distress, their safety may be at risk so they are next priority.
  - Anyone **close to a potential source of danger or trauma**. If there are bodies, visibly injured people, people vocalizing distress in disturbing ways, etc. then try to separate bystanders from these hazards as quickly and quietly as possible.

Immediate Prevention Intervention

- Privacy barriers around disturbing things like bodies/very wounded people
- Tell bystanders not to stop and look at disturbing things. **People may feel an instinctive "need" to look at something upsetting because they think it will help them make sense of what has happened**. It won't help. The image may haunt them. Prevent this secondary injury.

Practical Interventions

- Direct people from the scene of the mass casualty to a designated safe area. Ideally this will have places to sit, stand, or lie down. Access to water, bathrooms, blankets, etc. is also good if it's possible. It must be physically secure and not so far from the scene that getting there is difficult or risky.
- If possible, remove weapons from anyone too agitated to handle them safely.
- **ASK ABOUT IMMEDIATE NEEDS**
  - **E.g. Before we talk, is there something right now that you need?**
- Provide calming interventions
  - **Box Breathing -** 4 cycles of 4 steps of breathing, each done for 4 seconds. Turns an autonomic process into an agential process
    - Inhale 4 seconds
    - Hold breath for 4 seconds
    - Exhale for 4 seconds
    - Pause for 4 seconds before next breath
  - **Bilateral stimulation -** with the person's consent, face them and gently tap both of their shoulders, alternatingly. This stimulates both sides of the brain and can be more effective a grounding technique than soothing touch on just one side of the body. If they are ok with eye contact, this can be combined with direct eye contact for greater effect. This can be helpful for people who are numb, shocked, or dazed. Can help ground in body/senses

- **Mindfulness Grounding Sensory exercise -** Look around. Have the person name 5 things they can see. Have them name 4 things they can hear. Have them name 3 things they can touch. Have them name 2 things they can smell. Have them name 1 thing they can taste. Repeat until sufficiently grounded.
- Prevent people from wandering off alone while in a state of reduced situational awareness. If people need to leave the designated safe area, try to get them to go with a group or call someone to come get them.
- Help people contact loved ones to let them know they're all right.
- Make sure everybody has a plan for how to get to wherever they're spending that night. Make sure they have what they need to get there.

Example
In this conversation, you have come to a woman standing outside the rubble of a fallen building. She is crying and shaking, although she isn't physically injured.
You: Hello, my name is __. I'm a street medic. May I talk with you?
Woman: It's terrible! I was going into the building when it started shaking! I don't understand what's happening!
You: Yes, it was an earthquake. It sounds pretty scary. What can I call you?
Woman: I'm Luna. I'm so scared! *[shaking, crying]* I wonder if I should go in there and try to find my colleagues? I don't know if they're all right!
You: Luna, it's not safe at all to go in the building now, you may get hurt. We can talk over there where it's safer and I can sit with you for a while. Would you like that?
Woman: Yes, please. *[You move to a nearby safe place.]*
You: Luna, is there anything you need right now in this moment that I can get for you?
Woman: I'm really thirsty- the air was so dusty when the building was coming down.
[If available, offer practical comfort like water or a blanket.]
Woman: I just want to sit here a moment.
[You sit quietly near the woman in silence for two to three minutes, until she begins to speak again.]
Woman: I was so scared…but I should have stayed in the building to help people!
You: I imagine it must have been terrifying.
Woman: I ran outside. But I feel so badly for the other people!
You: It's difficult to know what to do in a situation like this, and yet it sounds like you acted on good instincts by keeping yourself safe and getting out when you could.
Woman: I saw them take a body out of the rubble. I think it was my friend! *[crying]*
You: I'm so sorry. There is a rescue team working, and we will find out more as soon as we can.
[The conversation continues for another 10 minutes with you listening to the woman's story and asking for her needs and concerns. The conversation wraps up:]
Woman: I need to find out if my family is all right, but I lost my phone when the shaking started, and I don't know how to get home.
You: I can help you call your family, and then we can figure out together how you can get to them.
Woman: Thank you. That would help a lot.

In this sample conversation, notice that you:
» introduced yourself;
» asked the person if they would like to talk;
» addressed the person respectfully, by their name;

» protected the distressed person from further harm by moving to a safer place;
» offered the distressed person some comfort (for example, some water);
» listened and stayed near the person, without forcing them to talk;
» reflected back to the person ways they had acted appropriately;
» took the time to listen;
» identified the person's needs and concerns;
» acknowledged the person's worry over the possible loss of colleagues;
» offered to help connect the person with their family members.
More psychological first aid examples and tips:
https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230000/all/Contact_and_Engagement

Later

1) **Recognize and normalize distress responses. Do not Pathologize! Most will experience these and go on to recover.**

Some examples of distress responses to crisis:
» physical symptoms (for example, shaking, headaches, feeling very tired, loss of appetite, aches and pains)
» crying, sadness, depressed mood, grief
» anxiety, fear
» being "on guard" or "jumpy"
» worry that something really bad is going to happen
» insomnia,
» irritability, anger
» guilt, shame (for example, for having survived, or for not helping or saving others)
» confused, emotionally numb, or feeling unreal or in a daze
» appearing withdrawn or very still (not moving)
» not responding to others, not speaking at all
» disorientation (for example, not knowing their own name, where they are from, or what happened)
» not being able to care for themselves or their children (for example, not eating or drinking, not able to make simple decisions)

Watch for extension of stress response into persistent post-traumatic stress. Any combo of these may appear.

- Traumatic Nightmares
- Fear incongruent to the situation or incongruent lack of fear in risky situations
- Inability to stop thinking about the event or being unable to think about it (e.g. intrusive memories)
- Disturbances in sleep cycle, getting either too much or too little sleep
- Disturbances in appetite, overeating or forgetting to eat
- Unexplained irritability or anger
- Inability to concentrate
- Changes in sociability, such as fear of being alone, or isolating oneself
- Painful/negative/inhibiting (i.e. guilt inducing) changes in beliefs a/b self, others, and world across themes of power, safety, trust, control, esteem, intimacy
    1. Guilt/shame
- People may need further therapy if:

2. They want it.
3. Challenges are getting worse instead of better over time (DSM says >1 month).
4. Challenges interfere with normal activities for more than a few weeks.

- People may need support in the days/weeks after a major trauma:
    5. Reminders to eat, or food brought to them
    6. Reminders to wear clean clothes, help with laundry
    7. Reminders for self-care like showering, taking meds, drinking water
    8. Opportunities to talk about what happened or to be with other people without talking about it.
- Physical exercise to discharge some of the pent-up tension
- Various types of touch, ranging from cuddling to kickboxing

IF TIME:

Q+A

Takeaways - trauma can be impactful; resilience is th

How to give emotional support without overextending yourself

1. **I'm #1**
    a. It's not my emergency.
    b. Am I the right person to be addressing this issue? Should I help this person directly, or should I help them find another person?
    c. Am I in the right state of mind to be helpful?
    d. Is my mental and physical comfort sufficient for listening and focusing?

1. **What's going on with you?**
    a. Ask open-ended, nonjudgmental questions if needed to keep the person talking about what they're feeling at the moment.
    b. If you feel unable to say anything helpful, stock phrases like, "Wow that sounds like a lot" or "Woah, how did you feel when that happened?"
    c. DO NOT ask about specific details of the trauma. All you need is a general idea. Beyond that, focus on immediate needs.
2. **Don't get any on me**
    a. Boundaries (using DEARMAN or whatever works for you)
    b. Listening to the other person's feelings doesn't mean feeling them for the other person. They don't need you to do that and you will get exhausted if you try.
    c. Notice any feelings that arise in you as you listen. Acknowledge them and if you get overwhelmed go back to #1.
3. **Are there any more**
    a. Are there other mental or physical conditions exacerbating the current issue?
    b. Are there other people dealing with this same issue who might need the same help, or be able to provide support to each other? Does your person need someone else to talk to who has gone through something similar?
4. **Now we arrive**
    a. Once the situation is clear to you, it's time for interventions.

b. You may ask whether they want to vent or if they'd like practical help resolving a stressful situation.
c. You may ask whether they'd like some kind of soothing touch or you may offer them physical sustenance like food, water, warm clothing, etc.
d. Once the interventions are complete or the person is no longer interested in your immediate support, ask them if they have a friend or support person to follow-up with.

Boundaries
DBT workbook teaches a skill called DEARMAN:

Describe the situation without value judgement e.g. *"I've told you that I don't want to go to a bar, but you're trying to convince me that I should go anyway."*
Express your feelings *Work towards finding the happy medium of being expressive while maintaining a sense of self-control.*
Do this by asking yourself before each disclosure etc: "Will I like how I feel about myself if I express this now, and in this way?"
Assert
Avoid both passiveness and aggressiveness. (And passive-aggressiveness)
Reinforce
Remind yourself and other person of positive outcomes of respecting your request
Mindfulness
Practice radical acceptance, opposite action, and mindful breathing. Use these skills if you become unsure or overwhelmed or feel like you might succumb to pressure to allow your boundaries to be violated.
Appear confident *(ok this one is kind of a stretch to fit the acronym.)*
Practice self-validation by reminding yourself that your boundary is reasonable, and even if you feel unsure, push yourself a little bit to assume a calm, confident stance.
Negotiate
Decide in advance what kinds of compromise you are willing to accept and what you're not. Set your boundaries within yourself and articulate the consequences of what will happen to you if they are violated or compromised.
Anticipate what concessions you'd be ok living with and which you might regret.

Breaks, Sprains, Strains

Good news! Unless it is glaringly obvious, we cannot differentiate between types of musculoskeletal injuries in the field!

- Instead, an important question we ask when assessing musculoskeletal injury is: *useable or unuseable*
- That said
    - “break” refers to a fracture, or broken bone or bones
    - “sprain” refers to a partial or complete tear of connective tissues (tendons, ligaments)
    - “strain” refers to overstretching of tendons or ligaments

- As long as scene is safe, do not move the patient or ask them to move until an assessment has been completed
- Go through the complete patient assessment triangle before focusing assessment on patient’s complaint as below
    - Ask the patient to locate their pain; ask our OPQRST questions while we
        - LOOK at the skin level for swelling, discoloration, deformity; compare injured area to its mirror
            - gross deformity is an emergency for us, we should seek a higher level of care; see special considerations below
        - FEEL gently and observe for patient response - where did it hurt?
            - Point tenderness is indicative of tears in connective tissue and fracture of bones
        - CHECK circulation, sensation and motion (CSM)
            - assess perfusion distal to injury by gently squeezing nail bed and observing capillary refill (blood returning to capillaries following your momentary application of pressure)
                - How long did it take? Less than 3 seconds, cool man; greater than 3 seconds? Perfusion may be impaired, which is an emergency requiring a higher level of care
            - assess sensation by blocking the patient’s view of their limb (for example) distal to pain/injury, lightly pinching a finger or toe, and asking patient to tell you which one (choose pointer or pinky, big or little piggy for simplicity’s sake)
                - Did they get it right? cool man; wrong? may have damaged a nerve, which can be an emergency requiring a higher level of care
            - assess motion by asking patient to wiggle fingers/toes
                - can they do it? cool man; they can’t? sketchy, let’s consult a higher level of care
- Once we’ve completed our patient assessment triangle and assessed the patient’s chief complaint related to musculoskeletal injury, we can consider assessing useability
    - Are there signs of serious injury as assessed above?
        - Then we’ve already decided to seek a higher level of care and will skip this part, heading directly to some of the treatments described below
    - Sans signs of serious injury, have the patient move the injured part through its normal range of motion
        - compare range of motion with injured part’s mirror
        - assess level of pain; how is patient tolerating self-movement?
    - If the patient has tolerated self-movement of the injured part without a high level of pain or substantial loss of range of motion, we as medics will move injured part, adding stress at maximum stress points
        - assess level of pain; how is patient tolerating your manipulation?
        - consider range of motion compared to part’s mirror; how impaired is injured part?

- If the patient has tolerated the above manipulation well, let them use the injured part
    - ask if they are comfortable remaining in the street
    - ask if they are comfortable getting themselves home to rest
        - do they have people that can help get them to a restful place?

- treatments
    - if the injured part is unusable as assessed above, we splint
        - splinting is an art!
        - splinting means immobilizing to improve patient comfort and prevent further injury *while arranging a higher level of care*
            - general principles
                - check CSM
                - splint injury in position found/position of comfort
                    - surround injury site with padding
                    - support injury site with something rigid
                    - immobilize joints above and below injury; immobilize long bones above and below injured joint
                - check CSM
            - a little math for splint-building - padding + compression = rigidity (with the helpful addition of a rigid element

        - the sling and swathe
            - our example of splinting for this training
            - check CSM
            - rigid element
                - SAM splint; sleeping pad square; found cardboard
            - pad pad pad
                - improvise
            - ace wrap it up
            - immobilize shoulder/elbow with sling
            - immobilize shoulder/wrist with swathe
            - check CSM

        - Break out and practice

    - If the injured part is usable, we support with all kinds of fun athletic tape techniques that we gotta skip in this training
        - H-RICE
            - hydration, never a bad thing
            - rest
                - reduces swelling, prevents further injury
            - ice
                - reduces swelling, analgesic
                - not directly against skin
                - 20 minutes off, 20 minutes on
            - compression
                - wrap distal to proximal
                - check CSM after
                - don’t leave on overnight
                - prevents swelling
            - elevation
                - higher than patient’s heart
                - reduces swelling
                - DO elevate overnight
        - ace wrap it if they want to walk (hopefully your assessment findings match with patient’s wishes)

- heat should only be applied to loosen injured area after all pain and swelling have subsided without H-RICE intervention

- Special considerations
  - angulated fractures
    - a joint where none should be
    - stabilize as best you can, monitor CSM closely, get help fast
  - open fractures
    - exposed bone
    - irrigate irrigate irrigate (think wound care; no scrubbing)
    - stabilize as best you can, monitor circulation generally and CSM closely, get help fast
  - femur and pelvic fractures
    - love to bleed, think circulation emergency
    - assess for shock
    - stabilize as best you can, monitor circulation generally and CSM closely, get help fast
    - MOI for these fractures involves lots of force, think spinal injury, ABCs including LOC

Scenario: Major Trauma

Car drives through crowd

Burns and Blisters

- Anatomy: Damage to skin
  - 1st Degree: Superficial. Red, painful swollen. Most Sunburn
  - 2nd Degree: Deeper skin. Add blisters
  - 3rd Degree: Full thickness, extending to tissue beneath skin. Sometimes less pain (though surrounding 1st and 2nd degree remain painful) Pale, charred.
- Caused by:
  - Hot things (tear gas canister)
  - Radiation (sunburn)
  - Chemicals (generally not from chem weapons)
  - Electrical (generally not from tasers / stun guns though localized burns possible)
- Treatment Principles:
  - Cool area (extensive irrigation, no ice, avoid hypothermia)/ remove offending substance
  - non-stick gauze
  - Keep intact blisters intact
  - Ointment only for burns fully cooled and not needing further care
  - Pain control
  - Hydration
- Red Flags:
  - Airway burns from hot gas exposure. Facial burns, soot in mouth / nose, singed hair. Potential airway emergency, EMS
  - Circumferential burns
  - Extensive burns
- Further care:
  - Full thickness burns
  - Burns >10% TBSA (10 hands)
  - Uncontrolled pain
  - Anything beyond minor burns to hands, feet, neck, armpits, groin

Saturday Evening Wrap-Up

- Review bullet point skills learned today
- Acknowledge that students often feel overwhelmed at this point, trust us it will come together tomorrow
- Plan for tomorrow
    - Will be outside
    - Will get wet
    - Don't wear contacts
    - Bring friends for Sunday afternoon scenarios
- Low point / high point

Sunday Morning

Major Medical, Environmental

Welcome

- Go around
    - Name, pronouns, one thing you want to practice more
- Review Agenda
- Announcements, loose threads

Major Medical Intro

- We're going to run through nine common medical emergencies you may encounter at protests or out in the world.
- Importance of SAMPLE history

- **SEIZURE**
    - One trainer starts to seize, moving thorough absence -> partial -> generalized
    - Other trainer demonstrates clearing space around pt, rolling on side for airway if blood/secretions, timing length of seizure
        - Key points:
            - Not a 911 emergency if known history of seizures and less than five minutes - check for medi-alert
            - Distressing to bystanders - project calmness
            - Pt with be post-ictal after seizure, restore dignity, move to safe space, may need change of clothing / get cleaned up
            - Nothing in their mouth
        - Red flags:
            - No history or unknown history of seizure
            - Seizure >5min
            - Multiple seizures in a row

- **ASTHMA / SOB**
  - One trainer demonstrates moderate asthma attack, 1-2 sentence
  - Other trainer demonstrates calm, helps person find albuterol inhaler, position of comfort
    - Key Points
      - Different kinds of inhalers, albuterol is what we're looking for here (may have other medications as well)
      - We only facilitate using patients own inhaler, other crowd members may do differently, we shouldn't interfere
      - Calm person, move out of tear gas
      - Caffeine can help for mild asthma attack
    - Red flags:
      - No history of asthma or other lung disease (COPD big one)
        - Could be a ton of things, some of them scary, prob need ER. Sudden onset scarier then slow onset.
      - Don't get better in five minutes or they get worse

- **PANIC ATTACK**
  - Bodies response to emotional stressor
  - Massive dump of adrenaline and other flight / fight hormone
  - Pt breathing very fast, shaky, difficulty concentrating
    - Key Points
      - Often hard to tell panic attack from serious medical condition, when in doubt GET HELP
      - Ressuring:
        - History of panic attacks
        - Numb or cramping hands and feet
      - Treatment:
        - Medic needs to speak slowly: calm, comfort, reassure
        - Move to safe space
        - Try to connect patient to body, breathing exercises, 5-4-3-2-1 activity we learned in psych first aid
      - Red Flags:
        - Don't get better

- **CHEST PAIN**
  - Also could be a lot of things!
    - Key points:
      - Get help
      - Position of comfort
      - Ask if they have history of CP and any medications
        - I don't think we need to keep covering nitroglycerin, much less common med then in past
      - Classic signs of heart attack (also called myocardial infarction):
        - Crushing CP, radiates to jaw and L shoulder, accompanied by shortness of breath
      - Atypical signs, more common in diabetics, elderly, women:
        - abd pain, N/V, back pain, dizziness
      - For any concern for heart attack recommend calling ambulance even if pt doesn't want to go to hospital. Paramedics can run EKG and have more experience advising patients.
    - It's usually heartburn

- **ANAPHYLAXIS**
  - Patient trainer demonstrates getting stung by bee, fumbles with epipen
  - Treating trainer rushes up in panic, grabs pt's epipen, holds it backwards and jabs it into pt's thigh, injecting their own thumb.
  - Other trainer activates EMS, helps pt with their own epipen
    - Review signs and symptoms:
      - Difficulty breathing
      - Hives
      - Swelling
      - Nausea / vomiting
      - Restlessess
    - Key points:
      - ABC emergency, even if patient recovers should go to hospital, may need additional doses.
      - If other doses available administer them in five minutes if no significant improvement
      - Give epi early! Don't wait for full symptoms to progress
      - Different kinds of epinephrine auto-injectors, you only get one shot so slow down, read the label, do it right

- **ABDOMINAL PAIN**
  - If you thought there was a lot of causes for SOB and CP whoo boy
  - "Box of mystery"
  - Scott's Least Concerning -> Most Concerning activity

- **DIABETIC EMERGENCIES**
  - Two kinds, sugar too high and sugar too low
  - Sugar too low more common
    - Caused by increased exercise / stress, missing meals (protest much?)
    - Treatment: Give sugar, followed by meal
    - Get help:
      - No improvement in five minutes

- **FAINTING**
  - Temporary loss of consciousness with a spontaneous recovery, people generally awake and alert soon afterwards, as opposed to dazed and drowsy after most seizures.
  - Once again, can be caused by many things
  - Least concerning:
    - Otherwise healthy person with little to eat or drink standing for prolonged periods, blood pools in legs, body goes horizontal to get blood to brain.
      - Prevention: Hydration, keep moving
    - Otherwise healthy person sees blood
    - Treatment: stay horizontal for some minutes, drink water.
  - All other fainting:
    - Get help

- **HEADACHE / STROKE**
  - Most headaches are minor, but do full sample history, encourage hydration.
  - Sometimes headaches are a sign of a stroke (problem with blood supply to the brain). Strokes can often occur without any headache.
  - One trainer sitting patient, other trainer does FAST exam
    - Patient fails all points of the FAST exam
      - Face: Uneven smile - pay attention to naso-labial folds
      - Arms: Palms up, ten seconds, look for drift
      - Speech: Repeat sentence
      - Time: Time to call 911. Also: When did symptoms first start?

- **OVERDOSE**
  - Opioids decrease respiratory drive
  - Signs:
    - Trainer as patient, unresponsive slumped in chair. Unable to wake patient to pain, ABC emergency, activate EMS.
    - Slow, strange, or irregular respirations:
      - Check pulse - no pulse start CPR
      - If pulse, give two rescue breaths
      - Trainer demonstrates giving naloxone, intramuscular and intranasal
      - Continue rescue breathing

- Key points:
  - Legal in all 50 states for layperson to carry and administer
  - Can be obtained from pharmacy in Illinois without prescription
  - Shout out to Chicago Recovery Alliance
  - Patient may wake up and not want further treatment, however risk of needing additional doses of naloxone as naloxone can wear off while opioids still on board
  - Try to observe patient for at least two hours

Major Medical Round Robin

Environmental

In this section we're thinking about environment as weather conditions, high and low temperatures

It is easier to stay warm than to warm the hypothermic patient, easier to stay cool than to treat heatstroke, and easier to stay dry than to get dry.

best treatment when we catch early? change environment!

Our modality is this - there are problems of too much or too little heat

- Heat always moves from a place where there is a lot of it to a place where there is less; it spreads itself out
  - when we hold a glass of ice water, we are feeling that the glass and its water has less heat than our hand, and our heat will spread out to the glass and the water over time
- our bodies continuously produce heat by using energy to power all our body's functions
- we lose heat over a big surface area - our skin
  - through conduction, convection, radiation, and evaporation
    - conduction - heat travels from warmer thing to cooler thing
    - convection - heat lost directly to moving air or water
    - radiation - heat that is given off constantly by a warm object
    - evaporation - as water turns from liquid to gas it expends energy (heat)
      - our most important cooling mechanism
- we are always exchanging heat with our environment, losing it when the temperature is lower than our body's temperature, around 98 degrees F
- body generates and preserves heat through circulatory changes, activity level, and hydration
- Too much or not enough heat can be an emergency in itself, and can be complicated to treat
- dress in layers, choose clothing appropriate for weather, bring extras for yourself and patients
  - Ben is a big fan of dry wool socks for cold wet people

- Not enough heat - “cold” and hypothermia
    - prevent this!
        - know the weather
        - stay dry
        - keep your calorie bank full
        - hydrate
        - keep moving
        - identify places to get warm
    - Assessment findings
        - shivering - one of the first signs; body is working to generate heat
        - the umbles, from less to more severe: fumble, grumble, mumble, stumble, tumble
        - apathy/reclusiveness - not enough heat affects the brain, patient may not be aware they are in danger
    - red flags
        - not enough heat and decreased LOC? get help!
        - no improvement despite intervention? get help!
    - treatment
        - in the case of AMS
            - get help!
            - avoid lots of movement (their LOC is decreased, they can’t safely do it) - can lead to fatally abnormal heartbeats
            - prevent conductive heat loss to ground by laying patient on something (cardboard, sleeping pad, banners)
            - cover with emergency blanket, extra layers
            - don’t try to actively rewarm
        - everyone else
            - change environment!
            - get them as dry as possible
            - give fluids (warm is good) and easily digestible calories
            - stick some handwarmers near skin where big blood vessels pass (armpits, groin, inside of elbows)

    - frostbite
        - tissues of skin and sometimes deeper tissues are frozen
        - prevent this!
        - most common in fingers, toes, nose, ears
        - upon assessment, skin is cool to cold to touch; can be pale, red, gray, black, waxy and hard
        - we’re not rewarming frostbite at this level of training, we’re figuring out a higher level of care
        - DO NOT rub/massage

- too much heat - hyperthermia
    - sometimes the body wants to dump heat but cannot because of ambient temperature and humidity, which interferes with our body’s evaporative cooling
    - prevent this! Hyperthermia in its most dangerous form, heat stroke, kills roughly 50% of people who get it
        - know the weather and prepare
        - drink cool water frequently along with eating healthy snacks
        - collaborate with organizers to assure plentiful access to drinking water

        - protect from the sun
        - rest often in cooler, shady places
    - assessment findings
        - thirst, dry lips and mouth, dark urine, headache, dizziness, fainting, fatigue, nausea, muscle cramping, cool, clammy or flushed skin
    - red flags
        - altered mental status, vomiting, hot red skin
    - treatment
        - change environment!
        - give liquids if patient is alert
        - mist with water and fan
        - takes a while to recover; stay with person

- dehydration
    - common problem exacerbating both not enough and too much heat
    - we need lots of water, and can lose up to 3 quarts in an hour with major exertion
    - dehydration occurs when we lose more water than we're replacing

    - prevention
        - drink water!
        - balance electrolytes while replacing water by eating healthy snacks
    - symptoms
        - thirst, dry lips and mouth, dark urine, headache, dizziness, fainting
    - red flags
        - altered mental status/decreased LOC
        - if the patient can't drink, it's an emergency

- Best dressed protester fashion show

Sunday Afternoon

Police Tactics and Weapons, Scenarios

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Police Tactics and Weapons

Facilitator sets scene: *It's the second day of the DNC Convention in Chicago. The first day's protests included multiple large permitted rally, march rally's that were largely peaceful, without any arrests. Smaller pre-planned direct actions attempted to block delegate busses and resulted in eighty arrests, with minimal police violence and injuries. However, overnight Israel began a heavy bombardment of Rafah, with footage from Gaza showing bomb craters amidst tent encampments and a heavy civilian death toll. An emergency rally is called for Daley Plaza, and ten thousand protestors gather amidst a heavy police presence. While speeches are ongoing a smaller group of 800 protestors breaks away and begins marching in the street to delegate hotels, flanked by around 100 CPD bicycle and foot cops, congregating first at Arlo Chicago on Michigan Ave where delegates and tourists are gathered in a crowded sidewalk cafe. Tensions are high as the crowd starts to yell at cafe patrons, the blood of Gaza is on their hands. Some cafe patrons start to leave, while others start yelling back "do you think Trump is the answer?" a few cafe patrons start crying.*

Facilitator asks:

- What do you think the goals of CPD leadership, from Brandon Johnson down to street lieutenants are in this situation?
- What do you think the goals of rank and file CPD officers are in this situation?
- What tactics might the police use to accomplish their goals?

Facilitator lecture:

- Police have two main tactics for controlling dissent: fear and violence. We will be talking about police violence, but the goal is that by better understanding police violence we can break through some of the fear it causes.
- As medics, we help movements resist police tactics so that they may make their own choice to continue to demonstrate or voluntarily evacuate without fear. All street medics should strive to counteract the police culture of fear. Calm, comfort, reassure: consent and empowerment.
- We believe police abolition begins with the cop inside our own heads
- Not to diminish the very real harm and violence police cause to communities in Chicago and around the world every day, understand that generally speaking cops are much kinder and gentler to protestors then they are on the West Side of Chicago. When the state comes down hard on movements it looks like the repression we are seeing in Atlanta right now.
- Brainstorm: Which members of our movement are at heightened risk of police violence and repression?

Scott talks about the following
- Police physical presence
- Voice as weapon
- Shoving / fisticuffs
- Batons
- Bicycles and vehicles
- Barricades, Shields, Kettles
- Projectile Weapons
- Tasers
- Cheam weapons
    - Has anyone here been pepper sprayed and want to share that story?

Arrest, Jail, Jail Support, Handcuff Injuries

- In jail
    - When medics are arrested, we can continue our work in jail
    - Most importantly, we continue to spread calm!
        - check in with people, get to know people, start a song, be kind
    - we can also help other arrestees get in touch with the Cook County Public Defender's Office arrest hotline at 844-817-4448
- Jail support
    - want to help lots of people who have been injured by the police? catch 'em when they come out of custody!
    - there is a robust culture of jail support in social movements into which we can plug here in Chicago and elsewhere
    - as people are released, match energy and adapt; some will be fine, others not so fine
        - can be very emotional
        - having held it together in custody, some may suddenly let go
    - meet basic needs
        - connection
        - nicotine
        - water/snacks
        - finding their people
        - menstrual products
        - when Ben got out of jail Esther and Marta brought him cigarettes, snacks and water, his crazy creek and his book, which he finished as the rest were released
    - all kind of injuries/illnesses
        - sprains and strains
        - exacerbation of chronic medical problems
        - handcuff injuries
        - lacerations
    - consider advocating that people document their injuries

- handcuff injuries
    - very common; most prevalent when cops use plastic zip tie cuffs
        - plastic cuffs can impair circulation and damage nerves when they are applied too tightly
        - any prolonged restraint can lead to muscle soreness and injury
    - assessment to identify circulatory injury and/or nerve damage that requires a higher level of care
        - Check CSM
        - ask the person to squeeze your fingers
            - is there muscle weakness in hand?
                - if one hand is more impaired than the other, it might require more definitive care
            - ask about numbness or tingling; if these persist, escalate care
    - Treatment
        - treating handcuff injuries can be a long game as superficial nerve damage slowly heals over months
        - treatment as a musculoskeletal injury (cold, splinting, bandaging) can be harmful
        - arnica cream can alleviate pain associated with nerve damage
        - provide comfort and reassurance, consider staying in touch if they think that would help
            - scary and disabling to lose sensation due to nerve damage
            - can be a constant, painful reminder of trauma suffered during/after arrest

Scenario

Antifa Gets Shot

Gear Discussion

- Key Points
    - Gear is heavy, that extra water bottle feels a lot heavier after marching for eight hours.
    - Some gear is expensive, our movements can do a lot with a little money.
    - Start with some basics and add to it.
    - Consider where you are, city vs remote, weather, what other options there are.
    - Make your medic kit your own, and don’t carry what you aren’t trained to use!
    - Mo runs with a blanket, some rescue remedy, and a sucking chest wound kit (to ward off sucking chest wounds)
    - Chris comes from amateur race car safety team world and runs with a fire extinguisher
- Activity: Medics spread around room, dump their kits on a table, trainees wander around to look and ask questions

Mental Health Emergencies

Disclaimer: New section, one reason it hasn't been taught is that there is no consensus in street medic community about best practices, in particular whether it's ever okay to send someone to an ER without their consent, but also about paradigms of understanding mental illness and language used. Content warning and all that, absolutely a section trainees can leave the room for. Goal here is to share information so medics can make their own best possible decisions in difficult situations. This section is near the end because we're about to fill out evaluations - would love feedback on this section.

This section still a big maybe

Scenario

Scene Becomes Unsafe

Scenario Debrief

Street Medic Org

- Scott describes street medic response to NATO 2012
- Emissary describes current state of emissaries
- Scott describes Ujima Medics and Chicago Action Medical
- How to plug in

Evaluation

- On big poster paper, medics can stick around after training to fill out forms

Final Thoughts

- Big thanks - registration, space, food, kitchen, childcare, trainers
- Clean-up
- Upcoming events
- Low point / high point / Delta