Global Emergency Medical Registry (GEMR)

Initial Emergency First Aid Certification

for First Responder and Law Enforcement Personnel

Instructor Manual
Curriculum and Lesson Plans

3/23/2026

GLOBAL EMERGENCY MEDICAL REGISTRY

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COURSE SYLLABUS –Emergency First Aid

Global Emergency Medical Registry (GEMR) Initial Emergency First Aid Certification for First Responder and Law Enforcement Personnel

Course Title:	Emergency First Aid for First Responders
Provider:	The Resuscitation Group
Total Instructional Time:	16 Hours
Delivery Format:	In-person, instructor-led
Certification Period:	2 Years (This certification process aligns with ISO 17024 principles for personnel certification, ensuring validity, reliability, impartiality, and defensibility of assessment decisions).
Periodic Review:	This curriculum is subject to periodic review to maintain alignment with ISO 17024 standards, current ILCOR guidelines, and evidence-based practices.
Prerequisites:	None
Target Audience:	First Responders, Sworn law enforcement personnel, academy recruits, tactical team members, response volunteers.

I. COURSE DESCRIPTION

This initial certification course is designed to provide first responders and law enforcement officers with the medical, psychological, and ethical competencies required to respond effectively to emergency medical incidents encountered in operational environments over a 16 hour initial training session.

The course integrates evidence-based resuscitation practices, hemorrhage principles adapted for first responders and law enforcement, crisis response strategies, stress performance regulation, and structured ethical decision-making.

Instruction includes didactic learning, hands-on skill development, and scenario-based simulations designed to replicate real-world field conditions.

II. COURSE PURPOSE

The purpose of this course is to equip first responder and law enforcement personnel with the knowledge, skills, and judgment necessary to:

1. Preserve life in high-risk operational environments.
2. Provide immediate care for traumatic and medical emergencies.

3. Respond effectively to behavioral health crises.
4. Maintain performance under physiological stress.
5. Make ethically sound decisions during emergency response.

III. **LEARNING OUTCOMES**

Upon successful completion of this course, participants will be able to:

1. Perform high-quality adult CPR in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
2. Operate an Automated External Defibrillator (AED) safely and effectively in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
3. Apply hemorrhage control and airway management techniques in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
4. Conduct rapid patient assessments in field environments in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
5. Recognize and manage common life-threatening medical emergencies in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
6. Apply de-escalation techniques during mental health crises in accordance with the American Psychiatric Association (APA) evidence-based clinical recommendations.
7. Demonstrate physiological stress regulation techniques in accordance with the American Psychiatric Association (APA) evidence-based clinical recommendations.
8. Apply structured ethical reasoning during emergency care.
9. Perform effectively in team-based emergency scenarios.

IV. COURSE STRUCTURE AND CONTENT FOR INITIAL CERTIFICATION

DAY 1 (8 HOURS)

Module 1: Foundations of Law Enforcement First Aid

Duration: 1 Hour

Content Areas:

1. Scope of practice for law enforcement first responders.
2. Legal considerations and Good Samaritan protections (USA only students).
3. Duty to act and standard of care.
4. Scene safety and tactical awareness.
5. Consent, capacity, and care under custody.
6. Ethical prioritization of care.

Instructional Methods:

- Lecture presentation
- Facilitated discussion
- Case-based ethical review

Module 2: CPR and AED Certification

Duration: 3.5 Hours

Content Areas:

1. Chain of survival in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
2. Adult CPR (single rescuer and team-based) in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
3. Child CPR (single rescuer and team-based) in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
4. Infant CPR (single rescuer and team-based) in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
5. AED operation and troubleshooting in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
6. Team-based resuscitation dynamics in accordance with current International Liaison Committee on Resuscitation (ILCOR) CPR and First Aid guidelines.
7. CPR modifications for ballistic vests and confined spaces (Chen J, Lu KZ, Yi B, Chen Y. Chest Compression with Personal Protective Equipment During Cardiopulmonary Resuscitation: A Randomized Crossover Simulation Study. Medicine, 2016 Apr;95(14):e3262. doi: 10.1097/MD.0000000000003262. PMID: 27057878; PMCID: PMC4998794).

Skills Training:

1. Hands-on CPR practice
2. AED skill stations
3. Timed compression drills
4. Cardiac Arrest simulation
5. Officer-down simulations (for law enforcement)

Evaluation:

1. CPR.AED.Adult.Skill Sheet Documentation Form
2. CPR.AED.Child.Skill Sheet Documentation Form
3. CPR.AED.Infant.Skill Sheet Documentation Form
4. CPR.AED.Adult Ballistic Vest. Skill Sheet Documentation Form (if Law Enforcement)

Module 3: Hemorrhage Control

Duration: 3 Hours

Content Areas:

1. Preventable causes of death in tactical environments
2. MARCH assessment framework
3. Massive hemorrhage control
4. Limb Tourniquet application (self and buddy)
5. Junctional Tourniquet application
6. Wound packing and pressure bandaging
7. Chest seals for penetrating trauma
8. Airway positioning and oxygenation
9. Care under threat vs. tactical field care

Skills Training:

1. Timed tourniquet drills
2. Wound packing simulation
3. One-handed self-application
4. Casualty movement exercises
5. Oxygen Administration via Non-rebreather mask

Evaluation:

1. GEMR Bleeding Control (BLS) Skill Sheet Documentation Form.
2. GEMR Bleeding Control Combat Application Tourniquet (BLS) Skill Sheet Documentation Form.

Module 4: Stress Physiology and Performance Under Pressure
Duration: 0.5 Hour
Content Areas:
1. Autonomic nervous system response
2. Perceptual distortions under stress
3. Cognitive narrowing and performance degradation
4. Box breathing techniques
5. Emotional regulation strategies

Practical Exercises:
1. Controlled breathing drills
2. Elevated heart-rate decision exercises

DAY 2 (8 HOURS)
Module 5: Medical Emergencies in the Field
Duration: 3 Hours
Content Areas:
1. Cardiac emergencies
2. Stroke recognition
3. Seizure response
4. Diabetic emergencies
5. Opioid overdose and nasal naloxone administration
6. Respiratory distress
7. Recognition and management of shock

Skills Training:
1. Primary and secondary patient assessment
2. Recovery positioning
3. Naloxone nasal administration procedures
4. Epinephrine Auto-Injector administration procedures

Evaluation:
1. GEMR Naloxone Nasal Administration Emergency First Aid Skills Documentation Form
2. GEMR Epinephrine Auto-Injector Emergency First Aid Skills Documentation Form
3. GEMR Oxygen Administration via Mask Emergency First Aid Skills Documentation Form

Module 6: Mental Health Crisis Response
Duration: 2 Hours
Content Areas:
1. Recognition of psychiatric emergencies
2. Suicide risk indicators
3. Psychosis and acute agitation
4. Substance-induced behavioral crisis
5. Communication and de-escalation strategies
6. Crisis Intervention Team (CIT) principles
7. Referral and transport considerations

Scenario Training:
1. Role-play crisis encounters
2. Emotional resilience practice
3. De-escalation drills

Module 7: Ethical Decision-Making in Emergencies
Duration: 0.5 Hour
Content Areas:
1. Structured ethical decision-making models
2. Triage in multi-casualty incidents
3. Resource limitation decision-making
4. Documentation standards

Exercise:
1. Patient triage exercise

Module 8: Integrated Scenario-Based Training
Duration: 2 Hours
Scenario Examples:
1. Respiratory distress patient
2. Overdose patient
3. Cardiac arrest patient
4. Trauma patient with hemorrhage

Performance Evaluation Criteria:
1. Scene safety awareness
2. Clinical skill accuracy
3. Communication effectiveness

4. Stress regulation
5. Ethical judgment

Module 9: Final Evaluations
Duration: 1 Hour
Written Examination:

1. Complete the Global Emergency Medical Registry (GEMR) online Emergency First Aid written examination.
2. Minimum passing score is 85%
3. Note: At the discretion of the Global Emergency Medical Registry (GEMR), organizations approved by GEMR may offer the EFA written exam in class at the end of day 2 and provide the signed answer sheet to the student for uploading.

Practical Examination (done at end of each specific module with GEMR Skills Documentation Form):

1. CPR/AED Adult, Child, Infant competency through skills sheet completion during module
2. Tourniquet application competency
3. Intranasal naloxone administration
4. Epinephrine Auto-Injector administration
5. Oxygen administration via mask

The successfully completed skills sheets must be uploaded to the student's GEMR profile under "transcripts", prior to taking the written examination.

V. INSTRUCTIONAL METHODOLOGY AND RATIOS

This course utilizes:

1. Instructor-led lecture
2. Guided discussion
3. Skill stations
4. Repetitive psychomotor drills
5. Scenario-based simulations
6. Stress exposure training
7. Team-based operational exercises

Instruction is delivered using adult learning principles emphasizing repetition, realism, and performance feedback.

The instructional ratio for GEMR Emergency First Aid for First Responders and Law Enforcement is recommended at 6:1, the maximum ratio allowed is 8:1 with additional 30 minutes added to course time for evaluation. An instructor may evaluate no more than two persons at a time for skills completion.

VI. REQUIRED EQUIPMENT

Instruction for this course requires the following minimum equipment:

1. Adult CPR mannequin with feedback system, one per two students minimum.
2. Infant CPR mannequin with feedback system, one per two students minimum
3. AED training unit, one per CPR manikin.
4. Adult Training CPR Pocket Resuscitator Masks with Valves, one per student
5. Infant Training CPR Pocket Resuscitator Masks with Valves, one per student
6. Junctional tourniquet (training models), one for every four students.
7. Extremity tourniquet (training model), one for every student.
8. XSTAT Training Kit (or other hemostatic wound packing training kit), one for every four students.
9. Chest Seal Trainer device, one for every four students.
10. Trauma Manikin for hemorrhage control and chest seal application, one per four students.
11. Intranasal Naloxone training devices, one per every two students.
12. Epinephrine Auto-Injector training devices, one per every two students.
13. Oxygen cylinder (size D or E) with regulator and non-rebreather mask, one set for every four students (Oxygen cylinder may be filled with air rather than oxygen for training).
14. Simulation props and scenario scripts.

All equipment must be cleaned per ISO 17664 standards for medical training equipment.

VII. CERTIFICATION REQUIREMENTS

Participants must:

1. Attend the full 16 instructional hours
2. Successfully complete the GEMR online written examination with score 85% or better
3. Demonstrate competency in required practical skills and upload successful, signed, skills sheets to their GEMR profile under “transcripts”.
4. Demonstrate attendance at an Emergency First Aid course, compliant to the GEMR Emergency First Aid standards outlined in this document, by uploading certificate to “transcripts”.

GEMR Certification is valid for two (2) years from the date of course completion, renewal certification requires completion of a refresher course and skills sheets.

Certification decisions are based on objective evidence of competence, including successful completion of training, validated skills assessments, and standardized examination processes in alignment with ISO 17024 principles.

VIII. INSTRUCTOR QUALIFICATIONS

Instructors must:

1. Hold current CPR/AED instructor certification from an organization using ILCOR standards or hold a current GEMR Medical Instructor certification.
2. Be GEMR certified at the EFR, level or above.
3. Possess a minimum of two years' experience in law enforcement or prehospital emergency care; or be a current CPR/First Aid instructor with an ILCOR compliant organization.
4. Be approved by the organization sponsoring the training.

IX. STUDENT MATERIALS

The curriculum lesson plans show which student materials should be available to the students during the course.

Instructors or sponsoring organizations should have all student reference materials emailed to students prior to the course start date to allow the students to review the materials prior to class.

X. COURSE COMPLIANCE AND REVIEW

Under ISO 17024, this curriculum is subject to periodic review to ensure alignment with:

1. Current resuscitation science
2. Law enforcement operational standards
3. ILCOR standards

This GEMR curriculum is subject to periodic review to maintain alignment with ISO 17024 standards, current ILCOR guidelines, and evidence-based practices.

This GEMR certification process aligns with ISO 17024 principles for personnel certification, ensuring validity, reliability, impartiality, and defensibility of assessment decisions.

Instructor Lesson Plan – Emergency First Aid

Detailed Instructor Lesson Plan Package with Teaching Scripts for the 16-Hour Initial Emergency First Aid Certification Course for First Responders and Law Enforcement personnel. This document is written for delivery under The Global Emergency Medical Registry (GEMR) Emergency First Aid standards and structured so an instructor can teach directly from it with minimal preparation.

Global Emergency Medical Registry (GEMR) Initial Emergency First Aid Certification for First Responder and Law Enforcement Personnel

Course Title:	Emergency First Aid for First Responders – Initial Course
Provider:	The Resuscitation Group
Total Instructional Time:	16 Hours
Delivery Format:	In-person, instructor-led
Certification Period:	2 Years
Prerequisites:	None
Target Audience:	First Responders, Sworn law enforcement personnel, academy recruits, tactical team members, response volunteers.

Required Equipment:

Instruction for this course requires the following minimum equipment:

1. Adult CPR mannequin with feedback system, one per two students minimum.
2. Infant CPR mannequin with feedback system, one per two students minimum
3. AED training unit, one per CPR manikin.
4. Adult Training CPR Pocket Resuscitator Masks with Valves, one per student
5. Infant Training CPR Pocket Resuscitator Masks with Valves, one per student
6. Junctional tourniquet (training models), one for every four students.
7. Extremity tourniquet (training model), one for every student.
8. XSTAT Training Kit (or other hemostatic wound packing training kit), one for every four students.
9. Chest Seal Trainer, one for every four students
10. Trauma Manikin for hemorrhage control and chest seal application, one per four students.
11. Intranasal Naloxone training devices, one per every two students.
12. Epinephrine Auto-Injector training devices, one per every two students.
13. Oxygen cylinder (size D or E) with regulator and non-rebreather mask, one set for every four students (Oxygen cylinder may be filled with air rather than oxygen for training).
14. Simulation props and scenario scripts.

All equipment must be cleaned per ISO 17664 standards for medical training equipment.

DAY 1

MODULE 1: Foundations of Emergency First Aid for First responders and Law Enforcement

Duration: 60 Minutes

Learning Objectives, participants will be able to:

1. Define their role as a first responder in operational environments.
2. Identify legal and ethical responsibilities.
3. Apply basic ethical reasoning to emergency scenarios.

Required Materials

1. PowerPoint presentation
2. Whiteboard
3. Scenario handouts
4. Marker

Instructor Preparation

1. Review any Good Samaritan laws in place in the jurisdiction.
2. Review duty-to-act for first responders and law enforcement.
3. Review ethical case studies

Teaching Script

Opening (5 minutes)

"*Good morning. Today we begin with a simple reality: You are often the first medically capable person on scene. Not EMS – Just You. Your decisions and actions in the first 3–5 minutes determine survival."*

Pause.

"*This course is not about turning you into paramedics. It's about preventing avoidable death*."

Role of First Responders and Law Enforcement (10 minutes)

"*Your responsibility includes:*

1. *Scene safety*
2. *Immediate hemorrhage control*
3. *CPR/AED use*
4. *Stabilization until EMS arrival*

You are not expected to diagnose; you are expected to preserve life and limit injuries."

Ask:

"*What medical events have you encountered in the field*?"

"*What made them difficult*?"

Facilitate brief discussion with students, remember it's their stories – NOT yours.

Legal & Ethical Considerations (20 minutes)
"*Let's talk about protection and responsibility*."
Cover:

1. Duty to act (utilize Appendix 1 handout)
    a. Duty to Act (Law Enforcement Context)
        i. Duty to Act is the legal and professional obligation requiring a person to provide reasonable assistance when they are in a position of responsibility to do so.
        ii. For law enforcement officers, this duty typically arises because of employment, authority, and custody responsibilities, not simply because they are present.
    b. What Creates a Duty to Act?
        i. A duty to act is generally established when one or more of the following conditions exist:
    c. Employment Role
        i. Sworn officers acting within the scope of their official duties have a legal responsibility to respond to emergencies they encounter while on duty.
    d. Custody or Control
        i. When an individual is detained, arrested, restrained, or otherwise under officer control, the officer assumes responsibility for that person's safety and medical needs.
    e. Assumption of Care
        i. If an officer begins providing care, they are expected to continue until:
        ii. Care is transferred to equal or higher-level providers (EMS, hospital), or the scene becomes unsafe.
    f. Department Policy
        i. Agency policies often expand or clarify the officer's duty beyond general state law.
    g. What Does "Reasonable Care" Mean?
        i. Duty to act does not mean providing advanced medical care beyond training. It means:
            a) Acting within your level of training and certification
            b) Following accepted first aid standards
            c) Avoiding gross negligence
            d) Activating EMS promptly
            e) Reasonableness is judged by what a similarly trained officer would do under similar circumstances.
    h. Duty to Act vs. Good Samaritan Laws

i. Good Samaritan laws generally protect private citizens who voluntarily render aid; however, on-duty officers and responders who are in paid positions are not typically considered volunteers
ii. Their protection is usually derived from: Government immunity statutes, Qualified immunity principles, Agency coverage
iii. Good Samaritan protections are more relevant when officers provide aid off duty.

i. When Does Duty to Act End?
   i. Duty to act typically ends when:
      a) Care is transferred to EMS
      b) The officer is officially relieved
      c) The scene becomes unsafe and withdrawal is necessary
   ii. However, documentation remains part of the responsibility.

j. Ethical Dimension of Duty to Act
   i. Beyond legal obligation, duty to act reflects:
      a) Professional integrity
      b) Public trust
      c) Ethical responsibility to preserve life
   ii. For law enforcement personnel, it is tied directly to legitimacy and community confidence.

k. Practical Application in Your First Aid Course, in the context of your 16-hour certification program:
   i. Officers must understand that:
      a) CPR/AED response is not optional when on duty
      b) Hemorrhage control must be initiated when safe
      c) Medical complaints in custody require assessment
      d) Behavioral health crises still fall under duty to act
   ii. The standard is not perfection — it is reasonable, timely, and trained response.

2. Care under custody (reference student handout “Care under Custody)
3. Consent and implied consent (reference student “Consent and Implied Consent”)
4. Good Samaritan principles

Script:
“When someone is unconscious, consent is implied. When someone is in your care or custody, your duty increases, not decreases.”

Ethical Case Study (20 minutes)

1. Choose one or two Ethical Case Studies from APPENDIX 5 to present in the time limit.
2. Close with: “Ethical decisions in the field are rarely clean. Our standard is: preserve life based on survivability, not identity.”

Evaluation

1. Participation
2. Engagement in case discussion

MODULE 2: CPR and AED Certification
Duration: 3.5 Hours
Learning Objectives:
1. Demonstrate high-quality CPR for Adult, Child, and Infant.
2. Operate an AED correctly.
3. Perform team-based resuscitation.
4. Understand process for choking care

Materials:
1. CPR/AED (Adult) Emergency First Aid Skills Documentation Form (Appendix 6)
2. CPR/AED (Child) Emergency First Aid Skills Documentation Form (Appendix 6)
3. CPR/AED (Infant) Emergency First Aid Skills Documentation Form (Appendix 6)
4. CPR/AED (Adult Ballistic Vest) Emergency First Aid Skills Documentation Form

Teaching Script

Opening (10 minutes)
"*Adult Cardiac arrest survival depends on two things:*
1. Immediate compressions
2. Early defibrillation
Nothing else matters if those two fail."

Demonstration Script (CPR)
Instructor demonstrates Adult Chest Compressions.
- *Hands center of chest.*
- *Lock elbows and shoulders over patient's sternum.*
- *Push hard. Push fast.*
- *At least 2-2.5 inches deep.*
- *100–120 compressions per minute.*
- *Full recoil. Don't lean.*

Pause.
"*Bad CPR is worse than no CPR*."

Demonstration Script (Choking)
Instructor demonstrates choking treatment for conscious and unconscious adult, child, and infant.

Skills Station Structure

Station 1: Compressions (15 minutes)

1. Practice with minimum of 2-minute cycles
2. Utilize CPR Manikin with feedback system and provide real-time correction

Correction phrases to students:

1. "*Push deeper*."
2. "*Faster.*"
3. "*Let the chest recoil*."
4. "*Don't bounce*."

Station 2: AED (30 minutes)

Script:

- *Turn it on.*
- *Listen to it.*
- *Follow the prompts.*
- *Clear before shock.*

Practice:

1. Practice with minimum of 2 minute CPR cycles
2. Practice the AED arriving after 30-40 seconds of compressions, applying AED, Delivering Shock, then resuming Chest Compressions.

Station 3: Two Person Adult CPR (15 minutes)

1. Practice with 2 minute periods of 30:2 compressions and ventilations with two rescuers.
2. Integrate AED into practice.
3. When done correctly, per GEMR CPR/AED Adult Skills Documentation Form, the instructor may sign off a sheet for each student.

Station 4: Two Person Child CPR (30 minutes)

1. Practice with 2 minute periods of 15:2 compressions and ventilations with two rescuers.
2. Integrate AED into practice.
3. When done correctly, per GEMR CPR/AED Child Skills Documentation Form, the instructor may sign off a sheet for each student.

Station 5: Two Person Infant CPR (30 minutes)

4. Practice with 2 minute periods
5. Begin with a single rescuer performing 30:2 compressions to ventilations, then after 1 minute add a second rescuer and begin 15:2 compressions and ventilations with two rescuers.
6. Integrate AED into practice.
7. When done correctly, per GEMR CPR/AED Infant Skills Documentation Form, the instructor may sign off a sheet for each student.

Station 6: Four Person Response Team-Based Drills (30 minutes)

Assign roles:

1. Compressor
2. Airway
3. AED
4. Scene lead

Skill Rotations:

1. Run three rotations of 2 minute cardiac arrest cases, with the four person team beginning 30:2 compressions and ventilations immediately, and then AED being set up quickly and shock delivered, then two minutes of CPR. Conclude rotation after two minutes of CPR completed and begin again.

Evaluation (30 minutes)

1. Successful completion of GEMR CPR/AED Adult Skills Documentation Form
2. Successful completion of GEMR CPR/AED Child Skills Documentation Form
3. Successful completion of GEMR CPR/AED Infant Skills Documentation Form

MODULE 3: Hemorrhage Control
Duration: 3 Hours
Teaching Script:
Opening (10 minutes)
"*The number one preventable cause of death in trauma environments is hemorrhage.*"
Write on board:

M – Massive Hemorrhage
A – Airway
R – Respiration
C – Circulation
H – Head Injury/Hypothermia

"*This is your patient assessment method and mental checklist for trauma incidents.*"

Materials:
1. MARCH Assessment student reference handout located in Appendix 7.
2. AVPU Assessment student reference handout located in Appendix 8.
3. GEMR Tourniquet Application Skills Sheet located in Appendix 9.
4. Junctional Tourniquet student reference sheet located in Appendix 10.

Tourniquet Demonstration Script, stated while instructor places a tourniquet on a trauma manikin (10 minutes):
1. *"Place tourniquet approximately 1-2 inches above injury and keep tight"*
2. *"Pull tight until bleeding stops"*
3. *"Twist tightener until no distal pulse and all bleeding has stopped"*
4. *"Secure it"*
5. *"Note the time"*

"A conscious patient will feel pain when this is done"
"If it doesn't hurt, check level of consciousness and consider that it may not be tight enough"

Skills Stations

Station 1: MARCH Assessment (20 minutes):

Practice:

1. Instructor breaks students into two person teams and demonstrates the MARCH assessment.
2. Each team demonstrates the ability to check a carotid pulse rate and respiratory rate.
3. Each team shows the MARCH assessment on each other.

Station 2: Extremity Tourniquet Self-Application by student onto their own leg. (10 minutes)

Practice:

1. Utilize one hand
2. 60-second time limit

Station 2: Extremity Tourniquet Application by student onto trauma manikin or other student

Practice 1 (20 minutes):

1. Utilize both hands
2. 60-second time limit
3. Utilize GEMR Application Tourniquet Skill Sheet as a reference

Practice 2:

1. Each rescuer performs 30-seconds of jumping jacks or running in place.
2. Utilize both hands.
3. Immediately place limb tourniquet on trauma manikin or other student within 30 seconds.
4. Debrief: "What changed under stress?" "Did fine motor control degrade?"

Station 3: Junctional Tourniquet Application by student onto trauma manikin or other student

Practice (30 minutes):

1. Utilize both hands
2. 60-second time limit
3. Utilize Junctional Tourniquet Application Student Reference Sheet

Station 4: Wound Packing (30 minutes)

Script #1:

1. *"Find the source"*
2. *"Pack deep"*
3. *"Pack hard"*
4. *"Direct pressure for 3 minutes"*

Script #2:

1. *"Identify source of bleeding"*
2. *"Prepare X-Stat"*
3. *"Insert X-Stat into wound deeply"*
4. *"Depress X-Stat plunger"*
5. *"Remove from wound, holding direct pressure over wound to retain absorptive material until expansion"*

Practice:

1. Utilize X-Stat trainer on wound simulator or trauma manikin

Station 5: Chest Seal (30 minutes)

Script:

"Wipe. Seal. Monitor breathing."

Practice:

1. Place chest seal training device on trauma manikin.

Station 6: Trauma Scenario Drill (30 minutes)

Script:

1. *"Your trauma manikin is a 25 y/o male patient with severe bleeding from a right lower leg wound and right lower arm wound"*
2. *"Your patient has an open airway and is 30 breaths per minute, 120 beats per minute pulse, patient responds to pain stimulus with purposeful movement"*
3. *"In teams of two, please treat your patient"*

Practice:

1. Break students into groups of two.
2. Utilizing class equipment, treat presented patient in real time.

Evaluation:

1. Successfully completes GEMR Tourniquet application skills documentation form.
2. Completes all skills stations during module.

MODULE 4: Stress Physiology
Duration: 30 minutes
Materials: Overcoming Stress Physiology Student Quick Reference Tool, located in Appendix 11.

Teaching Script:

1. "Under stress: Heart rate spikes, Vision narrows, Hearing distorts, Fine motor skills degrade"
2. "This is biology — not weakness."

Practice 1:
Teach Box Breathing (4-4-4-4 Method)

1. "We are going to practice an evidence based approach to regulate stress physiology and attempt to lower our heart rate, improve focus, and restore fine motor control."
2. "All of us are going to participate, all at once, I will lead"
3. "First, everyone get ready, we are going to do 2 minutes of Chest Compressions, I will keep time and tell you when to start and stop"
4. "After two minutes, "Everyone stop and sit"
5. "We are going to use the 4-4-4-4 Method"
6. "Everyone follows my prompts"
7. "Inhale 4 seconds, Hold 4 seconds, Exhale 4 seconds, Hold 4 seconds"
8. "I will guide us all, through three cycles."

Debrief:

1. "What did you notice?"
2. "Where you successful at reducing your heart rate and returning focus?"

DAY 2

MODULE 5: Medical Emergencies

Duration: 2.5 Hours

Materials:

1. EFR.Naloxone Nasal Administration.Skill Sheet.2026 GEMR
2. EFR.Epinephrine Auto Injector Administration.Skill Sheet.2026 GEMR
3. EFR.Oxygen Administration via Mask.Skill Sheet.2026 GEMR

Teaching Script:

"Trauma is obvious; Medical emergencies are subtle — and often deadlier."

Discussion 1: Medical Emergencies (30 minutes)

Discuss with the group the following, using the tools listed:

1. Stroke:
    a. Stroke First Aid Student Reference tool located in Appendix 12 should be provided to all students; use this document to guide your discussion on stroke patients with the students.
    b. Explain FAST and importance of accessing advanced life support quickly.
    c. Explain treatment steps.
2. Acute Coronary Syndrome/Chest Pain
    a. Chest Pain First Aid Student Reference located in Appendix 13 should be provided to all students; use this document to guide your discussion on chest pain patients with the students.
    b. Explain symptoms and first aid steps for the chest pain patient.
3. Seizure
    a. Seizure First Aid Student Reference located in Appendix 14 should be provided to all students; use this document to guide your discussion on chest pain patients with the students.
    b. Explain signs and symptoms and First Aid steps for seizure.
4. Anaphylaxis
    a. Anaphylaxis First Aid Student Reference located in Appendix 15 should be provided to all students; use this document to guide your discussion on chest pain patients with the students.
    b. Focus on the Red Flags and Treatment process.
5. Insect Bites and Stings First Aid and Dangerous Marine Life First Aid
    a. Assure students have the Insect Bites and Stings First Aid Student Reference Sheet and the Dangerous Marine Life First Aid Student Reference Sheet for review.

b. Using the reference sheets, provide a question and answer period.
c. For students engaging in marine activities or in areas with significant marine issues, the instructor may wish to increase course time to provide a more through discussion on first aid for dangerous marine life.

6. Diabetic emergency
   a. Briefly cover signs and symptoms of diabetic emergencies and emphasize the need for Emergency Medical Services response.
7. Overdose
   a. Briefly discuss overdose symptoms.
   b. Emphasize the need for Emergency Medical Services response.
   c. Assure students have naloxone administration GEMR skills sheet.
8. Environmental Emergencies
   a. Assure students have the Hypothermia/Hyperthermia First Aid Student Reference Sheet

Station 1: Possible Opioid Overdose and Naloxone Administration (30 minutes)
Process:

1. Remind students about signs and symptoms, as well as ventilation.
2. Demonstrate naloxone administration on CPR or Trauma manikins, using the GEMR EFR Naloxone Nasal Administration Skill Sheet 2026.
3. Assure students have the GEMR EFR Naloxone Nasal Administration Skill Sheet 2026.
4. Break students into two person teams, explain they will treat the manikins, as if they are unresponsive possible overdose patients, using the GEMR EFR Naloxone Nasal Administration Skill Sheet 2026 and the Naloxone Intranasal Trainer devices.
5. Evaluate students' performance against the GEMR EFR Naloxone Nasal Administration Skill Sheet 2026 standard.

Station 2: Possible Anaphylaxis and Epinephrine administration (30 minutes)
Process:

1. Remind students about Red Flag indicators, as well as oxygen use and ventilation.
2. Demonstrate Epinephrine Autoinjector administration on CPR or Trauma manikins, using the GEMR EFR Epinephrine Auto Injector Administration Skill Sheet 2026.
   a. Show students the Epinephrine Autoinjector Trainer.
   b. Mention that there is an intranasal device also, the NEFFY® (epinephrine nasal spray).
3. Assure students have the GEMR EFR Epinephrine Auto Injector Administration Skill Sheet 2026.
4. Break students into two person teams, explain they will treat the manikins, as if they are unresponsive possible anaphylaxis patients, using the GEMR EFR Epinephrine Auto Injector Administration Skill Sheet 2026, using the Epinephrine Autoinjector Trainer.
5. Evaluate students' performance against the GEMR EFR Epinephrine Auto Injector Administration Skill Sheet 2026 standard.

Station 3: Oxygen Administration (30 minutes)

Process:

1. Remind students about indicators for oxygen administration: Severe Hemorrhage, stroke, chest pain, seizure, anaphylaxis, shock, or cardiac arrest.
2. Demonstrate Oxygen administration on CPR or Trauma manikins, using the GEMR EFR Oxygen Administration via Mask Skill Sheet 2026.
    a. Take special care to ensure students understand and follow the safety requirements for oxygen equipment, such as not standing tanks up, always lay tank on floor, assure tank is off when regulator is applied..
3. Assure students have the GEMR EFR Oxygen Administration via Mask Skill Sheet 2026.
4. Break students into four person teams, explain they will treat the manikins, as if they are unresponsive possible seizure patients, using the GEMR EFR Oxygen Administration via Mask Skill Sheet 2026, using the Epinephrine Autoinjector Trainer.
5. Evaluate students' performance against the GEMR EFR Oxygen Administration via Mask Skill Sheet 2026 standard.

Station 4: Recovery Position and Back Up Head Elevated Position (15 minutes)

Process:

1. Remind students about indicators for positioning.
2. Demonstrate the recovery position, using a student on the floor.
3. Demonstrate the Back Up Head Elevated position with a student.
4. Break students into two person teams, have the students practice the recovery position and the Back Up Head Elevated (BUHE) position.

MODULE 6: Mental Health Crisis Response

Objective:

By the end of the session:

1. Participants will identify suicide risk indicators, recognize hallucinations and psychotic symptoms, apply safety-focused de-escalation language, and practice verbal de-escalation strategies in crisis scenarios.
2. Participants will also understand decision points for seeking professional help and how to connect individuals to appropriate resources.
3. Participants will be able to identify potential medically caused mental health emergencies and begin first aid, while activating Emergency Medical Services immediately.

Target audience:

1. First Responders, Law Enforcement, maritime, educators, frontline staff, or students seeking Mental Health First Aid competencies. Adaptable for in-person or virtual delivery.

Duration and structure:

1. Total time: 120 minutes
2. Session layout:
    a. Introduction and framing (15 minutes)
    b. Module A: Suicide indicators and risk assessment basics (25 minutes)
    c. Break/quick activity (5 minutes)
    d. Module B: Hallucinations and psychosis in crisis (25 minutes)
    e. Module C: De-escalation language and communication techniques (25 minutes)
    f. Guided practice: Scenarios and role-plays (20 minutes)
    g. Wrap-up, resource mapping, and evaluation (10 minutes)

Required materials:

1. Slide deck with concise definitions, red flags, scripts, and sample dialogues
2. Handouts: Suicide indicators checklist, psychosis/hallucination/delirium quick reference, de-escalation language guide
    a. Use these handouts as quick-reference tools during training and infield practice
    b. Encourage participants to laminate or keep digital copies on mobile devices
    c. Combine with scripted role-plays to practice phrases and responses
3. Scenario cards (weighted toward first-aid context)
4. Space for role-play (physical or breakout rooms in virtual format)

Module content outline with integrated references:

Introduction and framing (15 minutes)

1. Define mental health first aid and its scope (not a substitute for professional care) and emphasize safety-first principles.
2. Outline session goals: recognize warning signs for suicide, identify psychosis-related symptoms (hallucinations, delusions), practice de-escalation language, and connect to help.
3. Emphasize ethical considerations: non-judgmental listening, respect for autonomy, and safety planning.
4. Rationale and evidence: Mental health first aid guidelines emphasize public-facing helping behaviors, including recognizing crisis signs and facilitating linkage to care (Cottrill et al., 2021; , Salani et al., 2021; Spencer et al., 2018; The Delphi-developed guidelines for psychosis emphasize approach, language, safety, and seeking help Cottrill et al., 2021; De-escalation is widely taught as an early intervention for crisis situations Spencer et al., 2018; Lavoie et al., 2022).

Section A: Suicide indicators and risk assessment basics (25 minutes)

Learning outcomes

1. Identify major suicide risk indicators (ideation, intent, plan, means, previous attempts, withdrawal, hopelessness, agitation) and understand when to seek urgent care.
2. Learn to ask directly about thoughts of suicide in a non-judgmental way.
3. Understand basic safety planning and emergency pathways.

Key content

1. Suicide risk indicators: prior attempts, current ideation, plan, access to means, hopelessness, agitation, behavioral changes from baseline, social withdrawal, substance use changes, recent loss or trauma. These factors are repeatedly highlighted in clinical and crisis response literature as central to risk assessment and decision-making about escalation or hospitalization (Jabbar et al., 2018; Kesic et al., 2012; González-Rodríguez et al., 2023; Pompili et al., 2021).
2. Direct inquiry and engagement: Evidence supports direct questioning about suicidal thoughts as part of crisis assessment; structured tools exist (e.g., C-SSRS). Curriculum development and healthcare training literature emphasize direct questions and structured assessment to determine crisis level and appropriate referral (Paulson et al., 2025).
3. Safety planning and next steps: safety planning and facilitating access to crisis resources reduces risk and supports linkage to care; training programs for crisis response stress the

importance of connecting to mental health services and crisis teams when indicated (Ghelani, 2021; , Nick et al., 2022; , Paulson et al., 2025).

Active learning activities

1. Quick mental model:
    a. "Is there a risk now?" with three domains: thoughts of dying or self-harm, intent/plan, and means.
    b. Have participants categorize scenarios as "low," "moderate," or "high" risk with instructor guidance.
2. Script practice:
    a. Model a direct, compassionate approach to inquiring about suicide. Example prompts to practice:
        i. "I'm glad you told me this. Are you thinking about hurting yourself right now?"
        ii. "Do you have a plan or some way you might act on these thoughts?"

References supporting module content

1. Delphi redevelopment and guidelines for psychosis first aid, including talking about experiences and safety planning (Cottrill et al., 2021).
2. Crisis intervention (CIT) training elements covering suicide risk assessment and safety planning in law enforcement and public-facing crisis response contexts Nick et al., 2022; Ghelani, 2021).
3. Public health and first-responder crisis response literature showing improvements in knowledge and attitudes after mental health training, with emphasis on suicide risk assessment and de-escalation components (Nick et al., 2022; Murray et al., 2022).

<u>Break/quick activity</u> (5 minutes)

1. Pause for hydration and a 2-minute reflective writing:
    a. "What signals would make you pause and contact a professional?", reinforcing that early recognition matters.

Section B: Hallucinations and psychosis in crisis (25 minutes)

Learning outcomes

1. Recognize common psychosis-related symptoms (hallucinations, delusions, disorganized thinking) and differentiate medical/psychiatric etiologies from social misinterpretations.
2. Understand safety considerations when a person is experiencing psychosis and how to respond.

Key content

1. Hallucinations and psychosis:
    a. Hallucinations (auditory, visual, etc.) and delusions may occur in psychosis, schizophrenia-spectrum disorders, mood disorders with psychotic features, or substance-induced states. Early recognition informs approach and safety planning (Salani et al., 2021; Jabbar et al., 2018; González-Rodríguez et al., 2023).
2. Public guidance for talking to someone experiencing psychosis:
    a. Guidelines emphasize calm, non-judgmental language, focusing on reality-based grounding, and avoiding confrontation about delusions or hallucinations; emphasize dignity and safety (Cottrill et al., 2021; González-Rodríguez et al., 2023).
3. Safety planning and crisis response:
    a. Recognizing the need for escalation to crisis services if there is danger to self or others, or if the person is overwhelmed or unable to care for themselves; strong emphasis on de-escalation as first-line in severe states (Cottrill et al., 2021; Spencer et al., 2018; Salani et al., 2021).

Active learning activities

1. Identification practice:
    a. Discuss short cases where participants identify whether the person is experiencing psychosis vs. other conditions and decide whether to continue supportive conversation or escalate to professional care immediately.
2. Language practice:
    a. Demonstrate language strategies for addressing hallucinations empathetically (e.g., acknowledge the person's experiences without endorsing false beliefs; redirect to real-world grounding and safety).

References supporting module content

1. Redevelopment guidelines for assisting someone experiencing psychosis; emphasis on how to approach, talk, respond to hallucinations, safety considerations, and de-escalation (Cottrill et al., 2021).
2. Crisis intervention and de-escalation strategy literature; de-escalation is central to reducing risk in crisis interactions with those experiencing psychosis or agitation (Ghelani, 2021; Spencer et al., 2018; Salani et al., 2021).
3. Public health and first-aid guidelines emphasize de-escalation language and steps to support someone in crisis with psychosis while maintaining safety (Cottrill et al., 2021; Salani et al., 2021).

Section C: De-escalation language and communication techniques (25 minutes)

Learning outcomes

1. Apply evidence-based verbal de-escalation techniques to reduce arousal and prevent escalation.
2. Use person-centered, trauma-informed, and culturally competent language to engage the person.

Key content

1. Core de-escalation principles:
    a. Use a calm voice, maintain safe distance, lower volume than the person, set clear boundaries, acknowledge feelings, validate, and offer choices.
    b. These fundamentals are repeatedly cited as essential first steps in crisis de-escalation and are included in CIT and MCIT training literature Ghelani, 2021; Nick et al., 2022; Lavoie et al., 2022).
2. Verbal strategies:
    a. Open-ended questions, reflective listening, normalization without minimizing distress, predictable and simple sentences, and grounding techniques.
    b. De-escalation frameworks emphasize language alignment to calmness and safety (Spencer et al., 2018; Comartin et al., 2020).
3. Safety and boundaries:
    a. Ensure personal safety, avoid arguing about delusions/hallucinations, and avoid coercive or forceful tactics where possible; recognize when to involve crisis teams or clinical professionals (Cottrill et al., 2021; Salani et al., 2021; Spencer et al., 2018; Salani et al., 2021).

Active learning activities

1. Language scripts practice: participants role-play dialogues using de-escalation language: greeting, setting boundaries, acknowledging distress, offering choices, and planning next steps.
2. Environmental and nonverbal awareness: discuss how positioning, eye contact, tone, and body language influence the encounter and how to adjust during a crisis (Pozo-Herce, 2025; Spencer et al., 2018).

References supporting module content

1. Discuss relational policing and de-escalation training in crisis response, emphasizing collaboration with community stakeholders and immersive practice to develop competencies in de-escalation and crisis communication (Lavoie et al., 2022).
2. Cochrane review on non-psychosis aggression underscores the need for skilled de-escalation and communication to prevent escalation (Spencer et al., 2018).

Guided Practice: Scenarios and role-plays (20 minutes)

Activity structure

1. Participants are divided into small groups (3–4 per group).
2. Each group works through two scenario cards, one focusing on suicide risk and one focusing on psychosis/de-escalation, applying the following sequence:
    a. Identify risk signals and immediate safety concerns.
    b. Decide whether to engage with the person using de-escalation language.
    c. Practice direct, non-judgmental inquiry about suicidality if present.
    d. Apply de-escalation scripts and grounding techniques.
    e. Determine next steps and resources (e.g., contact crisis lines, involve professionals, or advise seeking urgent care).
3. Debrief with whole group to capture varied approaches, discuss what worked, what could be improved, and what resources would be accessed.

Scenario suggestions (adapt as needed)

1. Scenario A (suicide risk): A neighbor reports a person expressing feelings of hopelessness, vague intent, and statements about not wanting to be here tomorrow. Role-plays focus on asking direct questions, ensuring safety, and connecting to crisis resources.
2. Scenario B (psychosis/hallucinations): A person appears convinced their phone is "listening" to them and that unseen forces are controlling events; maintain calm,

acknowledge distress, redirect to safety planning without arguing about delusional content, and assess need for professional help.

3. Scenario C (de-escalation focus): A crowd around a distressed individual who is agitated, but not outwardly violent; participants practice de-escalation language, body positioning, and boundary setting.
4. Scenario D (combined risk): A person with known mental health history exhibits escalating agitation and speaks of self-harm; apply suicide assessment and de-escalation sequence, then connect with crisis services if needed.
5. Scenario E (suicide risk): A person is reported as being severely depressed and her roommate calls for assistance. You find a well-dressed woman, approximately 20 yrs of age in her college apartment, she is calm, composed, with a mild voice and demeanor. She answers your questions and when asked, she states that she does intend to take her own life. When asked her plan, she states she is going to jump off the Golden Gate Bridge in San Francisco. When asked how she will carry out her plan, she removes a one way air ticket to Sand Francisco airport. What do you feel will be appropriate approach and intervention for this patient.

<u>Wrap-up, resource mapping, and evaluation</u> (10 minutes)

1. Review key takeaways:
    a. Signals of suicidality, psychosis indicators, de-escalation language, safety planning steps, and pathways to professional help.
2. Resource sheet distribution:
    a. Local crisis lines, mobile crisis teams, crisis centers, emergency numbers, and community mental health resources.
    b. Emphasize reaching out to professionals for high-risk cases or when safety is at risk.
3. Brief evaluation:
    a. Quick anonymous feedback (smiles/ratings or short form) to gauge confidence in recognizing suicide risk, identifying psychosis symptoms, and using de-escalation language.

Nuances and evidence synthesis:

1. Suicide indicators and risk assessment require direct inquiry and clear safety planning. Expert consensus and crisis response education emphasize structured inquiry and escalation pathways when risk is identified (Cottrill et al., 2021; Jabbar et al., 2018; Paulson et al., 2025).
2. Hallucinations and psychosis are best approached with calm, non-confrontational communication, focusing on safety and grounding rather than arguing about beliefs. Redeveloped psychosis guidelines stress language, safety, and seeking help when necessary (Cottrill et al., 2021; , González-Rodríguez et al., 2023).
    a. *BEWARE, many hallucinations are from medical pathology and patients should receive immediate Emergency Medical care*.
3. De-escalation language has robust instructional support but varying evidence on effectiveness; high-quality randomized evidence is limited, yet consensus supports de-escalation as a preferred early intervention in many crisis contexts Spencer et al., 2018; , Comartin et al., 2020), Lavoie et al., 2022; . The practical emphasis is on verbal techniques, nonverbal cues, safe environment, and involving appropriate professionals when needed (Ghelani, 2021; , Spencer et al., 2018)

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MODULE 7: Ethical Decision-Making

Duration: 30 minutes

Learning objectives

1. Identify core ethical principles relevant to first aid (autonomy, beneficence, nonmaleficence, confidentiality) and how they apply in acute, time-sensitive scenarios (Olick, 2001; Sheikh et al., 2013; Duvivier et al., 2010).
2. Demonstrate appropriate communication and consent practices in emergencies, including implied consent, empowering bystanders, and when to disclose or refuse help within ethical and legal bounds (Olick, 2001; Okoroafor & Christmals, 2023; Duvivier et al., 2010).
3. Recognize duties around patient safety, error disclosure, and professional accountability in first aid contexts, including when to involve authorities or medical professionals (Adkins et al., 2024; Champion et al., 2020).
4. Reflect on cultural, social, and legal factors that shape ethical decision-making in first aid, and how to respond with humility and professionalism (Barchi et al., 2014; Bleakley & Marshall, 2013; Bazmi et al., 2023).
5. Practice ethical reasoning and communication through a brief, structured case-based activity and debrief, with a focus on practical implications in real-world first aid settings (Olick, 2001; Duvivier et al., 2010).

Materials

1. Short slide deck (5 slides): ethics overview, consent and autonomy in emergencies, disclosure and apology, cultural considerations, and case prompts.
2. Printed or digital handouts with quick-reference ethics checklist for first aid (e.g., implied consent in emergencies, when to seek consent, privacy considerations).
3. Case cards (3–5 concise scenarios) for small-group discussion.
4. Role-play prompts for 2-minute micro-scenarios (e.g., bystander assisting an unconscious adult, treating a minor, language barrier, medical device presence).
5. Reflection prompt (2–3 questions) for end-of-session journaling or exit tickets.

Session outline (30 minutes)

0:00–0:05 Welcome and framing (5 minutes)

1. Introduce the ethical dimension of first aid and the relevance to all first responders and lay rescuers.
2. Brief ground rules for discussion and role-play: respect, confidentiality, and safety.
3. Reference context: medical ethics education emphasizes integration of ethics with practice and case-based discussion (Olick, 2001; Hertrampf et al., 2018; Duvivier et al., 20100.

0:05–0:12 Quick didactic: core ethical principles in first aid (7 minutes)

1. Autonomy and consent in emergencies: when patients cannot consent, implied consent applies; duty to act to preserve life when there is no explicit consent or contraindication (Olick, 2001; Duvivier et al., 2010).
2. Beneficence and nonmaleficence: acting to help while avoiding harm; in some cases, withholding care or delay may raise ethical concerns; discuss balancing speed with safety (Olick, 2001; Duvivier et al., 2010).
3. Confidentiality and privacy: sharing only necessary information with other responders or clinicians; safety considerations in public settings (Olick, 2001; , Duvivier et al., 2010; .
4. Brief note on disclosure and apology when errors occur disclosure practices and seeking support are important aspects of professional ethics in care settings; curricula show attention to error management and ethical disclosure in education programs (Adkins et al., 2024; Laird et al., 2024: Champion et al., 2020).
5. Law vs ethics intersection: ethical action often aligns with legal obligations, but divergence can occur; understanding this intersection helps responders decide actions in the field (Olick, 2001).

0:12–0:20 Case-based small-group discussion (8 minutes)

1. Divide into small groups (~4 per group).
2. Distribute 3 short case prompts (2–3 minutes per case discussion, then 1 minute for reporting back).
3. Example cases (adapt to your local context):
    a. Case A: An unconscious adult with no identification. Bystander must decide whether to provide CPR. Consider implied consent, safety, and whether to involve EMS promptly. Discuss autonomy and life-saving duties.
    b. Case B: A parent prohibits treatment for a frightened child who is conscious but distressed. Parent consents to basic care, but a potential life-threatening risk exists if

not treated. Weigh autonomy of parent vs welfare of child and implied consent considerations.

c. Case C: Language barrier with a bystander who wants to help, but you cannot communicate effectively. How to obtain consent, ensure safety, and involve interpreters if available.

4. Prompt questions for each case:
   a. What ethical principles apply? (Autonomy, beneficence, nonmaleficence, confidentiality)
   b. Is consent implied or explicit?
   c. What actions are justified?
   d. What information should be shared and with whom?
   e. How would you address cultural or social factors that influence decisions?

0:20–0:25 Role-play quick scenario (5 minutes)

1. Two volunteers enact a brief 2-minute scenario that illustrates consent and communication in a first-aid context (e.g., responding to a distressed bystander who requests privacy vs public disclosure; or a bystander explaining CPR to a non-English speaker). The remainder of the group observes and notes ethical considerations.
2. Debrief with a few guiding questions:
   a. What communication strategies support informed decision-making?
   b. How did you handle consent, privacy, and dignity?
   c. What would you do differently next time?

0:25–0:28 Reflection and synthesis (3 minutes)

1. Individual reflection prompts (written or mental):
   a. What ethical challenge did you find most challenging, and why?
   b. How will you apply these ethics principles in real first-aid situations?
2. Facilitator summarizes key takeaways:
   a. Ethical action often aligns with legal duties, the importance of implied consent in emergencies, transparency in communication, and the value of humility and cultural awareness in first aid practice (Olick, 2001; Duvivier et al., 2010; Champion et al., 2020).

0:28–0:30 Closing and resources (2 minutes)

1. Provide a concise handout with the ethics checklist and further reading references.
2. Recommend ongoing education pathways: longitudinal ethics education and case-based learning as shown in medical education literature; emphasize the practical application of

ethics in first aid and the value of reflective practice (Olick, 2001; Sheikh et al., 2013; Duvivier et al., 2010; Champion et al., 2020).

Assessment suggestions

1. Formative:
    a. Observe participation in small groups and role-plays; use a brief rubric to assess demonstration of ethical reasoning, communication with simulated patients, and respect for autonomy and privacy.
2. Summative:
    a. Optional 5-question multiple-choice or short-answer quiz in a later session to reinforce understanding, with emphasis on consent in emergencies, implied consent, and bystander ethics (aligned with evidence highlighting the integration of ethics into curricula and effectiveness of case-based learning) (Olick, 2001; Duvivier et al., 2010; Champion et al., 2020).

Facilitator tips and nuances

1. Emphasize that ethical decision-making in first aid often occurs under pressure; quick reasoning and clear communication are essential (tied to the practical focus of ethics education and casuistic/case-based approaches) (Olick, 2001; Kim et al., 2024; Duvivier et al., 2010).
2. Acknowledge cultural variations in beliefs about autonomy, family decision-making, and the role of bystanders; respond with cultural humility and respect for diverse values (supported by literature on ethics education and professionalism) (Barchi et al., 2014; Bleakley & Marshall, 2013; Laird et al., 2024).
3. If legal context differs (e.g., different jurisdictions on duty to act), frame consent discussions within the ethical guidelines while noting local legal obligations (Olick, 2001).

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GLOBAL EMERGENCY MEDICAL REGISTRY

MODULE 8: Integrated Scenarios

Duration: 2 hours

Purpose:
Provide a final "putting it together" session for the students, utilizing simulations done in real time with the students operating in teams of 2-3 persons.

Instructor utilizes scenario evaluation tool provided here and observes team process, allowing all people to be in the team leader role during the scenario's sessions. The Instructor will use close observation to assure Clinical skill, Communication, Leadership, and Emotional regulation

Final Evaluation Integrated Scenarios are in APPENDIX 20 of this Curriculum and Lesson Plan Manual

Final Debrief and Course Closing Instructor Script:

"Skill fades. Mindset stays."
"The goal isn't perfection, it's immediate, decisive action."
"You now have the tools to prevent avoidable death."
Pause.
"Train like it matters — because it does."

"For those who need certification for this Global Emergency Medical Registry (GEMR) Emergency First Aid (EFA) course, I am going to explain the process to complete the Global Emergency Medical Registry (GEMR) Emergency First Aid written exam and complete your certification process"

"I will provide you an Emergency First Aid Course Completion certificate and a copy of the required skills documentation forms from GEMR to upload to your GEMR account."

GEMR STRONGLY urges the Instructor to provide the course completion certificate and skills documentation forms to the individual students via email attachment, allowing the students to move the documents straight to their GEMR account for uploading.

GLOBAL EMERGENCY MEDICAL REGISTRY

Final Written Exam and Global Emergency Medical Registry EFA Certification:

The GEMR Emergency First Aid certification is valid for two years from the time of your course attendance certificate. To renew your EFA certification, you must attend and successfully complete a GEMR Emergency First Aid refresher course, which is 8 hours in length and complete the documents on your GEMR Profile.

Certification decisions are based on objective evidence of competence, including successful completion of training, validated skills assessments, and standardized examination processes in alignment with ISO 17024 principles.

To complete the process for Emergency First Aid certification through the Global Emergency Medical Registry (GEMR), the student must accomplish the following:

Step 1:
Go to www.gemr.org and click on the Emergency First Aid (EFA) button and register with GEMR for EFA certification and pay your registration fee. The student must register with GEMR and take the exam within 21 days of completing their class.
You must complete the following once you have established your profile:

1. Fill out your GEMR profile completely.
2. Upload your EFA Course Completion Certificate to your "transcript" section of your profile.
3. Upload your Cardiac Arrest AED (BLS) Skills Documentation Form to your "transcript" section of your profile.
4. Upload your CPR/AED (Infant) Emergency First Aid Skills Documentation Form to your "transcript" section of your profile.
5. Upload your Epinephrine Auto Injector Administration Emergency First Aid Skills Documentation Form to your "transcript" section of your profile.
6. Upload your Naloxone Nasal Administration Emergency First Aid Skills Documentation Form to your "transcript" section of your profile.
7. Upload your Oxygen Administration via Mask Emergency First Aid Skills Documentation Form to your "transcript" section of your profile.

Step 2:

1. You will be assigned to take the GEMR Emergency First Aid Written Exam.
2. Once assigned, go to your "Tests" tab and take the written exam.

3. 85% is required for successful completion of the exam.
4. If you have obtained 85% or better, your test will show “Pass”.

Step 3:

1. Once successfully completing the exam, the registrant may return tot heir profile and print their certification card and/or certificate.
2. The registrant is certified for two years from their course completion; to renew their certification, the participant must complete a GEMR Emergency First Aid curriculum course and successfully complete their required skills documentation forms.
3. Once completed, the registrant may submit for renewal by uploading their course completion certificate and skills documentation forms to their “transcript” and pay their renewal fee.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 1
Duty to Act Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

DUTY TO ACT

Student Handout – First Responder and Law Enforcement Emergency First Aid

What Is "Duty to Act"?

Duty to Act is the legal and professional obligation requiring first responders and law enforcement officers to provide reasonable assistance when acting within the scope of their official duties. Unlike private citizens, responders are generally **not acting as volunteers** while on duty. The responsibility to respond is part of the job.

When Does Duty to Act Apply?

An officer's or first responders' duty to act typically exists when:

✓ You are on duty and encounter an emergency

✓ You are dispatched to a call involving medical need

✓ A person is detained, restrained, or in custody

✓ You begin providing care

Once you assume care, you are expected to continue until:

- Care is transferred to EMS or higher-level providers
- You are relieved by another qualified responder
- The scene becomes unsafe

What Does "Reasonable Care" Mean?

Duty to act does **not** require advanced medical care beyond your training.

It means:

- Acting within your certification level
- Providing care consistent with training
- Activating EMS promptly
- Avoiding gross negligence
- Not abandoning a patient

The legal standard is what a similarly trained responder would reasonably do in the same situation.

Special Considerations: Custody

When a person is: Handcuffed, Restrained, In a patrol vehicle, or In a holding facility

The officer assumes a heightened responsibility for their safety and medical needs.

Failure to respond to medical distress in custody can result in:

- Civil liability
- Department discipline
- Criminal investigation in severe cases

Duty to Act vs. Good Samaritan Laws

Good Samaritan laws typically protect **voluntary civilian responders**.

On-duty responders and officers are generally protected under:

- Governmental immunity statutes
- Qualified immunity principles
- Department policy and coverage

Off-duty responders and officers may fall under Good Samaritan protections depending on jurisdiction.

Ethical Dimension

Duty to act is not only legal — it is professional and ethical.

It reflects: Commitment to preservation of life, Public trust, and Professional integrity

First Responder and Law enforcement credibility depends on consistent, competent medical response.

Key Takeaways

✓ If you are on duty, you likely have a duty to act.

✓ Provide care within your level of training.

✓ Activate EMS early.

✓ Do not abandon a patient once care begins.

✓ Individuals in custody require heightened attention.

✓ Document your actions thoroughly.

Remember: The expectation is not perfection — it is a reasonable, timely, and trained response.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 2

Care Under Custody Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

CARE UNDER CUSTODY
Student Handout

Initial First Aid Certification – First Responder and Law Enforcement Emergency First Aid

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PURPOSE

This handout provides guidance for law enforcement personnel responsible for providing medical care to individuals who are detained, restrained, or otherwise in custody.
Custody creates a **heightened duty of care**. Officers must balance:

- Medical necessity
- Legal responsibility
- Ethical standards
- Officer safety

I. DUTY TO ACT

Once an individual is in custody, law enforcement personnel assume responsibility for:

- Monitoring the individual's condition
- Responding to medical complaints
- Recognizing signs of deterioration
- Activating EMS when indicated

Failure to respond to obvious medical needs may create:

- Civil liability
- Criminal exposure
- Departmental discipline
- Constitutional violations

II. LEGAL FOUNDATIONS

Care under custody is influenced by:

- Constitutional protections (e.g., 4th, 8th, and 14th Amendments)
- Deliberate indifference standards
- Departmental policy
- State-specific statutes

Key Legal Principle:
Officers must not demonstrate **deliberate indifference to serious medical needs**.
This means:

- Do not ignore credible complaints.
- Do not delay care unnecessarily.
- Do not assume intoxication equals non-emergency.

III. MEDICAL PRIORITIES UNDER CUSTODY

Always apply the same medical standards to:

- Suspects
- Arrestees
- Detainees
- Prisoners

Medical care must not be influenced by:

- Criminal charges
- Officer frustration
- Use-of-force history
- Personal bias

IV. HIGH-RISK CUSTODY SITUATIONS

The following conditions require heightened monitoring:

1. Post-Use-of-Force Incidents

- Head injury risk
- Internal bleeding
- Respiratory compromise

2. Excited Delirium / Extreme Agitation

- Sudden collapse risk
- Cardiac instability

3. Drug or Alcohol Intoxication

- Overdose potential
- Airway compromise
- Aspiration risk

4. Prone or Restrained Positioning

- Positional asphyxia risk
- Respiratory compromise

5. Mental Health Crisis

- Self-harm risk
- Sudden behavioral changes

V. POSITIONAL SAFETY

Avoid prolonged prone restraint.

After control is achieved:

- Move subject to side-lying or seated position
- Monitor breathing continuously
- Remove pressure from back and torso
- Check responsiveness regularly

If subject becomes unresponsive:

- Immediately reposition
- Assess airway and breathing
- Activate EMS
- Initiate CPR if indicated

VI. MONITORING REQUIREMENTS

Under custody, officers must:

- Observe breathing pattern
- Assess level of consciousness
- Monitor skin color and condition
- Reassess complaints of pain
- Document changes in condition

Red flags requiring EMS activation:

- Difficulty breathing
- Loss of consciousness
- Chest pain
- Seizure activity
- Cyanosis
- Persistent vomiting
- Altered mental status

VII. USE OF RESTRAINTS AND MEDICAL CARE

When providing medical care:

- Loosen restraints if necessary for airway access
- Remove obstructions preventing chest compressions
- Ensure restraints do not compromise circulation
- Prioritize life-saving intervention over restraint maintenance

Officer safety remains critical, but life-threatening conditions take precedence.

VIII. DOCUMENTATION BEST PRACTICES

Document:

- Initial condition
- Subject complaints
- Observations made
- Medical interventions provided
- EMS activation time
- Changes in condition
- Statements made by subject

Documentation should be:

- Objective
- Factual
- Time-specific
- Free of personal opinions

IX. ETHICAL CONSIDERATIONS

Care under custody requires:

- Professionalism
- Neutrality
- Respect
- Equal treatment

Ask yourself:

- Would I provide the same care if this person were not under arrest?
- Is my decision medically justified?
- Have I documented clearly and accurately?

X. SCENARIO APPLICATION REFLECTION

Consider:

1. A restrained subject says "I can't breathe."
    - What are your immediate actions?
2. A detainee appears intoxicated but becomes difficult to arouse.
    - What must you rule out?
3. A suspect collapses after a foot pursuit.
    - What medical risks are present?

Discuss these in training and apply structured decision-making.

XI. PERFORMANCE CHECKLIST (STUDENT REFERENCE)

During custody-based care, remember:

☐ Ensure scene safety

☐ Assess responsiveness

☐ Monitor airway and breathing

☐ Avoid prolonged prone restraint

☐ Activate EMS when indicated

☐ Document objectively

☐ Maintain professionalism

KEY PRINCIPLE

Custody does not reduce medical responsibility — it increases it.

Providing appropriate medical care protects:

- The life of the individual
- Officer safety
- Agency integrity
- Public trust
- Legal standing

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 3

Consent and Implied Consent Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

CONSENT AND IMPLIED CONSENT

Student Handout

Initial First Aid Certification – First responder and Law Enforcement Emergency First Aid

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1. WHY CONSENT MATTERS

As a law enforcement officer providing first aid, you are operating at the intersection of:

- Medical care
- Legal authority
- Individual rights
- Ethical responsibility

Providing care without appropriate consent can create legal risk and ethical conflict.
Understanding consent protects:

- The patient
- The officer
- The agency

---

2. TYPES OF CONSENT

A. Expressed (Actual) Consent

Expressed consent is **clearly communicated permission** to provide care.
It may be:

- Verbal ("Yes, help me.")
- Nonverbal (nodding, extending arm for treatment)

Requirements for Valid Expressed Consent:

1. Patient is conscious
2. Patient is alert and oriented
3. Patient has decision-making capacity
4. Patient understands what you are proposing
5. Patient agrees voluntarily

B. Implied Consent

Implied consent applies when:

- The patient is unconscious
- The patient is incapacitated
- The patient is confused and lacks decision-making capacity
- The injury is life-threatening
- Delay would increase risk of death or serious harm

The law assumes a reasonable person would consent to lifesaving treatment.

Example:
An unconscious subject with severe bleeding following a crash — you may initiate hemorrhage control immediately.

C. Informed Refusal
A conscious, competent adult has the right to refuse care — even lifesaving care.
Before honoring refusal, ensure:

- The patient understands the risks
- The patient demonstrates decision-making capacity
- The refusal is voluntary
- There is no coercion
- The patient is not impaired by drugs, alcohol, or mental illness

If refusal is accepted:

- Document thoroughly
- Consider obtaining a witness signature
- Notify EMS

---

3. DECISION-MAKING CAPACITY
A patient has capacity if they can:

1. Understand the situation
2. Understand risks and benefits
3. Communicate a choice
4. Demonstrate rational reasoning

Red flags for impaired capacity:

- Altered mental status
- Intoxication
- Severe head injury
- Hypoxia
- Psychiatric crisis
- Extreme emotional distress

When in doubt, treat under implied consent and document why.

---

4. SPECIAL CONSIDERATIONS FOR LAW ENFORCEMENT
A. Care Under Custody
Being detained does NOT remove a person's medical rights.
Officers must:

- Provide necessary care
- Avoid punitive withholding of treatment
- Balance safety with medical needs

B. Minors

Consent typically must come from:

- Parent
- Legal guardian

However, implied consent applies in emergencies.

Some jurisdictions recognize limited exceptions for:

- Emancipated minors
- Pregnancy-related care
- Substance use treatment

Follow agency policy and state law.

C. Mentally Ill or Suicidal Individuals

If a subject is:

- Actively suicidal
- Psychotic
- Gravely disabled

They may lack capacity.

Emergency detention laws may authorize involuntary evaluation.

Document behavior clearly.

D. Intoxicated Individuals

Intoxication may impair capacity.

Ask:

- Can they understand the risk?
- Can they communicate a consistent decision?

If not, implied consent likely applies.

---

5. WHEN CONSENT IS NOT REQUIRED

You may provide care without consent when:

- The patient is unconscious
- The patient is incapacitated
- There is a life-threatening emergency
- A minor has no guardian present in a critical emergency
- A court order or statute authorizes intervention

Always follow agency protocol.

---

6. DOCUMENTATION BEST PRACTICES

Thorough documentation protects you legally.

Include:

- Patient's mental status
- Statements made by patient

- Assessment findings
- Risks explained
- Patient response
- Witnesses present
- Time of refusal or consent

Avoid:

- Emotional language
- Assumptions
- Medical diagnoses beyond training

---

7. ETHICAL PRINCIPLES TO REMEMBER

- **Autonomy** – Respect the patient's right to choose
- **Beneficence** – Act in the patient's best interest
- **Non-maleficence** – Do no harm
- **Justice** – Treat individuals fairly and equally

Law enforcement officers must balance these with operational safety.

---

8. PRACTICAL FIELD CHECKLIST

Before providing care, ask yourself:

☐ Is the scene safe?

☐ Is the patient conscious?

☐ Does the patient appear competent?

☐ Did I clearly identify myself?

☐ Did I explain what I intend to do?

☐ Did I receive consent or is implied consent applicable?

☐ Have I documented my decision-making process?

---

9. SCENARIO APPLICATION EXAMPLES

Example 1: Unconscious Driver

→ Implied consent applies.

Example 2: Handcuffed Suspect Refusing Care but Alert and Oriented

→ Assess capacity carefully; may refuse.

Example 3: Suicidal Subject Refusing Transport

→ Evaluate for impaired capacity; emergency detention laws may apply.

Example 4: Intoxicated Subject with Head Injury Refusing Care

→ Likely impaired capacity; treat under implied consent.

---

10. KEY TAKEAWAYS

- Consent is required whenever possible.
- Implied consent allows lifesaving care in emergencies.
- Capacity determines validity of refusal.
- Custody does not eliminate medical rights.
- Documentation is your legal protection.
- When uncertain, prioritize patient safety and follow agency policy.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 4

Good Samaritan Concepts Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

GOOD SAMARITAN CONCEPTS AND LAW

Student Handout

Initial First Aid Certification – First Responder and Law Enforcement Emergency First Aid

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1. PURPOSE OF GOOD SAMARITAN LAWS

Good Samaritan laws are designed to:

- Encourage individuals to provide emergency assistance
- Reduce hesitation due to fear of legal liability
- Protect rescuers acting in good faith

These laws recognize that immediate action during emergencies can save lives and that responders should not be penalized for reasonable efforts.

---

2. WHAT IS A "GOOD SAMARITAN"?

A Good Samaritan is generally defined as:
A person who voluntarily provides emergency care without expectation of compensation and acts in good faith.
In most jurisdictions, protection applies when:

- The care is given at the scene of an emergency
- The responder acts voluntarily
- The responder acts within the scope of their training
- There is no gross negligence or willful misconduct

---

3. HOW GOOD SAMARITAN LAWS APPLY TO LAW ENFORCEMENT

Law enforcement officers are unique because:

- They often have a **duty to act** while on duty.
- They may be considered professional responders.
- Agency policy may define medical response expectations.

Important distinction:

- **On duty:** Protection may derive from employment law, agency policy, and governmental immunity statutes.
- **Off duty:** Officers may be protected under general Good Samaritan statutes, depending on state law.

Always follow agency policy and state-specific statutes.

---

4. WHAT GOOD SAMARITAN LAWS PROTECT AGAINST

Generally, these laws protect against liability for:

- Ordinary negligence
- Unintended adverse outcomes
- Errors made despite reasonable effort

Protection typically requires:

- Good faith action
- No expectation of compensation
- Acting within training level

---

5. WHAT GOOD SAMARITAN LAWS DO NOT PROTECT

These laws do NOT protect:

- Gross negligence
- Reckless conduct
- Intentional harm
- Abandonment of patient
- Actions outside scope of training
- Criminal acts

Example of gross negligence:

Ignoring obvious life-threatening bleeding and failing to intervene when properly trained to do so.

---

6. DUTY TO ACT VS. VOLUNTARY RESPONSE

A. Duty to Act

A duty to act exists when:

- You are on duty
- You are dispatched to an incident
- Your agency requires intervention
- A custodial relationship exists

Failure to act when a duty exists may result in liability.

B. Voluntary Response

When off duty, you may:

- Choose to assist voluntarily
- Be protected under Good Samaritan statutes

However:

- If you initiate care, you must not abandon the patient until relieved by equal or higher care.

---

7. SCOPE OF PRACTICE

You must operate within:

- Your training
- Agency policy
- State law
- Equipment issued or authorized

Example:

Providing CPR and hemorrhage control — within scope if trained.

Performing invasive procedures without authorization — outside scope.

Operating outside your scope increases liability risk.

8. STANDARD OF CARE

Standard of care means:

Acting as a reasonable and similarly trained person would under similar circumstances.

Consider:

- Environmental conditions
- Available equipment
- Threat level
- Number of casualties
- Officer safety

You are judged based on what is reasonable in the field — not hospital standards.

9. ABANDONMENT

Abandonment occurs when:

- Care is initiated
- The patient is left without equal or higher care
- No reasonable transfer of responsibility occurs

Proper transfer includes:

- Verbal report to EMS
- Clear communication of care provided
- Documentation

10. DOCUMENTATION PROTECTS YOU

Good documentation demonstrates:

- Good faith effort
- Appropriate assessment
- Care provided
- Patient response
- Reasonable decision-making

Include:

- Time of intervention
- Patient condition
- Interventions performed
- Transfer details

Avoid speculation or emotional language.

11. PRACTICAL FIELD CHECKLIST

Before providing care, consider:

☐ Is this within my training?
☐ Is the scene safe?
☐ Am I acting in good faith?
☐ Am I following agency policy?
☐ Have I avoided reckless conduct?
☐ Will I remain until properly relieved?
☐ Will I document appropriately?

---

12. ETHICAL FOUNDATION

While Good Samaritan laws provide legal protection, your professional foundation includes:

- Preservation of life
- Respect for human dignity
- Fair and impartial care
- Professional accountability

Legal protection is not a substitute for professional judgment.

---

13. KEY TAKEAWAYS

- Good Samaritan laws encourage emergency intervention.
- Protection applies when acting in good faith and within training.
- Gross negligence is not protected.
- On-duty officers may operate under additional duty-to-act standards.
- Documentation and adherence to policy are critical.
- Always prioritize scene safety and reasonable care.

REMEMBER

Legal standards vary by state, region, and country.
Always consult:

- Agency policy
- State statutes
- Legal counsel guidance when necessary

This handout provides general educational information and does not replace jurisdiction-specific legal instruction.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 5

Ethical Case Studies for the Instructor

GLOBAL EMERGENCY MEDICAL REGISTRY

ETHICAL CASE STUDY #1

Pediatric Cardiac Arrest – 8-Year-Old Child

Initial Certification Course – First Responder and Law Enforcement Emergency First Aid

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Scenario Overview

First Responders and Law Enforcement Officers are dispatched to a residence for a report of an unresponsive child. Upon arrival, they find an 8-year-old child lying on the living room floor.
The child is pulseless and not breathing.
The child's mother is present, screaming and attempting to shake the child awake.
The father is shouting at officers to "do something" while recording on his phone.
Scene safety is secure.
EMS has been activated with an estimated arrival time of 6 minutes.
You begin CPR. An AED is available in your patrol vehicle.
After two cycles of CPR and AED analysis, no shock is advised. The child remains pulseless and you continue CPR and AED use until arrival of EMS.
The mother begs you not to stop and insists the child "just needs more time."
The father demands to ride with the child in the ambulance and becomes increasingly agitated.

Ethical Tension Points

- Emotional response to pediatric arrest
- Maintaining professional performance under distress
- Family presence during resuscitation
- Communication during active life-saving efforts
- Managing family interference
- Respect for parental authority
- Allocation of emotional attention vs. clinical focus
- Handling recording/public scrutiny

Guided Discussion Questions

Clinical & Ethical Judgment

1. Does the age of the patient influence your ethical obligation?
2. How do pediatric arrests affect decision-making under stress?
3. Should emotional intensity change clinical actions?

Family Presence & Autonomy

1. Should the parents be allowed to remain in the room during CPR?
2. When does family presence become unsafe or disruptive?
3. How should officers communicate realistic expectations during resuscitation?

Emotional Regulation

1. How do you manage your own physiological stress response?
2. What cognitive distortions may occur during pediatric emergencies?
3. How can emotional overload impact CPR quality?

Resource & Termination Considerations

1. Who determines when resuscitation stops?
2. Would your actions differ if EMS arrival were significantly delayed?
3. How do you balance hope with medical reality?

Documentation & Public Scrutiny

1. How should documentation reflect emotional dynamics on scene?
2. How might public video recording influence behavior?
3. What protects you ethically and legally in high-profile pediatric deaths?

Instructor Guidance & Teaching Points

1. Equal Value of Life

Ethically, **all patients are treated with equal commitment**, regardless of age.
However, pediatric cases carry a significantly higher emotional burden.
Key principle:

- Clinical standards do not change because a patient is a child.
- Emotional intensity must not degrade compression quality or decision-making.

---

2. Family Presence During Resuscitation

Evidence in emergency medicine suggests:

- Family presence can be beneficial when managed appropriately.
- One responder or officer (if available) should manage family communication.
- Safety and interference determine whether removal is necessary.

Ethical balance:

- Compassion
- Scene control
- Clinical effectiveness

---

3. Emotional Bias and "Rescue Fantasy"

Pediatric arrests can trigger:

- Overexertion beyond evidence-based protocols
- Difficulty accepting non-shockable rhythms
- Prolonged resuscitation beyond scope

Responders must recognize:

- The desire to "save at all costs" may conflict with protocol.
- Emotional attachment must not alter clinical standards.

---

4. Professional Composure Under Recording

Ethical professionalism includes:

- Maintaining calm, clear communication
- Avoiding defensive language
- Providing factual statements

Documentation should reflect:

- Time CPR initiated
- AED findings
- Family behavior if relevant to scene safety
- EMS transfer details

---

5. Psychological Impact on Officers

Pediatric deaths are high-risk for:

- Acute stress response
- Delayed emotional impact
- Compassion fatigue

Ethical leadership requires:

- Encouraging debrief
- Normalizing stress response
- Offering peer support or follow-up

Optional Extended Ethical Twist (Advanced Discussion)
After EMS arrival and continued resuscitation, EMS pronounces the child deceased on scene.
The mother collapses and blames responders and officers for not "trying harder."
A bystander posts a partial video clip online criticizing the response.
Discussion additions:

- How should responders and officers process blame in emotionally charged scenes?
- What protects ethical practice when outcomes are tragic?
- How does moral injury develop in pediatric fatality cases?

Debrief Framework for Facilitators
After discussion, ask participants:

- What emotions surfaced for you?
- Did you feel pressure to exceed protocol?
- How would this scenario affect you after shift?
- What support should agencies provide after pediatric fatalities?

Core Ethical Themes Reinforced

- Beneficence
- Nonmaleficence
- Justice
- Professional duty
- Emotional self-regulation
- Compassion with boundaries
- Protocol adherence under stress

GLOBAL EMERGENCY MEDICAL REGISTRY

ETHICAL CASE STUDY #2

Motor Vehicle Collision: Severely Injured Passenger & Intoxicated Driver

---

Scenario Overview

First Responders and Law Enforcement Officers respond to a single-vehicle rollover crash at night on a rural roadway.

Upon arrival:

- The **front right seat passenger** is unconscious, trapped, with significant bleeding from the head, bleeding from right arm, and suspected chest trauma. Breathing is shallow/irregular.
- The **driver** has exited the vehicle. He has minor lacerations and is ambulatory. He smells strongly of alcohol, is slurring his speech, and is shouting, "She wasn't wearing a seatbelt, it's not my fault!"

No other units are on scene yet.

EMS Paramedic Unit ETA is 10 minutes.

The driver becomes increasingly agitated and attempts to approach the passenger; he is unsteady but mobile.

There is broken glass and leaking fluids near the vehicle.

You have basic medical equipment including gloves, a trauma dressing, and a tourniquet.

Ethical Tension Points

- Prioritization of care (severely injured passenger vs. intoxicated driver)
- Managing an intoxicated individual who may become combative
- Care under potential criminal culpability
- Balancing scene control with life-saving care
- Determining decision-making capacity of intoxicated driver
- Allocation of attention and limited resources
- Role duality: first responder vs. law enforcement investigator
- Documentation and evidentiary integrity

Guided Discussion Questions

Triage & Prioritization

1. Who receives immediate care and why?
2. Does suspected intoxication affect medical prioritization?
3. How does the severity of injury ethically guide action?
4. If you are alone, how do you divide attention?

Care Under Custody & Criminal Conduct

1. Once the driver is detained, what is your duty of care toward him?
2. Does potential criminal responsibility change your ethical obligations?
3. How do you maintain impartiality in emotionally charged situations?

Capacity & Autonomy

1. Does intoxication eliminate decision-making capacity?
2. If the driver refuses evaluation, what factors determine next steps?
3. How should officers assess impairment in the context of medical care?

Scene Safety vs. Medical Urgency

1. When does controlling the driver take priority over treating the passenger?
2. How do you ethically justify delaying medical care to ensure safety?
3. What if the driver becomes physically aggressive?

Documentation & Public Perception

1. How should documentation distinguish medical care from investigative actions?
2. How might body-worn camera footage influence post-incident review?
3. What language should be avoided in reporting?

Instructor Guidance & Teaching Points

1. Triage Principles Govern Priority

Medical ethics and triage principles require:

- Care based on severity and survivability
- Immediate attention to life-threatening conditions

The unconscious passenger with airway compromise and major bleeding is the priority.
Criminal status does not alter medical priority.

---

2. Role Conflict: Officer vs. Care Provider

Officers must navigate:

- Enforcement duties
- Preservation of life

Ethical clarity requires recognizing that:

- Immediate life threats supersede investigation.
- Scene safety is foundational to effective care.
- Securing the intoxicated driver may be necessary to safely treat the passenger.

3. Intoxication and Capacity

Intoxication does not automatically remove decision-making capacity.

However, impairment may affect:

- Understanding
- Appreciation of risk
- Rational reasoning

If the driver is:

- Medically stable
- Not an immediate threat
- Oriented and communicative

He may retain partial capacity.

If severely impaired, protective medical oversight may be warranted.

---

4. Emotional Bias

Officers may feel anger or frustration toward:

- A suspected impaired driver
- A preventable injury

Ethical practice requires:

- Neutrality in care delivery
- Avoiding punitive withholding of medical attention
- Recognizing emotional triggers

---

5. Scene Safety and Ethical Justification

If the driver interferes with care:

- Temporary detention is ethically justified
- Responder and Officer safety is a prerequisite to patient care
- Documentation should clearly articulate safety concerns

---

6. Documentation Integrity

Reports should:

- Objectively describe observable behavior (e.g., “odor of alcohol,” “unsteady gait”)
- Avoid emotionally charged language
- Separate medical care timeline from investigative actions
- Record timing of interventions

Advanced Ethical Twist (Optional)

While rendering aid to the passenger, the driver begins vomiting and complains of chest pain.

Discussion extension:

- Does this alter prioritization?
- Could intoxication mask serious injury?
- How do you reassess triage dynamically?

Debrief Questions for Participants

- Did you feel emotional judgment toward the driver?
- How do you prevent bias from influencing care?
- What stress reactions might impair decision-making?
- How would media portrayal affect your confidence in your actions?

Core Ethical Themes Reinforced

- Justice (equal care regardless of fault)
- Beneficence (act in patient's best interest)
- Nonmaleficence (avoid harm)
- Duty to act
- Scene safety as ethical prerequisite
- Neutral professionalism
- Separation of care from criminal judgment

GLOBAL EMERGENCY MEDICAL REGISTRY

ETHICAL CASE STUDY #3

"Bleeding in the Crowd"

SCENARIO OVERVIEW

You and your partner are the first law enforcement (or First Responder) unit to arrive at a late-night street altercation outside a crowded entertainment venue.
Upon arrival you observe:

- A male adult (approximately 25 years old) lying on the sidewalk with **severe bleeding from his upper thigh**.
- A rapidly expanding pool of blood beneath him.
- He appears pale, diaphoretic, and semi-conscious.
- No EMS is yet on scene (estimated paramedic unit arrival 10 minutes).

Approximately 20–25 bystanders surround the scene.
Several individuals are shouting:

- "That's the guy who started it!"
- "Don't help him!"
- "He stabbed my friend!"
- "Let him bleed!"

One visibly agitated bystander approaches within 6 feet and states: "If you help him, you're protecting a criminal."
Your partner looks to you for direction.
The crowd is escalating emotionally.
You assess that the patient may bleed to death within minutes without intervention.
You are wearing standard patrol gear and have your Emergency First Aid kit with you.
No additional units have arrived.

CLINICAL FACTS

- Suspected femoral artery injury.
- Massive hemorrhage likely to result in death without immediate tourniquet application.
- Patient status as aggressor is not yet confirmed.
- Scene is not yet fully secured.
- No visible weapon in the immediate area.

ETHICAL TENSION POINTS

1. Duty to preserve life vs. community hostility
2. Officer safety vs. immediate medical intervention
3. Suspect status vs. patient status
4. Resource limitation (2 officers, hostile crowd, no EMS)
5. Public perception and trust
6. Risk of escalation if crowd believes suspect is being protected

GUIDED DISCUSSION QUESTIONS

1. Duty to Act

- Does the suspected criminal behavior of the patient affect your obligation to provide life-saving care?
- At what point does a suspect become a patient?

2. Scene Safety

- How do you balance hemorrhage control with crowd control?
- Is it ethical to delay medical intervention until backup arrives?
- What level of risk to yourself is ethically acceptable?

3. Prioritization

- If another injured person is discovered nearby with less severe injuries, how should care be prioritized?
- Should emotional pressure from bystanders influence triage decisions?

4. Communication Strategy

- What statements could de-escalate the crowd while maintaining authority?
- How might transparent communication affect public trust?

5. Legal & Ethical Framework

- What principles apply here?
  - Beneficence (do good)
  - Nonmaleficence (do no harm)
  - Justice (equal treatment)
  - Professional duty
- Are there circumstances where withholding care would be ethically defensible?

DECISION PATH OPTIONS (FOR ANALYSIS)

Option A: Immediate Intervention

Apply tourniquet immediately while partner manages crowd verbally.

Risks:

- Crowd escalation
- Reduced officer situational awareness

Benefits:

- Likely survival of patient
- Ethical consistency

Option B: Secure Scene First

Delay intervention until additional units arrive.

Risks:

- Patient death from hemorrhage
- Ethical and public trust implications

Benefits:

- Reduced responder and officer safety risk

Option C: Split Roles
One officer (or Responder) applies tourniquet while the other establishes perimeter and commands crowd control.
Risks:
- Reduced individual officer safety margin
- Increased stress load

Benefits:
- Preserves life
- Maintains some scene control

ETHICAL ANALYSIS FRAMEWORK

Instructors may guide discussion using this structure:
1. Identify competing obligations.
2. Identify immediate life threats.
3. Evaluate risk to officer safety.
4. Apply least harmful option.
5. Consider long-term impact on trust and professional integrity.

KEY LEARNING POINTS

- A patient's criminal status does not remove the ethical obligation to treat life-threatening injuries.
- Scene safety is essential but must be balanced against imminent preventable death.
- Communication can significantly influence crowd behavior.
- Ethical decision-making under stress requires pre-planned frameworks.
- Equal application of care reinforces legitimacy and professionalism.

INSTRUCTOR DEBRIEF NOTES

Emphasize:
- The concept of **dual-role conflict** (law enforcement officer vs. medical responder).
- The ethical principle of justice (equal treatment regardless of alleged wrongdoing).
- The importance of rapid hemorrhage control in preventable trauma death.
- Maintaining calm command presence under emotional pressure.
- Tactical positioning during medical intervention.

OPTIONAL VARIATION SCENARIOS

To deepen discussion, modify one variable:
- The patient regains consciousness and becomes combative.
- A second victim is located behind the crowd.
- A weapon is discovered nearby.
- The crowd begins physically advancing.
- A bystander begins filming and narrating live.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 6

GEMR EFR CPR/AED Skills Documentation Forms

GLOBAL EMERGENCY MEDICAL REGISTRY

CPR/AED (Adult) Emergency First Aid Skills Documentation Form

Candidate (Print): _____ Date: _____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Evaluation Type: ☐ Initial Certification ☐ Remediation ☐ Renewal

Team Resuscitation: ☐ Team Resuscitation ☐ 2 Rescuer ☐ 1 Rescuer

Note: Examiner will use a CPR manikin, AED trainer, and filter mask for this skill.

PASS _____ FAIL _____

Task	Correct	Incorrect
Initial Response and Scene Management:		
Ensures scene is safe for emergency first aid personnel to approach		
Uses appropriate Personal Protective Equipment (PPE)		
Checks responsiveness appropriately		
Activates emergency medical response or directs bystander to accomplish activation		
High Quality Compressions/CPR Section:		
Correct Chest Compression hand placement (center of chest, lower half sternum)		
Chest Compression depth 2–2.5 inches (5–6 cm)		
Chest Compression rate 100–120/min		
Allows full chest recoil		
Minimizes interruptions (<5 seconds) to compressions for ventilation or switch compressors		
Maintains proper body mechanics during chest compressions		
Perform chest compressions continuously until AED, mouth to mask device, and/or second rescuer arrives		
Perform chest compressions correctly at a 30:2 ratio with ventilation once an AED is utilized, a mouth to mask device is available, and/or a second rescuer arrives		
Automated External Defibrillator (AED) Operation Section:		
Powers on AED immediately		
Applies Defibrillation Pads per manufacturer recommendation		
Pauses CPR and clears all contact with patient during AED rhythm analysis period		
Clears contact with patient before defibrillation shock administered		
Immediately resumes chest compressions after shock is delivered		

Airway and Ventilation Section:		
Opens airway (head tilt–chin lift or jaw thrust)		
Provides 2 effective ventilations during 30:2 CPR with a one way valve mouth to mask device		
Visible chest rise achieved on patients with ideal body weight		
Avoids excessive ventilation		
Team Based Resuscitation Section (if applicable)		
Communicates clearly with team		
Directs role assignments appropriately		
Coordinates compressor rotation every two minutes with less than 5 seconds of interruption to compressors		
Maintains safety awareness		

Critical Failure Criteria

	Failure to establish oxygenation and compressions (CPR) for the patient
	Failure to utilize AED correctly
	Failure to identify cardiac arrest
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

CPR/AED (Child) Emergency First Aid Skills Documentation Form

Candidate (Print): _____ Date: _____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Evaluation Type: ☐ Initial Certification ☐ Remediation ☐ Renewal

Team Resuscitation: ☐ Team Resuscitation ☐ 2 Rescuer ☐ 1 Rescuer

Note: Examiner will use a CPR manikin, AED trainer, and filter mask for this skill.

PASS _____ FAIL _____

Task	Correct	Incorrect
Initial Response and Scene Management:		
Ensures scene is safe for emergency first aid personnel to approach		
Uses appropriate Personal Protective Equipment (PPE)		
Checks responsiveness appropriately		
Activates emergency medical response or directs bystander to accomplish activation		
High Quality Compressions/CPR Section:		
Correct Chest Compression hand placement (center of chest, lower half sternum), may use one hand for compressions		
Chest Compression depth is one-third of the anterior-posterior diameter of the chest, not exceeding 2.0 inches (5cm)		
Chest Compression rate 100–120/min		
Allows full chest recoil		
Minimizes interruptions (<5 seconds) to compressions for ventilation or switch compressors		
Maintains proper body mechanics during chest compressions		
Perform 30:2 chest compressions and ventilation via mouth to mask device		
Perform chest compressions and ventilations correctly at a 15:2 ratio once a second rescuer arrives		
Automated External Defibrillator (AED) Operation Section:		
Powers on AED immediately		
Applies Defibrillation Pads per manufacturer recommendation		
Pauses CPR and clears all contact with patient during AED rhythm analysis period		
Clears contact with patient before defibrillation shock administered		
Immediately resumes chest compressions after shock is delivered		
Airway and Ventilation Section:		
Opens airway (head tilt–chin lift or jaw thrust)		
Provides 2 effective ventilations during 30:2 CPR with a one way valve mouth to mask device; switching to 15:2 when a second rescuer arrives.		
Visible chest rise achieved on patients within ideal body weight		
Avoids excessive ventilation		
Team Based Resuscitation Section (if applicable)		
Communicates clearly with team		
Directs role assignments appropriately		
Coordinates compressor rotation every two minutes with less than 5 seconds of interruption to compressors		
Maintains safety awareness		

Critical Failure Criteria

	Failure to establish oxygenation and compressions (CPR) for the patient
	Failure to utilize AED correctly
	Failure to identify cardiac arrest
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

CPR/AED (Infant) Emergency First Aid Skills Documentation Form

Candidate (Print): _____ Date: _____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Evaluation Type: ☐ Initial Certification ☐ Remediation ☐ Renewal

Team Resuscitation: ☐ Team Resuscitation ☐ 2 Rescuer ☐ 1 Rescuer

Note: Examiner will use a CPR manikin, AED trainer, and filter mask for this skill.

PASS _____ FAIL _____

Task	Correct	Incorrect
Initial Response and Scene Management:		
Ensures scene is safe for emergency first aid personnel to approach		
Uses appropriate Personal Protective Equipment (PPE)		
Check for responsiveness and breathing/pulse (no more than 10 seconds). If no pulse or pulse less than 60 beats per minute with poor perfusion, begin CPR.		
Activates emergency medical response or directs bystander to accomplish activation		
High Quality Compressions/CPR Section:		
Correct Chest Compressions in the center of the chest just below the nipple line, use the 1-hand technique		
Chest Compression depth is at least one-third of the anterior-posterior diameter of the chest (approx. 1.5 in or 4 cm).		
Chest Compression rate 100–120/min		
Allows full chest recoil		
Minimizes interruptions (<5 seconds) to compressions for ventilation or switch compressors		
Maintains proper body mechanics during chest compressions		
Perform 30 compressions followed by 2 breaths via mouth to mask device (30:2) for single rescuers.		
Perform chest compressions and ventilations correctly at a 15:2 ratio once a second rescuer arrives		
Automated External Defibrillator (AED) Operation Section:		
Powers on AED immediately		
Applies Defibrillation Pads per manufacturer recommendation		
Pauses CPR and clears all contact with patient during AED rhythm analysis period		
Clears contact with patient before defibrillation shock administered		
Immediately resumes chest compressions after shock is delivered		
Airway and Ventilation Section:		
Opens airway (head tilt–chin lift or jaw thrust)		
Provides 2 effective ventilations during 30:2 CPR with a one way valve mouth to mask device; switching to 15:2 when a second rescuer arrives.		
Visible chest rise achieved on patients with normal BMI		
Avoids excessive ventilation		
Team Based Resuscitation Section (if applicable)		
Communicates clearly with team		
Directs role assignments appropriately		
Coordinates compressor rotation every two minutes with less than 5 seconds of interruption to compressors		
Maintains safety awareness		

Critical Failure Criteria

	Failure to establish oxygenation and compressions (CPR) for the patient
	Failure to utilize AED correctly
	Failure to identify cardiac arrest
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 7

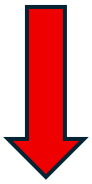
MARCH Assessment Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

MARCH Trauma First Aid Assessment
Student Quick Reference Sheet

Massive Hemorrhage
Airway
Respirations
Circulation
Head Trauma/Hypothermia

M — Massive Hemorrhage
Priority - Control life-threatening bleeding FIRST
Look For:
Spurting or pooling blood, Partial/complete amputation,
Blood-soaked clothing, and/or Signs of shock
First Aid Interventions:
Apply direct pressure
Pack wound with hemostatic gauze
Apply pressure bandage
Place tourniquet (high & tight if needed)
Reassess bleeding frequently



A — Airway
Assess:
Is the patient talking? Airway obstructed? Gurgling, stridor, snoring?
First Aid Interventions:
Manual airway positioning (head tilt–chin lift or jaw thrust)
Recovery position to drain fluid from airway

R — Respirations
Assess:
Rate & quality of breathing, Chest rise symmetry, Penetrating chest wounds,
Severe respiratory distress, and/or Unequal chest rise.
First Aid Interventions:
Seal open chest wounds, use chest seal if available.
Administer oxygen if available.
Provide mouth to mask ventilations if not breathing.

C — Circulation

Assess:

Pulse (rate, strength), Skin color/temp, and/or Capillary refill

First Aid Interventions:

Control any remaining bleeding

Lay supine

Keep warm

If there is no pulse, start CPR.

H — Hypothermia / Head Injury

Assess:

Level of consciousness (AVPU)

Pupils reactive?

Signs of head injury?

Body temperature?

First Aid Interventions:

Prevent heat loss (blankets, heat packs, heater, warm environment)

Elevate head 30° (if no spinal contraindication)

Monitor mental status frequently

Quick Reminders!

Ensure scene safety.

Use Personal Protective Equipment (PPE).

Reassess after every intervention.

Massive bleeding control comes before airway.

Trauma patients get cold FAST and it will increase mortality — prevent hypothermia early.

Prepare for rapid transport in unstable patients when ambulance arrives.

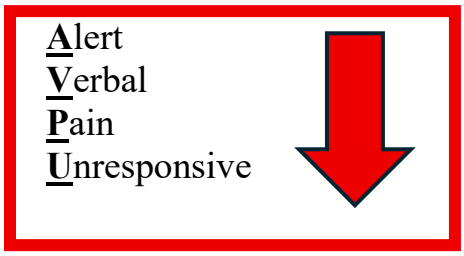
GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 8

AVPU Student Handout

GLOBAL EMERGENCY MEDICAL REGISTRY

AVPU Assessment Student Quick Reference Sheet



AVPU is a rapid method to assess level of consciousness (LOC).

A — Alert
Patient is:
Awake spontaneously
Oriented (person, place, time, event)
Able to speak clearly
Follows commands
Example: Patient answers questions appropriately and maintains eye contact.

V — Verbal
Patient responds to:
Verbal stimulation only
Talking, shouting, or calling their name
Patient may:
Open eyes when spoken to
Speak incompletely
Moan or make sounds
The patient is not fully alert.

P — Pain
Patient responds only to painful stimuli
Examples of stimuli:
Trapezius squeeze
Nail bed pressure
Response may be:
Purposeful movement (localizes pain)
Withdrawal from pain
Abnormal posturing
All indicate decreased neurological status.

U — Unresponsive
No response to: Voice or Pain
Medical emergency
Check airway immediately
Prepare for possible CPR

Quick Clinical Notes
Document as: LOC: A/V/P/U
Reassess frequently in unstable patients
Deterioration in AVPU levels is an escalating emergency
Consider that any of the following may cause decreased AVPU:
Hypoxia
Hypoglycemia
Head injury
Shock
Drug/ETOH intoxication

Example Documentation
"LOC: V — responds to verbal commands but disoriented."
"LOC: P — withdraws to trapezius squeeze."
"LOC: U — no response to painful stimulus."

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 9

GEMR Tourniquet Skills Sheet

GLOBAL EMERGENCY MEDICAL REGISTRY

Bleeding Control - Combat Application Tourniquet (BLS) Skill Documentation Form

Candidate (Print): _____ Date: _____

Examiner (Instructor or Licensed Provider): _____

Examiner Signature: _____

Pass _____ Fail _____

Task:	Correct	Incorrect
Applies direct pressure to the wound with gloved hand and/or gloved hand and dressing		
Examiner states wound continues to bleed		
Removes the Combat Application Tourniquet (C-A-T) from the carrying pouch.		
Slide the wounded extremity through the loop of the C-A-T Self Adhering Band or wrap around extremity.		
Positioned the C-A-T above wound; leaving at least two (2) inches of uninjured skin between the C-A-T and the wound site.		
Twist the C-A-T windlass rod until the distal pulse was no longer palpable.		
Lock the windless rod in place with the C-A-T Windlass Clip.		
Grasp the C-A-T windlass strap, pull it tight and adhere it to the Velcro on the C-A-T windlass clip.		
Using a marker, draw a "T" on the casualty's forehead and recorded the date and time the C-A-T was applied.		

Critical Failure Criteria	
	Failure to apply tourniquet correctly
	Did not mark the patient with “T” and time
	Failure to manage the patient as a competent healthcare provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention
	Failure to complete bleeding control within 5 minutes

NOTE: The “patient” should be supine or reclined with an extremity hemorrhage, and the candidate must have complete supplies (candidate should have time to familiarize themselves with tourniquet system provided).

NOTE: You must factually document any “incorrect” or critical failure criteria on back of this form

APPENDIX 10

Junctional Tourniquet Application Quick Reference

REFERENCES

1. Committee on Tactical Combat Casualty Care (CoTCCC). Tactical Combat Casualty Care Guidelines.
2. National Association of Emergency Medical Technicians (NAEMT). Tactical Emergency Casualty Care (TECC) Guidelines.
3. American College of Surgeons. Stop the Bleed & Trauma Care Principles.
4. Kragh JF Jr, et al. Survival with emergency tourniquet use in combat injuries. Journal of Trauma and Acute Care Surgery.
5. Joint Trauma System Clinical Practice Guidelines.

GLOBAL EMERGENCY MEDICAL REGISTRY

Junctional Tourniquet Application Student Quick Reference

PURPOSE

Used to control life-threatening hemorrhage at anatomical junctions where standard limb tourniquets cannot be applied.
Common areas: Groin (inguinal region), Axilla (armpit/shoulder junction), Proximal amputations.
It is indicated when bleeding is not controlled by direct pressure or wound packing alone.

MARCH PRIORITY – MASSIVE HEMORRHAGE

Extremity Tourniquet
Junctional Tourniquet (if indicated)
Wound Packing + Pressure

INDICATIONS

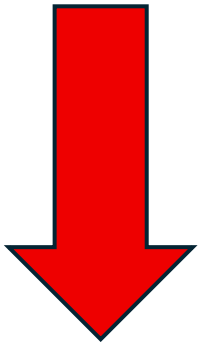
Severe groin or axillary bleeding.
Proximal extremity wound preventing limb tourniquet use.
Traumatic amputation near hip or shoulder.
Failed wound packing with continued hemorrhage.
Need for hands-free hemorrhage control.

CONTRAINDICATIONS / CAUTIONS

Not for neck wounds.
Not for isolated abdominal bleeding.
Requires accurate anatomical landmarking.
Reassess every 2–5 minutes.
Rapid evacuation required.

APPLICATION STEPS

1. Expose wound completely
2. Attempt wound packing if appropriate
3. Identify anatomical landmark
4. Secure device base around pelvis/torso or axilla per manufacturer instructions
5. Center compression disk over artery
6. Tighten or inflate per manufacturer instructions
7. Confirm bleeding control
8. Document time of application
9. Reassess every 2–5 minutes



GLOBAL EMERGENCY MEDICAL REGISTRY

Junctional Tourniquet Application Student Quick Reference Part !!

CONFIRM EFFECTIVENESS
Bleeding stops.
No distal pulse (if applicable).
No expanding hematoma.
Improved perfusion indicators.

DOCUMENTATION
Time Applied.
Location (Right/Left groin or axilla).
Device type.
Patient response.
Reassessments.

APPENDIX 11

Overcoming Stress Physiology Student Quick Reference Tool

References

1. Grossman, D., & Christensen, L. (2008). On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace.
2. Meichenbaum, D. (2007). Stress Inoculation Training: A Preventative and Treatment Approach.
3. LeBlanc, V. R. (2009). The effects of acute stress on performance. Journal of Applied Research in Memory and Cognition.
4. Andersen, J. P., et al. (2016). Heart rate variability and performance under stress in police officers. Frontiers in Psychology.
5. American Psychological Association (Stress effects overview).

GLOBAL EMERGENCY MEDICAL REGISTRY

Overcoming Stress Physiology Student Quick Reference Tool

What Happens Under Stress?
Activation of the Sympathetic Nervous System (SNS)
Adrenaline and cortisol release
Increased heart rate, blood pressure, and breathing
Decreased fine motor skills and cognitive flexibility

Performance Effects by Heart Rate
60–115 bpm: Optimal performance; fine motor skills intact
115–145 bpm: Complex motor skills decline
145–175 bpm: Cognitive narrowing; reduced decision quality
175+ bpm: Tunnel vision, auditory exclusion, possible freezing

Immediate Control Strategies
Box Breathing: Inhale 4 seconds – Hold 4 seconds – Exhale 4 seconds – Hold 4 seconds
Perform 3-6 cycles of Box Breathing.
Self-Talk Control: "Slow down." "Breathe." "One step at a time." Repeat 2-3 times.
Task Segmentation: Focus on the next single action (e.g., MARCH sequence)
30-Second Reset: Deep inhale, longer exhale, relax shoulders/jaw, identify next task.

Post-Incident Recovery
Controlled breathing and hydration
Peer debriefing
Light movement
Prioritize sleep

Please Remember!
Students should understand:
Stress response is NORMAL and adaptive.
Performance loss is physiological, not weakness.
Breathing is the fastest intervention available.
Repetition builds stress tolerance (see " Stress Inoculation Training").

APPENDIX 12

First Aid Student Reference Sheet: Stroke

References
1. American Heart Association. (2023). Stroke Symptoms and Warning Signs. https://www.heart.org
2. Centers for Disease Control and Prevention. (2023). About Stroke. https://www.cdc.gov/stroke
3. National Institute of Neurological Disorders and Stroke. (2023). Stroke Information Page. https://www.ninds.nih.gov
4. World Stroke Organization. (2022). Global Stroke Fact Sheet. https://www.world-stroke.org

GLOBAL EMERGENCY MEDICAL REGISTRY

Stroke First Aid Student Reference

What Is a Stroke?

A stroke (Cerebrovascular Accident or CVA) occurs when blood flow to part of the brain is blocked (ischemic stroke) or when a blood vessel in the brain bursts (hemorrhagic stroke). Brain cells begin to die within minutes without oxygen. Stroke is a medical emergency!

Recognize a Stroke – Use F.A.S.T.

Face: Ask the person to smile, one side droops and it is a symptom.

Arms: Ask them to raise both arms, if one arm drifts downward it is symptom.

Speech: Slurred or confused speech present, if yes, it's a symptom.

Time: Call 911 immediately, note the exact time symptoms started.

Other Warning Signs

Sudden numbness or weakness (especially one side)
Sudden confusion
Trouble seeing in one or both eyes
Severe sudden headache
Trouble walking, dizziness, loss of balance

First Aid Steps

Request Dispatch send Advanced Life Support Backup or Call 911 immediately.
Note the time symptoms began.
Keep the person safe and comfortable, slightly elevate head and shoulders 30 degrees.
Monitor breathing, if not breathing, begin CPR.
Do NOT give food, drink, or medication unless directed by EMS Dispatch.

Why Immediate Action Matters

Brain tissue begins to die within minutes.
Early advanced treatment reduces brain damage, improves recovery, and saves lives.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 13

Chest Pain First Aid Student Reference Sheet

REFERENCES

1. American Heart Association. 2020 Guidelines for CPR and ECC & First Aid Guidelines.
2. Centers for Disease Control and Prevention. Heart Attack Symptoms and Response. https://www.cdc.gov/heartdisease/heart_attack.htm
3. National Heart, Lung, and Blood Institute. Heart Attack Overview., https://www.nhlbi.nih.gov

GLOBAL EMERGENCY MEDICAL REGISTRY

Chest Pain First Aid Student Reference

TREAT ALL CHEST PAIN AS A MEDICAL EMERGENCY!

Chest pain may indicate a heart attack.
Early action saves heart muscle and lives.

RECOGNIZE THE SIGNS

Pressure, squeezing, fullness, or pain in the center of the chest
Pain lasting more than a few minutes or that goes away and returns
Pain spreading to the arm (often left), back, neck, jaw, or shoulder
Shortness of breath
Sweating
Nausea or vomiting
Lightheadedness or unusual fatigue
Women, older adults, and people with diabetes may have atypical symptoms, such as shortness of breath without chest pain, indigestion-like discomfort, extreme fatigue, and/or stating “I don’t feel well”.

FIRST AID STEPS

Request Advanced Life Support Backup from Dispatch or Call 911 immediately.
Do not allow the person to drive themselves.
Have the person sit upright, rest, remain calm, and loosen tight clothing.
Assist with prescribed nitroglycerin if available and directed by EMS dispatch.
If conscious and not allergic, chew one 325 mg aspirin or four 81 mg aspirin if advised by EMS.
Monitor continuously; if the person collapses, begin CPR and use an AED as soon as available.

DO NOT

Do not ignore symptoms
Do not allow the person to 'wait it out'
Do not give food or drink
Do not leave the person alone

WHY TIME MATTERS

Heart muscle begins to die within minutes of blocked blood flow.
Rapid advanced treatment reduces heart damage and improves survival.

GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 14

Seizure First Aid Student Reference Sheet

REFERENCES:
1. Centers for Disease Control and Prevention. *Seizure First Aid.* https://www.cdc.gov/epilepsy/about/first-aid.htm.
2. Epilepsy Foundation. *Seizure First Aid and Safety.* https://www.epilepsy.com. .
3. American Heart Association. *First Aid Guidelines (2020 Update).*

GLOBAL EMERGENCY MEDICAL REGISTRY

SEIZURE FIRST AID – Student Reference

Recognize a Generalized Tonic-Clonic Seizure

Tonic Phase: Body stiffens, possible cry out, possible sudden fall.

Clonic Phase: Rhythmic jerking, may have irregular breathing, possible cyanosis, possible loss of bladder control.

Postictal Phase: Confusion, fatigue, headache, gradual recovery.

First Aid Actions

- Protect from injury: Lower to ground, clear hazards, cushion head, loosen tight clothing.
- After jerking stops, place in recovery position and maintain airway.
- Time the seizure and activate EMS response.
- Stay with the patient and provide calm reassurance.

Do NOT

Do NOT restrain movements.

Do NOT place anything in the mouth.

Do NOT give food or drink.

Do NOT perform CPR unless breathing stops.

Activate Advanced Life Support and consider oxygen if:

Seizure lasts longer than 5 minutes.

Repeated seizures without regaining consciousness occur.

Injury occurred during seizure.

Breathing does not resume.

First known seizure.

Seizure occurs in water.

Patient is pregnant, diabetic, or medically complex

Documentation

Start and stop time.

Type of movements observed.

Loss of consciousness.

Injuries sustained.

Interventions performed.

APPENDIX 15

Anaphylaxis First Aid Student Reference Sheet

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ANAPHYLAXIS First Aid Student Reference Sheet

What Is Anaphylaxis?

Anaphylaxis is a severe, rapid-onset, life-threatening allergic reaction that can cause airway obstruction, breathing failure, shock, and cardiac arrest.

Anaphylaxis typically involves two or more body systems, or severe symptoms in one system after allergen exposure.

It requires immediate recognition and prompt administration of epinephrine.

Common Triggers

Foods (peanuts, tree nuts, shellfish, milk, eggs), Insect stings (bees, wasps), Medications, Latex, Unknown exposures.

Signs & Symptoms

Skin / Mucosal: Hives (urticaria), Itching, Flushing, Swelling of lips, face, tongue.

Respiratory: Shortness of breath, Wheezing, Stridor, Throat tightness, Hoarse voice.

Cardiovascular: Weak pulse, Hypotension, Dizziness, Fainting, Pale or clammy skin.

Gastrointestinal: Nausea, Vomiting, Abdominal cramping.

Neurological: Anxiety, Sudden sense of impending doom, Altered level of consciousness.

Red Flag Signs - Immediate action required if an of these are present: Airway swelling, Stridor, Persistent vomiting, Hypotension, Collapse, and/or Rapid progression of symptoms.

Important Points!

When in doubt — administer epinephrine.

Early epinephrine significantly reduces morbidity and mortality.

Patient's Autoinjector is safe to give - delay increases mortality.

Important Clinical Points

Epinephrine is the only first-line treatment.

Do NOT delay epinephrine for antihistamines.

Antihistamines and steroids are adjunctive only, use only if directed to do so by EMS Dispatch.

Monitor for biphasic reactions (symptom recurrence).

All patients must be transported for medical evaluation.

ANAPHYLAXIS First Aid Student Reference Sheet – Part II

FIRST AID MANAGEMENT

1. Recognize Early - Anaphylaxis can progress within minutes.
2. Activate EMS (or call 911).
3. All suspected anaphylaxis patients require emergency evaluation.
4. Administer Patient's Epinephrine via their epinephrine auto-injector, general Epinephrine Autoinjector Administration Steps:
   a. Remove safety cap,
   b. Place firmly against the outer thigh (Autoinjector may be given through clothing),
   c. Push until click is heard,
   d. Hold in place per device instructions,
   e. Remove and massage briefly.
5. Position the Patient:
   a. If breathing difficulty: allow position of comfort.
   b. If unconscious but breathing: recovery position.
   c. If no pulse: begin CPR and apply AED.
6. If symptoms persist after 5–10 minutes, and EMS has not arrived, administer a second dose of Epinephrine if available.

Documentation Checklist

- ✓ Known trigger (if identified)
- ✓ Time of symptom onset
- ✓ Time Epinephrine given
- ✓ Dose and site administered
- ✓ Patient response
- ✓ EMS activation time

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APPENDIX 16

Bites and Stings Student Reference Sheet

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First Aid for Bites and Stings: Recognition, Immediate Care, and When to Seek Help

Scope and purpose:
This handout provides evidence-based, practical first aid guidance for bites and stings from insects and other arthropods, including recognition of allergic reactions and when to seek emergency care. It synthesizes guidance and data from primary reviews, consensus statements, and examinations of anaphylaxis and venom reactions to support accurate, actionable recommendations for lay readers and frontline responders.

Key messages (summary for quick reference)

- ✓ Many bites and stings cause mild local symptoms, but some can trigger life-threatening allergic reactions (anaphylaxis) requiring prompt epinephrine administration and emergency care (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016)
- ✓ Seek immediate emergency help if there are signs of anaphylaxis: trouble breathing, swelling of tongue or lips, throat tightness, wheeze, dizziness or fainting, widespread hives, or collapse after a sting or bite (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016).
- ✓ For suspected Hymenoptera (bees, wasps, hornets) venom allergy, epinephrine auto-injectors are lifesaving. Do not delay in a suspected anaphylactic reaction (Bilò et al., 2016).
- ✓ First aid actions: remove the person from exposure, wash the area, apply cold packs for local reactions, treat itching with approved remedies, monitor for signs of systemic reaction, and prepare for escalation to professional care if symptoms worsen or do not improve (Steen et al., 2005, Pesek et al., 2014, Pesek et al., 2014, Bilò et al., 2016).
- ✓ Venom immunotherapy and specialist care are central to prevention for those with confirmed venom allergy; educational and action-plan measures reduce risk of future reactions (Steen et al., 2005, Pesek et al., 2014, Bilò et al., 2016).

Section 1: Recognition: local, large local, and systemic reactions

- Local reactions: Typically, pain, redness, swelling at the sting or bite site. These usually resolve within hours to days and can be managed with basic first aid (cold compresses, elevation if limb is involved, oral antihistamines if appropriate) (Steen et al., 2005, Pesek et al., 2014).
- Large local reactions: More extensive swelling extending beyond the sting site, sometimes lasting several days. Management remains supportive; seek clinician advice if symptoms are persistent or worsening (Steen et al., 2005, Pesek et al., 2014).

- Systemic reactions (allergic/anaphylactic): Rapid onset and may include hives, facial or tongue swelling, wheezing, throat tightness, vomiting, dizziness, fainting, or confusion. These require immediate epinephrine and emergency transport. Venom exposure (especially Hymenoptera stings) is a well-established trigger and can be fatal without rapid treatment (Steen et al., 2005, Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016).
- Other severe toxic reactions (rare): Cases exist where multiple stings or certain venoms cause toxic systemic effects (e.g., rhabdomyolysis, renal injury). These are medical emergencies needing intensive care; such presentations are uncommon but underscore the need for rapid escalation in severe cases (Przybilla & Ruëff, 2010, Kurmana et al., 2024) .

Section 2: Immediate first aid actions (for laypersons and first responders)

1. Ensure safety and remove exposure
    a. Move away from the source to prevent further stings or bites. For suspected venom exposure in large numbers, seek urgent medical care (Steen et al., 2005, Pesek et al., 2014).
    b. If the stings are from a bee, do not squeeze the stinger; scrape it out with a flat edge (Pesek et al., 2014, Pesek et al., 2014).
        i. Note: Some sources emphasize sting removal to minimize venom load; this action is standard in first-aid guidance for Hymenoptera stings (Pesek et al., 2014).
2. Assess for anaphylaxis and act quickly
    a. If any signs of systemic reaction occur, administer epinephrine immediately if available, and call emergency services. Do not wait for symptoms to worsen before treating if available (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016).
    b. If using an epinephrine auto-injector, follow the device instructions: intramuscular injection into the mid-outer thigh, then seek urgent medical care (some guidelines emphasize seeking emergency care after auto-injector use) ("PDM volume 10 issue 2 Cover and Front matter", 1995; "PDM volume 9 issue 3 Cover and Front matter", 1994; Suryana & Sindhughosa 2022).
3. Local wound care
    a. Wash the area with soap and water to reduce infection risk; avoid breaking blisters on large local reactions.
    b. Apply a cold pack wrapped in cloth for 10–15 minutes to reduce swelling and pain. Repeat as needed.
    c. Elevate the affected limb if feasible to reduce swelling.

   d. For itching, consider oral antihistamines if there's no contraindication; avoid placing irritants such as chewing tobacco or alcohol on stings (Steen et al., 2005, Pesek et al., 2014, Pesek et al., 2014).
4. Pain and prevention of secondary infection
   a. Analgesia as needed (e.g., acetaminophen or ibuprofen per age/medical condition). Do not apply unapproved topical irritants. Monitor for signs of infection (increasing redness, warmth, pus) over the next 24–72 hours and seek medical care if suspicion arises (Steen et al., 2005, Pesek et al., 2014).
5. What to do after a bee/wasp sting in a person with known venom allergy
   a. They should have an emergency action plan and carry an epinephrine auto-injector if prescribed. Venom immunotherapy (VIT) is a proven long-term preventive treatment for venom allergy in selected patients; discuss with an allergist if risk factors for future severe reactions are present. Ensure rapid access to emergency care after a sting (Steen et al., 2005, Suryana & Sindhughosa 2022, Bilò et al., 2016).

Section 3: Special considerations for venom allergy and anaphylaxis

1. Epinephrine is the first-line treatment for anaphylaxis due to insect stings; delaying or withholding treatment increases mortality risk (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016).
2. Venom immunotherapy significantly reduces risk of systemic reactions in venom-allergic patients and is a central preventive strategy for Hymenoptera venom allergy; consider referral to an allergist for assessment and potential VIT if systemic reactions have occurred (Steen et al., 2005, Suryana & Sindhughosa 2022, Bilò et al., 2016).
3. Self-medication guidelines emphasize education on recognizing early signs of anaphylaxis, proper use of auto-injectors, and the importance of seeking professional care; incorrect or delayed administration reduces effectiveness (Bilò et al., 2016).

Section 4: When to seek urgent care

1. Immediate emergency help for any suspected anaphylaxis after a bite or sting: rapid onset of breathing difficulties, throat swelling, fainting, dizziness, severe throat tightening, confusion, or wheezing (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al., 2016).
2. If large local reactions are worsening, if there are signs of infection after 24–72 hours, or if there are risk factors for severe reactions (age, comorbid conditions), seek prompt medical evaluation (Steen et al., 2005, Pesek et al., 2014).

3. In children, regional data indicates significant proportion of presentations require timely ED care; ensure access to epinephrine when indicated and follow-up with allergy clinics as appropriate (Weber et al., 2022).

Section 5: Roles of medications and devices

1. Epinephrine: First-line emergency treatment for anaphylaxis; auto-injectors improve timely access; no absolute contraindication in true anaphylaxis; correct dosing and administration are critical ("PDM volume 10 issue 2 Cover and Front matter", 1995; "PDM volume 9 issue 3 Cover and Front matter", 1994; Suryana & Sindhughosa 2022, Bilò et al., 2016).
2. Antihistamines and corticosteroids: May be used as adjuncts after the acute event, particularly for local or mild systemic symptoms; not a substitute for epinephrine in anaphylaxis (Steen et al., 2005, Pesek et al., 2014, Pesek et al., 2014).
3. Venom immunotherapy: Long-term preventive option for Hymenoptera venom allergy; efficacy ranges widely but is generally protective against future systemic reactions; requires specialist management (Steen et al. 2005, Pesek et al. 2014).

Section 6: Public health and education context

1. Public awareness and training in recognizing and responding to anaphylaxis improve outcomes; many cases involve underutilization of epinephrine in ED settings, highlighting the need for education and access to epinephrine auto-injectors (Wall & Sorensen 2013, Kattan & Sicherer, 2013, Bilò et al. 2016).
2. First aid education guidelines emphasize prevention, rapid recognition, and rapid action in allergic emergencies, with attention to limited EMS resources in many settings (relevant to adapting content to local contexts) (Ioannidis & Clucas 2021, Mbarie & Abiodun, 2025).

Section 7: Quick-reference patient handouts (condensed version)

1. If stung and having mild local symptoms: wash with soap and water, apply cold pack, elevate limb, consider an oral antihistamine or analgesic as appropriate, monitor for worsening symptoms.
2. If you have signs of anaphylaxis: call emergency services immediately; use epinephrine auto-injector if prescribed, then seek emergency care. Do not delay treatment for observation.
3. After any sting: avoid further exposure, check for signs of infection, and seek medical evaluation if symptoms persist or systemic symptoms develop.
4. For known venom allergy: carry and know how to use an epinephrine auto-injector; discuss venom immunotherapy with an allergist if recommended.

Citations and evidence base

1. Recognition and management of anaphylaxis in insect stings and bites are described in comprehensive reviews and consensus statements that emphasize prompt epinephrine use and emergency care (Wall & Sorensen 2013, Suryana & Sindhughosa 2022, Bilò et al. 2016).
2. The role of epinephrine auto-injectors, including dosing, administration, and the need for immediate administration in suspected anaphylaxis, is documented in multiple sources and educational reviews ("PDM volume 10 issue 2 Cover and Front matter" 1995, "PDM volume 9 issue 3 Cover and Front matter" 1994, Suryana & Sindhughosa 2022, Bilò et al. 2016).
3. Insect sting hypersensitivity management and venom immunotherapy are detailed in reviews and immunology-focused sources, highlighting long-term preventive strategies for venom allergy (Steen et al. 2005, Pesek et al., 2014, Pesek et al. 2014, Bilò et al. 2016).
4. Emergency department data on pediatric anaphylaxis and triggers including insect stings support the significance of timely recognition and management in clinical practice (Weber et al. 2022).
5. Public health and educational perspectives on first aid for bites and stings stress prevention, recognition, and prompt treatment, with emphasis on effective education for laypersons and responders (Ioannidis & Clucas 2021, Mbarie & Abiodun 2025).

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APPENDIX 17

First Aid for Dangerous Marine Life Student Reference Sheet

First Aid for Dangerous Marine Life Student Reference Sheet

Learning objectives

1. Recognize common dangerous marine life encounters and the typical emergency priorities.
2. Apply appropriate, species-informed first-aid actions to minimize harm and buy time for professional care.
3. Understand when to seek advanced medical help and what information to provide responders.

Scope and evidence base

This handout synthesizes guidance from reviews and position statements on marine envenomation and bites, jellyfish and cnidarian stings, venomous fish injuries, sea snakes, stingrays, cone snails, and related marine toxins. It emphasizes first aid steps with consensus support (e.g., rapid removal from water, avoiding harmful actions like tourniquets in many cases, and hot-water immersion for many cnidarian envenomation) and notes areas of ongoing debate or variation by region and organism (Ericsson et al., 2006; Isbister, 2007; Wilcox & Yanagihara, 2016; Marks et al., 2019; Hughey et al., 2024; , Ottuso, 2013; Scharf, 2002; , Fenner, 2000; Niżnik et al., 2024; O'Neil et al., 2007).

Key marine life groups and first-aid priorities:

Cnidarians (jellyfish, sea anemones, box jellyfish, Irukandji)

1. First aid priorities:
    a. Get the person out of the water and away from further stings (Isbister, 2007; Wilcox & Yanagihara, 2016; Kadler et al., 2024).
    b. Do not rub or scrub the affected area; remove tentacles if safely possible and visible, using protective barrier (gloves or swift method to avoid nematocyst discharge; avoid bare hands) (Isbister, 2007; Wilcox & Yanagihara, 2016).
    c. Rinse with seawater if available; avoid using fresh water or vinegar on all cnidarian stings unless guidelines specify otherwise for particular species; vinegar is recommended for some jellyfish (e.g., box jellyfish) as part of first aid in certain regions, but evidence is mixed across cnidarians and protocols vary by species (Wilcox & Yanagihara, 2016; Kadler et al., 2024; Isbister, 2007; O'Neil et al., 2007).
    d. Hot-water immersion (approximately 40–45°C, 20 minutes) is frequently recommended to relieve pain for non-life-threatening cnidarian stings and has broad support in reviews; avoid hot water for stings from sea snakes or envenomation where

indicated by local protocol (Wilcox & Yanagihara, 2016; Niżnik et al., 2024; Ottuso, 2013).

2. Seek urgent Emergency Medical Services response for:
    a. Severe pain, systemic symptoms (dizziness, breathing difficulty, chest pain), or signs of anaphylaxis.
    b. Sting involves the face, mouth, throat, or is near airway; in Irukandji or box jellyfish envenomation, rapid deterioration can occur (Ericsson et al., 2006; Isbister, 2007; Wilcox & Yanagihara, 2016; O'Neil et al., 2007); care for the patient with preparation for CPR and/or Oxygen assistance until Emergency medical personnel arrive.
    c. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond*.
3. Nuances and disagreements:
    a. Some sources emphasize vinegar as a universal rinse for cnidarian stings; others caution that vinegar may not be beneficial for all cnidarians and that seawater is a safer neutral rinse in many protocols. Responders should align with local guidelines and species encountered. This nuance is reflected across reviews and regional guidance (Wilcox & Yanagihara, 2016; O'Neil et al., 2007).

<u>Venomous fish</u> (e.g., stingrays, stonefish, scorpionfishes, lionfish) and related fish injuries

1. First aid priorities:
    a. Stabilize and remove the person from water; immobilize the affected limb to reduce venom spread; avoid squeezing or rubbing wound (Scharf, 2002; Isbister, 2007; Ottuso, 2013).
    b. Do not apply tourniquets or cutting to the wound (risk of tissue damage and diffusion of venom) unless life-threatening hemorrhage exists; control bleeding with gentle pressure (Isbister, 2007; Scharf, 2002; Ottuso, 2013).
    c. Soak affected area in hot water (approximately 40–45°C) for 30–90 minutes or until pain improves, as heat can denature certain venom components and provide analgesia in many venomous fish envenomation (Scharf, 2002; Isbister, 2007; Ottuso, 2013).
    d. Do not attempt venom removal by cutting spines or probing; *activate Emergency Medical Services for medical assessment with potential systemic effects and infection* risk (Scharf, 2002; Isbister, 2007).
2. Nuances:
    a. Some venomous fish have highly toxic venoms with potential life-threatening effects; management may escalate to antivenom and hospital care in severe cases; first aid aims to palliate pain and prevent further venom absorption (Scharf, 2002; Isbister,

2007; Ottuso, 2013); *if the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond*.

Stingrays and other elasmobranch injuries

1. First aid priorities:
    a. Move the person to safety and remove from water; remove barbs if accessible with minimal manipulation; wash wound with clean water; soak in hot water as tolerable and effective for pain relief if no contraindication (Scharf, 2002; Isbister, 2007; , Ottuso, 2013).
    b. Early wound care and tetanus status assessment; monitor for secondary infection (Scharf, 2002; Ottuso, 2013).
    c. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*
2. Nuances:
    a. Stingray envenomation often presents with severe local pain and potential tissue injury; hot water immersion is commonly recommended, but always adapt to local guidelines (Scharf, 2002; Ottuso, 2013).

Sea Snakes (marine venoms)

1. First aid priorities:
    a. Rescuing from water to prevent drowning; airway management if needed; immobilize the limb; seek rapid antivenom administration per local protocols; activate Emergency Medical Services response (Ericsson et al., 2006; Hughey et al., 2024; Isbister, 2007; Ottuso, 2013).
    b. Do not rely on tourniquets; antivenom is a key treatment in many settings; supportive care is paramount (Ericsson et al., 2006; Hughey et al., 2024; Isbister, 2007).
    c. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond*.
2. Nuances:
        a. Sea snake envenomations are rare in some regions but carry high morbidity; regional guidance emphasizes rapid transport and antivenom when indicated (Ericsson et al., 2006: Hughey et al., 2024; Isbister, 2007).

Cone snails and other marine mollusks

3. First aid priorities:
    a. Avoid handling live venomous mollusks; if stung, remove the person from water and provide supportive care; seek emergency care for systemic symptoms; antivenoms exist for some cone snail envenomations in certain regions but accessibility varies; focus on airway, breathing, circulation, and pain control (Ericsson et al., 2006; Hughey et al., 2024; Isbister, 2007).
    b. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*
4. Nuances:
    a. Cone snail envenomation can be severe with neurotoxic effects; regional differences in availability of antivenom and treatment protocols exist (Ericsson et al., 2006; Hughey et al., 2024; Isbister, 2007).

Box jellyfish, Irukandji syndrome, and other jellyfish injuries

1. First aid priorities:
    a. Immediate removal from water; tentacle management with protective barriers for rescuer; rinse with seawater; apply vinegar for certain box jellyfish exposures if recommended by local protocol; hot-water immersion may relieve pain for many stings; monitor airway and vital signs; Activate Emergency Medical Services for severe symptoms (Ericsson et al., 2006; Isbister, 2007; Wilcox & Yanagihara, 2016; O'Neil et al., 2007).
    b. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*
2. Nuances:
    a. Irukandji syndrome can present with severe systemic pain and autonomic symptoms; management often requires analgesia and monitoring; antivenom is regionally available but not universally, depending on healthcare system (Ericsson et al., 2006; Isbister, 2007; O'Neil et al., 2007).

General considerations across marine envenomations

1. When to seek Emergency Medical System response:
    a. If there is significant pain, swelling, spreading redness, signs of systemic illness (nausea, vomiting, dizziness, difficulty breathing, chest pain, fainting) activate Emergency Medical System response immediately (Warwick & Steedman, 2012;

Ericsson et al., 2006; Bury et al., 2011; Isbister, 2007; Marks et al., 2019; O'Neil et al., 2007).

2. First aid framework (common across many marine envenomations):
    a. Scene safety and personal protection; ensure the responder's safety; remove the person from water if needed; provide first aid measures focused on pain relief and stabilization; monitor for deterioration (Ericsson et al., 2006; Isbister, 2007; Wilcox & Yanagihara, 2016; Marks et al., 2019; O'Neil et al., 2007).
    b. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*
3. Education and prevention:
    a. Public health and educational programs should emphasize awareness of local marine hazards, recognition of high-risk activities, and the importance of early first aid and timely emergency medical care; knowledge gaps exist among populations in some regions, stressing the need for targeted training (Kan et al., 2016; O'Neil et al., 2007).

Practical first-aid checklists (quick-reference)

1. General approach for suspected marine envenomation or bite
2. Ensure safety; remove person from water; call for help from water safety professionals if conditions are difficult or if you are not trained in water rescue.
3. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*
4. Identify the likely organism when possible; if uncertain, treat as envenomation with general supportive care.
5. Remove the person from the water; protect yourself; avoid direct contact with tentacles or venom sources.
6. For cnidarian stings: remove tentacles; rinse with seawater; use hot-water immersion when appropriate; consider vinegar based on local guidance; monitor for anaphylaxis.
7. For venomous fish and stingrays: cleanse wound; soak in hot water if tolerable; control pain; immobilize limb; avoid tourniquet.
8. For sea snakes and cone snails: immobilize limb; keep the patient calm; activate Emergency Medical Services; do not apply home remedies.
9. For all injuries: assess airway, breathing, circulation; treat and monitor for signs of anaphylaxis; ensure tetanus status is up to date; arrange for medical care.
10. When to call emergency medical services:

a. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond.*

Safety and limitations of this handout

1. Regional variation exists in recommended first-aid measures depending on species distribution and available treatments; responders should consult local guidelines and poison control centers for species-specific protocols (Ericsson et al., 2006; Hughey et al., 2024; Isbister, 2007; O'Neil et al., 2007).
2. Evidence on some first-aid methods (e.g., vinegar use for certain jellyfish stings) is evolving; hot-water immersion has broad support for many cnidarian envenomations but may not apply universally to all marine envenomations; clinical judgment and local guidance are essential (Wilcox & Yanagihara, 2016; , O'Neil et al., 2007).

Supplementary materials and further reading

- Comprehensive reviews on medially important venomous animals: guidance on prevention, first aid, and clinical management (Ericsson et al., 2006; Isbister, 2007; Wilcox & Yanagihara, 2016).
- Forensic and epidemiological perspectives on marine envenomation and associated fatalities to inform knowledge about risk and response patterns (Bury et al., 2011; O'Neil et al., 2007).
- Regional summaries of marine envenomation management practices and emergency treatment strategies in high-risk areas (e.g., Australia, South Africa, Okinawa, etc.) to illustrate best practices and variations (Isbister, 2007; Hughey et al., 2024; Marks et al., 2019; Hughey et al., 2024).

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GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 18

Hypothermia/Hyperthermia First Aid Student Reference Sheet

First Aid for Hypothermia and Hyperthermia
Student Reference Sheet

Overview and Definitions

1. Hypothermia:
    a. Core body temperature below 35°C (95°F).
    b. It ranges from mild to severe and is associated with impaired thermoregulation, altered mentation, and potentially life-threatening arrhythmias if not addressed promptly (Brumberg et al., 2024; Allen & Brandon, 2011; Giesbrecht, 2018; Grapatsas et al., 2018).
    c. Early recognition and prevention are critical (Eidstuen et al., 2018; Brumberg et al., 2024; Allen & Brandon, 2011).
2. Hyperthermia:
    a. Includes heat illness and heat stroke conditions.
    b. Generally associated with excessive heat exposure or impaired heat dissipation, leading to heat exhaustion or heat stroke.
    c. First aid focuses on cooling, hydration, and recognizing signs of progression to organ dysfunction (Brumberg et al., 2024; Allen & Brandon, 2011; Chen et al., 2018; Farouji et al., 2021).

Initial Assessment and Scene Considerations

1. Scene safety and PPE:
    a. Ensure scene is safe; perform a rapid assessment (Airway, Breathing, Circulation, Disability, Exposure) as applicable in first aid contexts, with emphasis on airway and breathing in hypothermic/hyperthermic victims where impairment is common (Idland et al., 2023; Brumberg et al., 2024; Allen & Brandon, 2011).
2. Triage and prognosis cues:
    a. Hypothermia: look for altered mental status, shivering (may be absent in severe cases), cold/clammy skin, slowed movements, and stiff joints. In trauma, preventing heat loss at the scene of injury improves outcomes (Eidstuen et al., 2018; Brumberg et al., 2024; Allen & Brandon, 2011).
    b. Hyperthermia: assess level of consciousness, skin warmth or sweat, dehydration signs, and core symptoms such as dizziness, confusion, nausea. Early cooling is indicated for heat-related illness prior to EMS arrival when safe to do so (Brumberg et al., 2024; Allen & Brandon, 2011).

First Aid for Hypothermia:

1. Immediate actions:
    a. Move to a warmer environment if possible; remove wet clothing and replace with dry, insulating layers and a blanket. Avoid rough handling that could cause arrhythmias in

severe hypothermia; gentle handling is advised (Eidstuen et al., 2018; Brumberg et al., 2024; Allen & Brandon, 2011).

b. For conscious individuals with intact swallowing, offer warm fluids, avoid hot fluids that could cause burns or shock (Brumberg et al., 2024; Allen & Brandon, 2011).

c. Protect extremities; do not rub or massage extremities or rewarm too aggressively in the field if evacuation is imminent. Use passive rewarming (blankets, shelter) as the primary method in mild cases; active rewarming measures (radiant heat, heated fluids) are reserved for use by Emergency Medical Services (Brumberg et al., 2024; Allen & Brandon, 2011).

2. Temperature monitoring and medical escalation
   a. Monitor core temperature if available (tympanic/axillary thermometers can be used in field triage but recognize limitations). Hypothermia assessment guides triage decisions and helps determine urgency of transport to higher-level care (Brumberg et al., 2024; Allen & Brandon, 2011).
   b. If the patient exhibits confusion, unconsciousness, or loss of protective reflexes, assume significant hypothermia and activate Emergency Medical Services immediately; in severe cases (core <28°C) consider active rewarming strategies while waiting for EMS arrival (Brumberg et al., 2024; Allen & Brandon, 2011; Grapatsas et al., 2018).
3. When not to delay transport
   a. Any patient with altered mental status, signs of organ compromise, chest pain, severe bradycardia, or hypothermia with trauma or suspected cardiac instability should have Emergency Medical Services response immediately; prehospital temperature management should never delay EMS activation and transport (Brumberg et al., 2024; Allen & Brandon, 2011; Grapatsas et al., 2018).
4. Special considerations
   a. For victims with prolonged exposure or “cold water” immersion, consider the risk of arrhythmias; use gentle handling and avoid rough movement that could precipitate complications (Eidstuen et al., 2018; Brumberg et al., 2024; Allen & Brandon, 2011).
   b. If using a hypothermia wrap or passive insulation, ensure the patient remains dry and insulated; do not cover with multiple layers that trap moisture or cause overheating in non-wet conditions (Brumberg et al., 2024; Allen & Brandon, 2011).

<u>First Aid for Hyperthermia (Heat-Related Illness)</u>

1. Recognize and categorize
   a. Heat exhaustion: dizziness, fatigue, sweating, paleness, nausea, headache.
   b. Heat stroke: altered mental status, confusion, collapse, absence of sweating or possible profuse sweating from exertion, very hot dry skin or red skin may be present in some cases; immediate Emergency Medical Services response is required for heat stroke (Brumberg et al., 2024; Allen & Brandon, 2011).
2. Immediate actions
   a. Move to a cooler environment, remove excess clothing, fan, apply cooling measures (cool water mist, sponges, or immersion if feasible and airway safety is guaranteed;

avoid aggressive cooling that can cause shivering and vasoconstriction in some individuals) (Brumberg et al., 2024; Allen & Brandon, 2011).

b. Hydration:
   i. Offer small sips of water if conscious and able to swallow.
   ii. Avoid alcohol or caffeinated beverages.
   iii. In vomiting or unconscious individuals, do not give fluids by mouth.
   iv. Seek EMS assistance immediately
   v. (Brumberg et al., 2024; Allen & Brandon, 2011).

c. If a heat stroke is suspected (confusion, loss of consciousness, very high body temperature), call for Emergency Medical Services immediately; begin cooling using fans/ice packs on the neck, armpits, groin as available (Brumberg et al., 2024; Allen & Brandon, 2011; Chen et al., 2018).

3. When to escalate
   a. Heat stroke requires rapid Emergency Medical Services involvement; aggressive cooling in a controlled environment (ED or ICU) may be necessary (Brumberg et al., 2024; Allen & Brandon, 2011; Chen et al., 2018).

General Principles and Common Pitfalls

1. Do not delay transport for definitive rewarming if EMS access is limited. Field management aims at preventing further heat loss in hypothermia or preventing progression of heat illness while awaiting EMS (Eidstuen et al., 2018; Brumberg et al., 2024; Allen & Brandon, 2011).
2. Avoid overheating a hypothermic patient or undercooling a hyperthermic patient; balance the approach with the environment and patient status. Use passive warming for mild hypothermia; use active warming only when EMS has arrived and directed; for hyperthermia, focus on rapid cooling and hydration as appropriate (Brumberg et al., 2024; Allen & Brandon, 2011; Chen et al., 2018).
3. Documentation: record signs, symptoms, estimated temperature if possible, time of exposure, and actions taken. This supports feedback on training programs and future guidelines (Idland et al., 2023; Mazur et al., 2019; Giesbrecht, 2019).

<u>Evidence Synthesis and Nuances</u>

1. There is consistent emphasis across sources that hypothermia prevention and careful rewarming are critical in trauma and environmental exposure contexts; bystanders and first responders can influence outcomes through early prevention and careful handling (Eidstuen et al., 2018; (Brumberg et al., 2024; Allen & Brandon, 2011).
2. Tools for assessing bystander first aid quality (e.g., FAQA) illustrate the ongoing effort to quantify and improve field care quality, including hypothermia prevention measures (Idland et al., 2023).
3. There is ongoing discussion about the optimal rewarming modality in various settings (prehospital vs. in-hospital), emphasizing that decisive, stage-appropriate care improves outcomes but may require advanced resources beyond lay first aid (Brumberg et al., 2024; Allen & Brandon, 2011; Grapatsas et al., 2018).

Quick Reference Checklist

1. Hypothermia
    a. Scene: move to warmth, dry and insulate; avoid rough handling.
    b. Airway/Breathing: assessment and provide supportive measures as feasible.
    c. Temperature: monitor if possible; call for emergency evacuation for suspected severe hypothermia.
    d. Rewarming: passive first; active rewarming only if EMS or hospital care is available.
    e. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, slow or fast pulse, and/or cardiac symptoms immediately activate Emergency Medical Services to respond*.
2. Hyperthermia
    a. Scene: move to shade and remove excess clothing.
    b. Cooling: apply tepid water via spray bottle and arrange fan across patient; monitor closely for shivering and stop cooling if shivering occurs.
    c. Hydration: offer water if conscious and swallowing reflex intact, do not allow with vomiting or altered mental status.
    d. *If the patient is experiencing any severe symptoms, severe bleeding uncontrolled with gentle pressure, altered mental status, respiratory symptoms, and/or cardiac symptoms immediately activate Emergency Medical Services to respond*.

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GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 19

Mental Health First Aid Student Reference Sheet

Handout Set:
Mental Health First Aid Essentials
Suicide Indicators Checklist,
Psychosis/Hallucination Quick Reference,
De-escalation Language Guide

Important notes:
These handouts are designed for public-facing responders.
They are not a substitute for professional assessment or treatment!
Use with care: if there is imminent risk of harm, respond per your region's protocol.
Always prioritize safety, respect autonomy, and be trauma-informed in your approach.

GLOBAL EMERGENCY MEDICAL REGISTRY

Mental Health First Aid Essentials Suicide Indicators Checklist

Purpose:
To help you quickly identify warning signs of potential suicide risk and decide when to escalate to professional help or crisis services.

When communicating:

1. Emphasize empathy, non-judgmental language, and respect for autonomy.
2. Explain that you will document the conversation to help coordinate care with professionals.

Core risk indicators (watch for any combination)

1. Explicit ideation
    a. Statements about wanting to die, not wanting to live, or hopelessness about the future
2. Intent and plan
    a. Expressions of intent to act, detailed plan, or means to carry out the act
3. Means and access
    a. Access to weapons, medications, collection of items to self-harm
4. Previous risk markers
    a. Prior suicide attempt, previous self-harm, family history of suicide
5. Acute risk signals
    a. Agitation, sudden behavioral withdrawal, giving away possessions, writing goodbye notes, risky behaviors
6. Contextual risk
    a. Recent loss, trauma, severe illness, substance use changes, major life stressors
7. Protective factors (note for conversation)
    a. Reasons for living, strong relationships, access to care, engagement in treatment, religious or cultural beliefs, future plans

Direct inquiry prompts (use calmly and directly)

1. “Are you thinking about hurting yourself right now?”
2. “Do you have a plan or means to act on these thoughts?”
3. “Have you thought about what would stop you from acting on these thoughts?”
4. “What would help you stay safe tonight/this week?”

Safety planning steps (keep it simple)

1. Identify warning signs and triggers with the person
2. Create a short, practical coping plan (e.g., hold on to a grounding object, contact a trusted person)
3. List crisis resources (hotlines, mobile crisis teams, emergency services)
4. Remove or restrict access to means if feasible and safe
5. Decide on the next contact: immediate check-in, escalation to urgent care, or on-site support
6. Safety planning should be collaborative; never promise confidentiality if safety is at risk.

Escalation criteria (when to seek urgent help)

1. Imminent plan or means with high likelihood of use
2. Person requests urgent assistance or expresses intent to act
3. Difficulty ensuring safety or the person is in immediate danger or self-harm is imminent
4. The person has difficulty engaging in self-care or decision-making due to distress

Resources to share (local and national)

1. National or regional suicide crisis lines
2. Mobile crisis teams or urgent care centers
3. Local mental health helplines, hospital emergency departments

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Mental Health First Aid Essentials Psychosis/Hallucinations/Delirium Quick Reference

Purpose:
A rapid reference to recognizing hallucinatory experiences and respond in a grounding, safety-focused manner without reinforcing delusions.

Key presentations:

1. Hallucinations
   a. Auditory: hearing voices or sounds that aren't there
   b. Visual: seeing things others don't see
   c. Olfactory or tactile: smelling or feeling sensations without a cause
2. Psychosis indicators (may include)
   a. Delusions (firm beliefs not shared by others), disorganized thinking, suspiciousness, flat or incongruent affect
   b. Disorganized speech, incoherence, incoherent or tangential conversations
   c. Distress or agitation, impairment in daily functioning
3. Delirium
   a. Delirium is a disturbance of consciousness with reduced ability to focus, sustain or shift attention.
   b. *Delirium is a Medical Emergency*, immediately activate Emergency Medical Services and provide first aid supportive care.
4. Differential considerations
   a. Substance use, withdrawal, medical or neurological conditions, mood disorders with psychotic features, delirium, sleep deprivation
   b. *Hallucinations and/or Psychosis with possible medical pathology should result in immediate Emergency Medical Services activation*.

Approach and language (what to say and do)

1. Assess safety first
   a. "Are you safe right now? Is anyone at risk of harm?"
2. Validate distress, don't argue about beliefs
   a. "I'm sorry you're experiencing this. It must be very distressing."
   b. "I don't share your belief, but I believe you're distressed and I want to help."
3. Grounding and reality orientation (without confrontation)
   a. "Let's focus on what we can do right now to stay safe."

   b. "What's something you can see, hear, or feel that is real right now?"
4. Redirect toward safety and support
   a. "Would you be willing to sit somewhere quieter with me for a moment?"
   b. "I can stay with you and help you contact a clinician or trusted person"
5. Boundaries and de-escalation
   a. "I'm here with you. I want to help, but we need to stay safe. Let's work on a plan together."
6. When to involve professionals
   a. If there is danger to self or others, inability to care for self, severe agitation, or incoherence, contact crisis services and Emergency Medical Services.

Practical grounding techniques:

1. 5-4-3-2-1 sensory grounding:
   a. "Name 5 things you can see",
   b. "Name 4 things you can touch",
   c. "Name 3 things you can hear",
   d. "Name 2 things you can smell",
   e. "Name 1 thing you can taste".
2. Breathing and slow pace:
   a. Model slow breathing; invite the person to breathe with you
3. Safe space suggestion:
   a. "Would you like to move to a quieter area or sit here with me?"

Red flags for escalation:

1. Sudden escalation in risk thoughts or intention.
2. Persistent danger to self or others.
3. Inability to care for basic needs or make safe decisions.

Notes for the First Aider:

1. Do not challenge delusions or hallucinations; acknowledge the person's experience and focus on safety, grounding, and help-seeking.
2. Recognize that hallucinations can occur in various contexts (psychiatric illness, substance use, medical conditions) and require appropriate assessment.

GLOBAL EMERGENCY MEDICAL REGISTRY

Mental Health First Aid Essentials De-Escalation Language Guide

Purpose:
A concise reference to effective verbal and nonverbal strategies to reduce arousal and prevent escalation during crisis encounters.

Core principles:

- Tone and pace
  - Speak in a calm, even tone; slow tempo; simple, respectful language
- Nonverbal stance
  - Open posture, relaxed shoulders, safe distance, non-threatening movements
- Safety and boundaries
  - Acknowledge distress, set clear boundaries, and offer choices
- Person-centered and trauma-informed approach
  - Respect autonomy, safety planning, and cultural sensitivity

Core phrases and scripts

- Open with warmth and presence
  - "Hi, I'm here to help. My name is _."
  - "I'm glad you're with me. I want to understand what you're experiencing."
- Acknowledge feelings without arguing
  - "It sounds really tough right now."
  - "I can see you're upset. I'm listening."
- Reflective listening
  - "So what I'm hearing is that you feel overwhelmed because…"
- Offer choices and control
  - "Would you like to sit here, or move to a quieter space?"
  - "Would you prefer to contact someone you trust or a professional?"
- Grounding prompts
  - "Let's take a few slow breaths together."
  - "Name three things you can see, two you can touch, one you can hear."
- Boundaries and safety
  - "I'm here with you, and I want to help. If at any point you feel unsafe, we can pause and reassess."
  - "If you're in immediate danger, I may need to involve others to keep you safe."
- Escalation language (when to involve professionals)

- "I want to connect you with someone who can help right now. Can I call a crisis line or a mobile unit with you?"
- "If we can't ensure safety here, we'll need to seek urgent care or emergency support."

Nonverbal best practices

- Maintain an even, calm gaze; avoid staring or blocking requested space
- Stand at a comfortable distance; avoid towering over the person
- Keep hands open and visible; avoid sudden movements
- Create a quieter, safer environment when possible

Cultural and ethical notes

- Be mindful of language that could imply blame or judgment
- Respect cultural differences in expressions of distress
- Obtain consent for sharing resources and for involvement of others when feasible

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GLOBAL EMERGENCY MEDICAL REGISTRY

Mental Health First Aid for Patients in Crisis
A Quick Reference for First Aid Students

Purpose

1. Equip first aid students with foundational, evidence-informed practices for supporting individuals experiencing a mental health crisis.
2. Emphasize de-escalation, safety planning, trauma-informed care, collaboration with professionals, and appropriate referral to higher-level care.
3. Provide concise, actionable steps that can be applied in community, campus, or clinical training settings.

Key Aims in a Mental Health Crisis

1. Ensure immediate safety for the person, bystanders, and responders.
2. Establish calm, trusting communication to de-escalate acute distress.
3. Assess risk and connect to appropriate help (emergency medical services, social worker response, mental health response resources, campus resources, or community mental health supports).
4. Avoid retraumatization and minimize use of coercive interventions where possible.
5. Document and handover care to trained professionals when they arrive.

Principles to Guide Your Response (Trauma-Informed, Person-Centered, De-Escalation Focus):

1. Safety first: physical and emotional safety for all present (Nizum et al., 2020; Istanboulian et al., 2023; Chavulak et al., 2023).
2. Trust and transparency: introduce yourself, explain what you're doing, and what comes next (Nizum et al., 2020; Istanboulian et al., 2023).
3. Collaboration: involve the person in decisions to the extent possible; offer choices and control where feasible (Nizum et al., 2020; Istanboulian et al., 2023).
4. Empowerment: acknowledge strengths and support coping strategies; provide hope and continuity of care (Nizum et al., 2020; Istanboulian et al., 2023).
5. Cultural humility: respect diverse backgrounds, identities, and languages; adapt communication accordingly (Nizum et al., 2020; Istanboulian et al., 2023).
6. Non-coercive approach: prioritize de-escalation, debriefing, and least-restrictive options; use restraints only when absolutely necessary and in line with policy and training (and with safety as the last resort) (Baker et al., 2022; Chavulak et al., 2023).

Immediate Actions (Step-by-Step)

1. Ensure safety
    a. Position yourself at a non-threatening distance, remove potential hazards if safe to do so.
    b. If the person becomes acutely agitated or violent, call for assistance from trained personnel and follow local crisis protocols.
    c. Do not threaten or corner the person; provide clear, calm directions and keep voice steady (Nizum et al., 2020; Istanboulian et al., 2023).
2. Approach and communicate
    a. Introduce yourself; state your role and intention (e.g., “I’m here to help you stay safe and connect you with the right support”).
    b. Use simple, concrete language; speak slowly; offer one question at a time; allow silences for processing.
    c. Validate feelings without judgment: “I can see you’re really overwhelmed right now. I’m glad you’re safe.” Avoid arguing, lecturing, or dismissing concerns (Nizum et al., 2020; Istanboulian et al., 2023; Chavulak et al., 2023).
3. Assess and respond to risk
    a. Gently assess for immediate danger to self or others and any known risk factors (self-harm, suicide risk, aggression, substance use). Use brief, non-intrusive questions; do not press for full disclosure in crisis.
    b. If there is imminent danger, implement appropriate emergency procedures and seek urgent help (call emergency medical services and field mental health response if available). Document observations succinctly for medical and mental health responders (Nizum et al., 2020; Istanboulian et al., 2023; Chavulak et al., 2023).
4. De-escalation techniques
    a. Use open body posture, relaxed tone, and empathetic listening.
    b. Acknowledge distress and avoid arguing about reality or perspectives.
    c. Offer choices and control: “Would you prefer I stay with you here, or would you like me to step back a moment and talk later?” Provide options for location, pacing, and next steps when possible (Nizum et al., 2020; Istanboulian et al., 2023).
    d. Encourage grounding and short coping strategies (breathing, counting, grounding in the present moment) if appropriate and acceptable to the person.
5. Trauma-informed care during crises
    a. Recognize prior trauma may shape reactions; minimize re-traumatization by avoiding coercive tactics and maximizing consent and collaboration.
    b. Respect the person’s safety needs and preferences; avoid re-living past traumas through insensitive wording or invasive questioning during acute distress (Nizum et al., 2020; Istanboulian et al., 2023).
6. Involve support networks and plan next steps
    a. If appropriate and with consent, involve a trusted family member, friend, or clinician who can provide ongoing support.

   b. Provide information about available resources: campus counseling services, local crisis lines, or urgent care options.
   c. Create a simple safety plan: who to contact, where to go, and what to do if distress escalates in the next hours/days.
   d. Offer to connect with follow-up services or a clinician as needed.
   e. (Olmedo & Muir, 2025; Nizum et al., 2020; Istanboulian et al., 2023).
7. Document and handover
   a. Record key details: observed behaviors, stated concerns, risks assessed, de-escalation attempts, and any agreed-upon next steps.
   b. Ensure a clear handover to responding professionals or on-site crisis teams, including relevant safety plans and contacts (Olmedo & Muir, 2025; Johnston et al., 2022; Istanboulian et al., 2023).

What Not To Do (Common Pitfalls)

1. Do not dismiss or minimize the person's distress; avoid sarcasm or judging language.
2. Do not promise outcomes you cannot deliver; avoid giving false assurances.
3. Avoid coercive or forceful measures unless trained, policy dictates, and safety requires; restraint should be a last resort and used according to established protocols (and with immediate supervision) (Chavulak et al., 2023).
4. Do not retraumatize by interrogating about past traumatic events in the middle of a crisis; focus on immediate safety and coping. Trauma-informed principles guide you to minimize harm (Nizum et al., 2020; Istanboulian et al., 2023).

De-escalation Techniques to Practice (Practical Tips)

1. Presence and tone:
   a. Maintain a calm, even tone.
   b. Keep your voice at a low, steady volume.
2. Validating statements:
   a. "That sounds really tough. I'm here with you."
   b. Avoid arguing about perceptions.
3. Offer grounding aids:
   a. Breathing prompts, safe space, or a seat.
   b. Keep surroundings non-threatening.
4. Pace and timing:
   a. Give the person time to respond.
   b. Do not rush decisions during peak distress.
5. Nonverbal alignment:
   a. Open posture, nodding, and appropriate eye contact.
   b. Reduce sudden movements.

When to Seek Higher-Level Help

1. If risk is imminent (self-harm or harm to others), contact emergency medical services and crisis teams as per local protocol.
2. If crisis persists or escalates despite de-escalation attempts, coordinate with field mental health responders or community mental health services for urgent assessment and care.
3. If the person requests or requires admission or long-term support, facilitate referrals to appropriate providers and coordinate if applicable (Olmedo & Muir, 2025; Nizum et al., 2020; Istanboulian et al., 2023).

Special Considerations for Diverse Contexts (What the Evidence Suggests)

1. Crisis response models show benefits of civilian-led or co-response teams to reduce reliance on police and improve de-escalation and crisis management when implemented with trauma-informed care and adequate training (Rowe et al., 2025; Nizum et al., 2020; Istanboulian et al., 2023; Canada et al., 2020).
2. Peer support involvement in crisis response may improve patient experience and reduce the use of restraints in some settings; incorporate peer support where available and aligned with policy (Nath et al., 2025; Rowe et al., 2025; Nizum et al., 2020; Istanboulian et al., 2023).
3. Training in de-escalation and trauma-informed care for crisis responders, including EMS, nurses, and social workers, supports better outcomes and reduces adverse events; ongoing education and supervision are critical (Nizum et al., 2020; Istanboulian et al., 2023; Chavulak et al., 2023).
4. Alternatives to ED-based crisis care (e.g., crisis hubs, crisis stabilization units, or community-based supports) can reduce unnecessary hospital presentations and improve person-centered outcomes, suggesting a broader ecosystem of care beyond immediate first aid response (Postorivo et al., 2024; Hudson et al., 2025; Hill et al., 2021).

Target Audience for this Handout

- ✓ First aid students and lay responders who may encounter someone in mental health crisis in community, school, workplace, or campus settings.
- ✓ Law Enforcement personnel who need reference for handling contact with crisis mental health patients.
- ✓ Healthcare and social care trainees who may need a concise, portable guide for crisis de-escalation and referral.

Recommended Language and Phrasing

1. Use plain, non-stigmatizing language; avoid labeling the person by diagnosis.
2. Emphasize safety, empathy, and connection over diagnosis.
3. Provide clear next steps and who to contact in the local context (campus health center, emergency medical services, crisis lines).

References for Further Reading (Selected)

1. De-escalation competencies and crisis response frameworks supporting training and evaluation in crisis settings (Lavoie et al., 2025; Olmedo & Muir, 2025).
2. Trauma-informed approaches and patient-centered crisis care, including strategies to reduce restraint use and improve safety (Nizum et al., 2020; Istanboulian et al., 2023; Chavulak et al., 2023; Bausman et al., 2024).
3. System-level models of crisis response, civilian-led teams, and crisis hubs as alternatives to emergency departments, informing best practices for crisis care ecosystems (Rowe et al., 2025; Postorivo et al., 2024; Hudson et al., 2025; Hill et al., 2021).
4. Evidence on the role of peer support and co-response in crisis management, with implications for training and policy (Nath et al., 2025; Rowe et al., 2025; Canada et al., 2020).

Note on Evidence Synthesis

1. The content above integrates themes from multiple sources on de-escalation, trauma-informed care, crisis response models, and alternatives to hospital-based care.
2. When implementing, adapt to local policies, available training, and the resources of your institution or community.
3. Where specific claims could be nuanced or contested, the references indicate ongoing debates about best models (e.g., civilian-led versus police-led responses), training duration, and the effectiveness of various crisis-care configurations.
4. See the cited works for deeper detail and study design context (Lavoie et al., 2025; Olmedo & Muir, 2025; Postorivo et al., 2024; Rowe et al., 2025; Nizum et al., 2020; Istanboulian et al., 2023; Hudson et al., 2025; Hill et al., 2021; Chavulak et al., 2023; Bausman et al., 2024).

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GLOBAL EMERGENCY MEDICAL REGISTRY

APPENDIX 20

Final Evaluation Integrated Scenarios Evaluation Documents

GLOBAL EMERGENCY MEDICAL REGISTRY

EFA Cardiac Arrest AED (BLS) Scenario Form

Candidate- Team Leader (Print): _____ Date: _____

Candidate – Team Members (Print): _____

_____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Note: Examiner will use a full scale AED simulator and manikin for this case to reflect a cardiac arrest with a shockable rhythm and no pulse or respirations. State the unresponsive patient said "I feel so weak" before losing consciousness and becoming pulseless. The examiner may conclude the case following proper adherence to the skills sheet by having patient achieve ROSC after three shocks with a pulse present and respirations at 10/min, but the patient remains unresponsive.

PASS _____ FAIL _____

Task	Correct	Incorrect
Identifies unresponsiveness and activates Emergency Medical Services (EMS) response		
Identifies cardiac arrest		
Ensures chest compressions started at 110-120/min		
Ensures Automated External Defibrillator (AED) pads are attached, and defibrillation is performed at AED recommendations every two (2) minutes with no more than 10 seconds interruption of compressions every two (2) minutes for AED use.		
Assures proper oxygenation and ventilation of the patient by one of the following means: 1. Utilizes a mouth to mask with one way valve to ventilate patient in two rescuers 30:2 CPR. 2. Utilizes a month to mask with one way valve and oxygen attachment to ventilate patient in two rescuers 30:2 CPR.		
Once pulse present and respirations resume, the patient may be placed into a back up head elevated or recovery position and monitored.		
If available, the patient may have oxygen provided via mask.		
Upon EMS arrival, report incident, actions, and outcome to EMS personnel.		

Critical Failure Criteria

	Failure to establish compressions (CPR) and utilize AED for the patient
	Failure to take appropriate intervention
	Failure to identify cardiac arrest
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

EFA Trama #1 Scenario Form

Candidate- Team Leader (Print): _____ Date: _____

Candidate – Team Members (Print): _____

_____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Note: Examiner will use a trauma manikin for this case to reflect an unconscious patient who has fallen through a window, the patient has multiple small lacerations to buttocks and arms, as well as a very large laceration to her left posterior thigh with extensive bleeding and blood loss. State the unresponsive patient fell backwards through a glass window three feet to the ground, her pulse is 120/min and difficult to feel in her arm, respirations at 30/min and shallow. The examiner may conclude the case following proper adherence to the skills sheet by having patient's blood loss stop and quality of pulse improve.

PASS _____ FAIL _____

Task	Correct	Incorrect
Identifies critical patient and activates Emergency Medical Services (EMS) response		
Identifies hemorrhage and shock.		
Cuts away clothing over wounds rapidly to visual wounds.		
Performs rapid assessment and focuses on significant posterior thigh wound.		
Attempts manual control of bleeding with dressings and direct pressure without success (Instructor states the direct pressure is NOT working).		
Applies tourniquet to left leg above thigh wound and applies tourniquet pressure until bleeding is reduced to no flow from wound (Instructor states when bleeding has ceased).		
Once major hemorrhage is stopped, care giver focuses on non-life threatening wounds and applies dressings and bandages to wounds to reduce blood loss and stop minor bleeding.		
If available, the patient may have oxygen provided via mask.		
Upon EMS arrival, report incident, actions, and outcome to EMS personnel.		

Critical Failure Criteria

	Failure to establish assess patient for wounds and identify life threatening wound.
	Failure to utilize tourniquet to stop leg hemorrhage.
	Failure to take appropriate intervention
	Failure to identify critical patient
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

EFA Trama #2 Scenario Form

Candidate- Team Leader (Print): _____ Date: _____

Candidate – Team Members (Print): _____

_____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Note: Examiner will use a trauma manikin for this case to reflect an unconscious patient who was struck by a vehicle. State the unresponsive patient was struck on her left side by a vehicle, her left leg is torn away at the knee level, and her left lower arm has multiple fractures and deep lacerations which are bleeding excessively, her pulse is 120/min and difficult to feel in her right arm, respirations at 30/min and shallow. The examiner may conclude the case following proper adherence to the skills sheet by having patient's blood loss stop and quality of pulse improve.

PASS _____ FAIL _____

Task	Correct	Incorrect
Identifies critical patient and activates Emergency Medical Services (EMS) response		
Identifies hemorrhage and shock.		
Cuts away clothing over wounds rapidly to visual wounds.		
Performs rapid assessment and focuses on significant left leg and left arm hemorrhage.		
Attempts manual control of bleeding with dressings and direct pressure without success (Instructor states the direct pressure is NOT working).		
Applies tourniquet to left leg above wound and applies tourniquet pressure until bleeding is reduced to no flow from wound (Instructor states when bleeding has ceased).		
Applies tourniquet to left arm above elbow wound and applies tourniquet pressure until bleeding is reduced to no flow from wound (Instructor states when bleeding has ceased).		
Once major hemorrhage is stopped, care giver focuses on non-life threatening wounds and applies dressings and bandages to wounds to reduce blood loss and stop minor bleeding.		
If available, the patient may have oxygen provided via mask.		
Upon EMS arrival, report incident, actions, and outcome to EMS personnel.		

Critical Failure Criteria

	Failure to establish assess patient for wounds and identify life threatening wound.
	Failure to utilize tourniquet to stop leg hemorrhage.
	Failure to utilize tourniquet to stop arm hemorrhage.
	Failure to take appropriate intervention.
	Failure to identify critical patient
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

EFA Anaphylaxis Scenario Form

Candidate- Team Leader (Print): _____ Date: _____

Candidate – Team Members (Print): _____

_____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Note: Examiner will use a trauma manikin or human actor for this case to reflect a patient who was having lunch and had a sudden onset of respiratory distress. State the patient was having lunch and felt fine, then 20 minutes later experiencing severe respiratory distress, patient is only able to speak in one word sentences, patient is shaking and very panicked, pulse is 120/min, respirations at 30/min and have audible wheezing, and patient seems to have some swelling of her face and airway. The patient does have an epinephrine autoinjector, but they can't use it due to the respirator distress and their hands shaking.
The examiner may conclude the case following proper adherence to the skills sheet by having patient improvement.

PASS _____ FAIL _____

Task	Correct	Incorrect
Identifies critical patient and activates Emergency Medical Services (EMS) response		
Identifies anaphylaxis		
Asks patient if they have an epinephrine auto injector, which they do.		
Performs rapid assessment.		
Tells the patient they are going to use their epinephrine autoinjector on them.		
Correctly prepares the epinephrine autoinjector for use.		
Correctly utilizes the epinephrine autoinjector to inject the patient.		
Reassess the patient and notes some improvement.		
If available, the patient may have oxygen provided via mask applied at any time.		
Upon EMS arrival, report incident, actions, and outcome to EMS personnel.		

Critical Failure Criteria

	Failure to assess the patient
	Failure to identify anaphylactic shock.
	Failure to utilize epinephrine autoinjector.
	Failure to take appropriate intervention.
	Failure to identify critical patient
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.

GLOBAL EMERGENCY MEDICAL REGISTRY

EFA Overdose Scenario Form

Candidate- Team Leader (Print): _____ Date: _____

Candidate – Team Members (Print): _____

_____

Examiner (Instructor Name Printed): _____

Examiner Signature: _____

Note: Examiner will use a trauma manikin or human actor for this case to reflect a patient who was at a party and was found unconscious in a bathroom of the building. State the patient was dancing 30 minutes ago with friends, then took a drink and felt "weird" then went to the bathroom, currently unresponsive in bathroom, pulse is slow, respirations are very slow, and patient seems pale/cyanotic.
The examiner may conclude the case following proper adherence to the skills sheet by having patient improvement.

PASS _____ FAIL _____

Task	Correct	Incorrect
Identifies critical patient and activates Emergency Medical Services (EMS) response		
Identifies possible opioid overdose		
Performs rapid assessment.		
Places patient in recovery or back up head elevated position.		
Correctly prepare the Naloxone nasal injector for use.		
Correctly utilize the Naloxone nasal injector to administer Naloxone to the patient.		
Reassess the patient and notes some improvement.		
If available, the patient may have oxygen provided via mask applied at any time.		
Upon EMS arrival, report incident, actions, and outcome to EMS personnel.		

Critical Failure Criteria

	Failure to assess the patient
	Failure to identify overdose.
	Failure to utilize Naloxone nasal injector.
	Failure to take appropriate intervention.
	Failure to identify critical patient
	Failure to manage the patient as a competent provider
	Exhibits unacceptable affect with patient or other personnel
	Uses or orders a dangerous or inappropriate intervention

NOTE: You must factually document any "incorrect" or critical failure criteria on the bottom or back of this form.