

# Unit Five: Disaster Medical Operations Part 2

## I. Unit Overview and objectives

### A. Unit Overview

1. When disaster victims are sheltered together for treatment one of the public health concerns is to avoid the spread of disease. This unit will address public health concerns related to sanitation, hygiene, and water purification.
2. Treatment areas must be established as soon as casualties are confirmed. This unit will explain how to organize disaster medical operations and establish treatment areas.
3. To do the most good for the greatest amount of people, individuals who receive CERT training will be able to employ basic treatments for wounds, fractures sprains and other common injuries. This unit will build upon information learned in Part 1 of Disaster Medical Operations (Unit 4).

### B. Objectives

At the end of this unit participants should be able to:

1. List and explain the four major sub-functions of disaster medical operations.
2. Explain how to establish a Disaster Medical Treatment Area and know the functions and requirements of each.

### Unit Overview (continued)

3. Understand how to perform head-to-toe patient evaluations to identify injuries that need immediate treatment.
4. Identify and classify burns and their treatments.
5. Apply splints to suspected fractures and sprains.

## II. Public Health Considerations

A. When disaster victims are sheltered together for treatment, public health becomes a concern. Measures must be taken, both by CERT members and programmatically, to avoid the spread of disease. Primary public health measures include: maintaining proper hygiene, maintaining proper sanitation, and purifying water if necessary.

1. Maintaining Hygiene - Maintenance of proper hygiene is critical even under makeshift conditions. Some steps that individual workers can take to maintain hygiene are to:
  - a. Wash hands frequently using soap and water. Hand washing should be thorough, at least 12 to 15 seconds, with an antibacterial scrub if possible.
  - b. Wear medical (latex or hypoallergenic) gloves at all times. Change or disinfect gloves after examining and/or treating each patient. As explained earlier, under field conditions, workers can use rubber gloves that are sterilized between treating victims using bleach and water (1 part bleach to 10 parts water).
  - c. Wear a mask and goggles. If possible, wear a mask that is rated "N95."
  - d. Keep dressings sterile. Do not remove the over wrap from dressings and bandages until use. After opening, use the entire dressing or bandage, if possible.
  - e. Avoid contact with body fluids. Thoroughly wash areas that come in contact with body fluids with soap and water or diluted bleach as soon as possible.

## Disaster Medical Operations pt. 2

### Public Health Considerations (Continued)

2. Maintaining Sanitation - Poor sanitation is also a major cause of illness, disease, and death. CERT medical operations personnel can maintain sanitary conditions by dealing with waste products appropriately.

a. Controlling the disposal of bacterial sources (e.g., latex gloves, dressings, etc.)

b. Putting waste products in plastic bags, tying off the bags, and marking them as medical waste. Keep medical waste separate from other trash, and dispose of it as hazardous waste.

c. Appropriate disposal of human waste:

- Burying
- Keep away from water
- Stored in covered buckets
- Use of diapers and other waste collecting pads

3. Water Purification - Clean, sanitary, and drinkable water is referred to as potable water. Potable water supplies are often in short supply or are not available in a disaster.

a. Purify water for drinking, cooking, and medical use by heating it to a rolling boil for 1 minute, or by using water purification tablets or unscented liquid bleach.

b. Rescuers should not put anything on wounds other than purified water. The use of other solutions (e.g., hydrogen peroxide) on wounds must be the decision of trained medical personnel.

### III. Functions of Disaster Medical Operations

A. There are four major sub-functions of disaster medical operations: triage, treatment, transport and morgue.

1. Triage: The initial assessment and sorting of victims for treatment based on the severity of their injuries

2. Treatment: The area in which disaster medical services are provided to victims.

## Disaster Medical Operations pt. 2

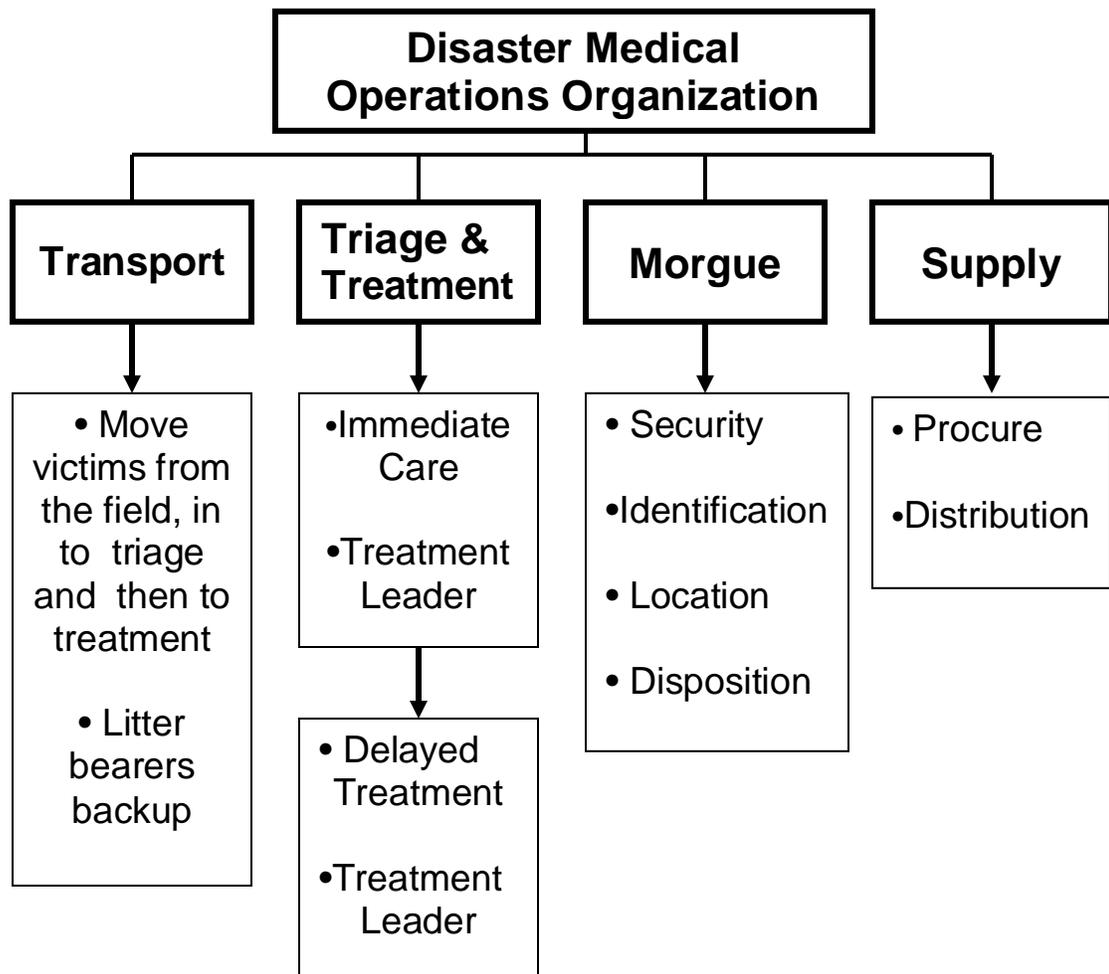
### Functions of Disaster Medical Operations (Continued)

3. Transport: The movement of victims from the triage area to the treatment area. If professional help will be delayed, for efficiency of operations, victims can be transported to the treatment area by CERT members.

4. Morgue: The temporary holding area for victims who have died as a result of their injuries.

5. Supply: Is a holding area for materials procured

## Unit Five: Disaster Medical Operations Part One Visual One: Disaster Medical Operations

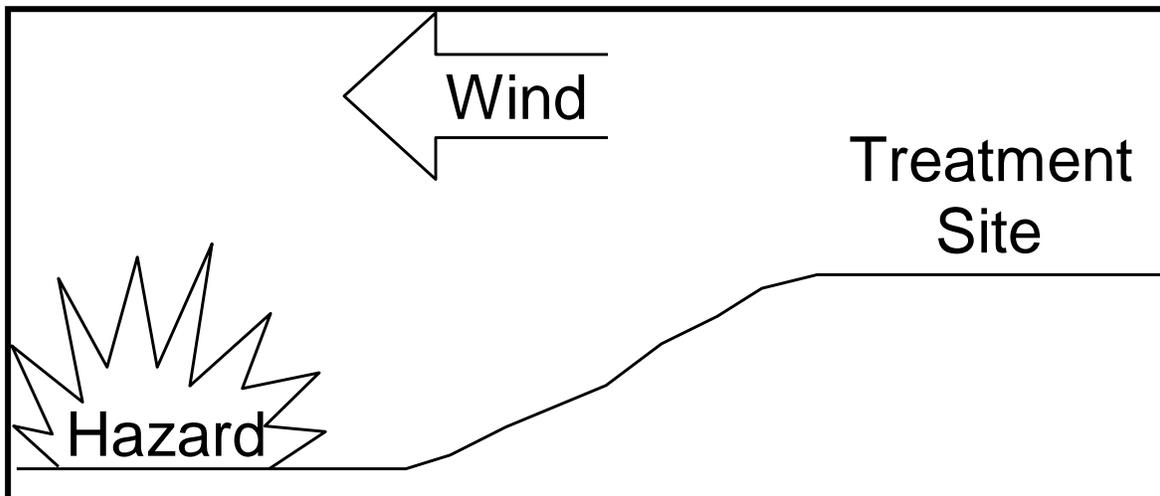


#### IV. Establishing Treatment Areas

A. Site selection for medical treatment - Because time is critical during a disaster, CERT medical operations personnel will need to select a site and set up a treatment area as soon as injured victims are confirmed. The treatment area is the location where the most advanced medical care possible will be given to victims. When selecting a site keep in mind it should have the following four qualities.

1. Be in a safe area, free of hazards and debris.
2. Be close to but upwind and uphill from the hazard zone(s).
3. Be accessible by transportation vehicles such as ambulances, trucks and helicopters.
4. It should be expandable.

### Unit Five: Disaster Medical Operations Part Two Visual Two: Treatment Area Site Selection



When selecting a Treatment Area attempt to find a place that is both uphill and upwind from the hazard.

## Disaster Medical Operations pt. 2

### Establishing Treatment Areas (Continued)

#### B. Treatment Area Layout

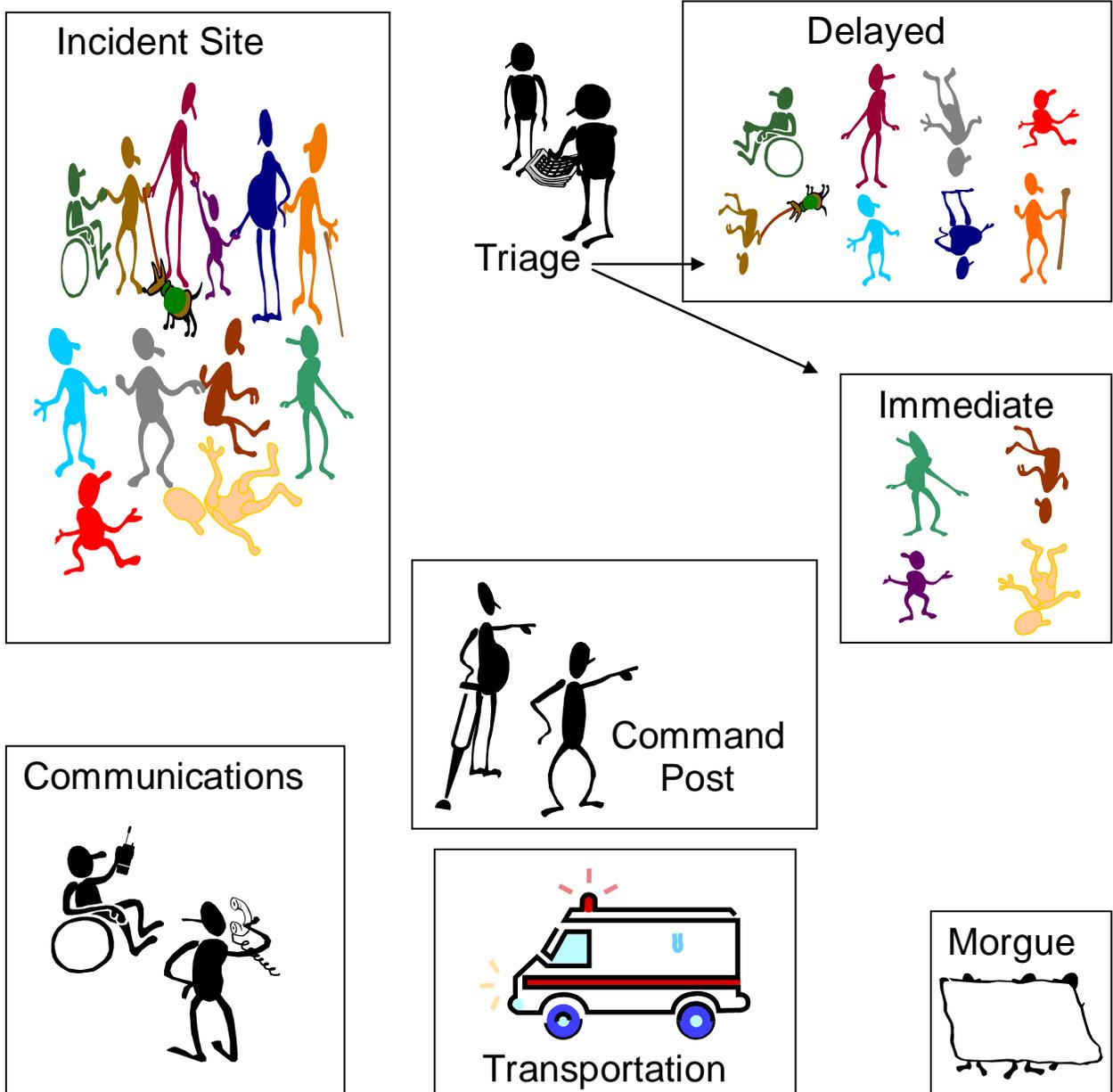
1. The treatment area must be protected and clearly marked using a ground cover or tarp. A clearly marked treatment area will help people transport victims to the correct location. Signs should identify the subdivisions of the area:
  - a. "I" for Immediate care.
  - b. "D" for Delayed care.
  - c. "DEAD" for the morgue.
2. The *Immediate Care* and *Delayed Care* divisions should be relatively close to each other to allow:
  - a. Verbal and visual communication between workers in the two areas.
  - b. Shared access to medical supplies which should be securely stored in a central location.
  - c. Easy transfer of patients whose status has changed.
3. Patients in the treatment area should be positioned in a head-to-toe configuration with two to three feet of space between victims. This system will provide:
  - a. Effective use of space.
  - b. Effective use of available personnel.
  - c. As a worker finishes one head-to-toe assessment, he or she turns around and finds the head of the next patient.

Establishing Treatment Areas (Continued)

Treatment Area Layout showing organization for the incident site, command post, triage, communications, and morgue

**Unit Five: Disaster Medical Operations Part Two**  
**Visual Three: Treatment Area\* Layout**

\*Service animals are permitted in these areas



## Disaster Medical Operations pt. 2

### Establishing Treatment Areas (Continued)

#### C. Treatment Area Organization

1. The CERT team must assign leaders to maintain control in each of the medical treatment areas. The function of these leaders is to:

- a. Ensure orderly victim placement.
- b. Direct assistants to conduct head-to-toe assessments.
- c. Thoroughly document victims in the treatment area, including:
  - o Available identifying information.
  - o Description
  - o Clothing.
  - o Injuries.
  - o Treatment.
  - o Transfer location.

#### D. Treatment Area Planning

1. If you are a member of a Community Emergency Response Team that will train and stay together as a team that will be called out to respond together, you can make certain plans before disaster strikes, including:

- a. Assign personnel to specific roles in the treatment area.
- b. Gather setup equipment that might be needed such as ground covers, tarps and signs for identifying treatment divisions (immediate, delayed, morgue).
- c. Take part in practice exercises so that you can develop a good operational plan and practice rapid treatment area setup.

## V. Conducting Head-to-Toe Assessments

A. The first steps that you will take when working with a victim will be to conduct a triage and rapid treatment. During triage, you looked for ‘the killers’: airway obstruction, excessive bleeding and signs of shock. After all victims in an area have been triaged, CERT members will begin a thorough head-to-toe assessment of the victim’s condition. A head-to-toe assessment goes beyond ‘the killers’ to try to gain more information to determine the nature of the victim’s injury. During a head-to-toe assessment, look for the following:

1. Bruising.
2. Swelling.
3. Severe pain.
4. Disfigurement.

B. A head-to-toe assessment can be done in place in a lightly damaged building. If the building is moderately damaged, the victim should be moved to a safe zone or to the treatment area for the head-to-toe assessment. Wear safety equipment when conducting head-to-toe assessments.

C. The objectives of a head-to-toe assessment are to:

1. Determine, as clearly as possible, the extent of injuries.
2. Determine what type of treatment is needed.
3. Document injuries.

D. If the victim is conscious, CERT members should always ask permission to conduct the assessment. **The victim has the right to refuse treatment.**

E. Head-to-toe assessments should be:

1. Conducted on all victims, even those who seem alright.
2. Everyone gets a tag.
3. Verbal (if the patient or assessor is able to speak).
4. Hands-on (if the patient can tolerate touch)

## Disaster Medical Operations pt. 2

### Conducting Head-to-Toe Assessments (Continued)

F. Whenever possible, you should ask the person about any injuries, pain, bleeding, or other symptoms. Pay careful attention: look, listen, and feel for anything unusual.

G. Conduct head-to-toe assessments systematically, checking body parts from the top to the bottom for continuity of bones and soft tissue injuries in the following order:

1. Head
2. Neck
3. Shoulders
4. Chest
5. Arms
6. Abdomen
7. Pelvis
8. Legs
9. Back

H. Completing the assessment in the same way every time will make the procedure quicker and more accurate.

I. Check your own gloved hands for patient bleeding as you complete the head-to-toe assessment.

J. Perform an entire assessment before beginning any treatment. Also, treat all unconscious victims as if they have a spinal injury.

### VI. Closed-Head, Neck, and Spinal Injuries

A. When conducting head-to-toe assessments, rescuers may come across victims who have or may have suffered closed-head, neck, or spinal injuries. **The main objective when CERT members encounter suspected injuries to the head or spine is to do no harm.** You should minimize movement of the head and spine, while treating any other life-threatening conditions.

B. The signs of a closed-head, neck, or spinal injury most often include:

1. Change in consciousness.
2. Inability to move one or more body parts.
3. Severe pain or pressure in the head, neck, or back.
4. Tingling or numbness in extremities.
5. Difficulty breathing or seeing.
6. Heavy bleeding, bruising, or deformity of the head or spine.
7. Blood or fluid in the nose or ears.
8. Bruising behind the ear.
9. "Raccoon" eyes (bruising around eyes).
10. "Uneven" pupils.
11. Seizures.
12. Nausea or vomiting.
13. Victim found under collapsed building material or heavy debris.

If the victim is exhibiting any of these signs, he or she should be treated as having a closed-head, neck, or spinal injury.

## Disaster Medical Operations pt. 2

### Closed-Head, Neck, and Spinal Injuries (Continued)

C. Keep the spine in a straight line when doing the head-to-toe assessment. In an extreme emergency, ideal equipment is rarely available, so the CERT members may need to be creative by:

1. Looking for materials that can be used as a backboard—a door, desktop, building materials—anything that might be available.
2. Looking for items that can be used to stabilize the head on the board—towels, draperies, or sandbags—by tucking them snugly on either side of the head to immobilize it.

### VII. Exercise: Conducting Head-to-Toe Assessments

A. Purpose: This exercise allows you to practice conducting head-to-toe assessments.

B. Instructions: Follow the steps below to complete this exercise:

1. Work in three-person teams of one victim and two rescuers.
2. The victim should lie on the floor on their back and with closed eyes. If the victim can not lie on the floor, remain in their chair or wheelchair with closed eyes.
3. The rescuers should conduct a head-to-toe assessment on the victim following the procedures explained in this unit.
4. After the rescuers have made at least two observed head-to-toe assessments, the victim and rescuers should change roles.

## VIII. Treating Burns

A. The objectives of first aid treatment for burns are to: cool the burned area and reduce the risk of infection.

B. Burns may be caused by heat, chemicals, electrical current, and radiation. The severity of a burn depends on the:

1. Temperature of the burning agent.
2. Period of time that the victim was exposed.
3. Area of the body that was affected.
4. Size of the area burned.
5. Depth of the burn.

C. Burn Classifications - The skin has three layers the: epidermis, dermis and subcutaneous. Burns are classified as first, second, or third degree. Depending on their severity, burns may affect all three layers of skin.

1. First Degree Burn - The epidermis, or outer layer of skin, contains nerve endings and is penetrated by hairs.
2. Second Degree Burn - The dermis, or middle layer of skin, contains blood vessels, oil glands, hair follicles, and sweat glands.
3. Third Degree Burn - The subcutaneous layer, or innermost layer, contains blood vessels and overlies the muscle and skin cells.

Treating Burns (Continued)

Unit Five: Disaster Medical Operations, Part 2  
Chart One: Burn Classifications

Burn Classifications		
Classification	Skin Layers Affected	Signs
1st Degree	Epidermis (superficial)	<ul style="list-style-type: none"> <li>○ Reddened, dry skin</li> <li>○ Pain</li> <li>○ Possible Swelling</li> </ul>
2nd Degree	Epidermis Partial destruction of dermis	<ul style="list-style-type: none"> <li>○ Reddened, blistered skin</li> <li>○ Wet appearance</li> <li>○ Pain</li> <li>○ Possible Swelling</li> </ul>
3rd Degree (Full Thickness Burns)	Complete destruction of epidermis and dermis Possible subcutaneous damage (destroys all layers of skin and some or all underlying structures)	<ul style="list-style-type: none"> <li>○ Whitened, leathery, or charred (brown or black)</li> <li>○ Painful or relatively painless</li> </ul>

Treating Burns (Continued)

D. Guidelines for treating burns include:

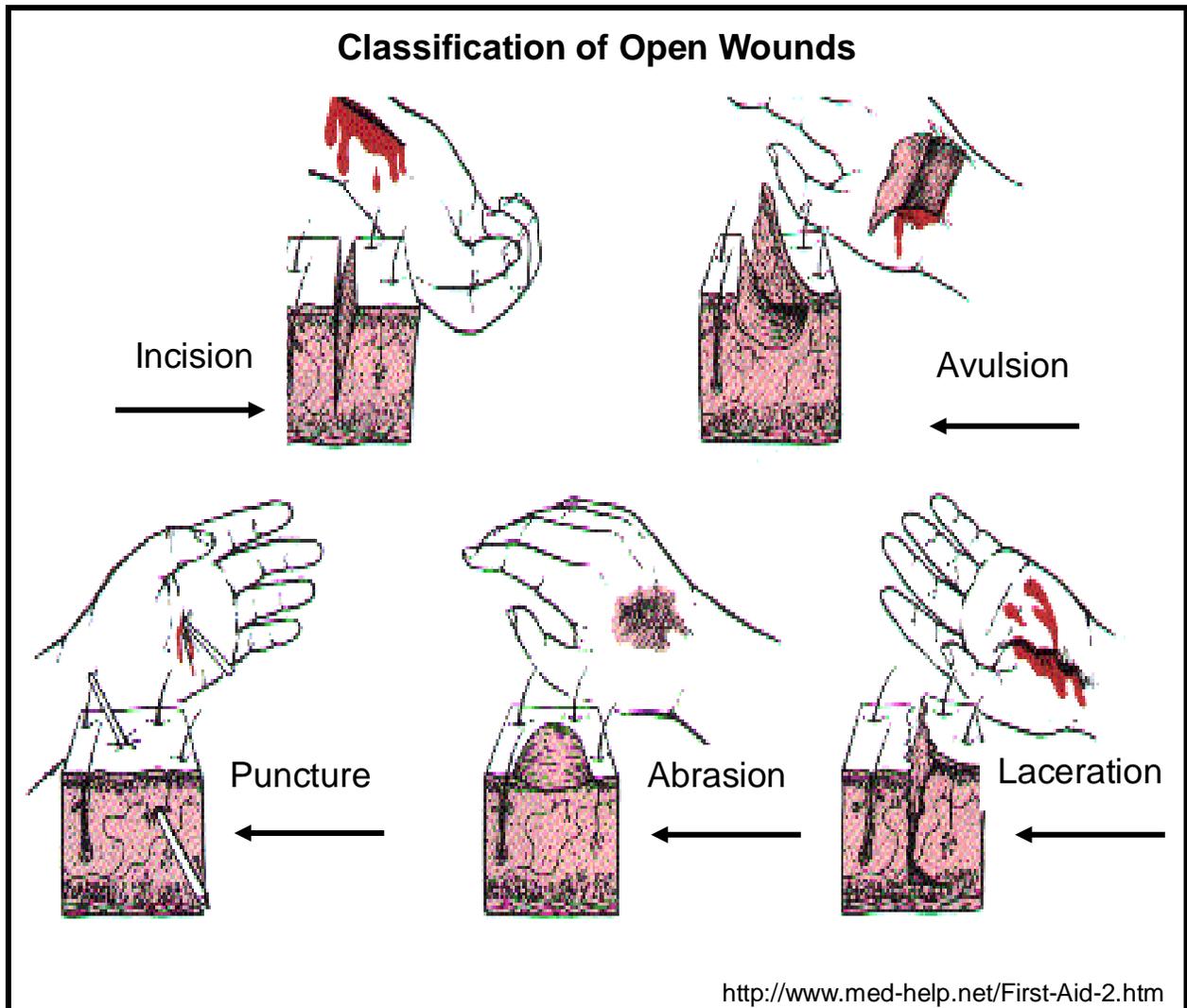
1. Removing the victim from the fire or burning source.
2. Put out any remaining flames and remove smoldering clothing unless it is stuck to the skin.
3. Cooling skin or clothing, if they are still hot, by immersing them in cool water for not more than 1 minute or covering with clean compresses that have been wrung out in cool water.
  - a. Cooling sources include water from the bathroom or kitchen; garden hose; and soaked towels, sheets, or other cloths.
  - b. Infants, young children, older persons, and persons with severe burns, are more susceptible to hypothermia. Therefore, rescuers should use caution when applying cool dressings on such persons. A rule of thumb is do not cool more than 15 percent of the body surface area (the size of one arm) at once, to prevent hypothermia.
4. Treat all victims of third-degree burns for shock.
5. Covering loosely with dry (or moist, based on local protocols), sterile dressings to deep fluids in and germs out.
6. Elevating burned extremities higher than the heart.
7. **Do not** use ice. Ice causes vessel constriction.
8. **Do not** apply antiseptics, ointments, or other remedies.
9. **Do not** remove shreds of tissue, break blisters, or remove adhered particles of clothing. (Cut burned-in clothing around the burn.)

IX. Wound Care

A. There are many injuries that need treatment after a disaster. This section on wound care will offer instruction on how to treat the most common types of open wounds: amputations, impaled objects, fractures, dislocations, sprains and strains, nasal injuries and hypothermia.

1. Open Wounds- can be classified as: incision, avulsion, puncture, abrasion and laceration. These are all different types of wounds to the skin that produce bleeding.

Unit Five: Disaster Medical Operations, Part 2  
Visual Four: Classification of Open Wounds



### Wound Care (Continued)

A. The objective of dealing with the many types of open wounds (incisions, avulsions, punctures, abrasions, and lacerations) is to focus on cleaning and bandaging to control infection:

1. Cleaning wounds - Wounds should be cleaned by irrigating with water, flushing with a mild concentration of soap and water, then irrigating with water again. You should not scrub the wound. A bulb syringe is useful for irrigating wounds. In a disaster, a turkey baster may also be used.

2. When the wound is thoroughly cleaned, you will need to apply a dressing and bandage to help keep it clean and control bleeding. The difference between a dressing and a bandage is:

a. A dressing is applied directly to the wound.

b. A bandage holds the dressing in place.

3. Continuously bleeding wounds - If a wound is still bleeding, the bandage should place enough pressure on the wound to help control bleeding without interfering with circulation. If there is active bleeding, such as the dressing is soaked with blood, redress over the existing dressing and maintain pressure and elevation to control bleeding.

4. Short-term follow-up care for wounds - In the absence of active bleeding, dressings must be removed and the wound must be flushed and checked for signs of infection at least every 4 to 6 hours. If necessary based on reassessment and signs of infection, change the treatment priority.

5. Signs of possible infection include:

a. Swelling around the wound site.

b. Discoloration.

c. Discharge from the wound.

d. Red striations from the wound site, (striations are thin red lines in patterns that extend out from the area of the wound like tree branches).

### X. Amputations

A. An amputation is the process of cutting off a limb or other appendage, either by surgical operation or by traumatic injury. The objective in treating an amputation is to control bleeding and treating for shock.

1. Controlling bleeding – follow the procedures explained in the above-mentioned section on wound care. Section IX Wound Care in Unit 4: Disaster Medical Operations part 2, page 17.
2. Treating shock – follow the procedures explained in the previously covered material in III. Recognizing and Treating Shock, Unit 3: Disaster Medical Operations part 1, page 14.

B. When the severed body part can be located, CERT members should: Save tissue parts, wrap in clean material and place in a plastic bag, if available.

1. Keep the tissue parts cool.
2. Keep the severed part with the victim.

C. Impaled Objects - You may also encounter some victims who have foreign objects lodged in their bodies, usually as the result of flying debris during the disaster. When a foreign object is impaled in a patient's body, you should:

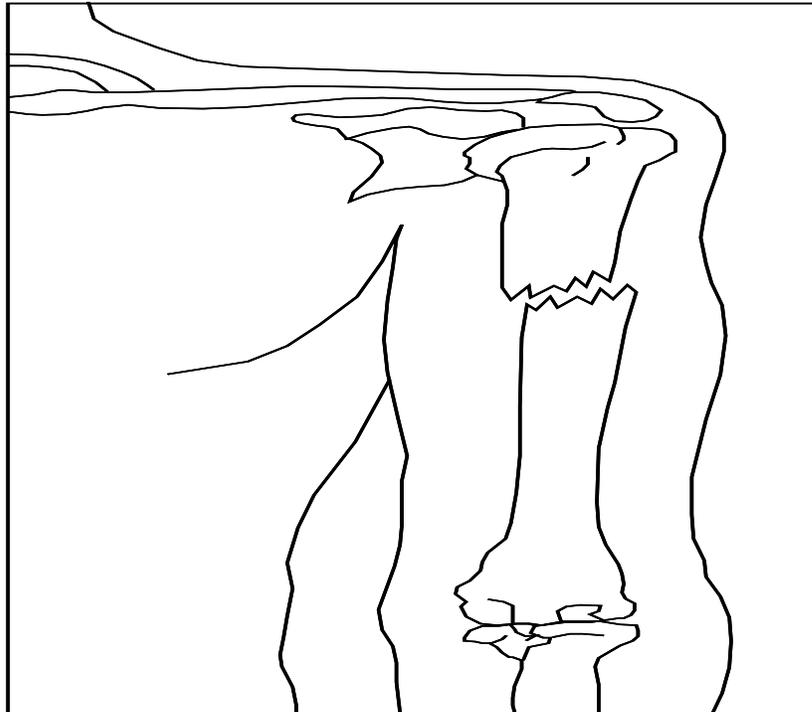
1. Immobilize the affected body part.
2. **Do not** attempt to move or remove the object unless it is obstructing the airway.
3. Try to control bleeding at the entrance wound without placing undue pressure on the foreign object.
4. Clean and dress the wound. Wrap bulky dressings around the object to keep it from moving

**XI. Treating Fractures, Dislocations, Sprains and Strains**

A. The objective when treating a suspected fracture, sprain, or strain is to immobilize the injury and the joints immediately above and below the injury site.

B. It is difficult to distinguish among fractures, sprains, or strains, if you are uncertain of the type of injury, treat the injury as a fracture which is a complete break, a chip, or a crack in a bone. There are several types of fractures: closed, open, displaced and nondisplaced.

**Unit Five: Disaster Medical Operations, Part 2**  
**Visual Five: A Closed Fracture**



A closed fracture is one in which the fracture does not puncture the skin.

## Disaster Medical Operations pt. 2

Treating Fractures, Dislocations, Sprains and Strains (Continued)

### Unit Five: Disaster Medical Operations, Part 2 Visual Six: An Open Fracture

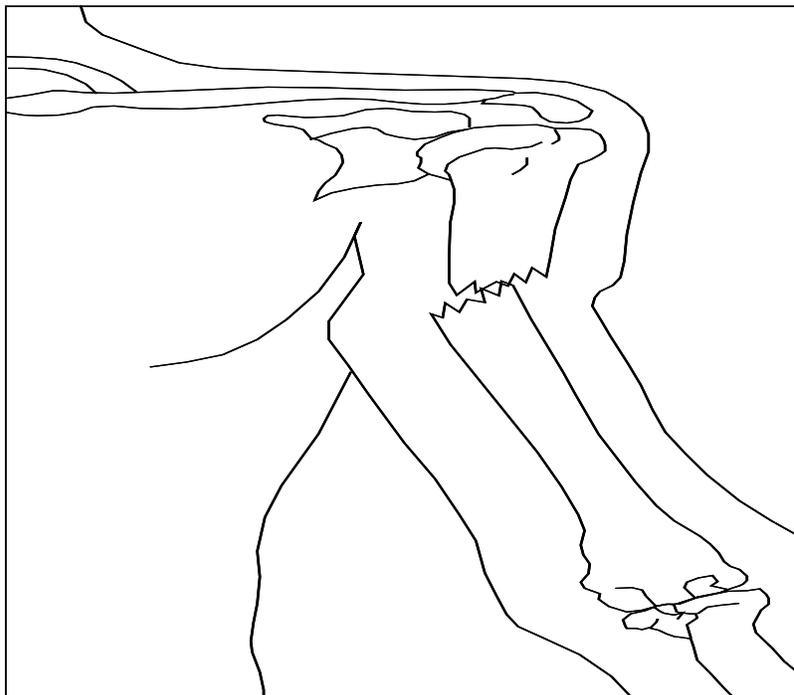


An open fracture is one in which the fracture causes the bone to protrude through the skin.

## Disaster Medical Operations pt. 2

Treating Fractures, Dislocations, Sprains and Strains (Continued)

### Unit Five: Disaster Medical Operations, Part 2 Visual Seven: A Displaced Fracture

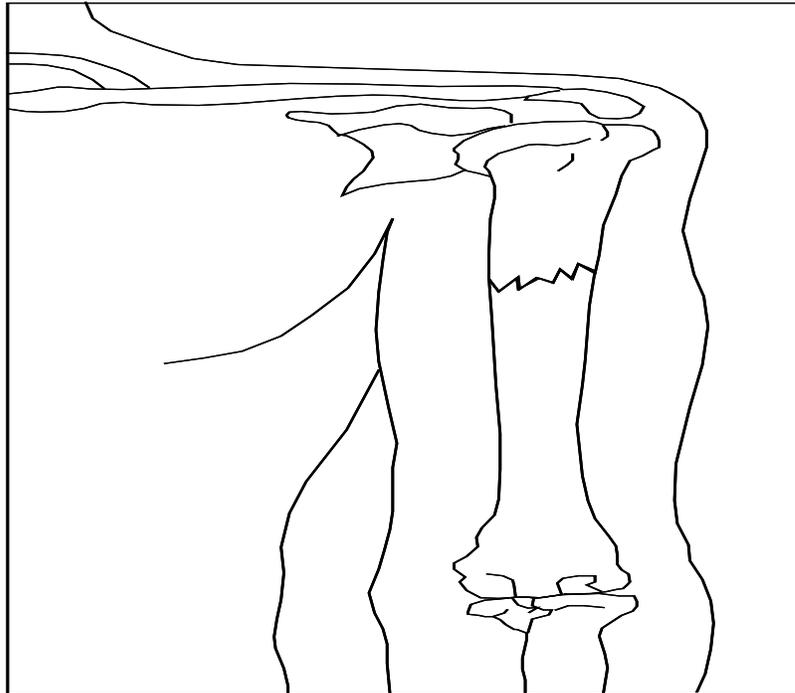


A displaced fracture is one in which the fractured bone is no longer aligned

## Disaster Medical Operations pt. 2

Treating Fractures, Dislocations, Sprains and Strains (Continued)

### Unit Five: Disaster Medical Operations, Part 2 Visual Eight: A Nondisplaced Fracture



A nondisplaced fracture is one in which the fractured bone remains aligned

## Disaster Medical Operations pt. 2

### Treating Fractures, Dislocations, Sprains and Strains (Continued)

1. Closed Fracture – (see visual 5 on page 19 of Unit 4) A closed fracture is a broken bone with no associated wound. First aid treatment for closed fractures may require only splinting.

2. Open Fracture – (see visual 6 on page 20 of Unit 4) An open fracture is a broken bone with some kind of wound that allows contaminants to enter into or around the fracture site. Therefore, they are a higher priority and need to be checked more frequently.

a. When treating an open fracture:

- Do not draw the exposed bone ends back into the tissue.
- Do not irrigate the wound.

b. You should:

- Cover the wound with a sterile dressing.
- Splint the fracture without disturbing the wound.
- Place a moist 4" x 4" dressing over the bone end to keep it from drying out.

3. Displaced Fracture – (see visual 7 on page 21 of Unit 4) Displaced fractures may be described by the degree of displacement of the bone fragments. If the limb is angled, then there is a displaced fracture.

4. Nondisplaced Fracture – (see visual 8 on page 21 of Unit 4) Nondisplaced fractures are difficult to identify, with the main signs being pain and swelling. Treat a suspected fracture as a fracture until professional treatment is available.

## Disaster Medical Operations pt. 2

### Treating Fractures, Dislocations, Sprains and Strains (Continued)

C. Dislocations – are another common injury in emergencies. A dislocation is an injury to the ligaments around a joint that is so severe that it permits a separation of the bone from its normal position in a joint.

1. The signs of a dislocation are similar to those of a fracture, and a suspected dislocation should be treated like a fracture.
2. You should not try to relocate a suspected dislocation. Immobilize the joint until professional medical help is available.

D. Sprains – A sprain involves a stretching or tearing of ligaments at a joint and is usually caused by stretching or extending the joint beyond its normal limits. A sprain is considered a partial dislocation, although the bone either remains in place or is able to fall back into place after the injury.

1. The most common signs of a sprain are:
  - Tenderness at the site of the injury.
  - Swelling and/or bruising.
  - Restricted use, or loss of use.
  - The signs of a sprain are similar to those of a nondisplaced fracture. Therefore, do not try to treat the injury other than by immobilization and elevation.

E. Strains – involve a stretching and/or tearing of muscles or tendons. Strains most often involve the muscles in the neck, back, thigh, or calf. In some cases, strains may be difficult to distinguish from sprains or fractures. When uncertain whether an injury is a strain, sprain, or fracture, treat the injury as if it is a fracture.

## XII. Splinting

A. A splint is a device made of rigid material used to keep a broken bone or injured body part from moving. Splinting is the most common procedure for immobilizing an injury. There are several forms of material you can use to create a splint in times of emergency.

1. Cardboard is the material typically used for “makeshift” splints but a variety of materials can be used, including:
2. Soft materials. Towels, blankets, or pillows, tied with bandaging materials or soft cloths.
3. Rigid materials. A board, metal strip, folded magazine or newspaper, or other rigid item can be used to create a splint.
4. Anatomical splints may also be created by securing a fractured bone to an adjacent unfractured bone. Anatomical splints are usually reserved for fingers and toes but, in an emergency, legs may also be splinted together.

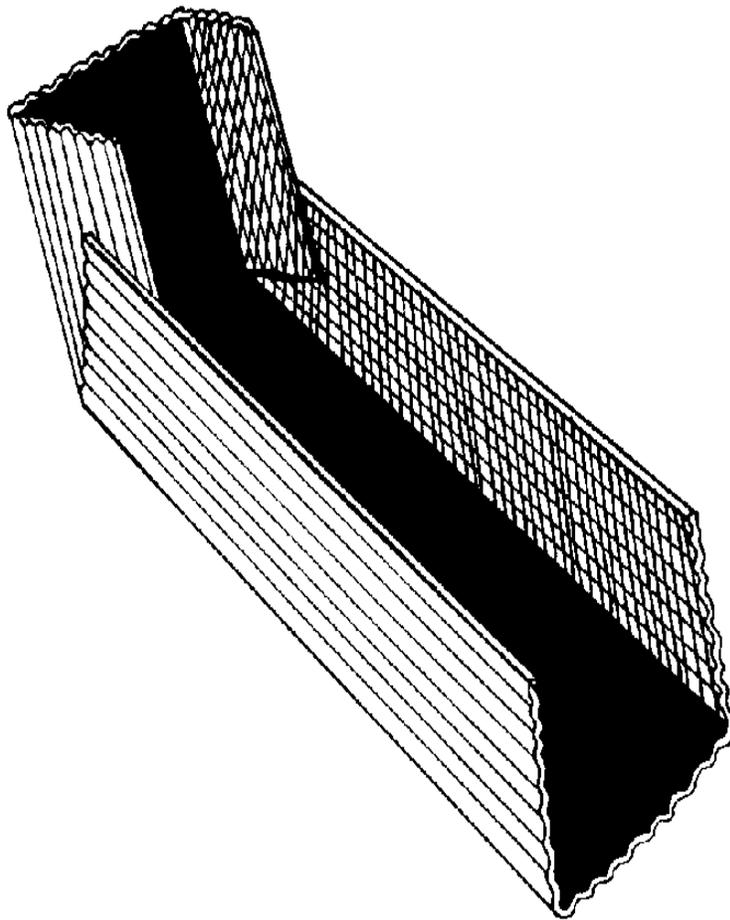
B. The guidelines for splinting include:

1. Support the injured area above and below the site of the injury, including the joints.
2. If possible, splint the injury in the position that you find it. Don't try to realign bones or joints.
3. After splinting, check for proper circulation by assessing warmth, feeling, and color.
4. With this type of injury, there will be swelling. You should remove restrictive clothing, shoes, and jewelry when necessary to prevent these items from acting as tourniquets.

### C. Exercise: Splinting

1. Instructions: Follow the steps below to complete this exercise which will allow you to practice the procedures for splinting:
2. Working in three-person teams, one person will be the victim and two persons will be the rescuers. Victims should lie on the floor on their backs or sit in a chair. The rescuer should apply a splint on the victim's upper arm using the procedure demonstrated earlier. Then, the rescuer should apply a splint to the victim's lower leg.
3. The victim and the rescuers should change roles.

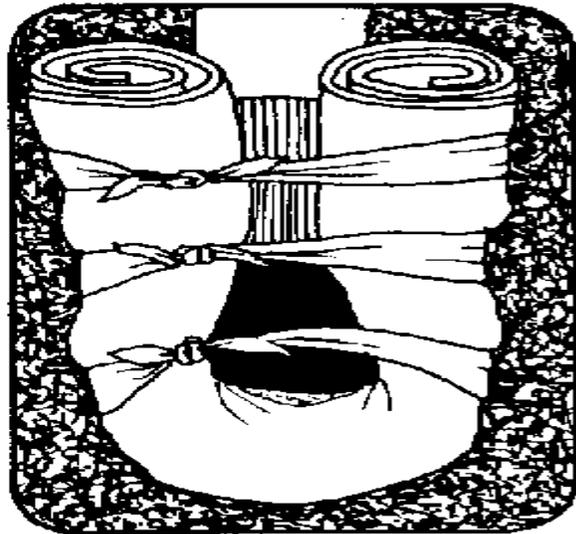
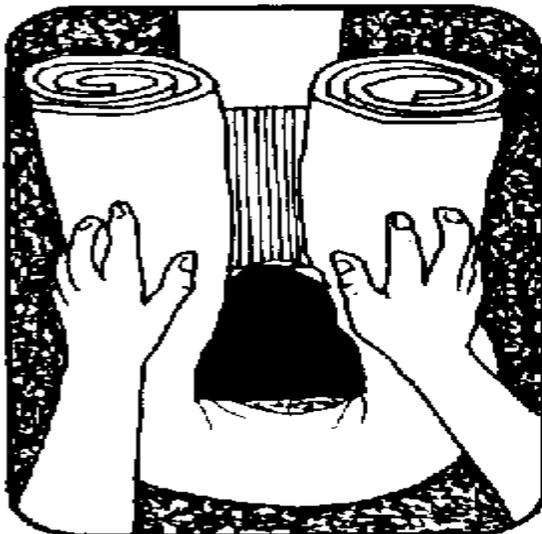
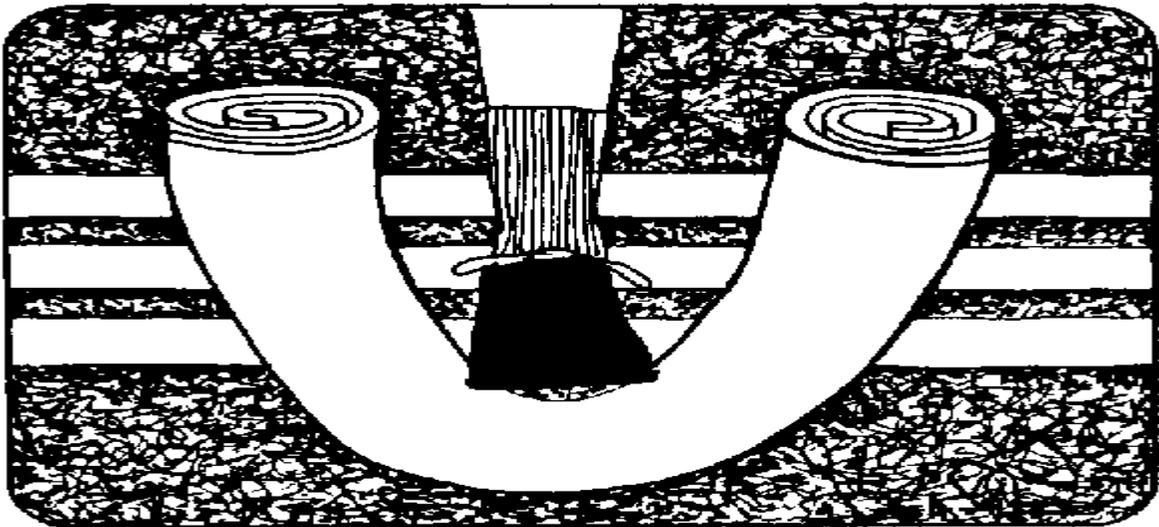
**Unit Five: Disaster Medical Operations, Part 2**  
**Visual Nine: A Cardboard Splint**



Cardboard Splint where the edges of the cardboard are turned up to form a “mold” in which the injured limb can rest.

Splinting (Continued)

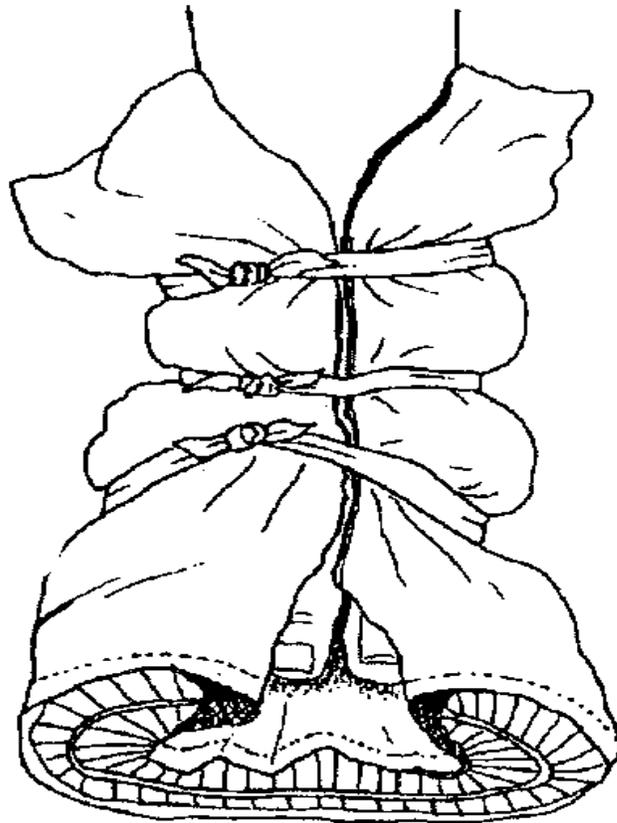
Unit Five: Disaster Medical Operations, Part 2  
Visual Ten: Splinting Using A Towel



Splinting using a towel, in which the towel is rolled up, wrapped around the limb and then tied in place

Splinting (Continued)

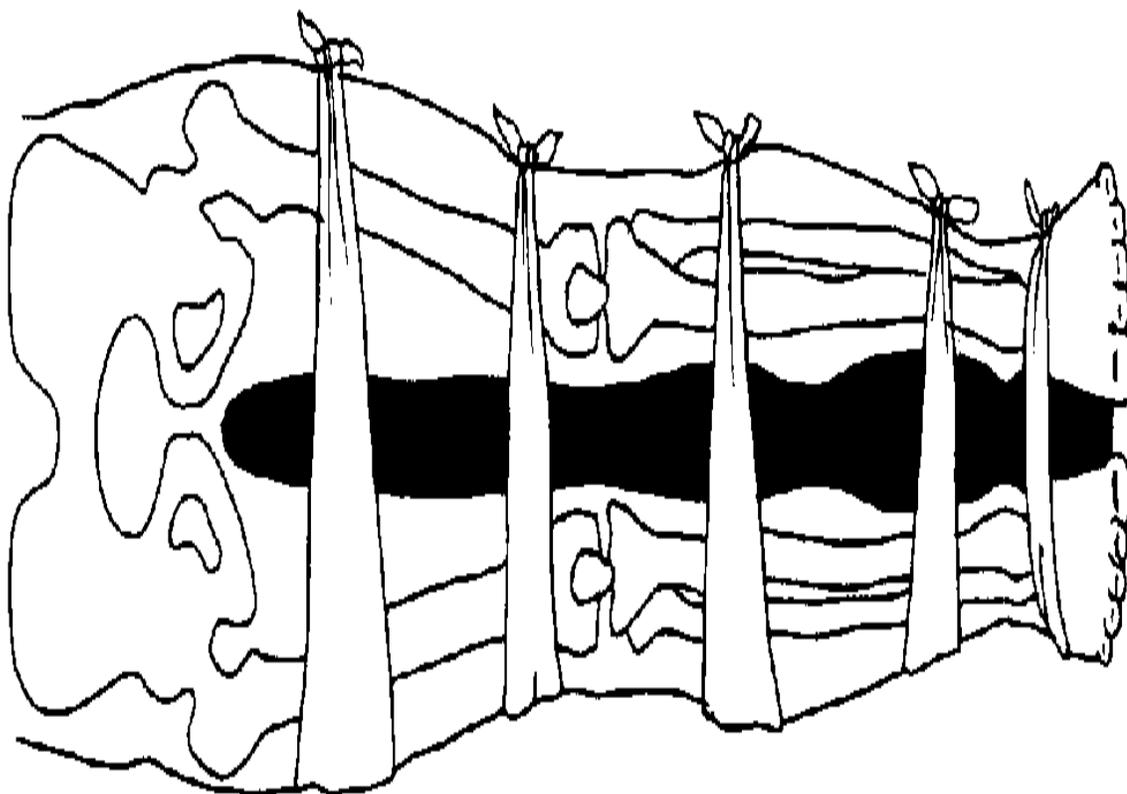
**Unit Five: Disaster Medical Operations, Part 2**  
**Visual Eleven: Pillow Splint**



This is a pillow splint showing how a pillow can be wrapped and then tied to secure the limb.

Splinting (Continued)

**Unit Five: Disaster Medical Operations, Part 2**  
**Visual Twelve: Splinting Using a Blanket**



Splinting using a blanket in which the victim's legs are immobilized by tying blankets at intervals from mid-thigh to the feet.

### **XIII. Nasal Injuries**

A. Bleeding from the nose can be caused by:

1. Blunt force to the nose.
2. A skull fracture.
3. Nontrauma-related conditions such as sinus infections, high blood pressure, and bleeding disorders.

B. A large blood loss from a nosebleed can lead to shock. Actual blood loss may not be evident because the victim will swallow some amount of blood. Victims who have swallowed large amounts of blood may become nauseated and vomit.

C. The methods for controlling nasal bleeding include:

1. Pinching the nostrils together.
2. Putting pressure on the upper lip just under the nose.

D. While treating for nosebleeds, you should:

1. Have the victim sit with the head slightly forward so that blood trickling down the throat will not be breathed into the lungs. Do not put the head back.
2. Ensure that the victim's airway remains open.
3. Keep the victim quiet. Anxiety will increase blood flow.

### **XIV. Treating Hypothermia**

A. Hypothermia is a condition that occurs when the body's temperature drops below normal. Hypothermia may be caused by exposure to cold air or water or by inadequate food combined with inadequate clothing and/or heat, especially in older people. The primary signs and symptoms of hypothermia are:

1. A body temperature of 95° Fahrenheit / 37° Celsius, or less.
2. Redness or blueness of the skin.

### Treating Hypothermia (Continued)

3. Numbness accompanied by shivering.
4. In later stages, hypothermia will be accompanied by:
  - Slurred speech.
  - Unpredictable behavior.
  - Listlessness.

B. Because hypothermia can set in within only a few minutes, you should treat victims who have been rescued from cold air or water environments by:

1. Removing wet clothing.
2. Wrapping the victim in a blanket or sleeping bag and covering the head and neck.
3. Protecting the victim against the weather.
4. Providing warm, sweet drinks and food to conscious victims.
5. **Do not** offer alcohol or massage.
6. Placing an unconscious victim in the recovery position.
7. Placing the victim in a warm bath if the victim is conscious.
8. **Do not** allow the victim to walk around even when he or she appears to be fully recovered.
9. If the victim must be moved outdoors, you should cover the victim's head and face.

## Disaster Medical Operations pt. 2

### NEXT . . .

1. If your CERT class continues on the same day, take your break and return to this classroom.
2. If your CERT class continues on another day (next week or next month) your **Homework Assignment** is to:
  - a. Read and familiarize yourself with Unit 6: Light Search and Rescue Operations before the next session.
  - b. Obtain a blanket for use during Unit 6.

End of Unit Five