

20-Hour Street Medic Course Student Companion Book



Event Date: July 2022

Email: nycactionmedical@riseup.net

Facebook: [facebook.com/NYCactionmedical](https://www.facebook.com/NYCactionmedical)

DAY ONE AGENDA

1. Welcome & Opening Materials
2. Action Medical: Who are Street Medics?
3. History of Street Medicine
4. Street Medic Operations, Part I
5. Quick Exercise: PEARLSY
6. Street Medic Values
7. Street Medic Operations, Part II
8. Quick Exercises: The Buddy Walk, The Human Barricade, Scene Assessment
9. COVID-19 Precautions
10. Jail Support
11. Street Medic Gear
12. Body Substance Isolation / Quick Exercise: Removing gloves
13. Emotional First Aid
14. Practical: Eye Flushes

Welcome

About this presentation & packet: This presentation is based on a combination of materials from the street medic community, and this is treated as a living document by NYCAM. We thank the entirety of the street medic community for their wisdom and knowledge that contributed to these materials. Contributors include Jason Odhner, RN, Elizabeth Diedrich, RN of Phoenix Urban Health Collective, Steel City Organizing for Radical Community Health in Pittsburgh, PA, National DSA Medics Health & Safety Handbook (March 2018), materials created by MC Erskine (April 16, 2017) from training written by Becca, Bugz, Amna, Shawn, David, Cea, Kenton, Greg etc., the Occupy Chicago Street Medic Manual (March 2012), and members of New York City Action Medical (2016-2022).

The course booklet was initially created by Brian Dominick, Miriam Roček and Diana Pho in October 2017 as part of NYCAM's 20-hour Street Medic Training Course. It was revised July 2022 by NYCAM.

Lead Instructors: Miriam Roček, Diana Pho, sangam 'alopeke
Assistant Instructors: Syn Hong, Che Broadnax

Schedule

- Friday July 1, 5pm - 9pm
- Saturday, July 2, 9am - 5pm
- Saturday, July 9, 9am - 5pm

Ground Rules

- Be responsible for yourself. Know your limits and boundaries, take a break if you need to. Breaks are also scheduled throughout the training.
- Be accountable for your words and behavior. Behave sensitively towards others, being mindful of privilege and divergent life experiences.
- Take care of each other, look out for one another.
- Take the training seriously. The situations in scenarios may be imaginary, but treating them as real is how the trainees will learn to help in real life situations.
- For discussion questions, use your imagination, but don't derail into "What if?"s.
- Be mindful of our limited time together; we have a lot to cover.
- * We always welcome feedback! We will listen to and actively address any concerns, whether they happen during the training process or in an interaction with a trainer or a volunteer. Attendees can speak with the in-person instructors (Miriam, Diana or Che) privately during the training, or emailed to us at nycactionmedical@riseup.net. Feedback forms will also be available and encouraged to fill out by the end of the training.
- All in all, we're doing the work to support the struggle, but we also have fun! Street medicine is a resource, but also a learning process that should be interesting and welcoming.

Our Commitment to You

- We will teach within our scope of expertise and your expected scope of practice.

- We will admit when we don't have an answer. We will name guesses as such.
- We will honor and respect the knowledge and experiences that you bring to this space.
- We will be honest about our assessment of your medic capacity.
- If, by the end of this training, you have reservations about being an effective street medic, we'll help build your skills and confidence.
- We will greet criticism with grace and appreciation, not defensiveness.

Our Anti-Oppression Stance

We do not tolerate bias or criticism based on race, ethnicity, religion, gender, sexuality, age, income, relationship to the means of production, body size, ideology, or any other bullshit reason. NYCAM does not support treating white nationalists, fascists, or cops while on duty as part of our street medic philosophy. We consider treating dangerous individuals who mean to do harm against marginalized communities as a violation of our "Do No Harm" stance as radical medical providers.

Expectations in this Space

- Be conscious how much space you take up. If you've been talking a lot, let others have the opportunity to speak. Respect stack, don't speak out of turn.
- Respect people's identities, backgrounds, pronouns, etc. If you aren't sure how someone wants to be addressed, ask.
- Apologize when you upset someone, considerately try to learn why, and then do better.
- Try to forgive people's honest mistakes.
- Be respectful of trainers. They are there for the education of the trainees. If you have questions related to the teaching material, consider leaving them until the break so as not to interrupt the training. If you have concerns, address them individually with trainers at the break.
- Be respectful of attendees. They are there to learn, and you are there to help them learn. They will make mistakes. Treat them with kindness and respect as peers and future medics. Leave general feedback for trainees related to medicking to the feedback session at the end of the scenario; don't break "character" while the scenario is ongoing unless it's absolutely necessary.

Expectations for working with ASL Interpreters

- Stick to the agenda. An outline with the planned discussion topics will have been provided to interpreters prior to the training; let's try not to derail from it.
- Limit cross-talk. Interpreters can only translate one voice at a time.
- The facilitator is responsible for determining who is asking for the floor, monitoring the chat box for comments, and assigning turns in an equitable manner (progressive stack). The facilitator will also keep an eye on the time.
- Trainers may have to speak in front of the Zoom laptop when presenting.
- Questions may be submitted in writing to the facilitator and read by trainers so that the interpreters can do their job easily. If questions are spoken, direct them at the trainers, not the interpreters
- Understand and be patient with interpretation lag/delay. The nature of interpreting English to ASL and ASL to English results in a slight delay in rendering the message. Please allow time for (or be mindful of) the interpretation to be completed before moving

on to the next topic.

Trigger Warnings

- Being a street medic often involves frequent exposure to trauma and violence.
- Trainings will include discussion and imagery of:
 - Bodily fluids (blood, vomit, saliva, excrement, etc.)
 - Body horror, including severe traumatic injuries that are likely to result in permanent disability or death
 - Violence, including the use of weapons, sexual violence, and fascism/police brutality
 - Substance use, paraphernalia, and harm reduction techniques
 - Mental illness including suicide, self-harm, and eating disorders
 - Poverty, medical neglect, and lack of access to medical care
 - Frank discussion about our limited ability to prevent life-threatening harm
- Scenarios may include realistic simulations of the above.

Housekeeping

- Bathrooms
- Breaks
- Meals
- Special needs
- The “What if...” sheet

Action Medical Intro

Who are street medics?

Street medics are a community of people who, for the last half-century, have provided medical support at protests, direct actions, uprisings, and natural disasters complicated by police or military targeting of the survivors.

Becoming a member of the street medic community involves

- ✓ completing a 20-28 hour training (or a bridge training for medical professionals), - working at an action as the buddy of an experienced street medic
- ✓ actively seeking out opportunities for continuing education
- ✓ maintaining relationships in the street medic community.

What is Street Medicine?

- Part of a wider radical, abolitionist movement, grounded in the histories and healing practices of colonized and enslaved people
- Specifically addresses the ways in which medicine as an institution has been weaponized to control and harm oppressed people—our bodies, our communities, and our struggle for liberation
- We work to dismantle the control our oppressors have over us through the institution of medicine by practicing care within our own communities in order to restore our collective autonomy
- We recognize and center the experiences of oppressed people in our practice of medicine.

Roles in action medical

embedded medics

Street medics who operate within an existing organization, who may or may not treat non-members.

affinity group medics

People with some level of first aid training, often less than a full 20 hour, who is designated the group medic. They may not be marked, but will carry a small first aid kit, along with any other items the affinity group feels are necessary.

action clinicians

Medics who hang tight in a removed/protected facility, typically able to provide more advanced care, privacy, and security than street medics.

community medics

The true badasses who work in communities when crowds and cameras are nowhere to be found.

infrastructure/support

All the people and orgs that support us as we train and operate. Not everybody has to be willing to deal with blood!

affinity groups

An affinity group is a team of people who come together to accomplish a shared goal. Affinity Groups may also be called Action Groups, Action Collectives, or Cells.

Street medic affinity groups & street medic collectives Street medic affinity groups are affinity groups that exist to support a mobilization by providing action medical services. Street Medic Collectives often engage in some form of radical community health work in between actions.

An Incomplete History of Street Medicine in North America*Overview of Slides*

The Medical Committee for Civil Rights
 Medical Presence Project
 Late 1960s
 1970s
 1980s
 1999: WTO protests (Battle in Seattle)
 Anti-Globalization Movement
 The early 2000s
 Disaster Response
 Emergency Response
 Occupy Wall Street (2011 – 2012)
 Standing Rock
 Hong Kong Protests
 The Future of Street Medicine in the United States

Street Medic Operations, Part I**The Buddy Pair**

Why do street medics always work in pairs?

- extra hands
- second opinion
- safety
 - eyes in the back of your head
 - crowd control
 - direct protection while treating
- A pair is not three.

Pairing up

- Compatibility is key, e.g.
 - risk tolerance
 - arrest
 - injury
 - mobility

- schedules
- Complementarity is also handy, e.g.
 - experience levels
 - medical
 - street/action
 - languages
 - Genders
 - Local knowledge

Syncing up with P E A R L S Y

P - physical needs

E - emotional/psychological needs

A - arrestability

R - roles you might play (roles include tactical lead, medical lead, communications)

L - loose ends

S - Supplies

Y – Running: Yes or No?

Street Medic Values

Anti-Oppression

We believe in interdependence. We strive to create relationships with other medics and patients to combat institutions which seek to isolate us. We see our work as acknowledging and resisting intersecting systems of oppression, including but not limited to white supremacy, heteropatriarchy, transmisogyny, and ableism.

Our work is rooted in generations of resistance to systems of oppression and domination. We seek solidarity with those struggling towards personal and collective liberation.

We collaborate with and support those working for a just and healthy society.

We seek to work in collaboration with and support of patients to ensure everyone's ability for autonomous action and decision-making.

Radical Consent & Patient Autonomy

Street medics get consent for everything.

CONSENT is a continuous process. Always ask whether you can do something to a person and describe what you are doing, and only do so if they are responsive enough and say yes.

How we get consent

- Approach calmly and cautiously.
- Introduce yourself confidently and swiftly, e.g.

Example: “Hello, my name is Inigo Montoya and I know first aid. I can help you. Would that be okay?”

Discuss: **Common reasons for refusing care**

REMEMBER: Treating someone who has not consented is assault.

How a street medic can encourage consent

- Be persistent but not pushy.
- Validate and address the patient's concerns, e.g.
 - "I can understand how this might be scary."
 - "Would you prefer if my partner takes care of you and I mostly keep watch?"
 - Establish privacy barriers.
- Innovate!
- **Always take "No" for an answer.**

***Special Note about Altered Mental Status and Implied Consent:**

Implied consent: if non-responsive, perform any action that assumes they want to live and you want that too.

NO ABANDONMENT: You must **stay** with someone once you start helping them, until you hand them off to someone with higher training or your own life is threatened. Your goal should be to transfer ASAP, with good communication.

Consent: Special Cases

Minors: Minors cannot legally consent. Seek a parent or guardian to provide consent if possible. However you may provide treatment if a guardian is not available and treatment is in the best interest of the patient.

Implied Consent: If a patient is unable to give consent we can assume that the patient would want life-saving treatment were they able to give consent but WE DO NOT call 911 on mentally ill or intoxicated people.

Radical Consent is Required: However, even if we have legal consent through a guardian or through implied consent, we always require that our patient agrees to our plan of treatment except when our patient is incapable of expressing a preference one way or the other.

Consent and Survivors of Violence

Consider how your identity/presentation inherently shifts power in an interaction and impairs a survivor's ability to give consent

Don't put the patient in the position where they have to enforce boundaries.
Invite them to set boundaries.

Is their flight, freeze, or fawn response activated? Signs to look out for:

Flight: putting space/distance between you and them, flinching from touch

Freeze: dissociation, being tense/silent/still

Fawn: saying yes to everything, trying to accommodate you/not be a burden to you, expressing gratitude to an abnormal/excessive degree ("hero worship")

Positive vs. negative consent → look for both

Positive: "Enthusiastic yes" a.k.a. saying yes through clear words/actions

Negative: "No means no."

Consent and Disability

People may have limited ability to give or express consent due to temporary or permanent disability.

Legal Complications: We assume the legal competence of all our patients unless we are forced to accept evidence to the contrary. However:

It is possible for an adult disabled person to have their bodily autonomy rights violated by a court of law. This is called a "guardianship."

Caregivers frequently assume they have decision making powers over a disabled person even when legally they do not. They do not actually have this authority unless granted by a court of law.

We require consent from the patient in any case regardless of the law.

Consent and Mobility Devices

- Do not touch a person's wheelchair or other medical device without their express consent
- Never move a mobility device or other piece of accessibility equipment outside the reach of its user, even if they give you permission to touch and move it
- Recognize that a mobility device, prosthetic, infusion pump, or other medical device is often an especially sensitive part of the patient's body and requires extra care when approaching it

Patient Care & Transfer of Care

Most importantly, once you start care, you DO NOT LEAVE the patient until:

- 1) They confirm care is completed or say they do not want further treatment.
- 2) You transfer them to a higher level of care (more experienced medics, EMS, hospital, etc).

To leave the patient otherwise is considered ABANDONMENT. Street Medics do not abandon their patients!

Security Culture

People trust street medics to keep their secrets.

- Signal App
- In-person comms is best
- Use a burner phone when possible, for comms on the ground
- Remember police can confiscate your phone if arrested
- More info on digital security at protests: <https://ssd.eff.org/en/module/attending-protest>
- Don't ask questions you don't need the answer to...
- Don't talk, don't brag, watch what you post online!

Autonomy of Risk

Professional EMS will stage outside a protest until the police declare the scene secure. But a street medic is accountable to no one except their buddy when deciding whether or not to enter a potentially dangerous situation.

Listen to your buddy. Consult with your buddy before taking risks.

But other than your buddy, no one in the world has the right to tell a street medic who wants to go in that they should hold back because it's too dangerous.

However a medic partner must NEVER pressure you to enter a situation that you feel presents an unwarranted risk.

Buddy pairs work together!

Horizontal Decision Making

Street medics organize and operate according to non-hierarchical principles of solidarity. We focus on how to creatively, effectively, and safely meet the needs of the communities we serve above all else.

Medical certifications and licenses, skill level, and experience are respected with regards to patient care, but do not translate into hierarchies of duty or administrative decision-making power.

We are learning organizations and must adapt very quickly to difficult environments. We cannot afford to neglect hidden talents within our ranks.

Commitment to the Cause

Street medics are unapologetically activists: we do what we do because we believe that infrastructure makes our movement stronger, and because we want the movement to succeed. Street medics are anti-oppression, anti-fascist, and pro-collective liberation. A good street medic is involved with the activist movements in their own community.

Tactical Neutrality

Many people say that marked medics don't participate in tactics. That isn't entirely true.

As stated earlier, we believe that having medics makes our side stronger, more resilient, and more likely to succeed.

Medicing itself is a tactic, not a passive act. That said, tactical neutrality does mean that, when we're marked, we don't participate in tactics ***other than being a medic.*** Medics do NOT direct or control the action.

Medics do NOT act as an authority above organizers or use their certs to "pull rank."

Another side of tactical neutrality is that Street Medics should try to stay out of debates about the "right way" to protest.

We are not there to police the movement. Whether it's a riot or a law-abiding candlelight vigil, or anything in between -- we try to let others debate tactics, while we focus on supporting every part of the movement.

Continuing Education

By identifying as Street Medics, we're committing ourselves to a lifetime of continuing education. It's best to think of the class that you're sitting in now as an initiation, rather than a training.

Your training will never end. Even doctors and nurses with years of experience and academic training still have to update their knowledge constantly.

Legal Risk, Good Samaritan Laws & Scope of Practice

- Remember, when you are a medic, outsiders (like the police and passersby) will still see you as a protestor! **Being a medic does not shield you from the risks of a protest. In fact, you may be confused for a protest leader when you are not.**

For licensed/certified professionals, always work according to your organization's **standard of care** to avoid further legal ramifications.

- LEGALITY:** You may perform interventions if you **act within your training & knowledge**, with **intent to save a life**. Check the local city & state Good Samaritan laws before going to an action.

(Varies by state.)

Good Samaritan Law in NYS

Drug or alcohol overdose: GSL allows people to call 911 without fear of arrest if they are having a drug or alcohol overdose that requires emergency medical care or if they witness someone overdosing

Use of defibrillators or CPR: GSL protects those who perform CPR or use an AED in the case of a sudden heart attack or heart-stopping injury

Street Medic Operations, Part II

Situational Awareness

Street Medics need to be aware of their surroundings at all times. It's important to avoid distractions to the extent possible and keep our eyes on the crowd.

- What are the protesters doing?
- What are the police doing?
- Who looks hot, cold, or tired?
- What risks are around you?
- Where is your buddy, and how are they doing?

Scene Assessment - 1 2 3 4 5

1) "Look out for #1" Survey the scene

- Halt! Do not rush in.
- Keep your own safety and buddy safety in mind
- If patient also poses a danger, you are not obligated to help them

2) What happened to you - first impressions of the scene

- Survey the area: What do you anticipate?

3) Don't get any on me! - BSI precautions

- Consider repositioning on-scene
- Put on protective gear
 - body substance isolation
 - physical protection

4) Are there any more? - how many patients are there? (triage)

Organize help

- Check in with your team
 - Who will perform which roles?
- Call for backup.
 - Other medics?
 - EMS?
 - Bystanders?
- Organize the crowd

5) Now keep them alive! - general impression of patient

Proceed with caution

- Medics do not run
- Medics walk swiftly with purpose
- Sometimes you have to walk swiftly away
- Stay calm and confident

More scene safety basics

- Never make a new patient!
- Continually reassess the scene for safety.
- Be prepared to move or protect your patient.

Crowd Management Tactics

The Buddy Walk: Demo

The Human Barricade: Demo

Other Roles

- **Dispatchers**
Facilitate communication between medic teams and between medics and the community during large actions. Provide situational awareness for medic teams by monitoring social media, live streams, and police radios.
- **"Care Bears"**
People who are not trained in first aid but who provide care during actions in the form of passing out water, snacks, sunblock, dry clothes, etc.
- **Trainers**
Veteran street medics who choose to pass on their skills and knowledge to create the next generation of street medics.
- **Logistical Support**
Provide all the organizational support necessary to keep medics in the street for example they handle finances, social media, technical support, scheduling, infrastructure, etc.

COVID-19 Precautions

Weigh your risks. Do not have close contact with someone with a non-life-threatening injury.

- Chemical weapons make people cough, increasing the spread of the virus.
- Wear a mask and bring extra to give out.
- Rescue breaths should only happen with EMS equipment, not mouth contact.
- Someone with pneumonia may already be in compensated shock or with a compromised airway for days. Recognizing that gets them treatment faster.

Jail Support

- What is Jail Support?
- Assessing needs of activists doing Jail Support
- Emotional Care is a large part of it; recognizing the experiences of people released from the jail system is traumatic
 - People may be angry, anxious, or bring the emotions from the action to jail support. Jail support should be treated as re-coup time/ time to support the arrested, NOT an extension of the action/rally/march, etc.
 - Good time to check on your fellow medics as well as action participants.
 - People may decompress in different ways -- that's OK!
 - Jail Support can also be fun! Bring cards, coloring books, fidget spinners, small quiet activities to distract and de-stress.

- People have a tendency to dwell on social media coverage of the action -- that can be OK, but make sure to check in on people so they are not bottling feelings/emotions/getting stressed out more from social media.
- Checking for injuries / recording injuries
 - If patient requests, you can photograph injuries, which can help should the patient pursue legal recourse later.
 - Make sure the background is neutral or a blank piece of white paper (for color balance).
 - Make sure not to use flash needlessly; keep the picture as accurate as possible for the coloration and scope.
 - Take multiple pictures from all angles.
 - Use the patient's camera phone only, not yours!

Street Medic Gear

Street medics beginning to use the skills in this booklet frequently begin by packing their kit in ways that are not very useful. For example:

- A street medic may identify medical supplies with social status and hoard unnecessary or rarely useful supplies, or supplies they do not know how to use. A chaotic bag means that they usually forget important basics or loses them in their bag.
- They may not prepare for the actual situations they are trained to manage and likely to encounter. For example, they may not keep exam gloves in their pocket, and so be unable to help much when a person asks to check out a bad foot or a smelly old wound.
- They may not know how to improvise well, or source readily-available things. For instance, they may carry a gallon of water instead of a refillable water bottle and knowledge of where to refill it.
- They may be prepared for everyone else's needs, but neglect to prepare for their own.

Basic Medical Kit: A Suggested List

- 15 pairs of nitrile gloves that fit you (they come in s, m, l, and xl), packed in a ziploc bag.
 - It's a good idea to keep 2-3 pairs of your gloves in a ziploc bag in your pocket in case you lose your kit
- 30 nonsterile 2" x 2" gauze squares packed in ziploc bags
- 5 sterile 2" x 2" gauze squares packed in a ziploc bag (one of these plus tape equals a band-aid)
- 5 sterile 4" x 4" gauze squares packed in a ziploc bag (one of these these plus wound ointment and roller gauze equals a dressing change)
- 5 gauze bandage rolls
- 1 roll of 1" medical tape (micropore, transpore, or silk tape)
- 1 liter of water in a bottle you don't drink from
 - For washing wounds, hands, etc.; scrub with non-sterile 2" x 2"s

- 1 liter of water with a squirt-top for eye flushes
- 1 small bottle of liquid soap (like Dr Bronner's) packed in a ziploc bag in case it leaks
 - For washing wounds, hands, etc.
- 1 bag of cough drops, slippery elm lozenges, or slippery elm bark
- Lightweight snacks like nuts, dried fruit, or energy bars
- Trauma shears
- A change of socks
- Menstrual hygiene products
- Bandana
- Pen and paper

Pack your kit in quart-size ziploc bags to shield it from leaks, weather, and contamination. Put these ziploc bags in a convenient location: a fanny pack, fishing vest, small backpack, or shoulder bag.

Hot weather care

- Water-based sunscreen
- Extra water
- Sunglasses / hats
- Bandanas

Cold weather care

- Your own personal preparation, including a buddy, so you do not become an additional casualty
- Hats and dry socks packed in ziploc bags; emergency ponchos
- Water; especially hot water in thermoses with refill options and disposable cups. Instant hot chocolate, instant miso soup, instant hot cider, ginger tea with honey, or Jell-o (with sugar) for the hot water; something to stir with
- Candied ginger and other snacks
- Instant handwarmers or a rice bag handwarmer system
- These additional items can come in very handy:
 - Talcum powder
 - Cayenne powder or flakes
 - Mylar emergency blankets and other insulating materials

Acquiring supplies

The most expensive place to get supplies is at a pharmacy. Good local medical supply companies are much better, and you can put in a big order then pick it up. Internet ordering is also a good idea. Try allmed.net, galls.com, and Ebay, or call manufacturers and ask for factory seconds or overstock as a donation. If you have a nonprofit sponsor it can be tax-deductible for the donor. Consider keeping a supply dump somewhere for your medic group with an inventory person who keeps everything organized so medics can resupply on the fly and can periodically replenish the supply dump when anything gets low.

Body Substance Isolation (BSI)

BSI works two ways

- Keeps you safe from your patients
- Keeps your patients safe from you

What substances are we talking about?

- blood
- vomit
- saliva

Rules of glove

- Always change gloves between patients
- Dispose of gloves if they get dirty or damaged

Choosing gloves

- Always use non-latex gloves:
 - No allergic reactions
 - No need to inquire about latex allergies
- Color makes a difference
 - Lighter colors show blood better
 - Black hides blood
 - Each offers advantages

DEMO: Removing exam gloves

Other personal protective gear

- goggles (chemicals, projectiles, and body substances)
- poncho (chemicals and body substances)

Emotional First Aid

Trigger warnings: Talk about mental health and the effects of trauma.

Why is it important to know emotional first aid?

- In any first aid situation, providing emotional first aid is the tool we always use
- Spread calm; assessing emotional state; integral part of providing care
- Being in a position of authority over another person makes understanding of emotional health or yourself and the treated necessary

What is emotional health? What should be a medic's mindset toward patient care?

- Differing baselines and realities: we don't define emotional health for anyone, they define it
- Medics get over own perceptions of what is 'good' for people
 - Just because someone's having an emotional issue doesn't mean it's new to them or that it's 'bad' for them
- Although we're looking for certain signs, we're not diagnosing/pathologizing people
 - Don't name what you think is happening
- Compassion
- Make sure to pay attention to when you can be seen as a threat or make a person feel unsafe
- Homeostasis; equilibrium; touching in with another person's "baseline"
- Not causing harm to self & others
- Does that person have support? Can they find someone else for support?
 - Your role might be to find someone they want to talk to; find patient's friends or support
- Culturally Aware: emotional first aid workers have to be able to recognize cultural differences
- Boundaries: being prepared for psychological emergency
 - You are not responsible for hand-holding but can act as a guide
 - You are not there to be a savior either; it is not responsibility to save someone, but to provide proper care; a working relationship between medic & treated
- Can be assertive: people in emotional crisis may feel lost or dissociative
 - An emotional first aid worker must be firm and directive if needed to keep people together

Common Signs of Distress

- What can emotional distress look like ?
- We recognize markers of distress but we never really know what is going on with someone.
- Psychological "fight-or-freeze (or flight)" people aren't in the right mental space to make the right decisions
 - e.g. "I see that you're here in the street. How about we move off to the side and take a break?"
- Ways that don't appear as distress

- e.g. playing music, complaining about minor things unrelated to thing, staring into space, missing things, get really talkative and repeat details over and over
- It's hard to know when someone is in distress, but one can always check in about their baseline
 - e.g. "I've noticed you've been doing this. Is that something you usually do? Is this an uncomfortable change for you? Do you need anything?"

Emotional First Aid during an event focuses on harm reduction

- Lessen risk for the treated
- How trauma is approached can help care's effectiveness: act to "re-humanize", establish relations
- Be aware that one's emotional self-care may be seen as harmful to others but not for that specific person
- When long-term/encampment protests happen, emotional stress can build for protesters and for medics

How to Treat Someone in Emotional Distress

- Helping your patient have agency over themselves/their situation
- Scene safety
- How does the scene effect how you're working with someone?
- Ask the person if they feel safe
- Ask what they need to feel safe
- If the scene is unsafe, it may be time to be directive!
 - Informing someone of what you would like to do and then taking action
 - e.g. "Being in the middle of this march feels unsafe to me, I'd like to link arms and move over to the sidewalk"
- Once the person is in a safer space, build a relationship
 - Exchange names, tell them your role tell them what resources you can provide
- Remind people they always have free choice

Technique: Grounding

- *Don't tell people to calm down*
- Good technique butterfly hands: crossed arms on chest and tap palms
- Physical: Can you feel your toes? Wiggle your toes? Ankles? Press your feet into the floor
- Mental: How many colors do you see? How many skyscrapers can you count? Count to ten? Pointing out things into the room
- Breathing: inhale for two seconds, exhale for five seconds, repeat five to ten times

Technique: Open-Ended and Closed Questions

- Both open-ended and closed questions are helpful doing emotional care.
 - Open-ended questions leave space for a person to identify and tell you and what they need

- e.g. Is there anything I can do to help you? Do you want to talk more about that? What do you need?
- Sometimes it is hard for someone in crisis to identify needs, then closed questions can be helpful
 - e.g. Can I get you some water? Would you like me to stay with you? Do you have anyone you can call that would help?
- Try to determine what person is most worried about
 - Address and take steps to resolve person's biggest concern
- "Has this ever happened to you before? How often?"

Attending to Emotional Care

- Check your boundaries: time/emotional commitment
- Consent
- Assess comfort needs (food/drink; cold/ warm)
- Allow space for people to speak, but don't pressure anyone to talk
 - Do not dictate what a person feels.
- Validate feelings / seek validation of feelings.
 - Don't minimize or compare to someone who "has it worse".
- When person is going into shock, it is also ok to point this out—it helps them to process the situation
 - "You're shaking, but that's ok; that's expected"

Speak using "I" Statements, not "We"

- Do not use "we" unless you are referring to something unrelated to events that you are actually going to do together
 - e.g. "We are going to eat because you said you wanted food"
- Saying "I Don't Know" is ok; own your confusion

Technique: Creating a Narrative for Processing an Event

- Feelings may be disorganized; asking them to tell a linear story can help
- "Look for the helpers"
 - It may be easier to start by talking about what helped during or after
 - Groups may start their debrief by discussing who or what had protective or healing effects during or right after the trauma
- Take as much time as needed; you can chitchat between asking about event
- Always give a person a summary after receiving a piece of information to make sure it is accurate as possible
- Active Listening
 - Be present
 - Give people room they need to process
 - Keep your questions open-ended

Red Flags/What's beyond your scope?

- suicidal inclinations/talk
- self-harm that you want to manage?

- it can be hard when one is taking on the emotional burden of someone else or an action
- it is important to be able to process and debrief
- actions that put others at risk

Intervening in acute situations

- Higher skilled medics, definitive medical care, 911
 - Why are you calling 911? Things to consider about that option
- Know your local resources! Local centers, crisis hotlines (talk about issues with crisis hotlines)

How to process trauma as a medic

- Realise when your emotions are getting in the way of action
- PTSD from street medic work
 - vicarious trauma and compassion fatigue are real and valid
- Think about your own emotional warning signs
- *Designate a support person/people or plan before going in for an action or long term event*
 - Tell the support person any risk factors for trauma such as:
 - History of mood disorders or personality disorders
 - History of previous trauma
 - Lacking social / family support, resources
 - Cultivate a broad sense of optimism about life, the movement, the action
- You can feel fine in the moment but process the trauma later; it is good to process with colleague also in the work later
 - Effects of traumatic events will not be felt immediately
 - Medics go through this stuff together; your buddy is someone you can call weeks later when you need them
 - Check in before or after with buddy, or person outside of action who are aware they will be used as support

Additional Resources

- The Icarus Project - Emotional First Aid Seminars
- *The Worst is Over: Psychological First Aid* by CCH, Judith Acosta LISW (Author), Judith Simon Prager PhD (Author)
- *Aftershock: Confronting Trauma in a Violent World: A Guide for Activists and Their Allies* by Patrice Jones
- *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others* by Laura Van Dernoot Lipsky and Connie Burk
- *Trauma is Really Strange* by Steve Haines (Author) and Sophie Standing (Illustrator)

Practical: Eye Flushes

1. Introduce yourself, offer help, and gain consent
2. Put on gloves
3. Contacts? Ask them to remove with a glove.
Glasses? Remove glasses and give them to the patient to hold
4. Have them kneel and hold their legs → prevents touching face
5. Tilt head back and slightly toward side of first eye. Hold eye open.
6. Aim from bridge of nose across eye. Squeeze bottle hard to push strong stream into the eye, from inner to outer, away from tear duct.
7. Repeat with the other side, mirrored. Repeat process until they can blink and see. (They may still be in pain.)
8. Rinse mouth. Wash glasses before putting them on again.
9. Wash bare skin with soap & water.
10. Discard and replace gloves for next flush.

Eye Flush Aftercare

1. Remove and bag clothing*
2. Discard or wash PPE
3. Wash hair thoroughly first by leaning backwards into water
4. Shower with soap and water
5. Take emotional and physical care of yourself
6. Your liver and skin will be processing exposure

*Wash clothing separately from all other clothing.

*Do not wash in public laundromats.

END OF DAY ONE

DAY TWO AGENDA

Morning

1. Initial Assessment Intro
2. Mechanism of Injury (MOI)
3. C-Spine Injury / Stabilization
4. Mental Status
5. Airway
6. Choking
7. Asthma
8. Breathing
9. Circulation
10. Disability & Environment
11. Triage
12. Practice: Initial Assessment

LUNCH BREAK

Afternoon

1. Secondary Assessment / SAMPLE / Head to Toe Assessment
2. Bleeding Control / Tourniquets
3. Practice: Tourniquets
4. Soft Tissue Injuries
5. Burns/ Blisters
6. Head Injuries
7. Hot Weather Ailments
8. Cold Weather Ailments
9. Musculoskeletal Injuries / Practical: Basic Splinting / Carries
10. Skills Round Robin

Initial Assessment Intro

Purpose of initial assessment:

To identify life-threatening or potential life-threatening conditions

Initial assessment is a protocol

- We perform it in a specific order.
- We do not skip steps.
- We only interrupt it to perform life-saving interventions.

Red flags

- The initial assessment is a search for red flags: indicators of potential life-threatening conditions.
- As soon as you find a red flag, you'll need to call for backup.
- There are lots of gray areas in first aid. Street medics tend not to rule conditions out.
- If it could be a red flag, it's a red flag.

DEMO: IA Run-through

Tips for learning initial assessments

- Initial assessment is probably the hardest skill medics perform.
- You will screw up more than you get right at first.
- It can be harder in trainings than IRL.
- Ask your partner for help if you get stuck.
- Make your mistakes in settings like this.

Tips for performing initial assessments

- It's unintuitive, but go slow.
- Vocalize steps as you go.
- *Only stop for life-saving interventions.*

Initial Assessment Overview

M - Mechanism of Injury

M - Mental Status

A - Airway

B - Breathing

C- Circulation

D- Disability

E- Environment

		Assessment
Step 1	A Airway	<ul style="list-style-type: none"> • Is The Airway Clear? • Is The Airway Maintained? • Can The Patient Speak? • Are Their Airway Noises? • Is There Air Movement?
		<ul style="list-style-type: none"> • Respiration Rate
Step 2	B Breathing	<ul style="list-style-type: none"> • Patient Colour
		<ul style="list-style-type: none"> • Manual Pulse • Blood Pressure • Colour • Capillary Refill Time
Step 3	C Circulation	<ul style="list-style-type: none"> • AVPU • Temperature • Blood Sugar • FAST • Pupils • Pain
		<ul style="list-style-type: none"> • Perform Head to Toe Examination, Front And Back
Step 4	D Disability	
Step 5	E Expose	

Mechanism of Injury (MOI)

MOI is the immediate cause of an injury or sudden illness.

- Do not think like a radical at this stage!
- It's not the root cause, but the direct cause

MOI determines:

- Whether the danger persists
 - potential harm to you
 - e.g. cops, traffic
 - continuing to harm the patient
 - e.g. burns, ongoing brutality, vehicle

Persistent MOI

The other potential red flag for the MOI stage is a persistent mechanism of injury.

1. What is the MOI for a burn?
 - Heat — so that's what we try to address.
1. How about MOI for an impaled object?
 - The object — we don't remove these, so we're going need further care.
 - Persistent MOI calls for intervention. If you cannot intervene safely or successfully, get help!

Cervical spinal injuries

- Injuries to the vertebrae in the neck can be fatal, even if the person appears alright at first
- **If you suspect a C-Spine injury, you must initiate C-Spine stabilization**
- Potential MOIs
 - Fall a long distance (e.g. twice one's height) or in a weird position
 - Struck by a large object with great force (car)
 - Direct trauma to the head/neck
 - severe motor vehicle accident
 - direct trauma to the neck
 - *If you suspect a C-spine injury, you must immediately initiate C-spine stabilization.*
- If these MOIs are present, you must assume that their cervical spine is compromised.

Intervention: C-spine stabilization

Principal: Prevent further injury to the cervical vertebrae and spinal cord by restricting movement.

- Approach from the front
- Tell the injured person to keep their head still.
 - *More important than keeping the patient still is keeping the neck stable and in line.*
- Gently bring the neck into alignment.
 - STOP! If:
 - the patient feels pain
 - there is grinding (“crepitus”)
 - Firmly hold both sides of the patient's head.
 - Someone must hold this position until advanced help arrives.

Mental Status

- **Is the patient alert and oriented?**

- Has the patient lost consciousness?
- Do they respond readily and as expected?
- **Any prior loss of consciousness or current altered mental status is a red flag.**

A V P U scale

A - alert and oriented (x4)

V - responds to verbal stimuli

P - responds to painful stimuli

U - unresponsive

Procedure

1. **A:** If the patient is alert, assess their orientation:
 - What's your name?
 - What happened just now?
 - What month is it?
 - Where are we right now?
 - Did you lose consciousness at any point?
1. **V:** If the patient is not alert, try addressing them loudly.
2. **P:** If verbal stimulus doesn't work, apply some acute pain by pinching the shoulder muscles or pinching and twisting the skin on the back of the hand).
3. **U:** If you observe no response, the patient is unresponsive.

Reasoning

We assess mental status for multiple reasons:

- The patient's critical medical needs.
- Our own safety in cases where an injured patient may be frightened or agitated.
- If we miss altered mental status or prior unconsciousness, we may be missing much more.

Notes on mental status assessment

- Stay aware of changes in mental status throughout treatment.
- Relay the patient's status history when handing off to advanced care.
- Don't ask closed-ended questions, such as, "Do you know where we are right now?"
- Questions with existentialist interpretations are preferred, such as, "Where are we?" and, "Who is in charge of the United States?"

ABCDE - Checking for life threats

Airway

MOI for airway obstruction

- choking
- injury to throat
- *An airway obstruction is a red flag. Call for backup immediately!*

MOI for airway compromise

- injury to throat
- unconsciousness with fluids in mouth
- unconscious and lying on back
- Airway compromise is cause for pausing your initial assessment to intervene.

Intervention: Open airway (unresponsive patient)

1. If your patient is or becomes unresponsive, check for breathing.
2. If the patient is not breathing, open their airway:
 - a. If no C-spine injury is suspected, use the head-tilt, chin-lift technique to open the airway.
 - a. For suspected C-spine compromise, use the jaw-thrust maneuver.
0. If the patient does not spontaneously breathe, initiate CPR.
1. If the patient begins breathing on their own, roll them into the recovery position.

DEMO: Head-tilt, chin-lift maneuver

DEMO: Jaw-thrust maneuver

DEMO: Recovery position

1. First, lay the person on their back and kneel on the floor beside them.
2. Extend the arm nearest to you at a right angle to the person's body with the palm facing up.
3. Take the person's other arm, folding it and pressing it to the cheek closest to you. Hold it in place.
4. Use your other hand to bend the person's knee (furthest from you) to a right angle.
5. Roll them to their side by pulling gently on the bent knee. Their bent arm supports their head and the other arm prevents you from rolling them too far.
6. Be sure that the bent leg is at a right angle.
7. Tilt the person's head back and lift their chin to open their airway.

Breathing

MOI for respiratory distress

- exertion
- aerosolized chemicals
- chronic condition
 - e.g. asthma, COPD

Signs of respiratory distress

- shallow breathing
- rapid breathing
- slow breathing
- unsteady breathing
- strained breathing
- wheezing/gasping
- "tripod position"

Choking & Breathing difficulties

Intervention: Choking (conscious patient)

1. Establish if the patient is choking.
2. Tell the patient to cough.
3. Apply 5 firm back thrusts between lower shoulder blades.
4. Apply 5 firm abdominal thrusts above the navel.

Intervention: Respiratory distress

- If chronic, do they have medicine?
- Tripod position.
- Breathe along with them.
- Be calming and reassuring.
- *Severe or prolonged respiratory distress are red flags! If the patient does not recover after 3-5 minutes, or if the distress is severe, call for backup!*

Intervention: Respiratory arrest (unresponsive person)

- Rescue breathing.
- Learn it in CPR course.
- If you don't know CPR, somebody nearby does.
- Get them to do it.

Asthma

Likely to be brought on by:

- Chemical weapons
- Smoke
- Allergens
- Running/exertion
- Stress
- Cold

If the person has their inhaler, help them administer it (2 puffs/20 minutes).

- Do not use someone else's inhaler on them.
- Help them into a sitting, "tripod" position and help them concentrate on breathing OUT
- Remove environmental trigger or transport patient if possible
- Caffeinated/mint/ginger drinks and menthol cough drops can help open the airways and provide temporary relief (for about 1-3 hours, depending on severity)

Circulation

We will only discuss wounds that constitute a life threat at this point. We will talk about aftercare, and the care of minor wounds at another time.

In a trauma situation (e.g. knife, gun, car, explosion), treat bleeds first.

- Arterial vs. Venous
- Arterial: bright, pulsing, forceful

Venous: dark, flowing

Arterial bleeds are always a life threat!

Pulse

Does the patient have a pulse?

- If they're breathing, they have a pulse!
- If someone is breathing for them, check for a pulse.

Bleeding

1. Is the patient bleeding severely?
 - a. This is also usually obvious.
 - a. Sweep unconscious patients.
0. Has the patient lost a lot of blood?
 - a. Check their pulse.
 - a. Check their perfusion.
 - b. Check their clothing, surroundings.

DEMO: Blood sweep for an unresponsive patient.

Wear gloves.

Tuck your hands under the areas where blood can pool

1. Back of neck
2. Small of back
3. Behind the knees
4. Behind the ankles

Check your hands after tucking each area for signs of blood. Note if blood has been pooling in a certain area.

Change gloves if you can once you note area of pooling blood so you don't mistake an area as a major site of bleeding.

Disability & Environment

Disability

Is there life-threatening danger the patient unable to perceive or avoid?

- Caused by recent injury.
- Also consider loss of mobility/perception aids.
- *Disability in a life-threatening situation calls for intervention, which may require backup.*

Environment

Are the immediate surroundings a danger to your patient?

- Any threat that prevents or disrupts lifesaving care.
 - severe weather
 - hostiles / chaotic crowds
- Think ahead: changing environments mean continually reassessing the threat.

Triage

Prioritization of care when patients outnumber available medics.

Purpose of triage:

- Quickly perform initial assessment on all patients.
- Organize medic resources, prioritizing the most critical cases.

Triage should be performed by the highest trained/most capable medic on scene.

1. Have anyone who can walk on their own and is not actively providing care move to a “green” area.
2. Perform rapid ABCDE assessment on all remaining patients.
3. Assign available medics to perform life-saving interventions in critical cases as you go.
4. After checking all patients, assign medical resources according to severity.

Secondary Assessment

After initial assessment is complete and life-saving interventions administered, it's time for a secondary assessment.

Purpose:

- Help catch factors that may inform your assessment or care.
- Gather information that may be helpful to further providers should conditions change, such as patient loses consciousness.

Check for consent for focused assessments, even if the patient already consented to initial assessment.

- “Can I ask you some more questions about your medical history and what’s going on?”
- “Is it okay if I examine you some more to make sure there’s nothing we’re missing?”
- Explain what you’re doing as you go!

DEMO: Secondary Assessment with patient

Now let’s break this demo down!

If your patient is alert, gather a focused medical history.

S A M P L E history

- S** - signs/symptoms
- A** - allergies
- M** - medications
- P** - past medical history
- L** - last food and drink
- E** - events leading up to illness/incident

Focused trauma assessment (head to toe)

If patient is found unresponsive: Check unresponsive patient for undetected blood loss collected in clothing or on the ground

Head-to-toe exams are administered whenever the mechanism of injury (MOI) suggests there may be injuries or signs you have missed.

- Maintain C-Spine stabilization if needed
- Have second medic perform a head-to-toe trauma assessment

DEMO: Focused (head to toe) trauma assessment

Now let’s break this demo down!

- 1) Perform a **blood sweep** to make sure patient isn’t bleeding out first.

- 2) Then check every single area to assess any signs of injury.
- 3) While inspecting each area, note any visible injuries, bleeding, signs of pain expressed by the patient. While you perform the head to toe:

- Documentation Is Important: Have your medic buddy take notes
- Communicate Throughout: Be sure to communicate clearly OUT LOUD with your patient throughout the assessment. Even if unresponsive, they may still hear you as they gain consciousness. Consent is important & communication is part of this.
- Keep an Eye on Bilateral Symmetry: When you are examining a patient, make note of any unusual asymmetry. This could mean a traumatic injury on that side.
- Assess Skin Throughout: Note if patient's skin seems unusually pale, flushed, cold, hot, clammy, or dry anywhere throughout the exam. Also note any lesions, abrasions, or rashes.

Areas to check for the "Head to Toe"

Head/Face

Palpate scalp and forehead.
 Check scalp for bumps, nits, lesions, etc
 Palpate skull for tenderness
 Check for symmetrical facial movements

Eyes

Check for "raccoon eyes" (head trauma sign)
 Assess state of patient's corneas with a pen light
 PERRL = Pupils Equal, Round, Reactive to Light

Ears

Each for Battle Signs (bruising behind the ear - head trauma sign)
 Look inside ear for any bleeding or clear, viscous fluid (head trauma sign)

Nose

Palpate nose and assess symmetry
 Check inside nostrils for bleeding

Mouth and Throat

If the patient is held in C-spine, BE CAREFUL when checking mouth. Do not move neck.
 Note Moistness and color of lips
 Inspect teeth and gums for any broken teeth/ airway obstructions

Neck and Shoulders

Palpate neck and trachea
 Check for JVD (bulging neck vein) could be sign of heart attack/ heart failure

Lungs and Chest

Palpate chest

Assess breathing -- is it even? steady? any lung sounds?

Is the chest bilaterally symmetrical?

Abdomen

Inspect abdomen

Palpate four quadrants of abdomen for pain/tenderness/ swelling

Pelvis

Palpate pelvis for any broken bones.

Arms and Hands

Palpate arms for any broken bones.

Legs and Feet

Palpate legs for any broken bones.

If you DO NOT SUSPECT C-SPINE injury, you can roll patient and feel down their back for any injuries. If C-Spine is being stabilized, your buddy can hold position as you roll.

Sounds like too much? Then just remember: check down the body for Anything Fucked Up!

Bleeding Control

Severe bleeding is always a red flag, no matter when it's discovered.

- Direct pressure (heel of palm, kneel into the wound, body weight pressure)
- Layer gauze on top of the wound if it bleeds through
- Change out the top layer ONLY if it bleeds through
- Never remove bandaging that is directly on the wound (may rip clotting)
- Note how much material was used to assess for seriousness of bleed (bled through 10 4x4s, 2 abdominal pads, etc.)
- Bleed should slow after 7-10 minutes of pressure
- Note if patient takes anticoagulants/blood thinners (Coumadin/heparin/warfarin, Plavix, daily use of aspirin, NSAIDs, etc.)
- NEVER apply direct pressure to a head or eye wound
- Patients can apply direct pressure to their own wound in many cases, which can be empowering. Exercise good judgment.

Intervention: Tourniquet

- Indications for tourniquet:
 - Amputation above the wrist or ankle

- Severe bleeding not stopped by direct pressure
- Direct pressure cannot be applied to site of wound
- How to apply a tourniquet
 - Get a manufactured tourniquet device and learn to use it
 - Use a dedicated tourniquet when available
 - Makeshift from flexible strap or durable fabric
 - Apply tourniquet just above the injury site or two inches above the joint
 - Tighten until bleeding stops or becomes oozing
 - Write the time you applied the tourniquet securely to the patient
 - NEVER release or loosen the tourniquet- that happens in the hospital

Indications for tourniquet:

- Amputation above the wrist or ankle.
- Severe bleeding not stopped by direct pressure.
- Direct pressure cannot be applied to site of wound.

Get a manufactured tourniquet device and learn to use it.

How to apply a tourniquet

- Use a dedicated tourniquet when available.
- Makeshift from flexible strap or durable fabric.
- Apply tourniquet just above the injury site.
- Tighten till bleeding stops or becomes oozing.
- Write the time you applied the tourniquet securely to the patient.
- Never release the tourniquet.

Do NOT do this lightly

- Tourniquets are extremely painful and cause damage
- They can also be ineffective if not applied correctly

DEMO: Tourniquet

DEMO: Improvised Tourniquet

Signs/symptoms of severe internal bleeding

- obvious bruising in abdomen or chest
- blood in vomit, stool, or urine
- abdominal pain and swelling

Patient definitely needs follow-up hospital care, but activate emergency response only if signs of shock are present.

Shock

- Heart unable to pump enough blood/oxygen to brain and organs
- Shock is an immediate life threat**

Compensated (body is rushing to get enough oxygen)

Sweaty, flushed skin
 Blue nail beds, inner lips, inner eyelids (conjunctiva)
 Panting (quick shallow breaths)
 Nausea
 Extreme thirst
 Rapid pulse
 Dizziness
 Confusion
 Panic

Decompensated (not enough oxygen, so the body starts to shut down)

Slow breathing
 Cool, clammy skin
 Pallor ("pale" in light skin tones or "gray" in darker skin tones)
 Weak pulse
 Fainting
 Unresponsive

Hypovolemic shock

- Caused by internal or external blood loss—technically, a severe loss of blood volume.
- Core organs compete for scarce or hard-to-get blood, causing slow overall decompensation. Shock kills!

Signs/symptoms of hypovolemic shock

- Is the patient bleeding severely? Has the patient lost a lot of blood?
 - Check their pulse
 - Check their perfusion
 - Check their clothing and surroundings
- Treatment
 - Keep warm
 - Control bleeding
 - Keep still and lying down
 - Transport quickly to higher care
 - Keep airway open, and give rescue breaths if applicable
 - Will need oxygen and blood infusion

Signs of shock associated with injury

Early

- Headache, dizziness, nausea, fatigue

Later (compensated) /severe (decompensated)

- cold/clammy/pale/ashen skin
- skin inside of lips, nail beds, etc is bluish
- rapid, shallow breathing
- disorientation/agitation/combativeness

First aid for shock

- Activate emergency response!
- Get them someplace warm if they can be moved and shelter is near.
- Lie the patient down.
- Cover them with a blanket.
- No food or liquids.
- Keep them as comfortable and calm as possible.
- Monitor level of consciousness and ABCs.

Soft Tissue Injuries

Some injuries we treat in the field:

- minor lacerations
- scrapes
- minor bruises

When no complications are associated with superficial injury, street medics may provide complete primary care.

Open wounds (general treatment)

Once bleeding is controlled:

1. Irrigate the wound with water, saline, or diluted providone-iodine diluted in water (1:10).
2. Securely apply clean bandaging to keep wound covered, clean, and dry and maintain gentle direct pressure.

Never use peroxide or alcohol, which damage tissue and slow healing.

Refer lacerations for suturing under these conditions

- animal bite
- over a joint
- cosmetic concerns- wound on face or other very visible place
- jagged edges / won't close easily / long wound
- Any tissue besides skin and blood visible

Puncture wounds

- Do your best to irrigate.
- Refer for care and warn of signs of infection.
- high risk of infection (no self-irrigation)
- difficult/painful to properly irrigate

Avulsions

- Replace the "flap" and bandage in place.
- Associated with increased risk of infection.
- Refer to ED or urgent care.

Impaled object

Never remove an impaled object larger than a splinter.

1. Loosely apply sterile dressing.
2. Bandage around object for stability.
3. Apply direct pressure near impalement without moving the object.
4. Refer to ED or emergency transport for large/deep objects

Impaled Object: Donut bandage

Missing teeth

1. Replace lost tooth into socket or store in container with patient's own saliva.
2. Have patient bite gently on wad of gauze.
 - Do not touch the root of the tooth.
 - Patient needs to see a dentist ASAP.

Eye injuries

1. Cover the injured eye completely.
2. bandaging uninjured eye with a pinhole to decrease likelihood of injured eye movement, or, if that isn't possible, bandaging uninjured eye entirely.

Contusions

- Minor bruising is treated with rest and ice.
- Major bruising gets referred to ED or urgent care.

Burns

- Causes: extreme temperatures, sun, chemicals, tear gas canister, radiation burn (including sunburns), electric (Taser), friction (inside of shoes, blisters)
- **Do not put ice on a burn.**
- Classify by degree:
 - **1st:** Stay out in the sun too long -- redness, pain
 - cool it down with cool, sterile water for 10 minutes or continuously flush
 - **2nd:** Redness, blisters, peeling skin
 - More dangerous because it is an open wound, prone to infection
 - Treatment for 1st and 2nd: cool, clean water for a couple of minutes; keep it clean with moist, sterile bandage/dressing
 - Burn dressings are specific
 - One can be made out of sterile gauze & saline
 - Do **not** break any blisters
 - **3rd:** Skin has been burnt/ charred/ gone
 - Deep tissue injury/ nerve damage
 - Will be surrounded by 1st and 2nd burns
 - Hospital needed immediately

BURN ASSESSMENT: Rule of 9s

- Each arm is 9%
- Each leg is 18%
- Torso is 9%

- Chest is 9%
- Upper back is 9%
- Lower back is 9%
- Genitals is 1%
- Head is 9%

Burns on more than 10% or more as a 2nd degree burns needs hospitalization

- Burns can affect other segments
 - e.g. Burns affect mobility and chemical burns affect airways
- SEVERITY and EXTENT determines hospitalization
- Be sure to remove all materials over the burn (clothing, jewelry) because of swelling of the body might cause this to restrict
- Do not wrap fingers together, or they might stick together
- For chemical powder (like old tear gas): Brush off before using water
- Burns, even mild sunburn, can weaken the immune system, so people should get lots more rest and hydration
- Burn Aftercare: Aloe; move burned part to retain full range of motion while healing

Blisters

- For WALKING blisters only (i.e. on sole of foot), if blister is about to burst or may break on its own, puncture on the side to drain
- Dress clean and keep padded

Red Flags for Burns

- Burn that compromises anything important (ABCD)
- Three layer 3rd degree burns
- Burns all the way around an extremity
- Burns that have been opened with no immediate sterile care
- Anyone with a compromised immune system (very young, very old, or very sensitive/insensitive to heat)
- Electrical burn
- Lightning Strike
- Any electrical injury that can affect the heart is dangerous
- Burns make people more vulnerable to hypothermia and shock

Head Injuries

- Head injuries can be caused by an object striking the skull, or by the brain striking the inside of the skull due to a sudden change in velocity, as in a car accident
- Brain can swell; bleeding maybe seen as fluid is forced out
- **Concussion:** if they sustain a concussion (ex. football injuries), a repeat injury is a danger for permanent damage
- **Red Flags:**
 - Bleeding from ears, nose

- Black eyes (raccoon eyes)
- Bruising or fluid collected behind the ear (Battle Sign)
- Disoriented, irritable, combative, comatose/unresponsive, seizures (DICCS)
 - In these cases, they CANNOT give informed consent; keep an eye, until consent is given or person becomes unresponsive
- Pulse slowing down (working harder)
- If there is a head wound on the skull: DO NOT APPLY direct pressure to stop bleeding; make a donut bandage to surround the wound but exert pressure around the wound

DEMO: How to dress a head wound

Used to cover head wound with little pressure; quick to use

- Remove any visible debris near the injury, using tweezers if needed, and clean the area as best as you can.
- Cover the area with gauze pads. If an object cannot be removed from the wound, **wrap the cloth around it, not over it and make donut bandage to cushion object in place.**
- Keep steady pressure on the injury until the wrap is in place.
- Fold the cloth into a triangle before placing it on the person's head, with the tip pointing to the back.
- Wrap the two ends around the back of the head, cross them back to the front, and tie the ends together.
- If there is excess fabric, tuck it under the wrap.

DEMO: How to make a donut bandage

Used to make sure the wound is treated without direct pressure

1. Use roller bandage
2. Loop the bandage around in a finger-width and curve around into a circle
3. Wrap bandage around head
4. Hook bandage wrap around the knob at the base of skull

Aftercare

1. Wake person up for every few hours (depending on Doctor's rec) for 48 hours to check their vitals
 - a. If there is double vision, dizziness, condition worsens in any way, "seeing stars", or flashes of light, they must go to hospital
0. For those who don't exhibit these signs, they should still be watched
 1. Cannot drink alcohol or take drugs for 48 hours
 2. Should have buddy to monitor them in case they develop these symptoms
 3. Continue to monitor A&O
 4. People with untreated head injury is susceptible to another injury with worse damage

Hot Weather Ailments

What do we see when it's hot and/or sunny out?

1. sunburn
2. heat exhaustion
3. heat stroke

Remember, heat ailments escalate (compensate/ decompensate)

Treatment for sunburn: cover up or get out of the sun!

Signs/symptoms of heat exhaustion:

- fatigue
- cool/pale/ashen skin with profuse sweating
- headache / dizziness / nausea / vomiting

Children and elderly folks are especially at risk.

Intervention for heat exhaustion:

1. Get the patient to shade
2. Fan the patient
3. Remove excess clothing
4. Have them drink water; no hardcore sports drinks or powders unless heavily diluted

Signs/symptoms of heat stroke:

- Skin may be moist or dry, as in no longer sweating
- Disorientation / deliriousness
- Loss of consciousness

Treatment for heat stroke:

- Get the patient somewhere cool right away
- Remove clothing
- Apply cold packs to neck, armpits, inner thighs
- Fan and mist but do not soak skin or clothes
- Always activate emergency response for heat stroke. An air-conditioned taxi to the nearest ED might be the best option.

Counsel prevention

To avoid these awful eventualities on hot days, encourage activists to:

- Cover as much of their body with light clothing as they can stand; slather the rest in sun block.
- Stay hydrated within their physical limits—overdoing it costs medical resources

Cold Weather Ailments

- **Hypothermia:** body-heat loss that threatens organ failure
- **Frostnip:** minor tissue damage due to cold
- **Frostbite** (rare): severe tissue damage, usually to extremities

Signs/Symptoms of hypothermia:

- severe shivering
- pale/bluish where should be pinkish
- slurred speech / mumbling
- slow / shallow breathing
- clumsiness / drowsiness / fatigue
- disorientation / memory loss / loss of consciousness

Factor in wind and rain: you may see hypothermia at temperatures as high as 50°F (10°C) or higher or in water up to 70°F (21°C).

Treatment of hypothermia:

- Get the patient out of the cold.
- Remove wet clothes and dry the patient.
- Warm liquids by mouth are okay if patient is alert
 - No alcohol or stimulants (such as cigarettes/coffee).
- Use active warming with heat packs to the armpits / thighs.
- This may be a good time to bust out that space blanket.
 - Always activate emergency response for hypothermia. A hypothermic patient is best warmed under advanced medical supervision.

Signs/symptoms of frostnip:

- reddened/lightened skin where exposed or in extremities (fingers/toes)
- itching / tingling / numbness

Treatment for frostnip:

1. Get to a warm place.
2. Warm the area with moderate heat, such as warm hands or insulated heat pack.
 - *Do NOT re-expose to cold.*
 - *Do NOT rewarm with friction.*

When frostnip symptoms worse, it turns into frostbite. Frostbite also includes these signs/symptoms

- white/yellow/waxy skin
- blotchiness
- blistering/swelling
- clumsiness due to joint/muscle stiffness

Treatment for frostbite:

1. Get the patient somewhere warm
2. Do not warm and then allow refreezing
3. Do not actively warm the site

Activate emergency response or rush to emergency department; minutes count because tissue is at stake.

Counsel prevention

- Properly dressed, fed, and hydrated activists rarely get hypothermia or frostbite.

- Extremities—including ears and noses—need coverage in cold weather.
- Water resistant clothing even in merely chilly weather.
- Layers, layers, layers, including a wicking layer on the inside.
- Send people indoors if they appear at risk; encourage them to rotate.

Musculoskeletal Injuries

Injuries to bones, muscles, and the stuff holding it all together, most especially:

- breaks (bone fractures)
- sprains (injury to the ligaments between bones)
- strains (injury to muscles and/or tendons)
- dislocations (dislodgment of long bone from joint)

Differentiating between breaks and sprains

Except in cases of obvious fractures (deformity/exposed bone), don't bother diagnosing; we treat them the same.

- Only an X-ray can rule out fracture, and it's never worth risking.
- Always refer what you think are sprains for immediate follow-up care.

Treatment is the same for all:

1. Examine the site.
2. Check pulses/perfusion (compare to opposite side).
3. Treat any wounds at the site.
4. **R I C E**

R - rest

I - ice

C - compression

E - elevation

- RICE treats pain, prevents exacerbation, and restricts swelling
- Rest includes immobilization and protection of the injury site
- Ice = 20 minutes on, 20 minutes off; some treatment advises not to over-ice, which would freeze the damage the tissue.

Principles for immobilizing musculoskeletal injuries

- For long bones, immobilize at least the joints “above and below” the injured bone.
- For joints, immobilize the long bones connected to the joint.
- Protect the injury site.
- Check perfusion before wrapping/splinting.

Dislocations in the field

- *If you have not been specifically trained to treat a specific type of dislocation, do not attempt to relocate a dislocated bone.*
- Treat with RICE and refer to ED or urgent care.

DEMO: Basic Splinting**END OF DAY TWO
DAY THREE AGENDA**Morning

1. Chemical Weapons
2. Police Weapons & Tactics
3. Protest Tactics
4. Medical Emergencies (stroke, poison, heart attack, diabetic, fainting, seizures)

Afternoon

1. Preparing for an Action
2. Practical Low Key scenario + debrief
3. Live Shooter Situation / Gunshot wounds
4. Street Medic Collectives
5. How to Join NYCAM Dispatch
6. Practical: Final Scenario + debrief

Chemical Weapons

How to treat chemical weapons

Prepare

- **Bring** face coverings, goggles, extra clothes, nitrile gloves, waterproof outerwear, sport-tip water bottle, liquid soap
- **Don't bring** contacts, oil-based lotion/makeup, milk

Treat

Treat pepper spray or tear gas with eye flush using WATER

You are physically flushing a substance out of the eyes, not countering the chemical.

Water is cheap, easy, safe, and widely agreed upon.

WATER.

Stay calm

Police use them to scare and disperse-trampling and other secondary injuries can occur as people flee

Be aware

May trigger respiratory distress and GI symptoms

Pepper Spray

- Irritant: oleoresin capsicum (OC)
- Delivery: mainly direct spray, sometimes projectiles
- Primary effects: pain, blindness, sometimes respiratory distress, mucous discharge
- Secondary effects: irritation, dryness, certain sense of singular injustice
- Primary treatment: water
- Secondary treatments: soap and water air
- IT WILL CONTINUE TO HURT once the pepper spray has been removed. This is because the patient has received minor chemical burns. Once the pepper spray is gone though there is no point continuing to flush; drying out eyes only leads to more irritation.

Treatment for the skin & aftercare

- Capsaicin is not soluble in water.
- When Pepper Spray dries, it will stop hurting.
- When it gets wet again, it will be re-activated and hurt again. You must use DISH SOAP to help clean this off.
- While medics have used liquid antacid + water (LAW) as a remedy, it should ONLY be used for skin, not eyes.

- Because LAW is mistaken for milk (#NOTMILK), and because it can mark dark-skinned patients as targets by police, we want medics to be careful using LAW to treat patients.
- Best practice is to blot off excess chemical from the skin, clean the eyes and mouth, and allow the chemical on the skin to dry.

When at home

- Contaminated clothing should be removed as soon as possible.
- Do not have patient travel home in an enclosed space (ex. subway; danger of degassing to others).
- When the patient returns home, they can clean it in the safety of their own home with copious water and strong detergent (degreaser or dish soap).
- Patients pepper-sprayed in the face should shower HEAD first (or affected body part first), facing the spray, with water streaming away from eyes/ mouth/nose, keeping body away from the water, then shower the rest of the body once affected areas are cleaned.

Tear Gas

Note: Tear Gas is NOT used by the NYPD in NYC.

- Irritant: CS, CN, other aerosolized/particulate agents
- Delivery: mainly by canister (launched or thrown), sometimes direct spray
- Primary effects: pain, blindness, tearing, and mucous discharge
- Worst effects: respiratory distress, blunt trauma from canisters, secondary injuries, hand burns
- Primary treatment: water
- Secondary treatments: soap and water, air

Which effects of tear gas cause medics the most trouble?

- blindness (disability)
- chaos (environment)
- blunt trauma from canisters
- burns (from “return to sender” techniques)
- These weapons become hot enough to start fires or cause full-thickness burns. Do not pick up any canisters. At best, spray down with water.

Tear Gas and Uterine Health

- Tear gas (e.g. chlorobenzylidene malononitrile) is a known endocrine disruptor

- Many experience abnormal reproductive symptoms after tear gas exposure
 - Menstrual cycle timings changed
 - Menses lasted longer
 - Heavier bleeding than normal
 - Spontaneous bleeding/spotting
 - Increased cramping
 - Chest tenderness
- Effects on pregnant people still unknown and need to be investigated, but some countries have reported increased risk of miscarriage

Police Tactics & Weapons

Remember: the most important weapon police use is fear & intimidation

But you know how to treat the injuries caused by weapons! Nothing different than you're already taught about trauma injuries.

Kettling

Injuries: Falls, crowd crush, panic attacks, asthma attacks

Stress Positions, direct police violence (hand to hand)

Injuries: Abrasions, Musculoskeletal, Psychological, Internal bleeding & trauma

Bikes

Can be used as a physical weapon as well as in kitting

Injuries: Fractures, Bruises, Falling, Head trauma, Internal bleeding, injuries to genitals and abdomen

Defenses: Padding, Shin guards for arms

Batons

Extension of physical violence

Injuries: Fractures, Bruises, Falling, Head trauma, Internal bleeding, injuries to genitals and abdomen

Defenses: Padding, Shin guards for arms

Barricades

Causes blunt trauma

Injuries: Musculoskeletal, especially to feet, ankles, lower legs, crowd crush

Scooters & Motorcycles

Causes blunt trauma, impact

Injuries: C-Spine, MS to feet and lower legs, friction burns & cuts, road rash, psychological

Cars

Injuries: Fractures, Bruises, Falling, Head trauma, Internal bleeding, injuries to genitals and abdomen

Defenses: Bike helmet, shields, padding

Shields

Used for physical contact, pushing

Injuries: Bruises, Fall injuries, crowd crush, hand and facial soft tissue injuries, crowd crush (suffocate)

Defenses: Padding, Shin guards for arms

Police horse

Causes blunt trauma

Injuries: fall injuries, feet injuries, crowd crush, head trauma, psychological

Horses WILL charge at protestors who are sitting and standing

DO NOT STRIKE A POLICE HORSE can be charged with assault & battery

Police dogs

Causes bites, trauma, bleeding

Injuries: fractures, lacerations, psychological, punctures, fall injuries, crush injury

If bitten, the reflex should be to push IN to let the dog go

DOGS ARE ALSO TREATED AS POLICE OFFICERS; DO NOT STRIKE A POLICE DOG can be charged with assault & battery

Sounds Cannons: LRAD: Long Range Acoustic Device

Causes: crowd crush, hearing injuries

Injuries: immediate pain (may exacerbate sensitivities), crowd crush, rush injuries, psychological

To escape: walk out of the “beam of sound” in a perpendicular direction

Water canon

Injuries: Bruises, Fall injuries, crowd crush, hand and facial soft tissue injuries, hypothermia

Arwen rounds (plastic, wooden, rubber bullets)

Causes blunt trauma

Injuries: head injuries, soft tissue injuries, eye injuries, facial, airway, crowd crush, abdominal, groin, neck injuries & airway crushed, internal bleeding

Designed to hit at ground and ricochet but almost never used that way

Can be combined with chemical weapons; filled with pepper spray

If seen being shoot; turn and lower head for quick protection

Defenses: Bike helmet, padded vests, backpacks

Defense: When being aimed at, turn around, duck and cover back of head (C-Spine) with hand

Tasers (Tom A. Swift Electrical Rifles)

Causes electrocution; sounds like loud clacking

Injuries: Fall, burning, puncture wounds, electrocution, cardiac, neurological

If taser injury is found with bars instead, find alternative to hospital

Treatment usually happens in jail support

Be aware of pools of water/ puddles when someone is being tasered

Concussion round/ grenade (flashbang)

Causes blunt trauma, impact

Injuries: crowd crush, disorientation, psychological (PTSD-vulnerable)

Beanbag shotgun

Causes blunt trauma, impact

Injuries: head injuries, contusions to torso

Defense: When being aimed at, turn around, duck and cover back of head (C-Spine) with hand

Percussion grenades (sound) & flash bang grenades (sound & light)

Causes heat & noise; panic, eye injury, chemical weapons

Injuries: burn, debris, sound injuries

Stinger grenade

Designed to be used in prison; Grenades explode and pellets bounce around

Injuries: trauma, blunt force, puncture

Protest Tactics

Note: Under “tactical Neutrality” it is NOT the street medic’s place to direct the action or impact the protestor tactics used.

Their duty, however, is to be mindful of possible injuries that could result from these tactics.

Black Bloc

- Not a “raging mob”
- Organized defense against counterprotestors and fascists. Black is to protect the identity of the participants.

Leftist Armed Formations

- Not as common nowadays, but who knows?
- Gun safety is priority. A medic who does not feel safe working in an environment with guns is OK to leave the scene.

Hunger Strikes

- Usually, part of longer protests or occupations
- Medics may be asked to monitor the patients’ health during a hunger strike

Balloon Banners / Banner Drops

- Wind hazards
- Anchoring

- Quick-release
- Power lines

Costumes & Puppets

- Heat Exhaustion
- Vulnerable to Infiltration by Counterprotestors
- Limited visibility
- Wind hazards

Barricades & Lock Boxes

- Be careful of crush injuries from unstable barricades

Sleeping Dragons

- First done in Europe but popularized in Seattle.
- Lots of ways to build but they can be very different.
- In past metal pipes was used, but now this is a better technique over plastic pipe with duct tape and a heat gun.
- Power tool will get gummed up with duct tape. Razor knife doesn't work due to chicken wire. Generally there are variants of this
- How can medics help?
 - o Yoga pads to lay on, snacks, what is missing? Sunscreen? Environmental protection? Pillows for positioning. Sunglasses.
 - o May be there for a while
 - o People planning on long term or radical acts - what helps them to last longer and stronger?
 - o Radical to provide snacks, etc
 - o Adult diapers

Barrel Blockades

- Drums full of cement. Arms thru it/handcuffed/etc.
- Plan ahead. "Is there a warehouse or building that can have camera on to be legal observer?" People can be easily injured and observers can be removed easily. Street medics can ensure that there are observers.
- Future tech: drones?
- Sitting on pavement: temperature matters.
- Making sure that realities of the action are discussed - encourage practice before etc.

Tripods

- If cops trying to get them down, negotiate with them. There is no safe way to get someone off a tripod.
- Diapers. Ready for falls. C-collar if you knew ahead of time. Way to get water to them - dehydration can be a problem.

Medical Emergencies

Stroke

- Signs: **F A S T**
 - Face: drooping, unevenness, muscles are dropping on one side
 - Arms: hold out their arms with eyes closed and have them push upwards; if one side drifts it is a sign of stroke.
 - Speech: words will come out slurred
 - Time: really urgent to call 911 if any of these signs are seen

Poisoning

- Inhaled, injected, exposed, eaten
- Call 911 and Poison Control Center 1-800-222-1222
- Common case is CO (Carbon Monoxide): flu-like symptoms, lethargic, sleepy
 - Treatment: Move them away from area, hydrate, educate

Heart attack

- Signs: Chest pain, shooting pains through left arm, back pain, abdominal pain, pain from your lower lip to your belly button in front or back, “I think I’m dying”
- Note: signs of a heart attack may express themselves differently in AFAB people: pain or discomfort in one or both arms, back, neck, jaw or stomach, shortness of breath with or without chest discomfort.
- Other signs such as breaking out in a cold sweat, nausea or lightheadedness.
- If they have nitroglycerine tablet, patient can take them
 - Do NOT touch the pills—they can be absorbed through skin
- Have patient SIT DOWN while taking them
- Learn CPR; enter businesses; ask someone if they know CPR

Diabetic Emergencies

- Complications of diabetes occur in conditions of high and low blood sugar
- Signs/symptoms of diabetic emergency:
 - missed meals
 - recent high activity
 - bracelet/necklace labeled DIABETES
 - fatigue
 - hunger / severe thirst
 - pale / sweaty / clammy skin
 - may seem and even smell intoxicated

- sudden loss of consciousness
- Treatment:
 - If patient is alert, administer glucose (sugar) in the form of fruit juice, energy bar, or similar beverage/snack
 - Diet soft drinks do not count.
 - If effective, patient should know what to do next
 - If ineffective: If patient is not alert, place in recovery position and activate emergency response

Fainting

- Causes: dehydration, head injury, psychic shock
- Falls twice their height or more is dangerous
 - They should have a C-Spine check
- People with fainting disorders would know their own care
 - If this is their first faint for no reason, they should be checked out
 - Call 911 if out for longer than 2 minutes
- DO NOT give unresponsive people water

Seizures

- Causes: people march without medication;
 - they will immediately drop to the ground hard on their back and convulse rapidly
 - people with disorder have an aura and would usually lie down if they recognize they are about to have one
- Less obvious signs:
 - confusion, slurred speech
 - may have soiled themselves; can be embarrassing
 - people can be angry
 - shaking, shaking head, trembling, grinding of teeth, being spaced out
- Results: They could vomit, release bowels, swallow spit and bite tongue
- Treatment during seizure:
 - padding under their head making sure they do not hit their head
 - privacy circle
 - talk reassuringly; monitor breathing for airway and breathing
 - Do NOT put things in people's mouth
 - Do NOT restrain the person
 - If Airway is blocked, you can try to put in recovery position to protect tongue-biting
 - Also good note to time seizures for frequency
- *CALL 911: Seizing longer than 5 MINUTES is great concern; most last 30-seconds to a minute*

Preparing for an Action

A Week Before

- Health & Safety Training
- Risk Coding
- Coordination of evacuations
- Establishing a landing area, or area for clinic space (if needed)

The Day Before

- Buddy up
- Double check bags
- Logistics follow up
- Water!
- Evacuation routes
- Intel briefing

The Day After

- Jail Support
- Aftercare
- Psychological first aid
- Debrief with buddy

A Week After

- Re-pack bags & re-stock supplies
- Touch base with buddy
- Report back, after-action debriefing

Gunshot Wounds / Live Shooter Situation

When live fire is going on:

- Medics never run, *except when there is live fire*
 - get out of open area or building
 - keep hands visible and raised, drop any bags you are carrying
 - note that law enforcement may be reacting & breaking formation, which can cause further panic
- If you cannot flee: hide in room, silence devices; shelter mode
- If trapped and confronted: fight with the intent to kill or disarm shooter
- Cover (wall, brick, cement, things that can stop bullets) vs. concealment (blocking view of direct line of fire like cars, trees, bushes, houses)

Gunshot Wounds

- What have we learned about treatment of traumatic injuries?**
 - Remember assessment order: C – A – B
- Circulation. Airway. Breathing.**

- Treat “C” first if gunshot is a perceived life threat that overcomes airway / breathing.
- **BLEEDING CONTROL:** Direct pressure (heel of palm, kneel into the wound, body weight pressure, 7 – 12 mins)
 - Layer bandaging on top of the wound if it bleeds through. You can change out top layer ONLY if it bleeds through, but never the one on the wound (may rip clotting.) Material used can be assessed for seriousness (ex. Bled through ten 4x4s, two abdominal pads, etc)
- Be alert for signs of compensated & decompensated shock
 - **SHOCK TREATMENT:** Keep warm. Control bleeding. Keep still and lying down, if possible. Transport quickly to higher care. Rescue breaths if applicable. Will need oxygen, blood infusion.

Bullet Wounds

- Note: Bullet entry wound are much smaller than exit wound.
 - Skin closes around a bullet wound upon entry
 - Important to find the wound if causing major bleed
- Bullets can ricochet inside the body, injuring multiple places internally.

Tension Pneumothorax

- Holes in the chest caused by GSW can cause this – be mindful
- Not as urgent as taking care of any life-threatening bleeds
- Make occlusive bandage: clean plastic and tape three sides, leaving third side open in the direction of gravity. Gorilla tape or duct tape very effective
- Can also carry chest seals

Wound packing

- Used in addition to direct pressure to get to a bleeding vessel. Best for wounds deep but close to the surface.
- Effective for jugular bleeds, bleeds in armpit or groin.
- DO NOT use in abdomen or chest.
- Use hemostatic gauze, gauze, or clean cloth, quick cloth (bandage NOT powder)
- Take all PPE precautions.

Wound packing procedure

- Wrap finger in clean gauze and insert into the wound, find the vessel.
- Apply direct pressure.
- Place second finger on other hand, wrapped in gauze, along side the first and “switch places”
- Repeat with clean gauze, switching fingers & applying pressure.
- TIME YOURSELF 3 mins (set a watch/phone!), then check bleeding. Could be still bleeding if you missed the vein, wound is not packed tight enough.

Street Medic Collectives in the United States

Bay Area, CA

Bay Area Street Medic Collective

facebook.com/BayAreaStreetMedicCollective

streetmedicsbayarea@gmail.com

Washington, DC

DC Street Medic Collective

facebook.com/dcstreetmedics

dcstreetmedics@gmail.com

Chicago, IL

Chicago Action Medical (CAM)

facebook.com/chistreetmedics

chicagoactionmedical@riseup.net

872- 333-9226

Boston, MA

Boston Area Liberation Medic (BALM) Squad

bostonstreetmedictraining.wordpress.com

Baltimore, MD

Baltimore Street Medic Collective

facebook.com/bmorestreetmedics

baltimorestreetmedics@gmail.com

Detroit, MI

Detroit Street Medic Collective

facebook.com/DetroitStreetMedicCollective

Minneapolis/St. Paul, MN

North Star Health Collective

facebook.com/NorthStarHealthCollective

northstarhealth@gmail.com

St. Louis, MO

StL Street Medics

facebook.com/StLstreetmedics

stlstreetmedics@gmail.com

Las Vegas, NV

Las Vegas Street Medics

facebook.com/LasVegasStreetMedics

702-530-4716

New York, NY
New York City Action Medical (NYCAM) [facebook.com/NYCActionMedical](https://www.facebook.com/NYCActionMedical)
nycactionmedical@riseup.net
917-768-5115

New York, NY
NYC DSA Medics
[facebook.com/nycdsamedicscollective](https://www.facebook.com/nycdsamedicscollective)
nycdsamedics@gmail.com
908-543-4986

Rochester, NY
Rochester Street Medic Collective
[facebook.com/RocStreetMedics](https://www.facebook.com/RocStreetMedics)

Portland, OR
Rosehip Medic Collective
rosehipmedics.org
rosehipmedics@gmail.com

Pittsburgh, PA
Steel City Organizing for Radical Community Health (SCORCH)
[facebook.com/scorchpittsburgh](https://www.facebook.com/scorchpittsburgh)
steelcityscorch@gmail.com

Houston, TX
Bayou Action Street Health (BASH)
[facebook.com/BayouActionStreetHealth](https://www.facebook.com/BayouActionStreetHealth)
bayouactionstreethealth@protonmail.com
832-303-9982

Richmond, VA
River City Medic Collective
[facebook.com/rivercitymedics](https://www.facebook.com/rivercitymedics)

Michigan and Ohio
Rustbelt Medics
[facebook.com/rustbeltmedic](https://www.facebook.com/rustbeltmedic)

Southern Appalachian Region
Appalachian Medical Solidarity
[facebook.com/applemedsolid](https://www.facebook.com/applemedsolid)

Getting Connected! With NYCAM Dispatch

Not all medics are on the ground!

Dispatch is important for medics and for protestors.

- ❖ Coordinating the medics before, during, and after, while acting off-site, away from the protest
- ❖ Provide resources for protestors (number to call/text to request help)
- ❖ For medics, provide advice for higher-level care
- ❖ Works with jail support afterwards / ensures all medics are accounted for after the event

For NYC-area medics, you must be vetted to be connected to NYCAM Dispatch. Email NYCAMVetting@gmail.com to start!

Street Medic Resources

- Much of the material in this booklet is based on the first aid chapter of Hesperian Health Guides' *Where There Is No Doctor*:
http://en.hesperian.org/hhg/New_Where_There_Is_No_Doctor
- An excellent, inexpensive pocket first-aid guide is Buck Tilton's *Backcountry First Aid and Extended Care* (4th or 5th edition; used copies are about \$1.50 online)
 - Check out NYCAM's compiled pamphlets, zines, etc. at:
tinyurl.com/NYCAMresources

CONGRATS!

*You have now completed NYCAM's 20-hour
Street Medic course!*

See you out in the streets.

**NYC Action Medical 20-Hour Street Medic Training: Feedback Form
July 1, 2 & 9, 2022**

Name: (optional)

Organization: (optional)

On a scale of 1 to 5, how satisfied were you with:

1. **The amount of information given? Did you learn everything you wanted to?**

Not satisfied		Neutral		Very satisfied
1	2	3	4	5

1. **The clarity of information given? Was the teacher clear and understandable?**

Not satisfied		Neutral		Very satisfied
1	2	3	4	5

1. **The pacing of the information given? Did you feel like the teaching was too fast?**

Not satisfied		Neutral		Very satisfied
1	2	3	4	5

1. **The facilitation of conversation? Did instructors manage exchanges well?**

Not satisfied		Neutral		Very satisfied
1	2	3	4	5

1. **How confident do you feel in your knowledge of street first aid?**

Not confident		Neutral		Very confident
1	2	3	4	5

On a scale of 1 to 5, how useful were the following teaching methods used during the training:

1. **Direct instruction**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **Instruction demonstration**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **Group discussion**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **Hands-on group exercises**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **Skills practice scenarios**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **Sunday practice scenarios**

Not useful		Neutral		Very useful
1	2	3	4	5

1. **What part of the training did you enjoy the most?**

1. **What part of the training did you enjoy the least?**

1. **Do you have any recommendations for NYC Action Medical for future trainings?**

1. **After taking this training, do you intend to run as a street medic?**