

What Do You Know About First Aid? Standard First Aid and CPR

<i>Check your knowledge:</i>	True	False
1. The goal of first aid is to prevent having to see a doctor.		
2. The law requires a trained first aider to give first aid whenever someone has a need for it.		
3. Always call 9-1-1 or your local emergency number for someone you find unresponsive.		
4. To prevent the risk of getting an infection, in no circumstances should you touch a bleeding victim.		
5. CPR should be used for every victim who is not breathing.		
6. All unresponsive victims should always be positioned on their back.		
7. To give rescue breathing to an adult, give breaths at a rate of 1 breath every 5-6 seconds.		
8. The best way to stop external bleeding is to put pressure directly on the wound.		
9. Use a tourniquet whenever there is significant bleeding from the lower leg.		
10. To treat a victim in shock, give the victim water to drink and keep the victim walking around if possible.		
11. For a victim with severe burns over most of the body, do <i>not</i> use cool water to cool the burned area.		
12. If a high-power line has fallen on a person, the first thing you should do is pull the person away from the wires.		
13. Tingling in the hands or feet could be a sign of a spinal injury.		
14. The first step in immobilizing a victim with a spinal injury is to turn the head so that it faces directly forward in line with the body.		
15. If an object is impaled in an injured victim's chest, leave it there when you give first aid.		
16. Before splinting a broken arm or leg, try to put the bone ends back in their normal position.		
17. A pillow can be used to splint broken ribs or a sprained ankle.		
18. The first sign of an impending heart attack is a sudden unexplained headache.		
19. If a person is having a seizure, quickly put something like a stick between the victim's teeth to bite down on.		
20. Never try to make someone who swallowed a poison vomit—unless the poison center tells you to.		
21. With a snakebite, cut across the fang holes to let blood flush the poison out of the body.		
22. The best first aid for a hypothermia victim is a hot shower or bath.		
23. If someone suffers heatstroke playing softball at a picnic, give him or her iced tea or a cold beer to help cool off.		
24. In any car crash, the most important thing is to get the victim out of the vehicle immediately because you never know when a fire may start.		
25. When you are unsure what to do in an emergency, call 9-1-1 or your local emergency number.		

Answers to “What Do You Know About First Aid?”

1. false
2. false
3. true
4. false
5. false
6. false
7. true
8. true
9. false
10. false
11. true
12. false
13. true
14. false
15. true
16. false
17. true
18. false
19. false
20. true
21. false
22. false
23. false
24. false
25. true

AURORA MEDICAL TEAM - CLASS EVALUATION

Instructor: _____ Date: _____

Class: _____ Location: _____

Please rate the following questions using:

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

The information presented today will be useful.	1	2	3	4	5
The text was effective.	1	2	3	4	5
The skill practice sessions were effective.	1	2	3	4	5
The primary instructor was effective.	1	2	3	4	5
Assistant instructor _____ was effective.	1	2	3	4	5
The audiovisual materials were effective.	1	2	3	4	5
My questions were answered.	1	2	3	4	5
The course length was appropriate.	1	2	3	4	5
The classroom environment helped learning occur.	1	2	3	4	5
I am confident in my ability to respond to an emergency.	1	2	3	4	5
I would recommend this class to someone else.	1	2	3	4	5
My reasons for taking this class were met.	1	2	3	4	5

What did you like about the course?

What would you change for future classes? Suggestions for instructors?



2010 Changes in First Aid, CPR and AED

In October 2010, new Guidelines for CPR and Emergency Cardiovascular Care were published, detailing how lay rescuers should perform some first aid and basic life support skills, based on scientific literature. Subsequently, first aid and CPR courses have changed in certain ways. The following tables summarize key changes.

Changes in First Aid

Care Technique	Previous Recommendations	New Recommendations
Cleaning a wound	Irrigate under running water for at least 5 minutes.	Clean wounds with large amounts of warm or room temperature water with or without soap until all foreign matter is washed away.
Controlling bleeding	Use manual direct pressure and pressure bandage to control bleeding.	Maintain manual pressure for a long time. Use elastic compression bandage to maintain pressure if manual pressure cannot be maintained continuously until help arrives. Use tourniquet only if direct pressure is not effective or possible, and only with proper training.
Thermal burns	Cool the burn with cold water for at least 10 minutes or until the area is pain free even after removal from the water.	Cool burns with cold water (15 - 25° C) until the area is free of pain even after removal from the water.
Chemical burns	Flush the area with running water for at least 30 minutes and apply nonstick dressing.	Continue to flush the area with copious running water until help arrives.
Shock	If no trauma, raise legs about 8 to 12 inches.	If no trauma, raise feet about 6 to 12 inches.
Potential spinal injury	Use manual inline stabilization.	Maintain spinal motion restriction manually.
Musculoskeletal injuries	Use RICE: <ul style="list-style-type: none"> • Rest • Ice • Compression • Elevate 	Use RICE – cold is best provided with a mixture of ice and water, or other cold methods, for 20 minutes (or 10 minutes if uncomfortable) with a barrier between the cold and the skin.
Asthma attack	Assist victim with using prescribed medication (inhaler).	If the victim is unable to administer inhaler without assistance, rescuer may administer prescribed medication if victim identifies the asthma attack and has a prescribed medication.

Care Technique	Previous Recommendations	New Recommendations
Anaphylaxis	Assist victim with epinephrine auto-injector.	If victim is unable to administer auto-injector, and if the rescuer is trained in its use and state law permits, administer the auto-injector for the victim.
Suspected heart attack	Call EMS and provide heart attack care for classic signs and symptoms of heart attack.	Call EMS and provide heart attack care for any victim with chest discomfort.
Hypothermia	Warm victim with blankets and other indirect methods; do not use active rewarming.	Warm victim with blankets and other indirect methods; use active rewarming if victim is far from care, such as placing victim near a heat source.
Heatstroke	Cool victim with water sponged or sprayed on the body or ice or cold packs around the body.	Cool victim by any means available, preferably through immersion to the chin in cold water.
Jellyfish stings	No guidelines	Wash with vinegar for 30 seconds, then immerse in hot water for at least 20 minutes.
Poisoning	Call PCC for responsive victim; call EMS for unresponsive victim.	Call PCC for responsive victim; call EMS for unresponsive victim or any victim with signs of a life-threatening condition.
Poisonous snake bites	Previously only for coral snake bites, wrap entire extremity with snug elastic bandage.	For all poisonous snake bites, wrap entire extremity with snug elastic bandage.
Tooth knocked out	Place tooth in milk.	Clean wound with saline or water; place tooth in milk (or clean water if milk is unavailable).

Changes in Life Support (CPR, AED)

Care Technique	Previous Recommendations	New Recommendations
Initial assessment	Check for responsiveness, then open the airway and check for normal breathing.	Check for responsiveness and simultaneously look for normal breathing.
CPR technique	Give 2 breaths before beginning chest compressions (ABC).	Begin CPR immediately with chest compressions (CAB).
Depth of compressions	1 1/2 to 2 inches in adult; 1/3 to 1/2 the depth of the chest in an infant or child.	At least 2 inches in an adult; at least 1/3 the depth of the chest in an infant (about 1 1/2 inches) or child (about 2 inches).
Rate of compressions	100 per minute	At least 100 per minute
AED for infants and children	Use AED with pediatric pads for child ages 1 to 8 years.	Use AED with pediatric pads for both infants and children up to age 8.

New CPR Protocols Effective October 2010

Based on medical research...changes have been announced for CPR. These are national and international changes. The CPR sequence of A-B-C (Airway Breathing Circulation) has been reordered to C-A-B (Compressions Airway Breaths).

If you are a volunteer CPR provider for an unconscious victim you should:

1. Check responsiveness – Are you OK? Quickly assess breathing by looking at the victim...DO NOT open Airway yet by tilting head...DO NOT Look-Listen-Feel...DO NOT check pulse
2. Not breathing? Get 911 going and send for AED if available
3. If there was no breathing (or if they are gasping) give 30 compressions
4. Head tilt chin lift to open airway and then two breaths
5. Continue with full CPR

Statistics show that if the volunteer provider sees no breathing by observing the victim during the responsiveness check (Are you OK?) then breathing is most probably not present and CPR should be started immediately. Also, if there is gasping (reported by EMS providers as present in some heart attack victims) then CPR should be started immediately.

Taking a pulse and the look-listen-feel was deemed to be of minimal value to the volunteer responder as it did delay the start of CPR. Once the volunteer responder observed no breathing then CPR can proceed without further delay.

Untrained bystanders are encouraged to start hands only CPR as soon as a collapse is observed. In recent years studies have shown that only about 70 to 80% of heart attacks with bystanders or family present receive no CPR until EMS arrives. Precious minutes are lost when they are most important to increase the chances of survival. Panic is listed as the primary reason why heart attack victims do not receive immediate care from bystanders/family members.

The definition of the three age groups has been redefined.

Infants: up to age 1 (not newborns)

Children: age 1 to onset of puberty

Adults: adolescents and older

The compressions to breaths ratio remains 30:2 for all age groups (for layperson CPR).

AED use has been extended to infants. Use adult pads on adults. Use pediatric pads on children if available, or use adult pads. Use pediatric pads on infants putting them front and back, or, use adults pads front and back if that is all that is available.

Compressions have been redefined as being AT LEAST 100/minute, and faster compressions are still OK up to 120/minute.

Depth has been redefined as being AT LEAST 1/3 of the way to the floor, which is AT LEAST 2 inches for an average adult. Shallow compressions are ineffective. Compressions that are deeper than 1/3 are still effective.

Protocols for Healthcare Providers/Professional Rescuer CPR reflect this new emphasis on compressions and reducing delays.

Except for diving accidents there is little evidence to show that Oxygen administration during the first phase of the heart attack significantly increases survival outcomes.

Survival rates are significantly increased if the AED is deployed during the 3-5 minute period of heart fibrillation. AED rapid deployment remains the standard protocol for volunteer responders.

Need training? We always have classes! www.auroramedteam.org/firstaid



INTERESTING ARTICLE ON TOURNIQUET USE IN FIRST AID

POSTED ON THE JOURNAL OF EMERGENCY MEDICINE WEB SITE

<http://www.jems.com/article/major-incidents/tourniquet-first>

Tourniquet First!

Safe & rational protocols for prehospital tourniquet use

Few issues in the long and colorful history of medicine have generated as much controversy and confusion as the use of tourniquets to arrest severe extremity hemorrhage. As with many strongly held, traditional beliefs, the tradition is strong, but the evidence weak.

Conventional teaching has upheld the belief that a tourniquet is a tool only to be applied as a last resort.¹ However, evidence is now available, both from the recent military use of tourniquets² and their long, safe history of operative use for bloodless extremity surgery,^{3,4} which compels a reevaluation of this potentially lifesaving device in civilian prehospital care. This article presents suggested protocols for the safe and rational use of extremity tourniquets by civilian EMS.

It is our opinion that any blood loss is detrimental to the patient's wellbeing and should be avoided. Modern tourniquets have been demonstrated to rapidly and effectively stop extremity hemorrhage, thus minimizing blood loss. Pressure dressings are, of course, also effective tools to stop bleeding, and are the preferred method of hemorrhage control because they do not risk limb ischemia or other complications. However, effective pressure dressing application requires more time, hands and supplies to apply, and may require a rescuer to stay with the patient to continue to apply pressure sufficient to arrest severe hemorrhage.

A tourniquet, on the other hand, can be applied quickly, with minimal personnel and no other equipment. In fact, most modern tourniquets are designed to be self-applied, if necessary.

This immediate hemorrhage control allows the rescuer to turn their attention to the airway, breathing, and circulation and assessment of other injuries. After completing this evaluation and stabilization, and when time and resources better allow—and if the wound allows—the well-trained EMS provider can remove the tourniquet and replace it with a standard pressure dressing.

Although this protocol contradicts the traditional dogma that a tourniquet, once placed, can be removed only by a physician when the patient arrives at definitive care, it's simply common sense to train EMS personnel to reassess the wound and replace the tourniquet with a pressure dressing if the situation allows.

Considerations for Use

Ischemic complications from tourniquet use have been found to be related to the amount of time the tourniquet is left in place.^{4,5} Extensive experience with operative tourniquet use has demonstrated that the incidence of injury is very low with tourniquet times of two hours or less; military experience has confirmed the safety of this two-hour limit in the field.^{4–8}

Urban EMS agencies, with generally short transport times, would rarely be confronted with this limitation. However, rural agencies in isolated areas will frequently encounter longer transport times that may exceed this safe interval. In these cases, attempts to replace the tourniquet with a less aggressive method of hemostatic dressing must be made to avoid the possibility of limb ischemia.

In the rare event that severe hemorrhage persists beyond two hours during a long transport, the medical rule “life over limb” is invoked. In these cases, it must be kept in mind that a patient with extremity hemorrhage severe enough to require a tourniquet for more than two hours would certainly have died without it.

Another consideration for the use of tourniquets: pain. The effective application of a tourniquet above arterial pressure will cause pain to the distal extremity, sometimes severe. Patients will generally require opiate pain medication, such as morphine or fentanyl, titrated to control such pain, particularly if the tourniquet is to be left in place for more than a short period of time.

Tourniquet Protocols

The following protocols provide a safe and rational technique for civilian EMS agencies to use tourniquets to minimize blood loss and morbidity in extremity trauma while reducing the risk of ischemic complications. These protocols are based on military battlefield and civilian operative experience.

1 Design: To minimize complications, particularly those related to direct injury to skin, muscle and neurovascular structures, emergency personnel must use a commercial tourniquet specifically designed for the purpose. Such tourniquets feature wide straps without sharp edges, uniform application of pressure and ease of application and removal.

Field-expedient and hastily devised tourniquets (such as the cravat and stick, belt, cord or twine) are much less likely to be effective because it's difficult to get them tight enough. Because of narrow girth, sharp edges and difficulty in accurately controlling tightness, such makeshift tourniquets are also much more prone to compressive neuropathy and other injuries resulting from direct trauma to the underlying tissues.

2 Models: A number of commercial tourniquets are available and have proven effective in testing and combat use. It's worth mentioning that a standard BP cuff can often be utilized as a safe and effective tourniquet. However, BP cuffs are not designed to hold pressures above arterial systolic pressure for prolonged periods of time. A cuff that

gradually loses pressure could result in recurrence of hemorrhage, which initially may go unnoticed by the busy EMS provider.

In addition, the BP cuff's wide girth, while minimizing the risk of underlying neurovascular or skin compressive injuries, may be difficult to apply to the short stump of an amputated extremity. So, while a BP cuff is probably the safest and most easily accessible improvised tourniquet available to you, wide-band commercial tourniquets are more versatile and reliable for severe extremity hemorrhage.

3 Tightening the Tourniquet: How tight you make the tourniquet depends on how severe or profuse the bleeding is, and whether it's arterial or venous bleeding (or both). Simply stated: The tourniquet should be gradually tightened until all hemorrhage ceases. With arterial bleeding, this will require a tourniquet pressure above the arterial pressure. <snip> Tourniquet pressure will require frequent reassessment as the resuscitation of the patient proceeds, and further tightening may be required as perfusion improves.

4 Initial Application: Figure 1 illustrates our suggested protocol for evaluation and application of a tourniquet to a bleeding extremity. The patient is initially assessed and determined to have severe extremity bleeding controllable with the equipment or resources immediately at hand.

This may simply mean that EMS personnel must open their kit and assemble the gauze, tape or elastic bandage necessary to apply a pressure dressing, and may need to apply a tourniquet to the patient for just the one or two minutes required to complete this task. Or this may mean the patient has severe extremity bleeding with other severe injuries, such as an unstable airway or an open chest injury. In this case, the tourniquet may be applied initially to stop the extremity hemorrhage, leaving the EMS provider free to focus their attention on stabilizing these other life-threatening problems.

If a short transport time (less than 30 minutes) is anticipated, then the tourniquet may be safely left in place, or replaced with a pressure dressing whenever the provider feels they have the time and resources to devote to this task. If transport is anticipated to be longer than 30 minutes, an effort to replace the tourniquet should be undertaken to minimize any possibility of limb ischemia and decrease the pain the patient may experience from prolonged effective tourniquet application.

Note: We strongly suggest 30 minutes as the time limit for replacing a tourniquet with a pressure dressing. Although the studies cited in the discussion above indicate two hours to be a safe limit, we use 30 minutes as a protocol guideline to ensure a wide margin of safety.

5 Reassessment: When the EMS provider has sufficient time, equipment and resources, they may decide to attempt to replace the tourniquet with a pressure dressing. Figure 2 outlines the Tourniquet Reassessment Algorithm to assist the medic

in determining if tourniquet replacement is advisable and safe and to suggest that the tourniquet be left in place if the patient or the overall situation is unstable.

6 Removal: If the EMS provider determines that the patient and clinical situation are stable, they should proceed to the Tourniquet Removal Algorithm, as shown in Figure 3. Note: In cases of amputation or near-amputation, the tourniquet should be left in place because of the difficulty of applying a pressure dressing to such wounds.

A pressure dressing is applied to the wound site and the tourniquet is then carefully loosened. If there's no further bleeding, the tourniquet should be left loosely in place in case it's needed again. For example, bleeding could resume as the patient is resuscitated and perfusion and flow to the injury are improved. If further bleeding isn't controllable with the pressure dressing, the tourniquet can be easily retightened until the bleeding is once again controlled.

7 Mass-Casualty Use: The Mass Casualty Algorithm (Figure 4) is designed to incorporate the tourniquet into the initial triage of patients at the scene of a large, resource-taxing MCI. As triage is performed, EMS providers can use tourniquets to control any visible extremity hemorrhage. They then assign a triage label to the patient and move to triage the next victim. Note: We recommend that any patient who receives a tourniquet be initially triaged at least "yellow-urgent" to ensure the victim is attended to (and the tourniquet reassessed) in a timely fashion.

It's possible that subsequent providers could overlook a tourniquet on a severely injured patient, as they attend to more obvious or urgent injuries. To minimize this risk, we recommend that any patient treated with a tourniquet should be clearly marked with the letters "TK" on their forehead and on the triage tag; the time the tourniquet was applied should also be noted prominently.

If possible, the tourniquet itself should be marked with brightly colored tape to make it stand out to all subsequent caregivers. If the patient is conscious, they should be instructed to tell every subsequent provider that a tourniquet is in place.

Conclusion

The tourniquet has traditionally been thought to be a dangerous tool of last resort. However, it is clear from recent experience with tourniquets on the battlefield and in the operating room that modern tourniquets are not only safe and useful, but lifesaving. It is our intent to encourage the safe and rational use of tourniquets in civilian EMS, using simple protocols and training to ensure they're used properly and safely.

In the past, the rule was "tourniquet last"; however, it's time we begin teaching the principle of "Tourniquet First!" in severe extremity hemorrhage.

Editor's Note: These protocols were originally published by the authors in "Tourniquets: A review of current use with proposals for expanded prehospital use," April–June 2008, Prehospital Emergency Care.

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Suggested Group First Aid Kit

Treatment Items

- Band Aids
- Antibiotic Ointment (Neosporin)
- Gauze Pads
- Gloves
- Self-Adhering Bandage (Coban)
- Elastic Bandage (Ace)
- Triangular Bandages
- Roller Gauze
- Saline or Wound Wash
- Soap + J&J Shampoo
- Small Splints (Finger Splints / Tongue Depressors)
- SAM Splints
- Mouth Barrier Device
- Tweezers
- Scissors
- Liquid Bandage (New Skin)
- Moleskin
- Glucose Tablets

- Cold Pack and/or Plastic Bags
- Small side cutters
- Diphenhydramine (Benadryl)
- Aspirin (for cardiac)
- Non-Adherent Bandage

Comfort Items

- Lip Balm
- Pepto Bismol / Antacid
- Tylenol
- Ibuprofen
- Pseudoephedrine (Sudafed)
- Loratadine (Claritin)
- Sun Screen / Moisturizer
- Throat Lozenges
- Guaifenesin cough medicine
- Thermometer
- Hand Sanitizer

Note: Many of the products listed here have generic alternatives.

Is Hydrogen Peroxide a Good Treatment for Small Wounds?

By ANAHAD O'CONNOR Published: June 19, 2007

THE FACTS

It is a staple in medicine cabinets everywhere, a first-line treatment for the small cuts and scrapes that a hazardous world can inflict upon our skin. But does hydrogen peroxide really make a difference?

According to most studies of its effectiveness, not really. Parents and school nurses might insist otherwise, but researchers have found that hydrogen peroxide has little ability to reduce bacteria in wounds and can actually inflame healthy skin cells that surround a cut or a scrape, increasing the amount of time wounds take to heal.

In a study published in *The Journal of Family Practice* in 1987, scientists compared the effects of various topical treatments by taking a group of volunteers, administering several small blister wounds on each of their forearms, and then infecting their wounds with bacteria. After applying a different treatment to each wound, they measured bacterial amounts and rates of healing. They found that hydrogen peroxide did not inhibit bacterial growth and that wounds treated with the antibiotic bacitracin healed far more quickly.

Another study, in *The American Journal of Surgery*, looked at more than 200 people who had appendectomies and found that hydrogen peroxide did not reduce the risk of infection at the site of their incisions. But according to the American Medical Association, hydrogen peroxide does have at least one benefit: it can help dislodge dirt, debris and dead tissue in some wounds.

THE BOTTOM LINE

Studies show hydrogen peroxide is not a very effective treatment for small wounds.

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FDA Guidance for Disposal of Medicine

DO NOT FLUSH unused medications and DO NOT POUR them down a sink or drain.

It is important to note that disposal by flushing is not recommended for the vast majority of medicines. Unused or expired medicines that do not have flushing directions in the label can be disposed of safely in the household trash by:

1. Mixing them with something that will hide the medicine or make it unappealing, such as kitty litter or used coffee grounds.
2. Placing the mixture in a container such as a sealed plastic bag.
3. Throwing the container in your household trash.

Below is some additional information about the disposal of medicine that is no longer needed.

4. Destroy or remove information and labels.

If you have additional questions about disposing of your medicine, please contact us at 1-888-INFO-FDA.

Another option is to check for approved state and local collection alternatives such as community based household hazardous waste collection programs. In certain states, you may be able to take your unused medications to your community pharmacy or other location for disposal.

Medicines play an important role in treating certain conditions and diseases, but they must be taken with care. Unused portions of medicines must be disposed of properly to avoid harm to others. Almost all medicines can be thrown away in the household trash after mixing them with some unpalatable substance (e.g., coffee grounds) and sealing them in a container.

However, certain medicines may be especially harmful and, in some cases, fatal in a single dose if they are used by someone other than the person the medicine was prescribed for. For this reason, a few medicines have special disposal directions that indicate they should be flushed down the sink or toilet after the medicine is no longer needed. If you dispose of these medicines down the sink or toilet, they cannot be accidentally used by children, pets, or anybody else.

We are aware of recent reports that have noted trace amounts of medicines in the water system. The majority of medicines found in the water system are a result of the body's natural routes of drug elimination (in urine or feces). Scientists, to date, have found no evidence of harmful effects to human health from medicines in the environment.

Disposal of a select few medicines by flushing contributes only a small fraction of the total amount medicine found in the water. FDA believes that any potential risk to people and the environment from flushing this small, select list of medicines is outweighed by the real possibility of life-threatening risks from accidental ingestion of these medicines.

This list from FDA tells you what unused or expired medicines you should flush down the sink or toilet to help prevent danger to people and pets in the home. Flushing these medicines will get rid of them right away and help keep your family and pets safe.

FDA continually evaluates medicines for safety risks and will update the list as needed.

Actiq, oral transmucosal lozenge * Fentanyl Citrate
Avinza, capsules (extended release) Morphine Sulfate
Daytrana, transdermal patch system Methylphenidate
Demerol, tablets * Meperidine Hydrochloride
Demerol, oral solution * Meperidine Hydrochloride
Diastat/Diastat AcuDial, rectal gel Diazepam
Dilaudid, tablets * Hydromorphone Hydrochloride
Dilaudid, oral liquid * Hydromorphone Hydrochloride
Dolophine Hydrochloride, tablets * Methadone Hydrochloride
Duragesic, patch (extended release) * Fentanyl
Embeda, capsules (extended release) Morphine Sulfate; Naltrexone Hydrochloride
Exalgo, tablets (extended release) Hydromorphone Hydrochloride
Fentora, tablets (buccal) Fentanyl Citrate
Kadian, capsules (extended release) Morphine Sulfate
Methadone Hydrochloride, oral solution * Methadone Hydrochloride
Methadose, tablets * Methadone Hydrochloride
Morphine Sulfate, tablets (immediate release) * Morphine Sulfate
Morphine Sulfate, oral solution * Morphine Sulfate
MS Contin, tablets (extended release) * Morphine Sulfate
Onsolis, soluble film (buccal) Fentanyl Citrate
Opana, tablets (immediate release) Oxymorphone Hydrochloride
Opana ER, tablets (extended release) Oxymorphone Hydrochloride
Oramorph SR, tablets (sustained release) Morphine Sulfate
Oxycontin, tablets (extended release) * Oxycodone Hydrochloride
Percocet, tablets * Acetaminophen; Oxycodone Hydrochloride
Percodan, tablets * Aspirin; Oxycodone Hydrochloride
Xyrem, oral solution Sodium Oxybate

*These medicines have generic versions available or are only available in generic formulations.

List revised: March 2010

**First Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO**

INTRODUCED

LLS NO. 09-0178.01 Richard Sweetman

SENATE BILL 09-010

SENATE SPONSORSHIP

Spence,

HOUSE SPONSORSHIP

(None),

Senate Committees
Health and Human Services

House Committees

A BILL FOR AN ACT

101 **CONCERNING ENCOURAGING THE USE OF AUTOMATED EXTERNAL**
102 **DEFIBRILLATORS.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Eliminates certain staffing and reporting requirements of a person or entity that acquires an automated external defibrillator (AED). Provides to a person or entity who, in good faith and without compensation, renders emergency care or treatment by the use of an AED immunity from liability for any civil damages for acts or omissions made in good faith as a result of such care or treatment, regardless of whether the person or entity that acquired the AED has satisfied statutory

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

requirements and other provisions of law.

1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** The introductory portion to 13-21-108.1 (3) (a) and
3 13-21-108.1 (3) (a) (III), (3) (a) (IV), (3) (a) (V), (4) (b), and (4) (c),
4 Colorado Revised Statutes, are amended to read:

5 **13-21-108.1. Persons rendering emergency assistance through**
6 **the use of automated external defibrillators - limited immunity.**

7 (3) (a) In order to ensure public health and safety, a person or entity who
8 acquires an AED shall IS ENCOURAGED TO ensure that:

9 (III) ~~There is involvement of a licensed physician in the program~~
10 ~~at the site of the AED to ensure compliance with requirements for~~
11 ~~training, notification, and maintenance;~~

12 (IV) ~~There are~~ Written plans ARE in place concerning the
13 placement of AEDs, training of personnel, pre-planned coordination with
14 the emergency medical services system, medical oversight, AED
15 maintenance, identification of personnel authorized to use AEDs, and
16 reporting of AED utilization, which written plans have been reviewed and
17 approved by a licensed physician; AND

18 (V) Any person who renders emergency care or treatment to a
19 person in cardiac arrest by using an AED activates the emergency medical
20 services system as soon as possible. ~~and reports any clinical use of the~~
21 ~~AED to the licensed physician affiliated with the program.~~

22 (4) (b) The immunity provided in paragraph (a) of this subsection
23 (4) extends to the licensed physician who is ~~involved with AED site~~
24 ~~placement~~ REVIEWED AND APPROVED THE WRITTEN PLANS DESCRIBED IN
25 SUBPARAGRAPH (IV) OF PARAGRAPH (a) OF SUBSECTION (3) OF THIS

1 SECTION, the person or entity who provides the CPR and AED site
2 placement, and the person or entity responsible for the site where the
3 AED is located.

4 (c) The immunity provided in this subsection (4) applies ~~only if~~
5 REGARDLESS OF WHETHER the requirements of subsection (3) of this
6 section are met.

7 **SECTION 2.** 22-1-125 (5), Colorado Revised Statutes, is
8 amended to read:

9 **22-1-125. Automated external defibrillators in public schools.**

10 (5) To ensure public health and safety, a school district that acquires an
11 automated external defibrillator shall meet the ~~training, maintenance,~~
12 ~~inspection, and physician involvement~~ requirements set forth in section
13 13-21-108.1 (3), C.R.S., and shall reference the requirements of that
14 section in the school district's safety, readiness, and incident management
15 plan pursuant to section 22-32-109.1 (4) (d).

16 **SECTION 3. Safety clause.** The general assembly hereby finds,
17 determines, and declares that this act is necessary for the immediate
18 preservation of the public peace, health, and safety.

Colorado Good Samaritan Law

13-21-108. Persons rendering emergency assistance exempt from liability.

(1) Any person licensed as a physician and surgeon under the laws of the state of Colorado, or any other person, who in good faith renders emergency care or emergency assistance to a person not presently his patient without compensation at the place of an emergency or accident, including a health care institution as defined in section 13-64-202 (3), shall not be liable for any civil damages for acts or omissions made in good faith as a result of the rendering of such emergency care or emergency assistance during the emergency, unless the acts or omissions were grossly negligent or willful and wanton. This section shall not apply to any person who renders such emergency care or emergency assistance to a patient he is otherwise obligated to cover.

(2) Any person while acting as a volunteer member of a rescue unit, as defined in section 25-3.5-103 (11), C.R.S., notwithstanding the fact that such organization may recover actual costs incurred in the rendering of emergency care or assistance without compensation at the place of an emergency or accident shall not be liable for any civil damages for acts or omissions in good faith.

(3) Any person, including a licensed physician, surgeon, or other medical personnel while acting as a volunteer member of a ski patrol or ski area rescue unit, notwithstanding the fact that such person may receive free skiing privileges or other benefits as the result of his volunteer status, who in good faith renders emergency care or assistance without other compensation at the place of an emergency or accident shall not be liable for any civil damages for acts or omissions in good faith.



