

Occupational First Aid

2017 training program revisions

Background

Periodically first aid training programs must be revised to reflect new scientific research, evolving best practices in education & training, and legislative changes. In 2017 WorkSafeBC will implement comprehensive changes to the Occupational First Aid (OFA) training and certification programs. These changes will further align WorkSafeBC's OFA program(s) with other nationally recognized first aid training programs, while maintaining our commitment to quality program delivery.

Many of the 2017 changes are driven by external factors, and we recognize that they will impact your business processes. We value your perspective and input as we implement the revised program(s). We are soliciting your feedback and consultation will be open from October 11th, 2016 until January 31st, 2017. Through consultation we hope to ensure minimal disruption to training providers, workers, and employers as we transition to the new program(s). Click [here](#) to provide feedback or visit www.surveymonkey.com/r/2017WorkSafeBCOFA .

What do I need to do?

As soon as possible:

- Review the 2017 training program revisions document (starting on page 3 below)
- Provide [feedback](#) to WorkSafeBC
- Adjust 2017 instructor scheduling as required

Early 2017:

- Purchase new equipment as required
- Plan to discontinue use of existing OFA materials on June 30, 2017
- Plan and implement instructor development and in-service sessions

Click [here](#) to provide feedback

Implementation timeline

Milestones	Start date	End date
Consultation with OFA training providers	Oct. 14, 2016	Jan. 31, 2017
Release of OFA 1 materials and training program	Mar. 3, 2017	
Updates and workshops for OFA 1 instructors conducted by OFA training agencies	Mar. 4, 2017	June 30, 2017
Release of OFA 2, 3, TE and PII materials and training program(s)	Mar. 17, 2017	
Training and workshops for OFA 2, 3, TE and PII instructors conducted by OFA training agencies <i>Note: Although new First Aid training materials will not be released until March 2017, training providers are strongly encouraged to provide professional development to OFA instructors focused on adult education; including formative & summative assessment (evaluation of learning), lesson planning, delivery methods and conflict resolution, <u>as soon as possible</u>. Although not mandatory, current OFA instructors who have not previously participated in train-the trainer programs are strongly encouraged to participate in formal train-the-trainer programs.</i>	Mar.18, 2017	Ongoing
Release of new (2017) WorkSafeBC OFA certificate templates	Feb. 27, 2017	
Release of 2017 edition of the Training and Certification Standard	Feb. 27, 2017	
Release of 2017 Agency Agreement Signed copies of the Agency Agreement must be submitted to WorkSafeBC by March 31, 2017.	Feb. 27, 2017	March 31, 2017
Withdrawal of all pre-2017 WorkSafeBC OFA certificates <i>Note: Training providers will no longer be authorized to issue the current version of WorkSafeBC OFA certificates after June 30, 2017.</i>	June 30, 2017	
Adoption and commencement of 2017 OFA program(s) <i>Note: To mitigate the impact to workers and employers, all training agencies will be required to commence delivery of the revised OFA program(s) on the same date – July 1st, 2017.</i>	July 1, 2017	
Change in certificate duration <i>Note: All WorkSafeBC OFA <u>and</u> equivalent certificates issued after June 30, 2017 will be valid for 2 years from the date of issue.</i>	July 1, 2017	

Critical program changes effective July 1, 2017

- Certificate duration will be two years from the date of issue.

Rationale: Evidence-based research shows that skill retention rapidly declines within 6 months of receiving training if the new skill is not applied. In addition, students frequently report via post course feedback surveys that three years between recertification is too long.

While it is not practicable to have OFA attendants retrained at six month intervals; historically employers and workers within BC have participated in first aid training in two year cycles.
- OFA 1 will include a new video component for medical conditions, MSIs, first aid records and the Priority Action Approach demonstration.
 - Rationale: The program revisions aim to be inclusive of all learner styles. As a result, dynamic media resources will be added to the program to support learning and skill acquisition.
- OFA 2, OFA 3, Transportation Endorsement and Paramedic-In-Industry programs will have a maximum class size of 12. OFA 1 maximum class size will remain at 18.
 - Rationale: Smaller class sizes are required as the new program(s) will have an increased emphasis on formative assessment. In addition, reducing the class size for our advanced-level first aid programs aligns with other nationally recognized advanced-level first aid programs.
- OFA 2 examinations will be conducted within the 5 days or 35 hours of allotted class time.
- OFA 2 examinations can be conducted by the instructor of record.
 - Rationale: Based on stakeholder feedback and changes to the OFA 2 program, a simplified assessment process will be used to determine competency of OFA candidates.
- OFA 3 examinations can be conducted by the instructor of record; although the examination will still occur after the 10 days or 70 hours of allotted class time.
- Within the OFA 3 program CPR and minor wounds skills will be assessed during the allotted class time by the instructor of record; reducing the overall length of the final (summative) practical exam.
 - Rationale: Based on stakeholder feedback, a simplified assessment process will be used to determine competency of OFA candidates. Due to the volume of material that must be covered within the OFA 3 program, the practical examination will occur after the allotted class time.
- New instructors must participate in a formal instructor training program. The mentoring process currently outlined in the Training and Certification Standard will be discontinued.

- Options for formal training programs will include: OFA instructor schools, nationally recognized first aid instructor training programs, train-the-trainer programs from accredited organizations, adult education diploma and certificate programs, and the Provincial Instructor Diploma Program. Upon completion of a formal instructor training program, instructor candidates will be required to co-teach until instructional competence is demonstrated.
- OFA instructors will be required to participate in ongoing professional development. Professional development should include formal instructor training. The process and specific requirements for ongoing professional development for OFA instructors has not been determined at this time. When the CSA standard on workplace first aid training [CSA Z1210 – *Workplace First Aid*] is finalized, WorkSafeBC will use this standard to guide our policies regarding ongoing professional development.
 - Rationale:
 - Instructors surveyed in 2014 & 2015 clearly expressed a need for additional training focused on instructional skills and methods.
 - Formalized training is an important part of quality control and standardization.
 - Nationally recognized first aid training providers use formal instructor training programs.
 - The revised OFA program requires all instructors to be competent adult educators.

Critical program changes are due to the following factors:

- *2015 ILCOR (International Liaison Committee on Resuscitation) recommendations*
- *2015 Canadian Resuscitation and First Aid Guidelines*
- *2015 Canadian Guidelines Consensus Task Force Guidelines*
- Current WorkSafeBC medical direction
- Alignment with national advanced-level first aid programs
- Alignment with *CSA Z1210 – Workplace First Aid*
- Stakeholder (agency and instructor) feedback

Click [here](#) to provide feedback

Additional equipment requirements – Effective July 1, 2017

Program	Equipment	Ratio
OFA 1		
OFA 1	Quick straps. AKA fracture straps or Zap straps	2 per candidate
OFA 1	Windlass Style Tourniquet, (e.g., CAT)	1 per 2 candidates

OFA 2		
OFA 2	Commercially available foam padded splint. AKA SAM Splint	1 per candidate
OFA 2	Quick straps. AKA fracture straps or Zap straps	2 per candidate
OFA 2	Windlass Style Tourniquet, (e.g., CAT)	1 per 2 candidates
OFA 2	Commercially available wrist splint (S,M,L)	1 of ea. size per class

OFA 3 and TE		
OFA 3 only	Quick straps. AKA fracture straps or Zap straps	2 per candidate
OFA 3 only	Windlass Style Tourniquet, (e.g., CAT)	1 per 2 candidates
OFA 3 only	Commercially available foam padded splint. AKA SAM Splint	1 per candidate
OFA 3 only	Commercially available wrist brace/support (S,M,L)	1 of ea. size per class
OFA 3/TE	Scoop style stretcher. AKA Clamshell or Robertson	1 per 3 candidates
OFA 3/TE	Sufficiently padded basket stretcher with solid bottom Example: Ferno Model 71 Basket	1 per 3 candidates
OFA 3/TE	Commercially available head immobilizer. Example: Ferno universal & HeadHugger disposable immobilizers	1 per 3 candidates
OFA 3/TE	Digital pulse oximeter	1 per 3 candidates
OFA 3 only	* Optional * commercially available leg splints, excluding traction splints	1 per 2 candidates

Protocol Comparison Chart

Your agency should continue to deliver the current curriculum as designed. Instructors should not attempt to adjust existing materials prior to July 1, 2017.

Topic	Current protocol	Effective July 1, 2017	Rationale
Use of oral airways	OPA attempted for unresponsive airway obstructions.	For unconscious airway obstructions (witnessed and unwitnessed) proceed directly to CPR.	The use of the OPA is unlikely to correct airway obstructions.
Use of oral airways	Use an OPA for unresponsive patients placed in the lateral/ $\frac{3}{4}$ prone position with an ongoing fluid airway.	If the patient is maintained in the lateral or $\frac{3}{4}$ prone position, the OPA is not required (Fluid airway only).	If the airway is patent while the patient is $\frac{3}{4}$ prone, there is little benefit to rolling the patient supine to insert the OPA.
Chest compressions vs. CPR	The OFA curriculum distinguishes between chest compressions for the purposes of clearing an airway and CPR.	All patients who are unresponsive and not breathing normally receive CPR.	Simplified to increase skill retention.
C-Spine and Spinal Motion Restriction	Based on the mechanism of injury, RTC trauma patients are fully immobilized until they arrive at medical aid (OFA TE/OFA 3).	Rule out the need for C-Spine control in accordance with the Canadian Spine Rule. Conscious RTC trauma patients who meet the criteria laid out by the Canadian C-Spine rule will have C-spine control ruled out after the primary survey whenever possible.	Evidence based research shows the use of full spinal immobilization can cause harm to the patient. Spinal motion restriction, where appropriate, can be achieved without fully immobilizing a trauma patient.

Topic	Current protocol	Effective July 1, 2017	Rationale
C-Spine and Spinal Motion Restriction - <i>Continued</i>		Increased emphasis on the use of Robertson & Clamshell type devices to transport patients. Hard wooden/plastic spine boards are only to be used for extrication from difficult environments/situations.	
Criteria for assisted ventilation	Rate less than 10 OR dyspnea OR cyanosis	Inadequate breathing as demonstrated by a combination of distressed breathing and/or signs of hypoxia (cyanosis).	More emphasis should be placed on the adequacy of breathing vs. the rate of breathing.
Assessing breathing rate	Breathing rate assessed during the primary survey, ABC reassessments, assisting ventilations and vitals.	Breathing rate assessed when vitals are taken.	Emphasis should be placed on assessing the adequacy of respirations. Unresponsive patients not breathing normally receive CPR.
Bag Valve Mask	Utilized by a trained rescuer assisting ventilations at the completion of the Secondary Survey	Requires 2 trained rescuers to use. Only OFA 3 and TE attendants who transport will be trained to use a BVM.	2015 Guideline recommendation
Hemorrhage Control	If direct pressure does not control bleeding, use a pressure point.	Increased emphasis on direct pressure. If direct pressure does not control the bleed, use a tourniquet.	2015 Guideline recommendation

Topic	Current protocol	Effective July 1, 2017	Rationale
Stroke recognition	Current protocol does not include a rapid assessment method for identifying stroke.	All candidates will utilize FAST to recognize stroke patients.	2015 Guideline recommendation
Concussion	Current information is limited and does not include a decision matrix for suspected concussion.	Additional concussion information and decision matrix is included.	2015 Guideline recommendation and medical advice recommendation more emphasis on recognition.
Pelvic fractures	Non-RTC pelvic fractures stabilized prior to packaging.	A suspected pelvic fracture places the patient in the RTC. The pelvis must be supported prior to patient packaging. The preferred method(s) for supporting the pelvis are: 1. Commercially available pelvic binder 2. Quick Straps	Medical Director recommendation
Upper limb fracture	Use either expanded metallic splints or pre-padded foam splints, to immobilize the arm. If the injury site is on the elbow or higher, the splint must extend from the patient's armpit to the fingertips.	Metallic mesh splints are not recommended. Long arm splint unnecessary to meet immobilization objective. Emphasis placed on the objective (immobilization) while ensuring patient comfort. The following can be used to immobilize the upper limb: SAM other pre-padded splints Combination of blankets/pillows and triangular	Commercially available products can be used to secure the arm. Medical Director recommendation; more emphasis on objectives of immobilization. The immobilization provided by a long arm splint can be accomplished with a transverse bandage

Topic	Current protocol	Effective July 1, 2017	Rationale
Lower limb fracture	Using a combination of short and long wooden splints and multiple triangular bandages, the leg is immobilized.	Only short leg splints are required. Increased emphasis on the use of commercially available splinting devices.	Medical advice recommendation more emphasis on objectives of immobilization. Reduced time on scene and potential for injury aggravation.
Use of epinephrine	One dose of patients own epinephrine.	If available, a second dose of epinephrine can be administered, if there is no improvement in the patient's condition after 5 minutes.	2015 Guideline recommendation
Use of oxygen	In addition to critical interventions which require oxygen; oxygen is routinely applied to patients who do not have signs of oxygen deficiency.	OFA 2 – Oxygen is only applied under specific criteria, and an ambulance must be en route OFA 3/TE – If transporting patients who have oxygen applied, or it is anticipated that oxygen will be applied for >20 minutes, oxygen saturation must be measured using a pulse oximeter. The oxygen should be titrated according to the patient's saturation levels.	2015 Guideline recommendation Medical Director recommendation
Minor wound cleansing	Minor cuts and scrapes are cleansed around the wound site using an antiseptic solution and/or soap, and then flushed with sterile saline.	Minor cuts and scrapes should be rinsed continuously with potable water (tap water). If the wound is visibly dirty soap should be used to remove dirt and other contaminants.	Current research suggests minimal benefit, if any, when using antiseptic and antibacterial products for the purposes of cleaning and preventing infections in minor wounds.