# Florida Regional Common

# EMS Protocols

# Section 1

# General Protocols

5th Edition, Version 1 September, 2016

# General Section Table of Contents

## 1.1    Intent and Use of Protocols

These medical treatment protocols have been developed as a part of the medical direction program for participating Emergency Medical Services (EMS) agencies. The medical director of an individual EMS provider may choose to modify certain treatment recommendations. In addition, some patients may require therapy not specified in these protocols. The treatment protocols should not be construed as prohibiting such flexibility. The paramedic/EMT must use his/her judgment in administering treatment in the following manner:

● The paramedic may determine that no specific treatment is needed; or
● The paramedic may consult medical direction before initiating any specific treatment; or
● The paramedic may follow the appropriate treatment protocol and then consult medical direction.
● The paramedic/EMT may contact medical direction at any time he/ she deems necessary.

When the paramedic/EMT is unable to make contact with other forms of medical direction, he/she may contact the receiving hospital for consultation with the emergency department physician. It is recommended that the paramedic/EMT make contact with the physician for consultation on complicated patients whenever possible. When the paramedic is unable to make contact with a physician for medical direction, the paramedic may administer BLS treatment according to his/her judgment. In this instance, the paramedic may administer ALS treatment only as authorized in the treatment protocols.

**Transport destination determination may include hospital and Free Standing Emergency Department (FSED), refer to the Hospital Capability Form in Section 6 and on-line forms.**

The definition of pediatric patients will be described below.  It is imperative to understand that the medical decision making for a pediatric patient should be based on the definitions provided below.  Transport (destination) decisions should be made using the Hospital Capability Form in Section 6.

**Pediatric Medical Decision Definitions:**
Newborn: A patient who has just been delivered.
Neonate: A patient who is younger than 6 weeks of age.
Infant:  A patient who is under 1 year of age.
Child: A patient ranging from 1 year of age to puberty (pubic hair, facial hair, breast development)
Adolescent:  A patient who has reached puberty.  Treat these patients using adult protocols.
**Transport Decision Definitions**:
Pediatric:   Trauma patient -15 years of age or younger
                    Medical patients - 17 years of age or younger.
The treatment protocols are divided into adult and pediatric sections, each with three parts:
**Supportive Care:** Actions authorized for the EMT or paramedic that are supportive in nature. EMT (BLS) and paramedic (BLS and ALS) actions are specified within each of these protocols.
**ALS Level 1:** Actions authorized for the paramedic or the EMT (only with specific Medical Director approval, i.e. establishing an IV), prior to physician contact.
**ALS Level 2:** Actions authorized only for the paramedic that require a physician consult. Authorization of procedures prior to physician contact in Level 1 allows the paramedic to initiate care promptly while getting a better idea of the patient's condition and evaluating his/her response to initial treatment.

The general protocols outline care for a typical case. As the protocol continues, the assumption is usually made that previous steps were ineffective. For example, the protocol for ventricular fibrillation authorizes three unstacked countershocks; however, the second countershock and third countershock are given only if the previous countershock was unsuccessful and the patient remains in ventricular fibrillation. If the patient went into asystole/PEA following the first countershock, the second countershock would not be given. The paramedic would then use the asystole/PEA protocol to guide further treatment. In this or other situations where a switch is made to a different protocol during the course of care, the paramedic's judgment must determine where entry into the new protocol sequence is appropriate.

It would be impractical to write protocols that specify every possible sequence of events. The order of treatment listed here may not be appropriate for all situations. In fact, not all treatment options may be indicated in every situation. The paramedic's judgment must be relied upon to determine which of the authorized treatment procedures are appropriate for a given situation. The treatment guidelines are given in bulleted list form as a general order of the steps necessary to treat the patient; however, it is assumed that interventions such as patient assessment, airway management, establishing medication access, applying AED/heart monitor, and so forth can be performed simultaneously.

Orders listed in ALS Level 2 may be expected from the physician. They may or may not be the orders that are actually given, however. The intention in listing ALS Level 2 orders is to allow for appropriate preparation and to guide the paramedic who wishes to request specific orders. The physician directing care in the field retains discretion in ordering specific treatment, even if that treatment conflicts with these protocols. ALS Level 2 orders require consultation with a physician.

The name of the physician authorizing ALS Level 2 orders must be documented in the patient care report (PCR). Physicians authorized to approve ALS Level 2 orders include the following individuals:

1. EMS provider's medical director (a).
2. Receiving hospital emergency department physician (a).
3. Physician present in his/her own office (b).
4. Online medical control physician (a).
5. Bystander physician personally known to the paramedic (c).
6. Bystander physician who presents a valid M.D. or D.O. (c).
7. Poison information center (d).

Note:
(a) Contact for ALS Level 2 orders by the EMS provider's medical director, online medical control physician, or emergency department physician should be initiated in the following order:
   1. Medcom.
   2. Telephone.
   3. Relay of information via dispatch.
(b) Only verbal or written orders that are signed by the physician that are given directly to the paramedic by a physician in his/her office are acceptable.

(c) A bystander physician, as described above, must accept full responsibility for patient care and accompany the patient in the ambulance to the hospital to give Level 2 orders.

(d) The Poison Information Center is authorized to direct all medical care (Supportive Care, ALS Level 1, and ALS Level 2) for the toxicology and hazardous material exposure patient. The Poison Information Center must be contacted via telephone at 800-222-1222

This policy is intended to provide emergency departments with sufficient notification of incoming patients to allow appropriate preparations to be made. Direct contact with the physician in the emergency department needs be made only when seeking consultation or authorization for ALS Level 2 orders.

An EMT or paramedic should evaluate all patients on responses to 911 emergencies, as deemed appropriate by the individual EMS provider's medical director.
The treatment protocols have been designed as clinical guides, not as educational documents.
The therapeutic rationale behind the treatment protocols reflects the general principles of field care outlined in the following standard EMS references.

**Standard List of EMS Resources**
Porter R, et al.: Essentials of Paramedic Emergency Care, Brady, Englewood Cliffs, NJ, current edition
Nancy Caroline's Emergency Care in the Streets current edition
American Academy of Pediatrics, Pediatric Education for Prehospital Professionals, Boston, 2014.
American Heart Association/American Academy of Pediatrics, Textbook of Pediatric Advanced Life Support, Dallas, 2015.
American Heart Association, "2015 Guidelines for CPR and ECC," Supplement to Circulation
American Heart Association: ACLS Provider Manual, Dallas, TX, 2010.
American Heart Association/American Academy of Pediatrics: Textbook of Pediatric Advanced Life Support, Dallas, TX, current edition 2015.
Walraven, G: Basic Arrhythmias, 7th edition, Brady, Englewood Cliffs, NJ, 2005.
Garcia, T. Miller, G; Arrhythmia Recognition, Jones and Bartlett, Sudbury Massachusetts.
Trauma NAEMT, Frame, Salomone: Pre-hospital Trauma Life Support, 7th edition, Mosby, St. Louis, MO, current edition.
Campbell JE: Basic Trauma Life Support, Advanced Pre-hospital Care, 5th edition, Brady, Englewood Cliffs, NJ.
Pain Control Paris P, Stewart R: Pain Management in Emergency Medicine, Appleton & Lange, Norwalk, CN, 1988.
McCaffrey M, Pasero C: Pain Clinical Manual, 2nd edition, Mosby, St. Louis, MO, 1999.
Toxicology and Hazardous Materials Exposure, State of Florida Hazardous Material Protocols
Additional educational materials, supplementary to these references, are included in this manual as Chapter 4 Medical Procedures.
Chapter 5 contains Drug Summaries for each of the drugs authorized in the treatment protocols.
These documents are provided to clarify protocol items and issues that might differ from the preceding references, or in which conflicts between references may occur.

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# 1.2    Behavioral Emergencies

**GUIDING PRINCIPLES**
1.  Respect the dignity of the patient.
2.  Assure physical safety of the patient and EMS personnel.
3.  Diagnose and treat organic causes of behavioral disturbances such as hypoglycemia, hypoxia, or poisoning.
4.  Use reasonable physical restraint only if attempts at verbal control are unsuccessful. Every attempt should be made to avoid injury to the patient when using physical restraint (Medical Procedure 4.23).
5.  Teamwork between EMS personnel and law enforcement will improve patient care.

**GENERAL APPROACH**
1.  Communicate in a calm and nonthreatening manner.
2.  Offer your assistance to the patient.
3.  Use reasonable physical force via law enforcement if the patient is a threat to themselves or to others.

**USE OF RESTRAINTS**
1.  Physical.
    a.  Use standard restraining techniques and devices (Medical Procedure 4.23, Physical Restraints).
    Use sufficient padding on extremity restraints on elderly patients or others with delicate skin.
2.  Chemical.
    a.  Use chemical restraints in conjunction with physical restraints if the latter are unsuccessful in controlling violent behavior.
    b.  Agents (Adult Protocol 2.5.2, Violent, Impaired Patient/Excited Delirium Syndrome).
3.  Any type of restraints.
    a.  Constantly monitor and observe the patient to prevent injury. If physical and/or chemical restraints are used, place the patient on an ECG monitor and pulse oximeter.
    b.  Carefully document the rationale for the use of restraints.

**TREATMENT PROTOCOL**
See Adult Protocol 2.5.2, Violent and/or Impaired Patient, for specific treatment protocols.
It may be appropriate for law enforcement to execute an involuntary certificate for psychiatric examination (Baker Act - FS Chapter 394.463). However, such a certificate shall not be an absolute condition for hospital                                                                                                      transport.
**TRANSPORTATION**
1.  All individuals being transported for psychological evaluation under the premises of the Baker Act should be accompanied by a police officer. The paramedic in charge shall determine whether the police officer will ride in the back or follow behind the Rescue Unit.
2.  In those situations where a female patient is being transported and a female is not part of the rescue crew, the paramedic should attempt to have a female police officer accompany the patient to the hospital. (This is imperative in situations such as possible rape.) Also document the beginning and ending mileages with dispatch via radio communication.
**BAKER ACT**
Florida Statute Chapter 394.463—Mental Health relates to the authorization of police, physicians, and the courts to dictate certain medical care for persons who pose a threat to themselves or to others
**INCAPACITATED PERSONS LAW**
Florida Statute Chapter 401.445 allows for examination and treatment of incapacitated persons in emergency situations. (Patients who are not capable of informed consent as provided in FS Chapter 766.103 cannot refuse medical care.) Florida Statutes may be viewed online at www.leg.state.fl.us/statues

**PURPOSE**

Critical Incident Stress Management (CISM) is a comprehensive, integrated, multicomponent, systematic program of crisis intervention. Its purpose is to provide education, support, assessment, and intervention for emergency ser-vice personnel who are often exposed to and/or affected by critical incidents. CISM was born out of emergency services and has become a world standard of care for first responders. Formulated and standardized by the International Critical Incident Stress Foundation (ICISF), CISM has proven to be effective in mitigating many of the common symptoms of critical incident stress. The goal when applying any of the CISM components is to assess, educate, and intervene as necessary and return individuals to their work with the tools and support needed to reduce the effects of a critical incident. The benefits of the intervention include a reduction in symptoms of post-traumatic stress, quicker return to normal productive functioning, increased job satisfaction, reduced worker's compensation claims, reduced absenteeism and presenteeism, reduced errors, enhanced group cohesion, increased personal confidence and extended longevity.

**OVERVIEW**

The Broward County CISM Team (Broward Region X CISM) is made up of trained and credentialed members of law enforcement, fire/rescue, corrections, communications, and others, as well as trained, credentialed, and licensed mental health professionals, all of whom have completed at least three (3) of the core ICISF courses. Broward's CISM Team is independent of any other organization or department in Broward County. The team is designed and organized to respond to any incident that occurs in any emergency services department or agency in Broward County on a 24 × 7 × 365 basis, within a maximum of two (2) hours after a critical incident has occurred and CISM services are requested. The team meets on a periodic basis for additional training and information.

**CONFIDENTIALITY**

Florida Statute 401.30(4) (e) protects the discussions held during a CISM intervention as being "confidential and privileged communication under section 90.503." Therefore, all information shared during any part of a CISM intervention is held in the strictest of confidence.

**CISM SERVICES**

The following types of services can be provided by the Broward CISM Team.
A.        Pre-event planning and preparation.
   1. Educational and informational programs about CISM.
   2. Pre-incident planning and education.
B.        Strategic planning and assessment.
   1. Pre- and post-incident assessment of needs.
   2. Development and implementation of a strategic plan for major events.
C.        Individual intervention.
   1. One-on-one services with a qualified CISM team member.
   2. Individual support and follow-up.

D.            Small group defusing.
1. Recommended within the first 12 hours after a critical incident occurs.
2. Best delivered as soon as possible after a critical incident.
3. Homogeneous groups.
4. Assessment and education with possible referral and follow-up.

E.            Small group debriefing.
1. 12-72 hours post-critical incident.
2. Prior to demobilization from extended deployment or upon return home from extended deployment.
3. Events of significant personal loss (expanded-phase defusing within first 12 hours).

F.            Crisis management briefing.
1. Appropriate for large incidents, incidents with high media involvement, respite/rehab centers, and demobilizations.
2. Best for large groups or mixed groups.
3. Primary focus on assessment and information.

G.            Family crisis intervention.
H.            Organizational consultation.
I.            Assessment of organizational needs.
J.            Development and recommendation for coordination and delivery of services.
K.            Pastoral/spiritual crisis intervention.
L.            Referral and follow-up.

**CISM CALL-OUT BASIS**

A critical incident is any situation that is either out of the norm or that challenges or would appear to challenge a person's normal coping mechanisms. Examples include the following situations:

● Pediatric injury or death
● Multiple youth fatalities
● Events with severe operational challenges
● Line-of-duty death or line-of-duty injury
● Officer involved in a shooting
● Off-duty death, suicide, homicide, or injury
● Events with multiple or mass casualties
● Prolonged events with loss of life
● Events when the victim(s) is (are) known
● Events with excessive media interest
● Any incident that could perceivably cause emotional impact

Emergency responders work under stressful conditions and situations. Training and continuing education about stress management contribute to the development and maintenance of improved emotional health, stress resistance, and resilience. Statistics demonstrate significantly higher instances of drug and alcohol abuse, marital and family strife, intimate-partner and domestic violence, heart attack, and suicide rates among emergency services personnel compared to the general population. These facts underscore the need for CISM services in any situation similar to those in the preceding list. Because one of the positive benefits of a group intervention is stronger group cohesion, all members of the group are encouraged to be present.

**CISM ACTIVATION PROCESS EXAMPLE (BROWARD COUNTY)**
A.          Requesting agency officer contacts the Communications Captain on duty at the Broward Regional Communications Center, requesting a CISM Team response.
B.          Communications Center number: 954-476-4720
C.          Requesting agency shall supply the following information:
   1. Agency name.
   2. Type of incident.
   3. Number of members involved.
   4. Call-back contact number or pager number.
D.          The Communications Captain shall page out the on-call CISM Team Leader.

**CISM CALL-OUT PROCEDURE**
1. When a critical incident event occurs or when an on/off scene command determines that an incident may or could have an emotional impact on the responding personnel, department, or agency, any person authorized to do so shall contact the NORTH Regional Communication Center at 954-476-4720 and ask for the Duty Officer to requests a CISM response, giving a brief description of the event, the caller's name, and his/her contact information. The Regional Communication Center shall contact the on-call CISM Team coordinator and, at the same time, pages and/or sends a text message to all members on the CISM Team list.
2. The Broward Regional Communication Center shall contact the on-call CISM Team coordinator and, at the same time, pages and/or sends a text message to all members on the CISM Team list.
3. The CISM Team Coordinator contacts the CISM Team Clinical Director or designee and provides the incident contact name and number. The CISM Team Coordinator then begins assembling peer team members for a response. No team member from the affected department, agency, or organization will be part of the responding CISM Team.
4. The CISM Clinical Director contacts the site or incident contact person, receives details about the incident, and advises the contact of the appropriate type and timing of the response.
5. Once the type, timing, and location of the response are determined, the Clinical Director contacts the Team Coordinator with the information necessary to conduct the appropriate intervention. The Clinical Director then contacts mental health members for the intervention as needed.
6. Upon arrival at the determined site, the CISM Team members assemble for a briefing with the Team Leader and then meet with the contact person or designee.
7. Personnel are assembled according to type, in a quiet and secure location. All personnel shall be either off-duty or out of service for the duration of the intervention and related services.
8. In the case of a critical incident stress defusing or debriefing, personnel are assembled according to rank, involvement in the incident, proximity to the incident, as determined by the responding Team Leader.
9. No written, audio, or video recording of the intervention shall be permitted.
10. The CISM Team consults with the contact person to provide general recommendations or for possible follow-up.
11. The CISM Team gathers for a team debriefing.

This protocol is divided into separate sections that cover the different situations involving death in the field that the paramedic will encounter. All patients found in cardiac arrest will receive cardiopulmonary resuscitation unless an exception is met as outlined in the following sections:

I.      Advanced Directives/Do Not Resuscitate Orders (DNRO).

II.      Determination of Death.

III.      Discontinuance of CPR.

IV.      Documentation

## I ADVANCED DIRECTIVES/DO NOT RESUSCITATE ORDERS (DNRO)

1.IV.1      Legislative authority. Under Florida Administrative Code (FAC) 64J-2.018. Do Not Resuscitate Order (DNRO) Form and Patient Identification Device. The Florida DNRO form is the only form approved in the State of Florida. If there is a DNRO/POLST/MOST/MOLST (see 1.8) form from another State presented by the patient or family, contact Medical Control as soon as possible for direction.

1.IV.2      An EMT or paramedic shall withhold or withdraw cardiopulmonary resuscitation:

1.IV.2.1.1      Upon the presentation of an original or a completed copy of DH Form 1896, Florida Do Not Resuscitate Order Form, December 2004, which is incorporated by reference and available from DOH at no cost, or, any previous edition of DH Form 1896; or

1.IV.2.1.2      Upon the presentation or observation, on the patient, of a Do Not Resuscitate Order patient identification device.

1.IV.3      The Do Not Resuscitate Order:

a.      Form shall be printed on yellow paper and have the words "DO NOT RESUSCITATE ORDER" printed in black and displayed across the top of the form. DH Form 1896 may be duplicated, provided that the content of the form is unaltered, the reproduction is of good quality, and it is duplicated on yellow paper. The shade of yellow does not have to be an exact duplicate;

b.      Patient identification device is a miniature version of DH Form 1896 and is incorporated by reference as part of the DNRO form. Use of the patient identification device is voluntary and is intended to provide a convenient and portable DNRO which travels with the patient. The device is perforated so that it can be separated from the DNRO form. It can also be hole-punched, attached to a chain in some fashion and visibly displayed on the patient. In order to protect this device from hazardous conditions, it shall be laminated after completing it. Failure to laminate the device shall not be grounds for not honoring a patient's DNRO order, if the device is otherwise properly completed.

1.IV.4      The DNRO form and patient identification device must be signed by the patient's physician. In addition, the patient, or, if the patient is incapable of providing informed consent, the patient's health care surrogate or proxy as defined in Section 765.101, F.S., or court appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S., must sign the form and the patient identification device in order for them to be valid. The form does not need to be notarized, once signed the form does not expire.

1.IV.5      An EMT or paramedic shall verify the identity of the patient who is the subject of the DNRO form or patient identification device. Verification shall be obtained from the patient's driver license, other photo identification, or from a witness in the presence of the patient. If a witness is used to identify the patient, this fact shall be documented in the EMS Run Report, which must include the following information:

a. The full name of the witness.

b. The address and telephone number of the witness.

c. The relationship of the witness to the patient

1.IV.6    During each transport, the EMS provider shall ensure that a copy of the DNRO form or the patient identification device accompanies the live patient. The EMS provider shall provide comforting, pain-relieving and any other medically indicated care, short of respiratory or cardiac resuscitation.

1.IV.7    A DNRO may be revoked at any time by the patient, if signed by the patient, or the patient's health care surrogate, or proxy or court appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S. Pursuant to Section 765.104, F.S., the revocation may be in writing, by physical destruction, by failure to present it, or by orally expressing a contrary intent.

1.IV.8    Oral orders from nonphysician staff members or telephoned requests from an absent physician do not adequately assure EMT/paramedics that the proper decision-making process has been followed and are NOT acceptable.

1.IV.9    In the near future Florida will be adopting POLST (Physician Orders for Life Sustaining Treatment Paradigm) The National POLST Paradigm is an approach to end-of-life planning that emphasizes patients' wishes about the care they receive. The POLST Paradigm is an approach to end-of-life planning emphasizing: (i) advance care planning conversations between patients, health care professionals and loved ones; (ii) shared decision-making between a patient and his/her health care professional about the care the patient would like to receive at the end of his/her life; and (iii) ensuring patient wishes are honored. As a result of these conversations, patient wishes may be documented in a POLST form, which translates the shared decisions into actionable medical orders. The POLST form assures patients that health care professionals will provide only the care that patients themselves wish to receive, and decreases the frequency of medical errors. POLST is not for everyone. Only patients with serious illness or frailty should have a POLST form. For these patients, their current health status indicates the need for standing medical orders. For healthy patients, an Advance Directive is an appropriate tool for making future end-of-life care wishes known to loved ones. Several States use the POLST program and there several other forms used by these States, Medical Orders for Life Sustaining Treatment (MOLST), Medical Orders for Scope of Treatment (MOST) and the Physician Orders for Scope of Treatment (POST) form.

Specific Authority 381.0011, 401.45(3) FS. Law Implemented 381.0205, 401.45, 765.401 FS. History–New 11-30-93, Amended 3-19-95, 1-26-97, Formerly 10D-66.325, Amended 2-20-00, 11-3-02, 6-9-05, Formerly 64E-2.031.5.

## II.  DETERMINATION OF DEATH

The EMT or paramedic may determine that the patient is dead/non-salvageable and decide not to resuscitate the patient under the following guidelines.

A. The patient may be determined to be dead/non-salvageable and will not        be resuscitated or transported if all four (4) presumptive signs of death and at least one (1) conclusive sign of death are identified.

   1.    The four presumptive signs of death that MUST be present are:
     a.    Unresponsiveness.
     b.    Apnea.
     c.    Pulseless.
     d.    Fixed dilated pupils.

2.  In addition to the four presumptive signs of deaths, at least one (1) of the following conclusive signs of death MUST be present:
    a.  Injuries incompatible with life (e.g., decapitation, massive crush injury, incineration).
    b.  Tissue decomposition.
    c.  Rigor mortis of any degree with warm air temperature. (Hardening of the muscles of the body, making the joints rigid).
    d.  Liver mortis (lividity) of any degree, (venous pooling of blood in dependent body parts causing purple discoloration of the skin, which does blanch with pressure).
3.  Patients with suspected hypothermia, barbiturate overdose, or electrocution require full ALS resuscitation unless they have injuries incompatible with life or tissue decomposition.
4.  EMS personnel may contact medical direction for a "determination of death" whenever support in the field is desired. Clearly state the purpose for the contact as part of the initial hailing.
5.  Children are excluded from this protocol unless EMS personnel make contact with medical direction for consultation. Only in cases of obvious, prolonged death should CPR not be started or discontinued on infants, children, or young adults, or in cases in which an unexpected death has occurred.

B.  A trauma victim who does not meet the "Determination of Death" criteria listed above may be determined to be dead/non-salvageable based on the following criteria:
1.  Pulselessness and apnea associated with asystole (confirmed in two leads) and
    a.                          Blunt trauma arrest.
    b.  Prolonged extrication time (more than 15 minutes) where no resuscitative measures can be initiated prior to extrication.
    c.  Arrest from primary brain injury or with no brain stem reflexes; arrest from blunt multiple injuries.
2.  If there is any concern regarding leaving the patient at the scene, begin resuscitation and transport.
3.  Consideration should be given for the possibility of organ harvest; however, this should not be the sole reason for resuscitation.

C.  Absence of pulse or spontaneous respiration in a multiple-casualty situation where EMS resources are required for stabilization of living patients.

The local law enforcement agency that has jurisdiction will be responsible for the body once death has been determined. The body is to be left at the scene until a disposition has been made by the Medical Examiner's Office or the local jurisdiction.

**III.   DISCONTINUANCE OF CPR**

A. Resuscitation that is started in the field by EMS personnel cannot be discontinued without an order from online, EMS Medical Director or online medical control.

B. EMS personnel are not obligated to continue resuscitation efforts that were started inappropriately by others at the scene.

C. When there is a delay in presenting a DNRO to EMS personnel, resuscitation must be started. However, once the DNRO is presented to EMS personnel, the EMT or paramedic with an order from medical direction may terminate resuscitation.

D. A paramedic with an order from medical direction may terminate resuscitation provided the following criteria are met:
   1. Appropriate BLS and ALS have been attempted without restoration of circulation and breathing.
   2. Advanced airway (supraglottic or ET) has been successfully accomplished.
   3. Intravenous (IV, IO, ETT) medication and countershocks for ventricular fibrillation have been administered according to the appropriate treatment protocol(s) (Adult Protocols or Pediatric Protocols).
   4. Persistent asystole (20 minutes and ETCO2 less than 10mmHg) or agonal ECG patterns are present and no reversible causes are identified.
   5. Patients with suspected hypothermia, barbiturate overdose, or electrocution require full ALS resuscitation, unless they have injuries incompatible with life or tissue decomposition.

E. Provide appropriate grief counseling or support to the patient's immediate family, bystanders, or others at the scene.
   1. Provide family members with appropriate referral information, if available.

F. Patient preparation.
   1. Once it has been determined that the patient has died and resuscitation will not continue, cover the body with a sheet or other suitable item. Do not remove any property from the body or the scene for any purpose.
   2. If the death is a suspected homicide (crime scene), do not cover the body (General Protocol 1.10).
   3. Immediately notify the appropriate law enforcement agency (if not done already), and remain on scene until their arrival.
   4. Advanced airway placement may be verified by two paramedics for patients who are determined to be dead in the field or for whom resuscitation measures have ceased. Improperly placed advanced airway tubes should be left in place and reported to the appropriate personnel. (Proper advanced airway tube placement must be confirmed prior to terminating resuscitation.).
   5. Consult the patient's family for "organ donor" information, if appropriate.

**IV.  DOCUMENTATION**

A. All death in the field patient reports need to have proper documentation on the EMS run report.

B. ECG rhythm documentation must be attached to the EMS Run Report.

C. The advanced airway should be left in place and its confirmation should be recorded on the EMS Run Report.

**MEDICAL EVALUATION OF EMERGENCY WORKERS ON EMERGENCY INCIDENTS OR TRAINING EVOLUTIONS**

A.  Purpose: Emergency operations require significant physical activity, but no rescuer will be required to perform emergency operations beyond safe levels of physical or mental endurance. This protocol is intended to examine and evaluate the physical and mental status of emergency workers working on an emergency incident or a training exercise and determine which treatment, if any, is necessary. Personnel rehabilitation using appropriate protocols in this area will decrease injury risk and enhance recovery for later emergency operations.

B.  Implementation: A Rehabilitation Area (Rehab Area) will be set up at the discretion of the Incident Commander. It is recommended that a Rehab Area be utilized at all working incidents to provide a staging area for on-scene personnel, as well as an immediate source of personnel for rescue or aid, and an area for recovery and rehabilitation of emergency workers. When a Rehab Area has been deemed necessary by the Incident Commander (IC), the first available EMS unit will be responsible for the management and coordination of the Rehab Area.

C.  Location: Establish a Rehab Area away from environmental hazards (e.g., in a shady, cool place that is, upwind and away from smoke and traffic) that is readily accessible to rescue personnel for transport and supplies. Air truck and canteen service will be stationed in this area. Multiple Rehab Areas may be needed on large incidents. If a specific location has not been designated by the IC, the Rehab Officer shall select an appropriate location based on the following site characteristics:

   1.  The Rehab Area should be in a location that will provide physical rest by allowing the body to recuperate from the demands and hazards of the emergency operation or training evolution.

   2.  It should be far enough away from the scene that members may safely remove their turnout gear and self-contained breathing apparatus (SCBA) and be afforded mental rest from the stress and pressure of the emergency operation or training evolution.

   3.  It should provide suitable protection from the prevailing environmental conditions. During hot weather, it should be in a cool, shaded area. During cold weather, it should be in a warm, dry area.

   4.  It should enable members to be free of exhaust fumes from apparatus, vehicles, or equipment (including those involved in the rehabilitation group operations).

   5.  It should be easily accessible by EMS units.

   6.  It should allow prompt reentry back into the emergency operation upon complete recuperation.

D.  Resources: The Rehab Officer shall secure all necessary resources required to adequately staff and supply the rehabilitation area. The supplies should include the following items:

   1.  Fluids—water, activity beverages, oral electrolyte solutions, and ice.

   2.  Food (for extended operations where crews are engaged for 3 hours or more) soup, broth, or stew in hot/cold cups.

   3.  Medical equipment—blood pressure cuffs, stethoscopes, oxygen administration devices, cardiac monitors, intravenous solutions, thermometers, and pulse oximeters (which include the ability to monitor SpCO).

4.  Other - awnings, "cool zone" misting fans, cooling chairs, heaters (according to climate), towels, and tarps.

E.  Staffing: Assign a minimum of two rescue personnel to monitor and assist fire fighters in the Rehab Area. An appointed Rehab Officer shall oversee the rehab operations. Their responsibility is to oversee provision of food, fluids, medical monitoring, establish and maintain an appropriate environment for rehab and rehabilitation operations in the area. These personnel will oversee the rehabilitation and availability for work of all emergency responders placed in this area.

F.  Medical evaluations: When the Incident Commander has established a Rehab Area, fire fighters and other emergency responders shall be evaluated following (a):

1.  The use of two SCBA bottles and/or 30 minutes of strenuous activity (e.g., use of chemical PPE, advancing hose lines, forcible entry, ventilation) (b).

2.  SCBA failure.

3.  Weakness, dizziness, chest pain, muscle cramps, nausea/vomiting, altered mental status, difficulty breathing, and other stress-related symptoms (c).

4.  At the discretion of the Incident Commander, Rehab Officer, Safety Officer, CISM Coordinator, and Company Officer.

Note:

(a)  A medical evaluation form shall be completed on all personnel entering the Rehab Area and before they return to emergency work.

(b)  This does not preclude an officer from having a team member evaluated if he/she deems it appropriate. A member may be evaluated any time he/she feels it necessary.

(c)  All personnel receiving ALS treatment and transport will have a patient care report completed for them.

G.  Examination: EMS personnel should evaluate persons arriving to the     Rehab Area as they appear. Arriving emergency workers must be questioned regarding any medical symptoms, be asked about any injury resulting from incident work, and have assessment of appropriate vital signs. Examination shall occur at 10-minute intervals and will involve a minimum of:

1.         Glasgow Coma Scale (GCS) score.
2.         Pupillary response.
3.         Vital signs (BP, P, R, CR).
4.         ECG (if applicable).
5.         Lung sounds.
6.         Skin condition.
7.         Signs and symptoms.
8.         Oral temperature.
9.         Pulse oximetry.
    a. Arterial oxygen saturation ($SpO_2$).
    b. Carboxyhemoglobin saturation (SpCO).

**An EMS Run Report and a Casualty Report shall be completed for each fire fighter or other emergency worker who is not routinely returned to emergency operations.**

H.  Guidelines for rehab: The following will occur: **REVIEW AGAINST FORM**
1.  Normal presentations: The emergency responder will rehydrate and rest before reporting to Manpower. Rest shall not be less than 15 minutes.
2.  Abnormal presentations:
    a.  Blood pressure values that are higher or lower than the person's usual level.
    b.  SpO2 values less than 94%.
    c.  Values for the pulse rate in an emergency responder will normally be less than 100 beats per minute (BPM) at rest and less than 120 BPM at a working incident. At no time should the pulse exceed 180 BPM.
    d.  Values for carbon monoxide (CO) oximetry will normally be 5% for a nonsmoker and less than 8% for a smoker. A CO oximetry reading of more than 12% indicates moderate CO inhalation; a reading of more than 25% indicates severe inhalation of CO.
3.  Body temperature greater than 100.6 F
4.  Management.
    a.  The emergency responder will rehydrate and rest. The emergency responder will report to Manpower when presentations are normal. Presentations should return to normal within 15 minutes.
    b.  If a team member's heart rate exceeds 110 BPM, an oral temperature should be taken. If the oral temperature exceeds 100.6 F, the member should not be permitted to wear protective equipment and should be treated for heat stress and monitored for worsening of the heat emergency (i.e., heat exhaustion and heat stroke).
    c.  The emergency responder will receive ALS treatment and transport if presentations are abnormal for more than 15 minutes. Abnormal presentation includes the following signs and symptoms:
        1)  $SpO_2$ value less than 94%.
        2)  Persistent heart rate greater than 120 BPM (lasting for 15 minutes or longer).
        3)  Any emergency worker with a CO oximetry reading of more than 8% but less than 15% must be given the opportunity to breathe ambient air for 5 minutes.
        4)  If the CO oximetry reading is still higher than 8%, the emergency worker should be given oxygen via mask until the value drops below 5%. Any worker with a CO oximetry reading of more than 25% must be completely evaluated and removed to a hospital, preferably one that has a hyperbaric chamber. No emergency worker should leave the Rehab Area until his/her CO level is less than 8%.
        5)  Blood pressure above or below the emergency worker's normal level.
        6)  Symptoms of heat stroke.
        7)  Oral temperature greater than 100.6 F, lasting longer than 15 minutes (after oxygen administration).
    d.  Any emergency responder with chest pain, difficulty breathing, and altered mental status will receive immediate ALS treatment and transport.
    e.  Any other abnormal presentation not specified herein, where the examining paramedic's judgment determines a need for treatment and transport will be managed accordingly.

F.  Treatment: Treatment will consist of one or more of the following measures. Prior to taking anything orally, the emergency responder will clean his/her hands and face. On-scene rescue personnel will provide water and a cleaning agent.
1.  Remove bunker gear
2.  Rest
3.  Oral rehydration and nutrition (air truck, canteen service); minimum of 1 to 2 quarts of fluids over a 15-minute time period (water then full strength electrolyte drink). Avoid any substance containing caffeine (e.g., sodas, coffee, tea).
    a.     Members should consume at least 1 quart of water per hour.
    b.     Members shall rehydrate with at least 8 ounces of fluid while SCBA cylinders are being changed.
4.  Oxygen.
5.  Cool environment utilizing "cool zone" fans and/or "cooling chairs" if available (e.g., shade, electric fan, air conditioning, showers).
6.  For extended operations lasting 3 or more hours, the Rehab Area should provide food such as soup, broth, or stew; these items are digested much faster than sandwiches and fast-food products. In addition, foods such as apples, oranges, and bananas provide supplemental forms of energy replacement. Fatty and/or salty foods should be avoided.
7.  Follow ALS/BLS protocols for further treatment.

G.  Return to emergency duties: Members assigned to the rehabilitation group shall enter and exit the Rehab Area as a crew. The crew designation, number of crew members, and the times of entry to and exit from the Rehab Area shall be documented by the Rehab Officer or his/her designee on the check-in/out sheet. Crews shall not leave the Rehab Area until authorized to do so by the Rehab Officer. Report to Manpower or Incident Commander when the following criteria have been met:
a)  Vital signs within normal limits.
b)  Absence of abnormal signs and symptoms.
c)  Minimum period of 15 minutes for rest and rehydration.
d)  Released by Rehab Officer.

H.  Documentation: A Rehab Medical Evaluation Form shall be completed for all personnel evaluated in the Rehab Area and forwarded to the appropriate Rescue (EMS) Division following all applicable patient confidentiality guidelines (e.g., HIPAA). A complete patient care report (PCR) shall be completed for any member who receives treatment/transport.

See Section 6 or Online Forms for the Emergency Worker Rehabilitation Form

**COMMUNICATION PROCEDURES**

The standard dispatch for an Air Rescue assignment should be one (1) engine company and one (1) rescue. The need for additional units should be dictated by the incident circumstances. It should be kept in mind that the unit assigned as the heli-spot (HS) group may need all of its personnel to properly secure the HS site. This may create the need for additional units to address patient care needs. Dispatchers should not take it upon themselves to modify this assignment, nor should they suggest modification of the assignment. As with any Fire Department assignment, the only personnel who can modify the assignment are Uniformed Fire Department Officers.

See General Protocol 1.10, Trauma Transport, Helicopter Transport Protocol.

**HELI-SPOT PROCEDURES**

Rescue Units, when requesting an Air Rescue assignment, should not concern themselves with an HS unless they know of one at or very near the incident site. The rescue personnel should concern themselves with proper and rapid patient packaging. In the event that the unit assigned as the HS group experiences difficulties in finding an HS, they should wait until Air Rescue arrives. Air Rescue has a better vantage point in choosing an HS, and its personnel will advise the HS group.

In the event that the HS is remotely located and appears to be safe for landing, the Pilot in Command (PIC) may elect to land without the assistance of an HS sector. This does not mean that the unit assigned to the HS should be canceled. These team members will be utilized for security, safety, and patient loading once the helicopter is on the ground. The Pilot in Command (PIC) is both legally and operationally responsible for the safety of the aircraft. There-fore, the final decision of the suitability of the HS site is that of the PIC.

When setting up an HS, there are several things to keep in mind:

1. The HS should be set up as to facilitate takeoffs and landings into the wind. (Do not rely on dispatch for correct wind direction; use visual indicators.)
2. If the HS group Officer in Command (OIC) is not sure of the wind direction or the direction from which the helicopter should approach, then he/she should wait until the helicopter is in the area and confer with the Air Crew on this decision.
3. The approach and departure ends of the HS should be clear of obstacles (any object more than 40 feet tall that is within 100 feet of the HS).
4. Debris such as wood, cans, and plastic should be removed from the HS. Flying debris can do damage to both the helicopter and personnel on the ground.
5. To minimize the hazard of blowing sand and dust, the HS should be hosed down (may be hosed down as necessary).
6. Once the helicopter has landed, the Marshaller should post a minimum of **one tail rotor guard** (two, if available). This person should be someone other than the Marshaller. The Marshaller shall remain at his/her post until the aircraft departs.
7. No *unauthorized* personnel shall be permitted to approach the helicopter. This is the general responsibility of all Fire Department personnel, but it is most definitely the overall combined responsibility of the PIC and the HS group OIC.

8. The HS group should assure that the Rescue Unit personnel are supplemented with an appropriate number of personnel to assist in the safe and efficient loading of patients into the helicopter.
9. Once the helicopter has landed, the Marshaller should confer with the Air Crew as to the helicopter's departure.
10. It is not necessary to have a hose line pulled and charged. In the event of a catastrophic event involving the helicopter, tactics and strategy will be left up to the Incident Commander.

The Marshaller is one of several tools that are at the disposal of the PIC for the accomplishment of a safe landing and departure. The PIC considers several factors when making an approach or departure into a confined area. As a consequence, he/she may not always follow the exact direction of the Marshaller. Note that most approaches will be to the ground, not to a hover. The PIC, at his/her discretion, may elect to land without the assistance of a Marshaller and may request that the Marshaller remain clear of the HS until after the helicopter has landed. If the PIC does not follow the exact direction of the Marshaller, be assured there are reasons for his/her actions.

**REVIEW YOUR MARSHALLING HAND SIGNALS**
  A.  Marshalling.
     1.   Positioning.
        a.  The Marshaller will stand at the outer edge of the HS perimeter on the windward side, with his/her back to the wind.
        b.  The Apparatus Lieutenant/Captain will have the primary responsibility for the marshalling duties.
        c.  An additional fire fighter who is assigned to the Marshaller will maintain constant radio contact with the helicopter as well as visual and verbal contact with the Marshaller.
        d.       Remain in eye contact with the pilot at all times.
        e.       Do not approach the helicopter; remain vigilant at your post.
     2.   Equipment.
        a.       Helmet with chin strap tightly secured.
        b.       Goggles on or visor down.
        c.       Gloves.
        d.       Full bunker gear with collar up.
        e.       Flash lights with wands for night operations.
     3.   Safety precautions and procedures.
        a.  Stay well clear of the tail rotor area.
        b.  Use caution when traversing uneven terrain.
        c.  Approach the helicopter in the pilot's field of vision and ONLY after an "All Clear" signal has been given by a helicopter        crewmember.
        d.  Use low crouch when approaching and departing the helicopter.
        e.  Do not use road flares. Do not shine spotlights or headlights at the helicopter or into the HS. The pilot will utilize the "night sun" to light up the HS as needed. Shining lights or strobes at the HS may cause vertigo, night blindness, or seizures of the pilot.

**RESCUE UNIT PROCEDURES**

The Rescue Unit OIC has the primary responsibility of patient care and should not become overly concerned with the availability of an appropriate HS. The following points should be kept in mind when deciding on Air Rescue as the mode of transport for the patient:

1. Make the decision to transport by air early. Have Air Rescue dispatched by the Incident Commander. Even if you are not sure that a patient meets the established criteria for air transport, place Air Rescue on standby status. You can always cancel the standby.

2. It is imperative that the ground Rescue Unit contact the receiving facility prior to Air Rescue's on-scene arrival. This will preclude any delay in transportation in the event the receiving facility cannot accept the patient. This early advisory is also necessary to allow the hospital time to prepare for an Air Rescue arrival. Air Rescue may monitor the medical channel and receive patient information while it is given to the receiving facility from the ground Rescue Unit.

3. Relaying information concerning HS location and any hazards is a priority (this information may be relayed to the Air Rescue team after they are airborne). The only patient information that the Rescue Unit needs to advise the Incident Commander about when requesting Air Rescue is the number of patients and the designated receiving facility. The ground Rescue Unit should not spend time advising Air Rescue of patient conditions over the incident frequencies. That time would be better spent communicating with the receiving facility.

4. There is no reason to provide the Air Rescue crew with a completed EMS Run Report. This may create an undue delay in the transportation of the patient. A "hard copy" of whatever information you do have should be provided to the Flight Medic.

5. All bandages and dressings shall be affixed securely

6. The patient will be secured to a backboard with a minimum of three (3) straps, unless contraindicated by his/her medical condition. If the patient is unruly, place an additional strap above the knees. Having a patient lie on a backboard with the head immobilized and nothing securing the body is unacceptable. In the event that straps are not available, another method of securing the patient should be improvised.

7. A minimum of four (4) personnel, one of whom will be a member of the Air Rescue crew, will carry the stretcher. Each member of this team should have a helmet with face shield and chin strap in place when loading the patient.

8. If the patient is difficult to carry, a stretcher may be utilized, provided the sheets, pillow, and mattress are removed.

9. The key to saving a trauma patient who requires surgical intervention is speed. Do not delay transport for invasive procedures other than those necessary to maintain the patient's airway. Most invasive procedures can be done while en route to the Trauma Center.

10. Be aware of the time you are on the scene with the patient. Attempts at certain procedures may be perceived as progressing at a rapid pace, but in reality they are taking an extended period of time that can better be used in moving the patient.

11. Advise the Air Rescue Unit if you have any need for additional equipment or assistance (e.g., for managing patient airway difficulties).
12. Remain at the incident side (or at least 100 feet from the HS) until the helicopter has landed.
13. Absolutely no personnel should approach the helicopter unless cleared "in" by an Air Rescue crew member.
    a. Do not approach the helicopter with a patient unless escorted by an Air Rescue crew member.
    b. It is the responsibility of all Fire/Rescue/EMS personnel to ensure that any and all unauthorized persons are prevented from approaching the helicopter. This is usually accomplished with visual and verbal warnings, but in some instances may require physical intervention.
14. In the event that the Air Rescue crew requires assistance with patient care, the ground paramedic in charge of patient care will accompany the patient during air transport. In this event, the ground paramedic, with Air Crew approval, will bring any equipment necessary to affect patient care during air transport. Any additional Fire/Rescue personnel will be determined by the Air Rescue crew and the ground paramedic in charge of patient care.

References
Broward County Aeromedical Transport Program
Miami-Dade Air Rescue Assignment Procedures
U.S. Coast Guard Helicopter Procedures

The heli-spot shall be a minimum of 100′ × 100′ (HS size may be increased by local protocol).

Hospital prenotification of all BLS or ALS (Non-Interfacility) transported patients is recommended. On initial contact by the paramedic with the supervising emergency physician, the following information should be communicated in this sequence:

1. Priority code and receiving facility
2. Rescue number/paramedic's name
3. Patient's age/sex
4. Patient complaint or major problem/time of onset
5. Assessment: mental status, ROM, pupils, skin, BBS, BP, P, R, ECG, hemodynamic condition
6. Glasgow Coma Scale (GCS) score
7. Mechanism of injury
8. History of illness, medications used, allergies
9. Treatment given
10. Estimated time of arrival

**MEDCOM PRIORITIES**
**Priority I: Critical**
Used only for patients who present with an immediately life-threatening illness or critical injury. As outlined in Trauma Alert Protocol.
**Priority II: Serious**
Used for those patients who present with an illness or injury requiring immediate medical intervention and that has the potential for becoming life-threatening if not treated promptly.
**Priority III: Stable**
Used for those patients who present with an illness or injury not requiring immediate medical intervention or that is so easily managed that medical direction is not required. Also used for notification of impending patient arrival to the receiving facility.
**Priority IV: Administrative Traffic (Optional)**
Used for all transmissions not involving care of a patient, such as radio checks, calibration test, and administrative traffic.

**MEDCOM CLASSIFICATIONS:** Adult or Pediatric, Cardiac, Medical, OB, Trauma
**TRAUMA PRE-ALERTS**
A Trauma Pre-alert is communicated via Fire Dispatch after initial patient contact (a second contact must be made via Medcom en route to the hospital) and must include the following information:
1. Rescue number/paramedic's name calling the alert.
2. Name of receiving trauma center.
3. Category (adult, pediatric, or obstetrical).
4. Trauma alert criteria.
5. Patient's sex.
6. Number of patients.
7. Estimated time of arrival to the receiving facility, via ground or air.
See the County Uniform Trauma Telemetry (CUTT) Report located in section 6 and on-line forms

**POLICY**

Any and all individuals who are involved as patients or potential patients should receive proper evaluation, treatment, and transportation to the appropriate medical facility. There may be times when this policy may not be carried out due to a refusal of care. The refusal of care procedure should be utilized in situations in which a patient refuses evaluation, treatment, and/or transportation by prehospital personnel. Persons should be presumed competent to make decisions affecting their medical care. In cases of minors, attention should be given to signs of child abuse (Appendix 6.2).

**DEFINITIONS**

A.  Patients able to refuse care.
    1.        A person can refuse medical care based on the following guidelines:
        a. Competent—defined by the ability to understand the nature and consequences of his/her actions by refusing medical care and/or transportation, and
        b.        Adult - eighteen (18) years of age or older, except:
            1)  An emancipated minor.
                i.                  A self-sufficient minor.
                ii.                 A married minor.
                iii.                A minor in the military.
            2)  A legal representative for the patient (parent or guardian). (Appendix 6.6, Consent for the Care of a Minor.)

B.         Patients <u>not able</u> to refuse care.
    1.  A person may be considered incompetent to refuse medical care and/     or transportation if the severity of his/her medical condition prevents the patient from making an informed, rational decision regarding medical care. Therefore, the individual may not refuse medical care and/or transportation based on the following guidelines:
        a.  Altered level of consciousness (e.g., head injury or under the influence of alcohol and/or drugs).
        b.  Suicide (attempt or verbal threat).
        c.  Severely altered vital signs.
        d.  Mental retardation and/or deficiency.
        e.  Not acting as "a reasonable person would do, given the same circumstances."
        f.  Younger than eighteen (18) years of age (except those persons outlined in A [1] [b]).

Implied consent.
    1.  If a person is determined to be incompetent, he/she may be treated and transported under the principle of "implied consent" (what the reasonable individual would consent to under the same circumstances). Also see General Protocol 1.2, Behavioral Emergencies.
    2.  If the patient is transported and/or treated on the basis of implied consent, field personnel should use reasonable measures to ensure safe transport to the closest appropriate facility.

**REFUSAL PROCEDURE**
A.      Single patient.
   1. Determine that the individual is involved in the incident.
   2. Determine that the individual is refusing to allow the proper evaluation, or necessary treatment, or necessary transport to the appropriate medical facility.
   3. Determine the mental status and extent and history of injury, mechanism, or illness.
      a. Ensure that the patient is conscious, alert, and oriented and understands (mental reasoning) his/her condition (patient GCS = 15).
      b. Unless the patient specifically refuses, do a complete physical assessment.
   4. Inform the patient and/or responsible party (parent or guardian) of the potential consequences of the decision to refuse treatment and/or transport to a definitive-care facility (loss of life or limb, irreversible sequelae), and ensure that the patient and/or responsible party fully understands the explanation.
   5. All measures should be taken to convince the patient to consent, including enlisting the help of family or friends.
   6. If the patient continues to refuse, the patient and/or responsible party may then sign a "Refusal of Care" form. Ensure that the following information is provided:
      a.   The release is against medical advice.
      b.   The release applies to this instance only.
      c.   EMS should be requested again if necessary or desired.
   7. After the "Refusal of Care" form is signed, it must be witnessed (including legibly printed name, contact information, and signature of witness).
   8.  If the patient or responsible party will not sign the release, then document this refusal on the EMS Run Report. If available, witness signatures should be obtained.
   9. Where possible, patients should be left in the care of family, friends, or responsible parties.
   10. Carefully document the assessment and vital signs, including all issues and circumstances indicated.

B.      Multiple patients.
The protocol does not allow for more than one refusal on a single EMS Run Report. However, individuals who refuse ALL assistance, including proper evaluation, can be combined on a single report (e.g., all parties deny injury). Once an examination is begun on an individual, a separate EMS Run Report must be filled out to record the examination. Also, any later refusal of care requires following the complete protocol outlined previously. The use of multiple refusals of care is primarily designed for incidents that have numerous participants (potential patients) where it becomes evident that some participants are not injured at all or refuse to be examined when approached by EMS personnel.
   1. Complete Steps 1 through 10 in section A.
   2. Document all names, addresses, and witnesses.

C.        Medical Direction: (The Physician at the destination facility or the agency's Medical Director).
   1. Medical direction should be contacted for consultation under the following circumstances (high risk refusal):
      a.   A low-severity patient who is under 18 years of age.
      b.   A patient whose refusal of care represents a significant risk to the patient or EMS system/agency.
      c.   A patient who is not his/her own legal guardian.
      d.   A patient who refuses transport after administration of any IV medication (also consider calling the Police Department for assistance).
   2. If any questions on the assessment of competency or refusal of care occur, contact medical direction for further guidance.

D.        Refusal of transport or transport destination.
   1. Patients who refuse to be transported to the closest appropriate facility and are adamant about being transported to a different facility should be considered to be refusing transport. The local department's supervisor should be contacted for further consultation on the transport destination according to local policy.
   2. When a patient refuses to be transported to any facility, medical direction should be considered for further consultation, when such refusal represents a significant risk to the patient or the EMS system/agency. Refer to local policy for further direction.

**PURPOSE**
To efficiently triage, treat, and transport victims of mass/multiple-casualty incidents (MCIs). The following protocol is applicable to all multiple-victim situations. This protocol is intended for the everyday MCI when the number of injured exceeds the capabilities of the first-arriving unit as well as for large-scale MCIs.

**PROCEDURE**
A. The officer of the first-arriving unit will establish Command and:
1. Perform a size-up, estimating the number of victims.

2. Request a Level 1, 2, 3, 4, or 5 response, and request additional units and/or specialized equipment as required.

3. Identify a staging area.

4. If it is an active assailant incident or any tactical environment with a MCI establish a Unified Command (UC) with Law Enforcement (LE). Consider establishing Liaisons for FD and LE, the Liaisons can interact with each other allowing the transfer of info between agencies. Law Enforcement will make entry with their contact team and provide feedback to the UC and the decision may be made to establish a Rescue Task Force (team of LE officers providing forced protection for rescue personnel). The Rescue Task Force will initiate triage and provide immediate life saving treatment (i.e hemorrhage control).

5. If the area is deemed safe to enter direct the remaining crew members and any additional personnel arriving to initiate triage.

6. Triage will be performed in accordance with START or JumpSTART.
   Prioritize victims utilizing color-coded ribbons:
   **Red**          Immediate care
   **Yellow**       Delayed care
   **Gree**n        Ambulatory (minor)
   **Black**        Deceased (non-salvageable)

7. Locate and direct the "walking wounded" to one location away from the incident, if possible. These victims need to be assessed as soon as possible. Assign someone to keep the walking wounded together.

8. Active assailant incidents considerations: Be on high alert for suspicious individuals, packages, vehicles or potential IEDs. Integrated active assailant response should include the critical actions contained in the acronym THREAT
   **T**hreat suppression
   **H**emorrhage control
   **R**apid **E**xtrication to safety
   **A**ssessment by medical providers
   **T**ransport to definitive care

B.  As additional units arrive, Command will designate the following officers:
1.          Triage (Initially the responsibility of the first-arriving officer).
2.          Treatment.
3.          Transport.
4.          Staging.

C.  Additional branches/sections may be required depending on the complexity of the incident. These officers may include, but are not limited to:
1.          Medical Branch.
2.          Landing Zone/Heli-spot.
3.          Extrication.
4.          Hazardous Materials (hazmat).
5.          Rehabilitation.
6.   Safety.
7.   Public Information Officer (PIO).
8.   Medical Intelligence - to assist with suspected or known WMD (weapons of mass destruction) events for decontamination, antidotes, and treatment.

D.  MCI: predetermined response plan.
1.          Considerations:
   a.  An MCI shall be classified by different levels depending on the number of victims. The number of victims will be based on the     initial size-up, prior to triage.
   b.  Levels of response will augment the units already on the scene, and units enroute will be included in the assignment. The exception would be in conjunction with a Fire Alarm assignment i.e., a fire with multiple victims may be a Second Alarm with an MCI Level 3 response; this will be two separate assignments.
   c.  Command can downgrade or upgrade the assignments at any time.
   d.  All units will respond to the staging area emergency response unless otherwise directed by Command.
   e.  When announcing an MCI, specify the general category (e.g., trauma, hazardous materials, smoke inhalation).
   f.  Any victim meeting trauma transport criteria must be reported to a state-approved trauma center for determination as to transport destination. Trauma transport criteria will be determined during the secondary triage in the treatment phase. When the trauma center(s) are overwhelmed they will notify MedCom of the need for units to transport to other trauma centers or non-trauma centers
   g.  Consider the use of air transport for patients with special needs, mass-transit resources for multiple "walking wounded" patients, and private BLS transport units.
   h.  Consider the use of mobile command vehicles, medical supply trailers, and communication trailers as needed.
   i.  Upon notification of an MCI, Medical Control (Medcom/MRCC) will gather information about each hospital's capability and relay this information to the Transport Officer or Medical Communication Officer.
   j.  On a large-scale incident, consider sending a Hospital Coordinator to each hospital to assist with communications.
   k.  Request law enforcement to set up a safety parameter.

2.            Definitions.
 a. Active <u>assailant</u>: The Department of Homeland Security's (DHS) definition of an active assailant is an individual actively engaged in killing or attempting to kill people in a confined, populated area; in most cases, active shooters use firearms and there is no pattern or method to their selection of victims.
 b. Active <u>assailant</u> Incident: Active <u>assailant</u> situations are unpredictable and evolve quickly; most are over within 10 to 15 minutes.
 c. Casualty Collection Point (CCP): A safe location(s) where fire rescue personnel can receive victims. Victims may have to be carried or dragged to the CCP. This may be inside a structure or exterior. This may be the same as the treatment area if located in the cold zone.
 d. Concealment: Concealment is a law enforcement term that represents an object that only provides protection from observation.
 e. Contact Team: Contact team is a law enforcement term used to designate the team of law enforcement officers that make entry with the specific intention of ONLY going after and neutralizing the perpetrator.
 f. Cover: Cover is a law enforcement term that represents an object or location that provides protection from direct gunfire.
 g. Improvised Explosive Device (IED): The Department of Defense (DOD) definition of an IED is a device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, or incendiary chemicals and designed to destroy, incapacitate, harass, or distract. It may incorporate military components, but is normally devised from nonmilitary components.
 h. Litter Bearer: A team of personnel assigned to Triage to move victims from the incident site to the treatment area or Transport Units.
 i. Rescue Task Force: Rescue personnel and Law Enforcement personnel formed to make entry into a structure to triage victims and provide life saving immediate treatment as needed i.e stopping hemorrhage.
 j. Strike Team: Five of the same type of units, including common communications and a leader (i.e., an ALS Transport Unit Strike Team would consist of five ALS Transport Units with a leader).
 k. Tactical Environment – Any environment that Law Enforcement has a tactical objective due to a threat assessment (which may require a Fire Rescue/EMS component).
 l. Task Force: Five different types of units, including common communications and a leader. MCI Task Force: May be two ALS Transport Units, two BLS Transport Units, and one Suppression Unit, including common communications and a leader.
 m. THREAT: acronym for Threat suppression, Hemorrhage control, Rapid Extrication, Assessment by medical providers, and transport to definitive care.
 n. Zones in relation to Active assailant/Mass Casualty Incidents :
    1. Hot Zone – Direct Threat Care/Care Under Fire - This zone shall be designated at the area of the structure that has not been cleared by law enforcement or the area that the perpetrator is currently in.
    2. Warm Zone – Indirect Threat Care/Tactical Field Care - This zone shall be designated at any area of the active assailant incident that has been declared available for entry by Fire Rescue/EMS personnel with armed LE coverage to perform immediate life saving treatment and triage to victims prior to their removal from the initial hazard.
    3. Cold Zone – Evacuation Care/Tactical Evacuation Care - This zone extends beyond the warm zone and is not reachable by the perpetrator. This zone shall encompass positions such as the command post, staging and other functional groups.

**MCI Level 1 (5-10 victims)**
- 4 ALS Transport Units
- 2 Suppression Units
- 1 Shift Supervisor
- 1 EMS Supervisor

Note - The two hospitals and trauma center closest to the incident will be notified by Medical Control (Medcom or local communications center).

**MCI Level 2 (11-20 victims)** (any active assailant incident until an accurate victim count can be made)

- 6 ALS Transport Units
- 3 Suppression Units
- 2 Shift Supervisors
- 2 EMS Shift Supervisors

Note - The three hospitals and two trauma centers closest to the incident will be notified by Medical Control (Medcom or local communications center).

**MCI Level 3 (21-100 victims)**
- 8 ALS Transport Units
- 4 Suppression Units
- 3 Shift Supervisors
- 3 EMS Shift Supervisors
- Command Vehicle
- MCI Trailer
- Operations Chief

Note – The four hospitals and three trauma centers closest to the incident will be notified by Medical Control (Medcom or local communications center). The Warning Point will notify the Emergency Management Agency.

**MCI Level 4 (101-1000 victims)**
- 5 MCI Task Forces (25 units)
- 2 ALS Transport Strike Teams (10 units)
- 1 Suppression Unit Strike Team (5 units)
- 2 BLS Transport Strike Teams (10 units)
- 2 Mass Transit Buses
- 2 MCI Trailers
- Command Vehicle
- Communications Trailer
- 5 Shift Supervisors
- 3 EMS Shift Supervisors,1 EMS Chief
- Operations Chief

Note - The 10 hospitals and 5 trauma centers closest to the incident will be notified by Medical Control. The Warning Point will notify the Emergency Management Agency.
In an ongoing, long-term MCI, the Metropolitan Medical Response System (MMRS) and the State Medical Assistance Response Team (SMRT), Medical Reserve Corp (MRC), Florida Advanced Surgical Team (FAST) Disaster Medical Assistance Team (DMAT) may be notified.

**MCI Level 5 (more than 1000 victims)**
- 10 MCI Task Forces (50 units)
- 4 ALS Transport Strike Teams (20 units)
- 2 Suppression Unit Strike Teams (10 units)
- 4 BLS Transport Strike Teams (20 units)
- 4 Mass Transit Buses
- 2 Command Vehicles
- 4 Supply Trailers
- Communications Trailer
- 10 Shift Supervisors
- 6 EMS Shift Supervisors
- 2 EMS Chiefs
- 2 Operations Chiefs

Note -The 20 hospitals and 10 trauma centers closest to the incident will be notified by Medical Control. The Warning Point will notify the Emergency Management Agency. In an ongoing, long-term MCI, the MMRS, DMAT, SMRT, MRC, FAST and the International Medical and Surgical Response Team (IMSURT) may be notified.

Strike Team: Five of the same type of units, including common communications and leader.
Task Force: Five different types of units, including common communications and leader. MCI Task Force: May be two ALS Transport Units, two BLS Transport Units, and one Suppression Unit, including common communications and leader.

**OFFICER RESPONSIBILITIES** - See Online Forms for Field Operating Guides.

A. **Command.**
1. Established by the first arriving officer. Radio designation "Command."
2. Follow Field Operation Guide (FOG) #1.
3. If active assailant or tactical environment incident get briefing from LE, establish a Unified Command and co-locate with LE. Consider establishing Liaisons for FD and LE, the Liaisons can interact with each other allowing the transfer of info between agencies.

4. Remain in a safe, fixed, and visible location, uphill and upwind of the incident.
5. Determine the MCI Level (1, 2, 3, 4, or 5). If unknown victims in an active assailant/tactical environment initiate a MCI level 2 until a count can be determined.
6. Designate a staging area.
7. Assign personnel to perform the functions of Triage, Rescue Task Force (if needed), Treatment, Transport, and Staging.
8. Advise the Communications Center of the number of victims and their categories once triage is complete.
9. During large-scale or complex MCIs (e.g., a fire with multiple victims/tactical environment incident), designate a Medical Branch to reduce the span of control.
10. If the incident is due to a known or suspected weapon of mass destruction (WMD event), refer to WMD FOG #8 and designate a Medical Intelligence Officer to assist with decontamination, antidotes, and treatment of victims.
11. If active assailant/tactical environment refer to FOG #9
12. Ensure proper security of the incident site, treatment area, and loading area; also provide for traffic control and access for emergency vehicles, including law enforcement.

B. **Medical Branch.**
1. Radio designation "Medical." Follow FOG #2.
2. Assure Triage, Treatment, and Transport has been established. If established by Command, Triage, Rescue Task Force, Treatment, and Transport will now report to the Medical Branch.
3. Work with Command, and direct and/or supervise on-scene personnel from agencies such as the Medical Examiner's Office, Red Cross, private ambulance companies, and hospital volunteers.
4. Ensure notification of Medical Control (Medcom/MRCC).
5. If the incident is due to a known or suspected WMD, refer to WMD FOG #8 and designate a Medical Intelligence Officer to assist with decontamination, antidotes, and treatment of victims.
6. If active assailant/ tactical environment refer to FOG #9
7. Ensure proper security of incident site, treatment area, and loading area; also provide for traffic control and access for emergency vehicles, including law enforcement.

C. **Triage Officer**.

Reports to Command or the Medical Branch. Supervises the Triage Personnel, Rescue Task Force (if needed) and Litter bearers. Also directs Medical Examiner personnel locate deceased victims.

1. Radio designation "Triage", follow FOG #3.
2. Organize the Triage Team to begin initial triaging of victims. Assemble the walking wounded and uninjured in a safe area. Use bullhorns or a public address (PA) system if necessary.
3. Advise Command (or the Medical Branch, if established) as soon as possible if there is a need for additional resources.
4. Coordinate with Treatment to ensure that priority victims are treated first.
5. Ensure that all areas around the MCI scene have been checked for potential victims, walking wounded, ejected victims, and so forth.
6. Maintain security and control of the triage area. Request the assistance of law enforcement.
7. If a RTF is formed designate a Triage Aide to communicate with the RTF.
8. If there is more than one RTF team, designate the teams as RTF 1, RTF 2 etc.
9. Have the RTF mark the doors with the victim count using a grease pencil R=__, Y=__, G=__, B=__ (greens should have left the area but may stay to assist with care or supervision, i.e. a teacher).
10. Report to Command/Medical Branch upon completion of duties for further assignments.

D. **Treatment Officer**.

Reports to Command or the Medical Branch. Supervises the Treatment Managers of the Red, Yellow, and Green Areas. Coordinates the retriage and tagging of all victims and the on-site medical care. Directs the movement of victims to the loading area(s).

1. Radio designation "Treatment", follow FOG #4.
2. Consider assigning a Documentation Aide to assist with paperwork.
3. Direct personnel to either begin treatment on the victims where they lay or establish a centralized treatment area.
4. Considerations for a treatment area:
   a. Capable of accommodating the number of victims and equipment.
   b. Consider weather, safety, and the possibility of hazardous materials.
   c. Designate entrance and exit areas, which are readily accessible (funnel points).
   d. On large-scale incidents, divide the treatment area into three distinct areas based on priority. Designate a Treatment Manager for each area (Red, Yellow, Green). Use appropriate-color tarps if available.
5. Complete a Treatment Log as victims enter the area.
6. Ensure that all victims are retriaged through a secondary exam and the assessment is documented on a triage tag (Disaster Management System [DMS] - All Risk Triage tag). The rescuer filling out the All Risk Triage tag will keep a corner of the tag for future documentation.
7. All red-tagged victims will be transported immediately as transport units become available. These victims should not be delayed in the treatment area.
8. Ensure that enough equipment is available to effectively treat all victims.
9. Establish communications with Transport to coordinate proper transport of the appropriate victims. Direct movement of victims to the ambulance loading areas.

E. **Transport Officer.**

Reports to Command or the Medical Branch. Supervises the Medical Communication Coordinator and Documentation Aide(s). The Transport Officer is responsible for the coordination of victims and maintenance of records relating to victim identification, injuries, mode of transportation, and destination.

1. Radio designation "Transport", follow FOG #5.
2. Assign a Documentation Aide with a radio to assist with paperwork and communications.
3. Assign a Medical Communication Coordinator to establish continuous contact with Medical Control (Medcom or MRCC).
4. Establish a victim loading area. Advise Staging of the location and direction of travel. Consider requesting law enforcement assistance for ensuring the security of the loading area.
5. Arrange for the transport of victims from the treatment area. Maintain a Hospital Transportation Log #5B. Keep a piece of the triage tag for future documentation.
6. Communicate with the Landing Zone (LZ)/Heli-spot Officer and relay the number of victims to be transported by air. Air-transported victims should be assigned to distant hospitals, unless the victims' needs dictate otherwise (e.g., trauma center, burn unit).

F. **Medical Communications Coordinator.**

Reports to the Transport Officer and is responsible for maintaining communication with Medical Control to assure proper victim transport information and destination.

1. Radio designation "Communication." Follow FOG #5A.
2. Establish communication with Medical Control (Medcom or MRCC[1]). Advise Medical Control of the overall situation (e.g., smoke inhalation, trauma, burns, hazardous materials exposure) and the number and categories of victims. Medical Control will survey area hospitals to determine their capabilities and capacities and then relay this information to the field. Document this information on the Hospital Capability Worksheet #5C and maintain this document for the duration of the incident.
3. When units are prepared to transport, advise Medical Control and supply of the following information:
   a.   The unit transporting.
   b.   The number of victims to be transported.
   c.   Their priority: Red, Yellow, or Green.
   d.   Any victims with special needs (e.g., cardiac, burn, trauma).
4. The Medical Communication Coordinator, in conjunction with Medical Control, will determine the most appropriate facility. Ground-transported victims should be assigned to hospitals on a rotating basis.
5. Once Medical Control receives the information from the Medical Communication Coordinator, Medical Control will notify the appropriate hospital. Transporting units will not contact the individual hospital on their own, unless there is a need for medical direction/care outside of protocols.

[1] Medical Resource Coordination Center (MRCC): The MRCC's prime function is to maintain status information—that is, the number of victims and the hospital readiness status to accept victims, to coordinate transportation, and to direct patients to the appropriate hospital during a disaster or other situation characterized by a high demand for medical resources

G. **Medical Supply Coordinator.**
Reports to the Medical Branch and is responsible for acquiring and maintaining control of all medical equipment and supplies.
1. Radio designation "Supply", follow FOG #6.
2. Assure necessary equipment is available on the transporting vehicle.
3. Provide an inventory of medical supplies at the staging area for use on scene.
4. Assure support vehicles are requested. (Broward County has four MCI supply trailers and Region 7 has three large MCI supply trailers available for use during a large-scale MCI.)

H. **Staging Officer**.
Reports to Command and is responsible for managing all activities within the staging area.
1. Radio designation "Staging", follow FOG #7.
2. Establish the location of a staging area and notify the Communication Center to direct any incoming units.
3. Maintain a Unit Staging Log #7A.
4. Ensure that all personnel stay with their vehicles unless otherwise directed by Command. If personnel are directed to assist in another function, ensure that the keys stay with each vehicle.
5. Coordinate with the Transport Officer the designation of a location for victim loading and the best route to the area.
6. Maintain a reserve of at least two transport vehicles. When the reserve is depleted, request additional units through Command.

**DOCUMENTATION**
A. The Incident Commander will, at the completion of the incident, coordinate the gathering of all pertinent documentation.
B. A Post-Incident Analysis (PIA) will be completed.

**MCI Kits For Responder Vehicles**

Each unit should carry an MCI bag. The following items are recommended:
A.  Two (2) triage packs recommend to have:
    1.  Four (4) combine dressings
    2.  Four (4) 4 × 4's
    3.  Gloves
    4.  One (1) pediatric face mask
    5.  Colored ribbons (Red, Yellow, Green & Black) either rolls or ribbons.
    6.  Trauma Tourniquets (2)
    7.  Hemostatic Dressing (2)
    8.  Chest Decompression Needles(2)
    9.  Chest Seals (2)
B.  Fifty (50) triage tags—Disaster Management Systems (DMS) All Risk Triage tags.
C.  Pencils/grease pencils and pens.
D.  Additional tourniquets, hemostatic dressing, chest seals & chest decompression needles (10)
E.  The following MCI FOGs, logs, and associated paperwork for each officer:
    1.  Command FOG #1 - White
    2.  Medical FOG #2 - Blue
    3.  Triage FOG #3 - Yellow
    4.  Treatment FOG #4 - Red
    5.  Treatment Area Log #4A - Red
    6.  Transport FOG #5 - Green
    7.  Medical Communication FOG #5A - Green
    8.  Hospital Transport Log #5B - Green. (10 logs)
    9.  Hospital Capability Worksheet #5C - Green
    10. Medical Supply FOG #6 - Blue
    11. Staging FOG #7 - Orange
    12. Unit Staging Log #7A - Orange
    13. MCI-WMD/Terrorist Event FOG #8 - Beige

**MCI SUPERVISOR KIT**
A.  Complete vest set with the following identification vests:
    1.  White for Command.
    2.  Blue for Medical Officer.
    3.  Yellow for Triage Officer.
    4.  Red for Treatment Officer.
    5.  Green for Transport Officer.
    6.  Green for Medical Communication Coordinator.
    7.  Blue for Medical Supply Officer.
    8.  Orange for Staging Officer.
 B.  Clipboard which contains paperwork for each officer, pens/pencils/grease pencils, and paper.
 C.  EMS Command Board.
 D.  Tarp set: red, yellow, green, black tarps.
 E. Patient tracking device/Scanner (if available)
 F  Bullhorn (if available)

**START SYSTEM OF TRIAGE**

This procedure is based on the Simple Triage and Rapid Treatment (START) process for adult victims and the JumpSTART adaptation for pediatric victims.

**PROCEDURE**

A. Initial triage: Using the START or JumpSTART method (described in the following two sections):
   1. Locate and direct all of the walking wounded to one location away from the incident if possible. Assign someone to keep them together (Fire Rescue Department personnel, Law Enforcement officer, or capable bystander).
   2. Begin assessing all non-ambulatory victims where they are found.
   3. Utilize the triage ribbons tied to an upper extremity in a visible location.
   4. Independent decisions should be made for each victim. Do not base triage decisions on the perception of too many reds, not enough greens, and so forth.
   5. If borderline decisions are encountered, always triage to the most urgent priority (e.g., for a Green/Yellow patient, tag as Yellow).

B.                      Secondary triage.
   1. Performed on all victims during the Treatment phase. If a victim is identified in the initial Triage phase as a Red and transport is available, do not delay transport to perform a secondary assessment.
   2. Utilize a triage tag (Disaster Management System [DMS] All Risk Triage tag) and attempt to assess for and complete all information required on the tag (time permitting). Affix the tag to the victim and remove the ribbon.
   3. The triage priority determined in the Treatment phase should be the priority used for transport. If trauma-related, the trauma transport criteria will be applied to trauma victims during the secondary triage in the Treatment phase.

Remember the mnemonic RPM (Respiration, Perfusion, Mental status). The first assessment that produces a Red stops further assessment. Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage, should be managed during the triage phase. Any major external bleeding should also be controlled at this time. Depending on the victim's injuries (burns, fractures, bleeding), it may be necessary to prioritize as Yellow

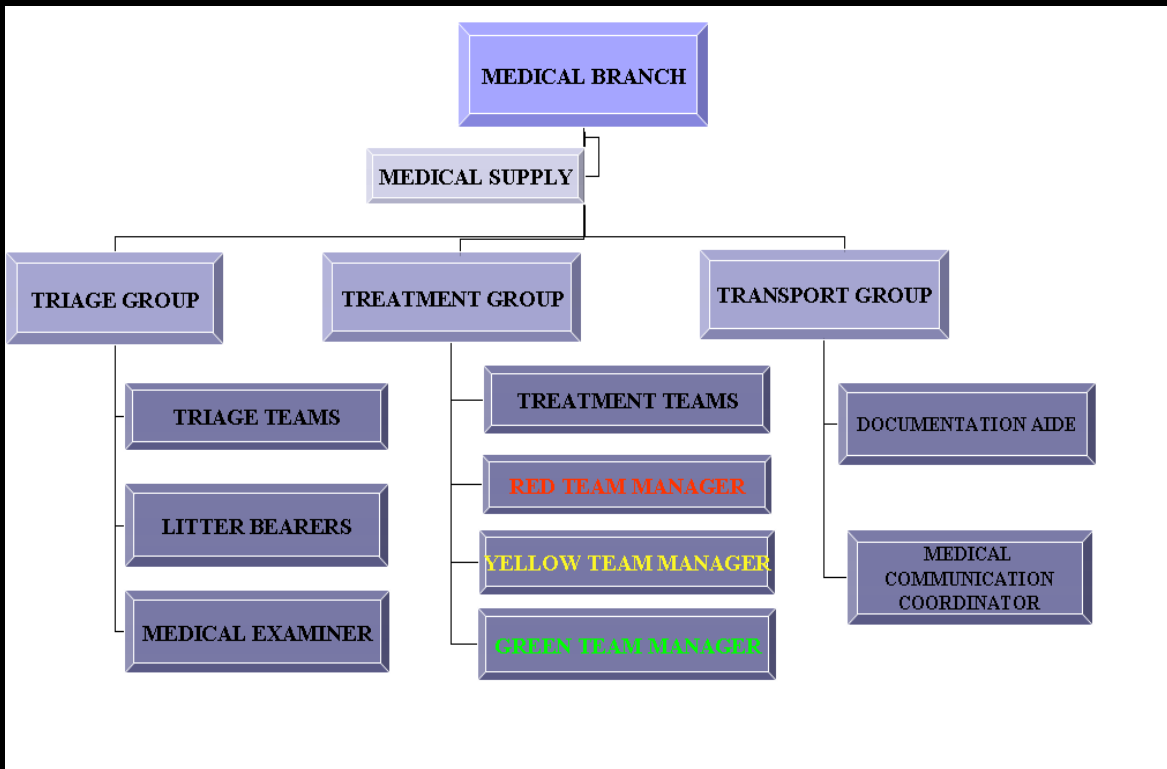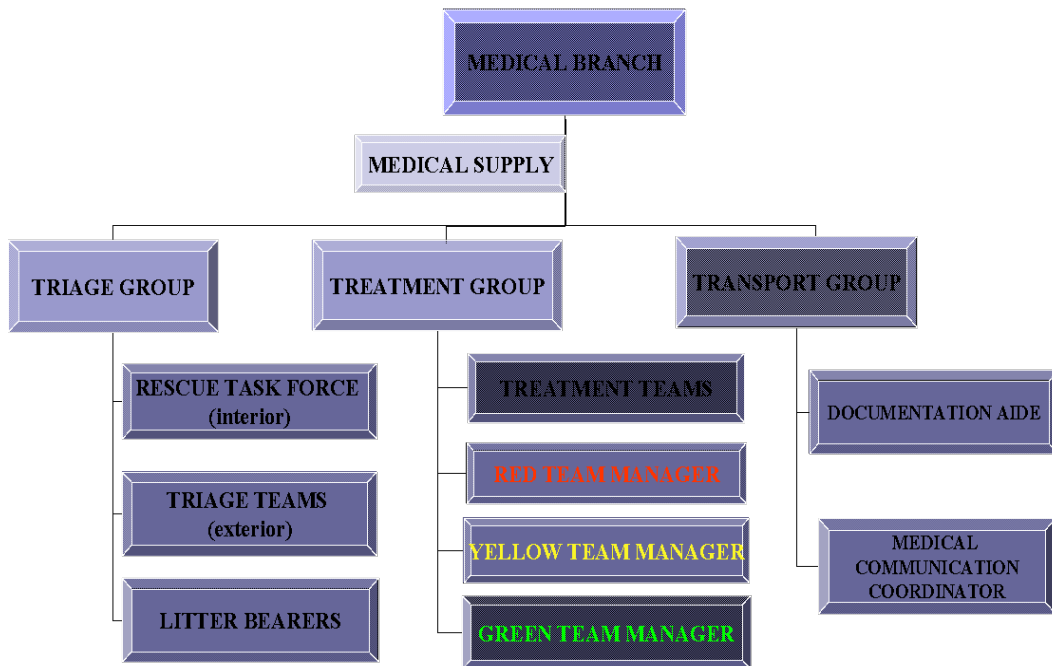| START *modified 9/2015* | |
|---|---|
| Move the Walking Wounded | **GREEN** |
| No Respiration after head tilt | **BLACK** |
| *Control Severe Bleeding* | |
| **R**espirations over 30/min/ Respiratory Distress | **RED** |
| **P**erfusion (No radial pulse) | **RED** |
| **M**ental Status (unable to follow commands) | **RED** |
| Stable RPM/Walking | **GREEN** |
| Stable RPM/Non ambulatory | **YELLOW** |
| *Conduct Secondary Triage in the Treatment Phase* | |
| | |

**JUMPSTART TRIAGE**

Physiological differences in children necessitate adaptation of the standard START triage method in children 8 years of age or younger, or in those victims with the anatomical or physiological features of a child in the age group. The same parameters (RPM) are utilized, with the adaptations indicated here.

| JumpSTART *modified 9/2015* | |
|---|---|
| Move the Walking Wounded (access as soon as possible) | **GREEN** |
| No Respiration after head tilt/No peripheral pulse | **BLACK** |
| **R**espirations    45/min or   15/min (   Work of Breathing) | **RED** |
| *No resp with pulse give 5 ventilations via barrier* | |
| *   Respirations resume* | **RED** |
| *   No spontaneous respirations* | **BLACK** |
| *Control Severe Bleeding* | |
| **P**erfusion (No radial pulse) | **RED** |
| **M**ental Status (AVPU) Alert/Verbal | **YELLOW** |
| Pain/Unresponsive | **RED** |
| *Stable RPM/Walking* | **GREEN** |
| *Stable RPM/Non ambulatory* | **YELLOW** |
| *Conduct Secondary Triage in the Treatment Phase* | |

Note -Infants who are developmentally unable to walk should be triaged using the JumpSTART algorithm either during initial triage or in the Green area if carried out by a nonrescuer. During triage, if the infant does not fulfill the criteria of a Red victim and has no other outward signs of significant injury; he/she may be triaged as a Green victim.

Note -The START Triage system was developed by Newport Beach Fire Rescue and Hoag Hospital. The JumpSTART Triage system was developed by Dr. Lou Romig.

MEDICAL BRANCH

MEDICAL SUPPLY

TRIAGE GROUP

TREATMENT GROUP

TRANSPORT GROUP

RESCUE TASK FORCE (interior)

TRIAGE TEAMS (exterior)

LITTER BEARERS

TREATMENT TEAMS

RED TEAM MANAGER

YELLOW TEAM MANAGER

GREEN TEAM MANAGER

DOCUMENTATION AIDE

MEDICAL COMMUNICATION COORDINATOR

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MEDICAL BRANCH

MEDICAL SUPPLY

TRIAGE GROUP

TREATMENT GROUP

TRANSPORT GROUP

TRIAGE TEAMS

LITTER BEARERS

MEDICAL EXAMINER

TREATMENT TEAMS

RED TEAM MANAGER

YELLOW TEAM MANAGER

GREEN TEAM MANAGER

DOCUMENTATION AIDE

MEDICAL COMMUNICATION COORDINATOR

**Above – Complex MCI Command Structure**

**Below - Active Assailant /Tactical Environment MCI Command Structure**

This protocol will be used when law enforcement personnel advise EMS that they have responded to a crime scene or EMS determines that a crime scene may exist.

A. Purpose: To ensure the protection of patient welfare as well as to ensure the ability to conduct an effective and thorough investigation.
B. Response/on-scene situations.
   1. Only those units assigned will respond to the call. Over-response tends to cause confusion at the crime scene and destruction of evidence.
   2. When approaching a potential crime scene that is being protected by law enforcement personnel, the paramedic/EMT may request entry into the area to determine the life status of the individual.
   3. If law enforcement personnel refuse access to the crime scene, do not become confrontational. Notify the EMS Agency Supervisor and complete an incident report as required.
   4. When personnel are allowed access into the scene, the minimum number of required EMS personnel should enter to minimize disturbance of the crime scene.
   5. Do not attempt resuscitation if the patient has no pulse, has no spontaneous respiration, and meets criteria outlined in General Protocol 1.4, Death in the Field.
   6. If treatment and/or resuscitation are warranted, follow the appropriate protocol.
   7. When on scene:
      a. Keep your medical equipment close to the victim.
      b. Stay close to the body.
      c. Keep your hands out of any blood that has pooled.
      d. Do not wander around the scene.
      e. Minimize destruction of the patient's clothing. If the patient's clothing has a puncture, do not use the hole in the clothing to start cutting. Begin cutting at another part of the garment. Removed clothing should be left with the patient or turned over to law enforcement personnel.
      f. Do NOT go through the victim's personal effects, clean the body, or cover the body with a sheet or other material (if expired).
      g. Do NOT move, take, or handle any object at the scene or litter the crime scene with medical equipment, dressings, bandages, or other supplies.
      h. If resuscitation efforts are deemed necessary, transfer the victim from the scene to the vehicle expeditiously and stabilize the victim in the vehicle, when possible.
      i. If the patient relates any information relating to the crime while in transit to the medical facility, inform law enforcement personnel at once.

## 1.11    Protocol Revision Procedure

Any person may submit input for changes to the Common Protocols. The following procedure will be used to receive and process this input.

**PROCEDURE** (Electronic)
1. Any member of a participating EMS agency will be permitted to submit queries and suggestions regarding the Common Protocols via the electronic web based version of the protocols.
2. The protocols will be located on www.GBEMDA.org and a link will be located on the Broward EMS Council's website www.Broward.org/BrowardEMS
3.      Simply click on a protocol item and review its contents.
4.      At the bottom right hand portion of the screen click on the "Make a Suggestion" link.
5.      Fill out the required fields:
    a.      Department
    b.       Full Name
    c.       Telephone Number
    d.       Email address
    e.       Protocol number
    f.       Comments
6.      Press Submit
7. Your comment will be sent via email to the Medical Director and EMS Chief for your particular EMS Agency
8. Medical Directors will meet yearly (or sooner if more emergent) to discuss the submitted items, reviewing their merit, and bringing substantiated items up for discussion and potential revision.
9. Once the changes to the Common Protocols have been implemented, the electronic protocols will be updated on the Broward EMS website and all hospitals will be notified.
10. It is the intent of this procedure that every EMS provider implements all approved changes to the Common Protocols.
11. The Medical Director of an individual EMS provider reserves the right to change portion of the protocols, however, if they are unique to that specific department, the information will be located on a department specific page within the PDF.