

From: Golden, Percy - FROD <PGolden@coj.net>

Sent: Wednesday, December 3, 2025 3:23:54 PM

To: Teal, Jason - CCSS <JTeal@coj.net>

Cc: Diamond, Rory - City Council Office <RDiamond@coj.net>; Latour, Makenzi - CCSS <MSConner@coj.net>; Blanton, Jake - FROD <JBlanton@coj.net>; Fackler, Michael <MFackler@coj.net>

Subject: RE: Duval DOGE Committee Telehealth Document Requests and Interrogatories

Good Afternoon Jason,

I've attached the zip file with the documents requested, and below are the responses to the interrogatories:

- How long has Dr. Brad Elias worked at Baptist Hospital in Jacksonville? **Dr. Brad Elias has worked at Baptist Hospital in Jacksonville since 2004.**
- Does Dr. Brad Elias personally provide medical services to JFRD or City patients or refer any JFRD or City patients to Baptist Hospital in Jacksonville for emergency medical services? **No. Dr Brad Elias does not provide medical services to JFRD or City patients or refer any JFRD or City patients to Baptist Hospital in Jacksonville for emergency medical services.**
- Does Dr. Brad Elias direct Emergency Resources Group to direct patients to a specific treatment facility? **No. Dr. Brad Elias does not direct Emergency Resources Group to direct patients to any specific treatment facility. Emergency Resources Group serves as a staffing agency for Dr. Elias, where he works one shift per month as an emergency medical physician. His role does not involve directing patient transport or treatment facility decisions.**

Please let me know if you need any additional information.

Thank you,

Percy Golden II
Director/Fire Chief
Jacksonville Fire & Rescue Department
515 N. Julia Street
Jacksonville, FL 32202



From: Teal, Jason - CCSS <JTeal@coj.net>

Sent: Thursday, November 20, 2025 4:52 PM

To: Golden, Percy - FROD <PGolden@coj.net>

Cc: Diamond, Rory - City Council Office <RDiamond@coj.net>; Latour, Makenzi - CCSS <MSConner@coj.net>; Blanton, Jake - FROD <JBlanton@coj.net>; Fackler, Michael <MFackler@coj.net>

Subject: Duval DOGE Committee Telehealth Document Requests and Interrogatories

Dear Chief Golden:

At the direction of the City Council's Duval DOGE Committee, please find attached a Request for Production of Documents and Interrogatories regarding the DOGE Committee's investigation of the City's telehealth contract with Telescope Health. This is an investigation from the City Council, and this request is not bound by public records exemptions or any other privacy or confidentiality laws. The deadline for the production of these documents and responses to these interrogatories is as soon¹ as is

Any questions that you may have regarding the attached document should be directed to Council Member Rory Diamond.

Sincerely,

Jason Teal

Jason R. Teal
City Council Secretary/Legislative Counsel
117 West Duval Street
Suite 425
Jacksonville, Florida 32202



STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE COMMUNICATIONS

CREATED: 07/25

REVISED: 00/00

TITLE: CALL HANDLING
FOR MEDICAL ALARM
INCIDENTS
SOP: 203

203.00

PURPOSE

To provide all Emergency Dispatchers (ED) with approved procedures for obtaining initial case information and subsequently processing calls for service initiated from medical alarm companies.

203.01

POLICY

When a call is received reporting a Medical Alarm, the ED shall process the call through Priority Dispatch EMD, following the process described below. It is the intent of this policy that the outlined method for processing Medical Alarms is adhered to consistently and without exception. All required questions must be asked unless the information has been explicitly provided by the caller or is otherwise obvious to the ED.

203.02

INITIAL CALL HANDLING PROCESS

Initial information will be gathered from the caller using the phrases and order below. The ED must ensure that all incident details are thoroughly and accurately documented in CAD comments so that responders can effectively review the incident details.

203.02.01

Answering the Call:

1. Greet the caller with: "Fire and Rescue, [Dispatcher's surname], what is the address of the emergency?"

203.02.02

Verify Caller and Purpose

1. Allow the alarm company to identify themselves and state the purpose of the call.

203.02.03

Gather critical Information in the Following Order:

2. Alarm Location
 - a. "What is the address of the alarm?"
 - b. "Is this a house, apartment, or business?"
3. Access Information
 - a. For all residential locations (apartments, condos, assisted living facilities, etc.) collect all necessary access information
 - Location name
 - Building letter/number
 - Apartment/room number



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- Enter this information accurately into the CAD incident.
- b. For all non-residential locations, collect all necessary access information
 - Business or building name
 - Floor number
 - Office or suite number
 - Specific entrance instructions
 - Intersection or street segment (for roadway incidents)
 - Enter this information accurately into the CAD incident.
- 4. Contact information
 - a. "What is the phone number of the premise including the area code?"
- 5. Alarm Company Identification
 - a. "What is your operator ID?"
 - b. "What is your company call back number?"
- 6. Patient and Access Details
 - a. Do you have the patient's name?
 - b. For responders, do you have any key or lockbox information on file?
 - c. Will you be attempting to contact any key holders?
 - d. Do you have contact with the patient?

203.02.04 Scenario-Based Call Processing

1. Scenario 1: Yes – Contact with the patient IS established (via a device)

- a. The ED will ask, "Okay, tell me exactly what happened?"
- b. Create incident in CAD using a call type that best describes what happened.
- c. Process the call in EMD as a 2nd party caller, using the most appropriate Chief Complaint, asking all non-obvious case entry & protocol questions.
- d. Give appropriate PDI's for 2nd party, using appropriate enhancements such as "tell the patient ...or tell them..." etc.
- e. Complete the call following guidelines in Sections 206.03 and 206.04 below.



2. Scenario 2: No – Contact with the patient has never been established through a device.

- a. Create the incident in CAD using call type 32MA
- b. Process the call in EMD as a 4th party caller
- c. The ED may ask “How old is the patient?” and “Is the patient male or female?” from case entry questions.
 - If this information is volunteered by the alarm company, enter the information as given.
- d. “Unknown” may be entered for all other case entry questions
- e. The call will be processed using the sub-chief complaint ‘Medical Alarm’ found under Protocol 32 ‘Unknown Problem’
- f. Enter ‘unknown’ to all protocol questions, except KQ #3 “Did you ever hear them talk/cry?”
 - For this KQ enter “No – alarm/device only”
- g. Give appropriate 4th party PDI’s.
- h. After completing the call with the alarm company as described in Section 206.03, attempt to contact the premises. If contact is made, proceed with Section 206.04 below.

3. Scenario 3: Alarm company advises ‘Contact was made, but we no longer have contact at this time’

- a. The ED will ask, “Okay, tell me exactly what happened.”
- b. If the alarm company can specify a complaint:
 - Process the call in EMD as a 3rd party caller, using the most appropriate chief complaint.
- c. If no specific complaint is known:
 - Process the call in EMD as a 3rd party caller, using the Medical Alarm sub-chief complaint under protocol 32 – *Unknown Problem*.
- d. Ask all non-obvious protocol questions
- e. Give appropriate 3rd party PDIs



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Before ending the call with the alarm company, the ED will:

1. Provide their operator ID (last name or last 3 digits of employee ID)
2. Advise that units have been dispatched
3. Document in the CAD comments field that the information was received from a medical alarm company for the benefit of the responders.

203.04 CONTACTING PREMISES

If a phone number to the premises is available, the ED will:

1. Call the premises on a recorded line
 - a. State the FR CAD incident number of the created call
2. If contact is made with someone at the premises, the ED will advise:
 - a. "A medical alarm has been received, and units have been dispatched."
 - b. Then ask, "Just to confirm, is help needed?"
3. If the caller confirms that help is needed:
 - a. Have the caller reconfirm the address.
 - b. Ask, "Okay, tell me exactly what happened."
 - c. Reopen the EMD case, make any necessary updates, and provide appropriate instructions.

Thank you in advance for your cooperation. Please direct inquiries to the Communications Supervisor or the Quality Assurance Unit (QAU).



**STANDARD OPERATING GUIDELINES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

TITLE: Communications

CREATED: 08/89

REVISED: 5/23

SOG: 401

401.00 PURPOSE

Establish guidelines for radio operations between field personnel and Fire Rescue Communications Center (FRCC) during emergency and non-emergency incidents.

Define JFRD Suppression/EMS assignments.

401.01 800 MHz RADIO

The JFRD performs radio communications on the *First Coast Radio System* (FCRS), an 800 MHz trunked radio system, using mobile and handheld portables.

There are six *Flights* available to the JFRD on the FCRS:

- ***A-Flight***
- ***B-Flight***
- ***C-Flight***
- ***Inter Op***
- ***Hospitals 1***
- ***Hospitals 2***

401.02 ASSIGNMENT OF 800 MHz RADIO FLIGHTS

Assigning incidents to Flights and Talk Groups is the responsibility of FRCC. Units may request to isolate an incident on an alternate Flight and Talk Group, when necessary, by notifying FRCC after dispatch.

FRCC may designate a Flight and Talk Group for the following:

- Incidents requiring 5 or more units
- Isolation of an Air Transport Unit (ATU) with Landing Zone Unit
- Mutual Aid assignments
- Special Event radio communications
- Non-emergency field communications
- Multi-department/agency communications
- Field training exercises



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401.03 A-FLIGHT

401.03.01 A1 (EMS-EAST)

A1 is the primary Talk Group for EMS incidents occurring East or South of the St. John's River requiring dispatch of four or less units. After dispatch, responding units will place their radios on A1.

Incidents assigned to A1 that require additional units which result in an assignment of 5 or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A1 will be monitored by FRCC at all times.

401.03.02 A2 (DISPATCH)

A2 is the dispatch Talk Group for both Suppression and EMS.

FRCC will simultaneously broadcast dispatches across A1, A2, A3, and A4 for the benefit of all units.

Available Suppression and EMS units are required to monitor A2 at all times.

After dispatch, all relayed incident information and field requests shall be conducted on the assigned Flight and Talk Group. After completing the incident, units shall advise their disposition on the assigned Talk Group prior to returning to A2.

All non-emergency status changes (*Available, In-Quarters, En-Route to Tactical Support, etc.*) shall be conducted on the PMDC or A2.

Units advising "*Available*" on A2 without identifying destination will be assumed *Available* in *first-due* territory.

A2 will be monitored by FRCC at all times.

401.03.03 A3 (EMS-WEST)

A3 is the primary Talk Group for EMS incidents occurring West or North of the St. John's River requiring dispatch of four or less units. After dispatch, responding units will place their radios on A3.

Incidents assigned to A3 that require additional units which result in an assignment of five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A3 will be monitored by FRCC at all times.



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401.03.04 A4 (SUPPRESS)

A4 is the primary Talk Group for Suppression incidents requiring dispatch of four or less units. After dispatch, responding units will place their radios on A4. Incidents assigned to A4 that require additional units which result in an assignment of five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A4 will be monitored by FRCC at all times.

401.03.05 A5 (SP EVENT 1) and A6 (SP EVENT 2)

Special Event teams will communicate on and monitor either A5 or A6, unless directed by FRCC to an alternate Talk Group. These channels are encrypted.

Units dispatched to assist Special Event teams with emergency incidents will be instructed by FRCC to change to either A5 or A6. If upgraded to include five or more units, the incident may be isolated on B-Flight by FRCC or by field request.

FRCC will monitor A5 and A6 when in use.

401.03.06 A7 (REPEATER7)

DVRS assigned to F7.

401.03.07 A8 (SUPPORT)

A8 shall be used for non-emergency communications between field personnel and Tactical Support personnel.

Units shall return to A2 and notify FRCC when placed *Out-of-Service* or when advised to respond to a service facility.

A8 is not routinely monitored by FRCC.

401.03.08 A9 (REPEATER9)

DVRS assigned to F9.

401.03.09 A10 (MARINE)

A10 is primarily used on marine incidents involving multiple agencies. It is permanently patched to JSO and FWC.

A10 is not monitored by FRCC.



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401.03.10 **A11 (TALK 1) and A12 (TALK 2)**

A11 and A12 are conventional, simplex radio frequencies used for short-range communication within distances of approximately one mile. These channels may be useful for deployments, company training, or any non-emergency close range communications.

A11 and A12 are not monitored by FRCC.

401.03.11 **A13 (HANNA)**

A13 belongs to Hanna Park. It is commonly used by Ocean Rescue staff assigned to Hanna Park, call sign OCEAN 72.

A13 is not monitored by FRCC.

401.03.12 **A14 (HUGUENOT)**

A14 belongs to Huguenot Park. It is commonly used by Ocean Rescue staff assigned to Huguenot Park, call sign OCEAN 73.

A14 is not monitored by FRCC.

401.03.13 **A15 (ATU)**

A15 is used for communication between JFRD and Air Transport Units.

A15 is monitored by FRCC when in use.

401.03.14 **A16 (TRAINING)**

A16 is used for communication between units engaged in training exercises.

A16 is not monitored by FRCC.

401.04 **B-FLIGHT**

There are four Talk Groups located on B-Flight for isolating major incidents (B1, B5, B9, and B13).

EMS and Suppression incidents requiring five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.



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FRCC will rebroadcast the assigned Talk Group 15 seconds after initial dispatch for the benefit of responding units.

All the Talk Groups have expansion capabilities, in addition to the Main / *Sector Fire Group*:

- 2 Expansion Fire Groups (Sector)
- 1 Announcement Group (AG)

Responding units will initially be assigned to the Main group. Incident Commanders (IC) will use expansion groups at their discretion. The Announcement Group (AG) is used for simultaneously broadcasting information across the assigned Talk Group as well as both its expansion groups. The AG cannot receive transmissions. Radio channels must be returned to *Main* or one of the other expansion groups in the assigned Talk Group to have two-way communications.

B-1 Talk Group	B-5 Talk Group
B1 (main/sector)	B5 (main/sector)
B2 (sector)	B6 (sector)
B3 (sector)	B7 (sector)
B4 (Announcement Group)	B8 (Announcement Group)
B-9 Talk Group	B-13 Talk Group
B9 (main/sector)	B13 (main/sector)
B10 (sector)	B14 (sector)
B11 (sector)	B15 (sector)
B12 (Announcement Group)	B16 (Announcement Group)

401.05 C-FLIGHT

The C-Flight is a shared system throughout City agencies, but some *Talk Groups* (specific channels within the Flight) are specific to an agency/department.

- **C1 - RPTR1** DVRS assigned to Fire 1
- **C2 - JB OR** Jacksonville Beach Ocean Rescue
- **C3 - CECIL OPS** Cecil Field Operations
- **C4 - JAA OPS** Jacksonville Airport Authority Operations
- **C5 - RPTR5** DVRS assigned to Fire 5
- **C6 - NIMSN** National Incident Management North Branch
- **C7 - NIMSS** National Incident Management South Branch



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- **C8 - NIMSE** National Incident Management East Branch
- **C9 - NIMSW** National Incident Management West Branch
- **C10 – JFRD/JSO** Common channel for JFRD/JSO joint operations
- **8TAC94 (C11)** National Mutual Aid Tactical 4, **Fire 8 Repeater**
- **8TAC93 (C12)** National Mutual Aid Tactical 3
- **8TAC92 (C13)** National Mutual Aid Tactical 2
- **8TAC92 (C14)** National Mutual Aid Tactical 1
- **8TAC92 (C15)** National Mutual Aid Tactical 0
- **MA - FLA (C16)** Florida Mutual Aid

401.05.01 National Mutual Aid Communications

C11 through C15 are the National Mutual Aid and Tactical Talk Groups used during incidents requiring assistance across county/state lines.

401.05.02 State Mutual Aid Communications

C16 (MA–FLA) is the Florida Mutual Aid Channel designated for use during a major incident within the state requiring statewide Mutual Aid.

401.06 **INTEROP**

The InterOp-Flight is dedicated to surrounding county Fire and Rescue agencies and the Emergency Operations Center.

401.07 **Hospital Flight 1**

Hospital Flight 1 is dedicated to area hospitals for unit to hospital communication, with each hospital having a dedicated channel.



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401.08 Hospital Flight 2

Hospital Flight 2 is dedicated to area hospitals and future hospitals for unit to hospital communication, with each hospital having a dedicated channel.

401.09 MUTUAL AID COMMUNICATIONS

When responding to immediate surrounding counties and municipalities, the means to communicate with other departments will vary. See Appendix E for detailed information.

At times, it may require FRCC or the other department to “patch” a radio channel between JFRD and that department. When a patch occurs, you will be able to use the assigned channel to communicate with both FRCC and the surrounding county’s units.

401.10 DIGITAL VEHICULAR REPEATER SYSTEM (DVRS)

The DVRS is a small rugged, self-contained radio base station that improves portable radio coverage in challenging structure types, such as high-rises. When utilized, the appropriate chief will announce for crews to switch to the appropriate radio channel (C1, C5, A7, or A9).

Fire 1, Fire 5, Fire 7, and Fire 9 currently have these devices in their vehicles.

Fire 8 is equipped with a standard conventional repeater that utilizes the **C11-8TAC94** channel. No specialized/dedicated channel is needed.

401.11 FLORIDA INTEROPERABILITY NETWORK (FIN)

FRCC is equipped with a *Florida Interoperability Network* (FIN) radio to communicate with other county agencies directly.

The FIN may be patched directly into the 800 MHz radio system, allowing JFRD field personnel to communicate with Mutual Aid counties, if necessary.

FRCC will notify JFRD units participating in a Mutual Aid incident of the designated Talk Group.



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401.12 METRO-JAX TALKGROUP

FRCC is equipped with the Metro-Jax Talkgroup. It is designed to allow for emergency dispatch centers to immediately communicate with the other public safety communication centers in the region when a major incident occurs.

This channel will be used to coordinate needs and responses among the communication centers.

401.13 EQUIPMENT PROBLEMS

Telephone, computer, printer, or software problems shall be relayed to ITD (Information Technologies Division). Requests for station equipment problems shall be submitted through the Tivoli system or by calling 255-1818. Urgent repairs occurring outside normal business hours that require overtime must be authorized by the FRCC shift supervisor.

Power failures at the station shall be reported to FRCC. Field personnel are responsible for monitoring the radio until the power is restored. Field personnel shall inform FRCC as soon as the power is restored.

401.14 FIRE RESCUE COMMUNICATIONS CENTERS

The Fire Rescue Communications Center (FRCC) has two locations. The Primary center is located at JFRD Headquarters (515 N Julia St), and the Back-Up Communications Center (BUCC) is located at Cecil Airport (5847 Aviation Ave).

Both Communications Centers are fully equipped for continuous JFRD operations and therefore may be used interchangeably or simultaneously. FRCC will keep personnel updated as to which is center is active and serving as the main dispatch center.

401.14.01 Fire Alarms and Investigations at FRCC

Should a Fire Alarm, investigation, or an unconfirmed fire occur at a FRCC location that is actively operating as the main dispatch center, the following shall apply:

- The first arriving unit must report to the Communications Center to determine if it is safe for FRCC staff to remain in place
- If deemed safe, the IC or Company Officer shall assign someone to remain in FRCC until the incident is under control



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401.15 FIELD RADIO OPERATION PROCEDURES

Unit identification will precede all field radio transmissions.

To facilitate field communications, units requesting location or status of another unit will be directed to the appropriate Talk Group by FRCC.

Units shall attempt to clear Talk Groups A1, A2, A3, and A4 after hearing emergency dispatch tones (Alert 3, three short beeps in succession) transmitted by FRCC.

Non-essential field communication, personal statements, and catcalls are not permitted.

FRCC shall repeat the following transmissions from field units, including pertinent additional information received from on-scene personnel:

- Disposition updates ("*Available*," "*On-Scene*," etc.)
- EMS Alerts (Trauma Alert, Cardiac Red, etc.)
- W Signals
- Maydays
- Signal 34s

FRCC will not acknowledge units advising "*En-Route*," as this statement is an acknowledgement of dispatch. If units advise "*En-Route*" from a specific location, FRCC will acknowledge the unit and repeat the location.

401.15.01 Unit Status Updates

In an effort to reduce radio traffic, units shall conduct all status changes via the PMDC without the involvement of FRCC. This includes both, dispositions (*Romeo, India, etc.*) and non-emergency status updates (*Available, In quarters, etc.*).

Units en-route to maintenance facilities or other non-emergency operations will advise FRCC when *Out-of-Position, On-Scene, Assignment Complete, and Back-In-Position*.

Upon returning to service in *first-due* territory (from maintenance, assigned incidents, etc.) units will be notified by FRCC of incidents in progress that the unit would normally be assigned to for response.



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401.15.02 Non-Emergency Field Requests

Units requesting to leave *first-due* territory while remaining in service will:

- Secure permission from the appropriate Chief
- Coordinate through FRCC

Units will coordinate with FRCC any unscheduled training or apparatus/equipment testing which may result in a delayed response.

401.15.03 Field Communications During Emergency Response

On-scene units shall directly inform responding units of response status when applicable ("*Cancel*," "*Rapid Response*," etc.) without involving FRCC.

On all EMS Alerts and W Signals, units shall include all pertinent information necessary for relay by FRCC.

Units shall relay any posted or key holder information to FRCC in order to assist in notifications.

Units shall immediately advise FRCC of changes in location or Call Description.

During multi-unit assignments, companies staging at hydrants will advise their location for the benefit of the IC. FRCC will repeat the unit and location.

Units shall notify FRCC immediately when emergency responses are delayed (slow moving train, road blockages, road obstructions, vehicle malfunctions, etc.). FRCC will dispatch the next closest available unit (assisted by the next-due fully staffed/ equipped unit, if applicable) immediately after receiving notification. Units may advise alternate routes and alternate units for dispatch to offset response delay. Units shall advise FRCC immediately when clear of delay and if continuing response.

The following notifications shall generate the 10-minute increment notification from FRCC: Incident Command, Signal 34, Mayday, STEMI Alert, Stroke Alert, Trauma Alert, and Trauma Red. FRCC will broadcast on the Talk Group involved, the location and duration of the incident in 10-minute increments. The 10-minute increments will begin when the applicable command or notification is advised, except for structure fires. The 10-minute increment timer for structure fires shall begin upon dispatch of the incident.

The 10-minute notifications will continue until FRCC has been advised that the situation is under control or patient transport is in progress. The 10-minute increments will be acknowledged by the person in charge.



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Cardiac Reds will generate a 20-minute timer.

When Incident Command is established, personnel establishing and assuming Command will utilize "*Command*" as their radio designation for the duration of the incident or until relieved of Command by another JFRD officer.

During multi-unit responses, units (including those equipped with PMDC's) shall report all *On-Scenes* directly to FRCC.

401.15.04 Hospital Communications

FRCC will advise Rescue Units when a hospital is unable to accept patients due to an *Internal Disaster* (e.g., power failure, water leak, fire).

Units advising Trauma Alert, Stroke Alert, STEMI Alert, Cardiac Red, or Trauma Red will do so as soon as practical, giving:

- Criteria if applicable
- Hospital destination
- ETA to hospital

After receiving a Trauma Alert, Stroke Alert, STEMI Alert, Cardiac Red, or Trauma Red notification, FRCC will contact the appropriate hospital emergency facility relaying all information received.

401.15.05 Other Agency Requests

FRCC shall note all other agencies contacted to assist JFRD units on initial dispatch in the additional information field (JEA en-route, JSO responding, Pop-A-Lock en-route, etc.). If the supporting agency(s) are not required, units should advise FRCC as soon as possible to cancel them.

Units requesting assistance from other agencies (JEA, JSO, Pop-a-Lock, etc.) shall specify the nature at the time of request. Just as is the case with JFRD, these other agencies need detailed information so that they can dispatch appropriately.

401.15.06 Apparatus Problems

Units with vehicle maintenance issues shall contact the Tactical Support Facility during business hours via A8. After hours or holidays, units shall contact FRCC.

401.15.07 Systemwide Radio Failure

Should a systemwide radio failure occur, on-duty personnel must return to their assigned station immediately.



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FRCC will continue to dispatch units via the CAD/PMDC, and Red Phone, as necessary.

Field units must make status updates (i.e., enroute, on-scene, available, etc.) via the PMDC. If unable to do so, or for other critical messaging, FRCC should be contacted by Red Phone or their direct line at 630-0522.

As a last resort, and for the benefit of being able to communicate with nearby units, the following conventional simplex channels shall be utilized. These channels will allow units that are within close range, approximately one mile, of each other to communicate.

- A11 for units East and South of the St. Johns River
- A12 for units West and North of the St. Johns River

Meanwhile, FRCC must also complete the following tasks as soon as possible:

- Contact the Radio Shop to determine the situation and expected length of outage
- Email "FIRE" advising of the situation and the need for on-duty units to return to their assigned station ASAP
- Issue BOLO message to all PMDCs advising of the situation and the need for all units to return to their assigned station ASAP
- Issue message to all Stations via the Purvis Station Alerting System advising of the situation and the need to remain at the station unless dispatched on a call
- Notify the JFRD Admin Group via the Ready Op messaging
- Notify all hospitals about the temporary inability to transmit Med Reports

401.16 DISPATCHED UNITS

401.16.01 Units Responding from Quarters

All dispatches of units in quarters will be preceded by an *Alert 1* (single alert tone of at least a 1-second duration), followed by all applicable dispatch information. It is the responsibility of field personnel to notify FRCC immediately if the unit dispatched:

- Is not in quarters
- Is not appropriately staffed to handle incident
- Has limited capabilities and is unable to handle incident

401.16.02 Available Units

All dispatches of units on an *Available* status will be preceded by an *Alert 2* (alternating "hi-low" alert tone of at least a 1-second duration), followed by all applicable dispatch information.



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If a response is not received from a dispatched unit within 15 seconds of initial dispatch, FRCC will attempt to contact the unit directly by radio and/or red phone. If the unit fails to respond after the second attempt, the next closest available unit will be dispatched and assisted by a fully staffed and equipped unit if applicable. FRCC will contact the appropriate Suppression or Rescue Chief and relay the unit's failure to respond.

It is the responsibility of field personnel to notify FRCC immediately if the unit dispatched:

- Is not closest responder at its current location
- Is not appropriately staffed to handle incident
- Has limited capabilities and is unable to handle incident

401.17 ACKNOWLEDGEMENT OF DISPATCH

401.17.01 Units Responding from Quarters

Units in quarters will acknowledge receipt of dispatch by performing one of the following in descending order:

- Pressing station FSAS confirmation button. This action by itself does not confirm you are enroute
- Confirming dispatch via red phone
- Advising Enroute on appropriate Talk Group
- Pressing the Enroute button on PMDC if equipped

401.17.02 Available Units

Available units shall acknowledge dispatch by advising "*En-Route*" and their current location on the appropriate Talk Group (this includes apparatus equipped with PMDC's) for the benefit of surrounding units. FRCC will acknowledge "*En-Route*" by repeating the unit's current location only.

Available units hearing dispatch of an incident or advised of an incident near their current location will briefly confer with initially dispatched unit to determine which is closer. The responding unit must advise FRCC of the decision.

When an incident is dispatched near their current location, *Out-of-Position* units that are on an *Available* status shall advise FRCC if they are closer than the responding units.



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401.18 FRCC DISPATCH PROTOCOL

The type and amount of information received will dictate the initial assignment dispatched.

The closest available unit will be dispatched to an incident and, if necessary, supported by the next available appropriately equipped and staffed company.

401.18.01 Diverting Units

FRCC shall divert units to other incidents based on the criteria that life takes precedence over property. If units are diverted, the next closest available unit will be dispatched to the first incident and assisted by a fully staffed/equipped unit, if applicable.

Responding units may divert to a second incident, which exceeds the initial assignment in priority after advising they are closer and receiving approval from FRCC. A second unit will be dispatched to the first incident, as FRCC is notified of such.

401.18.02 Cancellations

Only the patient or complainant may request cancellation of responding units prior to the arrival of JFRD or JSO personnel. Upon FRCC relaying complainant/patient request, units may cancel at their discretion.

FRCC will relay cancellation requests from units on-scene or JSO personnel to responding units. Responding units may advise "*Available*" or proceed at their discretion.

401.18.03 Fire Alarms/False Alarms

FRCC will relay all pertinent information received from alarm companies whether the units are en-route or on-scene. Field personnel will utilize this information at their discretion.

401.18.04 Downgrading/Upgrading Alarms

During multi-unit responses, the downgrading of an initial assignment may occur if an on-scene unit provides an initial report, a fire classification, and the appropriate Chief acknowledges the report. Chief Officers or FRCC may then direct responding units to utilize PMDC's or A2 to go available. Units on scene are not included.



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Companies that possess special or prior knowledge of a dispatched location or situation may alter an assignment (upgrade or downgrade) at any time by immediately notifying FRCC of their decision.

When information is received that would increase the amount and type of apparatus/equipment needed, assignments will be upgraded immediately.

FRCC shall upgrade an assignment based upon information received from a complainant, another agency, or field personnel, provided responding units have not arrived.

401.18.05 Limited Jurisdiction Areas

When an incident occurs near a county line or military base, FRCC personnel shall automatically contact the adjacent county or agency and inquire on the availability of emergency units for assistance.

JFRD Suppression apparatus will not be assigned to an EMS incident at NAS JAX or NAS Mayport unless specifically requested by the naval facility.

Misrouted emergency rescue requests from on-base naval housing received by FRCC will be relayed to the Navy Regional Dispatch Center. FRCC will dispatch units when assistance is requested by the naval facility.

FRCC shall contact UNF police for assistance at all incidents occurring on the University of North Florida Campus.

FRCC shall notify Atlantic Beach Police and Neptune Beach Police of all life-threatening incidents occurring within their jurisdiction.

401.18.06 Law Enforcement Dispatched for Scene Safety

The appropriate police agency will be dispatched to bars, lounges, or any high-risk location where JFRD field personnel may be in danger.

Responding units will be advised immediately as to any unusual or dangerous circumstances (fights in progress, suspect on scene, etc.)

The appropriate police agency will be dispatched for traffic control on the initial dispatch of commercial structure fires, apartment fires, hazardous material incidents, and mass casualty incidents.



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401.18.07 Automated Skyway Express

FRCC shall notify the Skyway Control Center Operator via the Red Phone if any incident involves the Skyway. FRCC shall instruct the operator to de-energize the rail system until verification of the incident location has been established.

If an emergency occurs outside normal Skyway hours of operation, FRCC will contact the Skyway Operations Manager to meet the awaiting Suppression Company at the Control Center.

401.18.08 Tankers

Tankers will automatically be assigned when they appear in the suggested assignments and upon field request.

401.18.09 Ladders

Ladder companies are the primary dispatch to all special details, low hanging wires, wires down, wires arcing or sparking, and children locked in vehicles when they are the closest available unit.

401.18.10 Squads

Squads are defined as an engine in their 1st, 2nd, and 3rd due territories. On all other assignments, their main duty is to establish a Rapid Intervention Team (RIT) with a focus on rapid intervention and firefighter survival.

All structure fires, Hazardous Materials incidents, and Special Operations incidents will require *at least* one Squad assigned as RIT.

401.18.11 Chiefs

The appropriate Chief will automatically be assigned when they appear in the suggested assignments, upon field request, or at the discretion of the FRCC Supervisor.

The Technical Rescue Team Chief (Fire 4) will respond to:

- Special Operations incidents
- Incidents requiring deployment of the Technical Rescue Team

The Firefighting/Marine Operations Chief (F8) will respond to:

- Significant ship/boat accidents and other marine incidents



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The Hazardous Materials Chief (Fire 9) will respond to:

- Hazardous Materials incidents requiring a full team

The Aircraft Rescue and Fire Fighting (ARFF) Chief (Fire 11) will respond to:

- Alerts at JAA operated airports (JIA, Cecil, Craig, and Herlong)
- Any incidents involving aircraft, regardless of location

401.18.12 Command Van

The Command Van will be assigned at the request of the Incident Commander or when they appear in the suggested assignments,

401.18.13 Air Truck

The Air Truck will be assigned to all confirmed W3s, when they appear in the suggested assignments, or upon request by field personnel.

401.18.14 Rehab Unit

The Rehab Unit serves as the primary apparatus for delivering rehabilitation equipment and supplies to an emergency scene.

The Rehab Unit will be assigned to all confirmed W3s, when they appear in the suggested assignments, or upon request by field personnel.

401.19 **FIELD REPORTS / BENCHMARKS**

401.19.01 Initial Report

The first-arriving unit of a multi-unit response shall transmit a brief initial radio report including:

1. Unit identification on-scene
2. Building/incident description (occupancy, size, construction)
3. Obvious conditions and initial tactics

401.19.02 Fire Classifications

Any fire that involves FLAME damage to the structure will require the response of a Suppression District/Battalion Chief.

- **W1** - One Suppression unit required to handle incident (see SOG 406, Appendix B for full description)
- **W2** - Two or more Suppression units required to handle incident (see SOG 406, Appendix B for full description)



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- **W3** - Full Assignment or Maximum Full Assignment required to handle incident (see SOG 406, Appendix B for full description)
- **2nd Alarm, 3rd Alarm, 4th Alarm, 5th Alarm** – See section 401.31

401.19.03 Suppression Benchmarks (see SOG 406.09.05)

- Primary Search Complete
- *Situation Under Control*
- *Secondary Search Complete*
- **W4**

401.19.04 EMS Alerts

- MCI Level I (5-10) victims
- MCI Level II (11-20) victims
- MCI Level III (21-100) victims
- MCI Level IV (101-1000) victims
- MCI Level V (over 1000) victims
- Trauma Alert
- Stroke Alert
- STEMI Alert
- Cardiac Red
- Trauma Red

401.20 **FIELD PERSONNEL EMERGENCIES**

401.20.01 Emergency Alarm Button

If an emergency arises that may compromise the health, safety, or welfare of on-duty JFRD personnel, the orange *Emergency Alarm Button* located on the portable radio should immediately be activated. Depending on whether it is a Mayday or Signal 34 situation, personnel should clearly state:

- Unit identification
 - “Mayday! Mayday! Firefighter down/missing!”
 - Present location of missing/trapped personnel, if known
- OR
- Unit identification
 - “Signal 34”
 - Present location

Activating the orange Emergency Alarm Button sets off an alarm and displays the unit’s portable radio ID on all radio positions in FRCC.



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Activating the orange Emergency Alarm Button will automatically lock down the channel and open the mic for 20 seconds, after that the mic must be physically keyed for Communications to receive any radio traffic.

Not all ID numbers reflect a company or unit's portable radio. The ID number displayed in FRCC may belong to the portable radio itself. Therefore, if possible, it is imperative each company or unit in distress announce their Unit name, number, and location. The Radio Shop programs the radio IDs.

The Emergency Alarm Button must be reset after the emergency has ended. To reset, the user must hold the button down until receiving a long steady tone (approximately five seconds), then release. Should there be difficulty in resetting the alarm, advise FRCC over the radio that the situation is under control, and you are attempting to reset.

401.20.02 Mayday

A "Mayday" is a transmission announced over the air by any firefighter that has or is in danger of becoming lost, disorientated, trapped, and or disabled during a fire or other emergency.

FRCC will activate *Alert 3* tone (three short beeps in succession) and repeat transmission including "Emergency Traffic Only!" on the assigned isolated Talk Group.

If multiple Talk Groups are in use for an incident, FRCC will also activate Alert 3 and repeat the transmission including "*Emergency Traffic Only!*" on the additional *Announcement Group(s)*.

Units should follow procedures outlined in Personnel Accountability SOG 404 - Procedures for Lost/Missing Firefighters.

In the event of a mayday or lost/trapped firefighter, Command will begin a Roll Call by requesting an *Alert 3* (short rapid tones) from FRCC. Following the Alert 3, FRCC will announce: "***All companies, stand-by for a Roll Call.***" FRCC will await further instructions from the Incident Commander.

401.20.03 Signal 34

Signal 34 is utilized in the event of a firefighter(s) in a potentially life-threatening situation. This signal can be announced over the radio or indicated by pressing the *Emergency Alarm Button*.

FRCC will attempt to contact the unit by radio to verify the emergency and location by repeating the transmission and receiving acknowledgement from the unit. If attempt is unsuccessful, FRCC will activate an Alert 3 tone for at least 1-second duration and broadcast the following on Talk Groups A1, A2, A3, and A4 simultaneously for the benefit of *Available* units:



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- “*Emergency Alarm activation for (unit name and number).*”
- “*Emergency traffic only!*”

Upon hearing an *Alert 3* tone and the broadcast of “*Emergency Traffic Only*” from FRCC, field units shall do the following:

- Units on *Available* status shall maintain radio silence and await instructions from FRCC
- Non-emergency status changes shall be advised by red phone or PMDC
- FRCC shall dispatch an *Emergency Assistance Request* Assignment to the last known location of the unit. If a unit is on *Available* status and does not advise their present location with the *Signal 34*, FRCC will continue attempting to contact the unit and notify the applicable Chief of the situation.

An Emergency Assistance Request Assignment shall consist of a Maximum Investigative Assignment (in addition to on-scene units) as well as the following:

- Rescue Unit
- Rescue Chief
- Appropriate law enforcement agency

The unit in need of emergency assistance must notify FRCC immediately once the situation is *Under Control* or *All Clear*. FRCC will repeat transmission for the benefit of units maintaining radio silence during the alert.

Note:

To maintain communication with the unit in distress, FRCC will not designate an alternate Talk Group until additional units arrive on scene and assess the situation.

401.21

COMPANY/UNIT TRANSFERS

To maintain sufficient coverage and decrease response time, units shall be transferred by FRCC into depleted areas when necessary.

401.21.01 Coverage

Stations **40, 48, and 55** shall always be covered.

Stations 16 does not require a transfer Engine for coverage as long as the Crash Units are available to respond.

Crash units shall not leave their assigned airport without approval from F11.

The suppression apparatus assigned to the Technical Rescue Team (Station 4), Hazardous Materials Teams (Stations 7 and 21), and the ARFF stations (Stations 16 and 73) shall not be used as transfer companies but may conduct standbys within their first-due territory on an *Available* status.



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In the combined territories of Stations 1, 2, 4, 5, and 9, two fully staffed Engine Companies and one fully staffed Ladder Company shall always be maintained.

In the combined territories of Stations 60 and 71, one fully staffed suppression apparatus with a pump shall always be maintained.

Field Chiefs may suggest and coordinate with the FRCC Supervisor for unit transfers to depleted areas and for *stand-by* assignments.

401.21.02 **Transfer Guidelines**

Units shall conduct transfers based on the following guidelines:

- Officers will ensure transfers are performed immediately but on a non-emergency status, unless otherwise advised
- Units must remain in transfer area until notified by FRCC to return to quarters

401.22 **SPECIALIZED RESPONSE TEAMS**

401.22.01 **Hazardous Materials (HazMat) Teams**

- **Station 7** - (Engine 7, Hazmat 7, Rescue 7, Tower Ladder 7)
- **Station 21** - (Engine 21, Hazmat 21 Rescue 21, Tower Ladder 21)

The Haz Mat Rescues are part of the Haz Mat Team when dispatched as part of a Haz Mat assignment. An additional Rescue Unit will be dispatched to satisfy various assignments.

401.22.02 **Decontamination Unit (Decon)**

The Decontamination Team is comprised of Fire Station 21 and will be dispatched at the request of the IC when information is received indicating numerous persons are ill and are experiencing the same type of symptoms. Fire 9 and a Hazardous Materials Team will be assigned to all incidents involving the Decon Unit.

401.22.03 **Technical Rescue Team (TRT)**

The Technical Rescue Team is compromised of all apparatus assigned to Station 4 and will respond *together* on all incidents involving:

- Confined Space Rescue Operations
- High Angle Rescue Operations
- Trench Collapse Rescue Operations
- Industrial machinery incidents involving entrapment



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- Structural Collapse
- Extrications involving Tractor Trailers, Buses, Trains or Multiple Vehicles
- High Rise Structure Fires
- Confirmed W-3's involving commercial buildings (IC should consider using the TRT as RIT)

F4 will be assigned to all incidents involving the Technical Rescue Team.

401.22.04 **Secondary Rapid Intervention Team (RIT) Assignment**

A secondary RIT consisting of the TRT will automatically be assigned on all W-3's involving large commercial structures (i.e., warehouse, strip mall, enclosed mall, office building, etc.). Fire 4 will be assigned with the secondary RIT to assist the on-scene Incident Commander with this expanded assignment. The Incident Commander can alter this assignment as needed.

401.23 **DEPLOYMENT TEAMS**

401.23.01 **Urban Search and Rescue (USAR) Team**

A team combined of all members of the Specialized Response Teams, on or off duty. The USAR Team will be activated by administrative request to assist with urban search and rescue deployments.

401.23.02 **Deployment Trailer**

The Deployment Trailer is a semi-tractor trailer mobile communication center utilized primarily for long-term, out-of-town deployment.

401.24 **AFTER HOURS NOTIFICATIONS**

The Duty Division Chief will be the primary administrative contact for serious and/or unusual events or incidents after normal working hours. If the Duty Division Chief is unreachable contact the applicable Division Chief or Deputy Division Chief.



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APPENDIX A

NOT TESTABLE

STANDARD SUPPRESSION ASSIGNMENTS

401.24 INVESTIGATIVE ASSIGNMENTS / SPECIAL DETAIL

401.24.01 Units

An *Investigative Assignment* consists of:

- Suppression Unit (Ladder or Engine)

Ladders are the primary response to the following incident types/call descriptions when they are the closest available unit.

401.24.02 Incident Types / Call Descriptions

- ****Assist a Citizen or Special Detail**
- ****Calls in which information received indicates a non-serious nature or the caller is convinced it is not serious**
- ****Tree Incident (fallen without injury)**
- Child locked in vehicle
- Elevator Incident with no injuries
- Low hanging wires, wires down, arcing, or sparking
- Wires burning

401.25 SINGLE ENGINE RESPONSE

Incident Types / Call Descriptions

- Brush fire (no potential for extension or life hazard exists (non-emergency))
- Chemical Leak/Spill (single family dwelling)
- Dumpster
- Electrical, gas, or chemical odor/investigation (single family dwelling or outside area)
- Fire (must specify - shopping carts, bikes, trees, etc.)
- Fuel Leak Vehicle (no more than 4 wheels)
- Grass Fire (no potential for extension or life hazard exists)
- Heater Malfunction
- Investigation (must specify)
- Mailboxes (commercial and residential)



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- Outdoor LP Gas Leak (20 lb. cylinder or less)
- Pleasure Boat Docked/Inland water source, lakes, ponds, nonnavigable waterways, etc.
- Private Dock (Inland water source, lakes, ponds, non-navigable waterways, etc.)
- Residential Fire Alarms (single family dwelling)
- Smoke Odor (single family dwelling or in the area)
- Transformer Fire
- Trash Fire (no potential for extension or life hazard (non-emergency)
- Unverified 911
- Vehicle Fire (autos, vans, pickups)
- **Bomb Threat (assist law enforcement)
- **Civil Disturbance
- **Land Clearing (no potential for extension or life hazard)
- **Oil Spill (less than 20 gallons)

** = Respond signal 15 status – no lights and sirens

401.26 MAXIMUM INVESTIGATIVE ASSIGNMENT

401.26.01 Units

A Maximum Investigative Assignment consists of:

- 1 - Engine
- 1 - Ladder
- 1 - Suppression Chief

401.26.02 Incident Types / Call Descriptions

- Appliance Fires - contained
- Chemical Leak/Spill Multi-Family Residence, Commercial
- Chemical Odor Multi-Family, Commercial
- Commercial Vehicle (smoking or on fire)
- Commercial Fire Alarms (includes apartments)
- Electrical, gas, or chemical odor/investigation (apartments, commercial building, daycare, enclosed mall, high life hazard, high rise, hospital, hotel, industrial, mercantile, motel, nursing home, restaurant, school, service station, strip mall, warehouse)
- Passenger Bus (smoking or on fire)
- Recreational Vehicle (smoking or on fire)



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- Smoke Odor (apartments, commercial building, daycare, enclosed mall, high life hazard, high rise, hospital, hotel, industrial, mercantile, motel, nursing home, office, restaurant, school, service station, strip mall, warehouse.)
- Tractor Trailer (smoking or on fire) (See Commercial)
- Vehicle Fire (commercial and recreational)

401.27 SPECIALIZED MAXIMUM INVESTIGATIVE ASSIGNMENT

A Specialized Maximum Investigative Assignment will consist of a ***Maximum Investigative Assignment*** plus the following additional field personnel or specialized apparatus or teams:

401.27.01 Barricaded or Hostage Incident (when requested by law enforcement)

- 1 - Rescue Unit

401.27.02 Bridge Collapse

- Maximum Investigative Assignment from each side of the river
- Technical Rescue Team
- Fire 4
- Fire 8
- 2 - Marine Units
- 1 - Squad
- 2 - Rescue Units from each side of the river
- 1 - Rescue Chief
- Command Van

401.27.03 Chemical Leak/Spill within a commercial building

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit

401.27.04 Chemical Leak/Spill involving a Tanker

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit



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- 401.27.05 Confirmed Bomb/WMD Threat
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 – Squad
 - 1 - Rescue Unit
- 401.27.06 Construction/Industrial Incident
- Technical Rescue Team
 - Fire 4
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief
 - 1 - Squad
- 401.27.07 Dock Fire (public/private in navigable waterways)
- 2 - Marine Units
 - F8
- 401.27.08 Emergency Assistance Request (Signal 34)
- 1 - Rescue Unit
 - 1 - Rescue Chief
 - Appropriate law enforcement agency
- 401.27.09 Gas Cylinder Fire (outside and < 100lb)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
- 401.27.10 Gas Cylinder Leak (outside and > 100 lb)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.11 Gasoline Leak (involving a Tanker)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit



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- 401.27.12 Gas Line Cut/Severed
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.13 Hostage Situation (Multi Family/Commercial Building)
- 1 - Rescue Unit
- 401.27.14 Industrial/Machinery Incident (Entrapment/Multiple Victims/etc.)
- Technical Rescue Team
 - Fire 4
 - 1 - Squad
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief
- 401.27.15 Passenger Bus Fire
- 1 - Rescue Unit
- 401.27.16 Radiation Incident (No WMD)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.17 RV/Commercial Vehicle
- 1 - Tanker
- 401.27.18 Railroad Incident – Freight Train
- Maximum Investigative Assignment from each side of RR tracks
 - Both Hazardous Materials Teams
 - Fire 9
 - Technical Rescue Team
 - Fire 4
 - 1 - Squad
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief



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401.27.19 Railroad Incident – Passenger Train

- Maximum Investigative Assignment from each side of RR tracks
- Hazardous Materials Team
- Fire 9
- Technical Rescue Team
- Fire 4
- 1 - Squad
- 3 - Rescue Units
- 1 - Rescue Chief

401.27.20 Train Fire – Freight Train

- Maximum Investigative Assignment from each side of RR tracks
- Both Hazardous Materials Teams
- Fire 9
- Technical Rescue Team
- Fire 4
- 1 - Squad
- 2 - Rescue Units
- 1 - Rescue Chief
- 1 additional Suppression Chief

401.27.21 Train Fire – Passenger Train

- Maximum Investigative Assignment from each side of RR tracks
- Fire 4
- Technical Rescue Team
- 1 - Squad
- 2 - Rescue Units
- 1 - Rescue Chief

401.27.22 WMD Investigations involving, chemical, biological, radiological/nuclear, high yield explosive weapons (includes “White Powder” investigations)

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit



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401.28 FULL ASSIGNMENT

401.28.01 Units

Full Assignment consists of:

- 4 - Engines
- 2 - Ladders
- 3 - Suppression Chiefs
- 1 - Squad
- 1 - Rescue Chief
- 2 - Rescue Units
- 3 - Tankers

If confirmed W3:

- 1 - Rehab Unit
- 1 - Air Truck (Sig. 15 response unless directed otherwise)

401.28.02 Incident Types / Call Descriptions

- All Structure Fires, excluding hospitals, nursing homes, convalescent centers, high rises, high-life hazard occupancies
- Gas cylinder leaks – inside a structure and < 100 lb
- Fire-related incidents involving the **Automated Skyway Express** (excluding trash receptacles)

401.29 SPECIALIZED FULL ASSIGNMENT

A Specialized Full Assignment consists of a **Full Assignment** plus the **following** field personnel or specialized apparatus or teams:

401.29.01 Building Collapse

- Technical Rescue Team
- Fire 4
- 2 - Rescues
- 1 - Tanker
- Command Van
- Air Truck

401.29.02 Chemical Leak/Spill (occurring within an industrial site)

- Hazardous Materials Team
- Fire 9



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- 401.29.03 Confined Space Rescue
- Technical Rescue Team
 - F4
 - 1- Rescue Unit
 - Command Van
 - Air Truck
- 401.29.04 Elevator Incident (Structural Failure)
- Technical Rescue Team
- 401.29.05 Fire JEA/Electrical Substation
- Hazardous Materials Team
 - Fire 9
- 401.29.06 Fire Tanker Truck
- Hazardous Materials Team
 - Fire 9
- 401.29.07 Gas Cylinder Fire (within a structure)
- Hazardous Materials Team
 - Fire 9
- 401.29.08 Gas Cylinder Fire (outside a structure and > 100 lb)
- Both Hazardous Materials Teams
 - Fire 9
- 401.29.09 Gas Cylinder Leak (within a structure)
- Hazardous Materials Team
 - Fire 9
- 401.29.10 Ship/Boat/Barge Fire or Incident
- Both Hazardous Materials Teams
 - Fire 9
 - Fire 4
 - Fire 8
 - 2 - Marine Units
 - Technical Rescue Team



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401.29.11 Storage Tank Fire

- Both Hazardous Materials Teams
- Fire 9
- Command Van
- Foam Unit

401.29.12 Structural Collapse

- Technical Rescue Team
- Fire 4
- Command Van
- Air Truck

401.29.13 Trench Collapse

- Technical Rescue Team
- Fire 4
- Command Van
- Air Truck

401.30 **MAXIMUM FULL ASSIGNMENT**

A Maximum Full Assignment will be dispatched to structure fires involving hospitals, nursing homes, convalescent centers, and high-rise buildings. The assignment will consist of a ***Full Assignment*** plus the following:

- 1 - Engine
- 1 - Ladder
- 1 - Tanker
- 1 - Suppression Chief
- 2 - Rescue Units
- 1 - Suppression Chief with mobile repeater system (F1, F5, F7, F9), if not already assigned

401.30.01 Additional units for High-Rise Building

- 1 - Engine
- 1 - Squad
- 1 - Rescue Unit
- Technical Rescue Team
- Fire 4



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401.31 ADDITIONAL ALARM ASSIGNMENTS (2ND, 3RD, 4TH, 5TH)

Each additional alarm will consist of:

- 2 - Engines
- 1 - Ladder
- 1 - Suppression Chief (at least 1 Suppression Battalion Chief must be assigned to any multi-alarm assignment)
- 1 - Rescue

If a Full Assignment or Maximum Full Assignment, depending on the type of structure involved, was not sent on the initial dispatch, the balance of the appropriate assignment will be dispatched along with the 2nd Alarm Assignment.

2nd Alarm Assignments shall be dispatched when advised by JFRD field personnel only.

For notification purposes only, FRCC will notify all stations of additional Alarm Assignments by activating the *All Stations* tones and broadcasting alarm, location, and Talk Group.

401.32 GENERAL ALARM

General alarms are events of such magnitude that the IC must consider calling in off-duty firefighters and mutual aid from surrounding counties. Once the General Alarm has been sounded, call back procedures and all future equipment requests will be tailored to the event.

401.33 W4

The W4 signal is not a tactical signal but a *health & safety* one. It can be declared before or after the signal 77 (under control) is given.

Once a W4 is declared, the following apparatus will be dispatched at a minimum:

- 1 - Engine
- 1 - Ladder
- 1 - Rescue
- Rehab Unit
- Air Truck



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APPENDIX B

NOT TESTABLE

SPECIFIED SUPPRESSION ASSIGNMENTS

401.34 ELECTRIC VEHICLE FIRES

401.34.01 Passenger vehicle

- 1 - Engine
- 1 - Suppression Chief
- 1 - Tanker
- Hazardous Materials Team
- F9

401.34.02 Commerical vehicle (bus, cargo truck, etc.)

- 2 - Engines
- 1 - Ladder
- 2 - Tankers
- 1 - Suppression Chief
- Hazardous Materials Team
- F9

401.35 WILDLAND FIRES

Response assignments to brush fires shall be determined by the Fire Readiness Level (FRL) provided daily by the Division of Forestry (DOF). FRCC shall obtain and advise field personnel of the daily FRL. The FRL definitions and assignments are as follows:

401.35.01 FRL 1 (Little to no fire activity)

- 1 - Engine
- 1 - Brush Truck

401.35.02 FRL 2 (Routine fire anticipated)

- 1 - Engine
- 1 - Brush Truck
- 1 - Tanker



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401.35.03 **FRL 3** (Fire occurrence above average)

- 2 - Engines
- 1 - Brush Truck
- 2 - Tankers
- 2 - Suppression Chiefs

401.35.04 **FRL 4/5** (Fire occurrence high/extreme)

- 3 - Engines
- 2 - Brush Trucks
- 2 - Tankers
- 2 - Suppression Chiefs
- 1 - Rescue Unit

401.36 **AIRCRAFT INCIDENTS**

401.36.01 Alert Definitions

The term "ALERT" is airport terminology for an aircraft incident. The pilot announces the emergency, and the alert level is determined by the air traffic control tower or the ARFF crew. Alert 1's and 2's should be expected at airports only.

- **Alert 1** - Aircraft is approaching the airport and is experiencing a **MINOR** issue.
- **Alert 2** - Aircraft is approaching the airport and is experiencing a **MAJOR** issue.
- **Alert 3** - Aircraft has crashed at an airport or off-site, is parked and is endangered by fire or explosives, aircraft is involved in a collision, or any emergency that the pilot in command requests immediate ARFF response.



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401.36.02 Aircraft Alert Assignments

401.36.03 Units

Aircraft Investigative Assignment

- ARFF Station only

Aircraft Maximum Investigative Assignment

- ARFF Station(s) if applicable
- 1 - Engine
- 1 - Ladder
- 1 - Suppression Chief
- F11
- 1 - Rescue Chief
- 1 - Rescue

Aircraft Full Assignment

- ARFF Station(s) if applicable
- 4 - Engines
- 1 - Ladder
- 1 - Squad
- 2 - Suppression Chiefs
- F11
- 2 - Rescue Chiefs
- 4 - Rescues
- 3 - Tankers
- Rehab Unit

Aircraft Max Full Assignment

- ARFF Station(s) if applicable
- 6 - Engines
- 2 - Ladders
- 1 - Squad
- 2 - Suppression Chiefs
- F11
- F4
- F9
- 3 - Rescue Chiefs
- 10 - Rescues
- 4 - Tankers
- Technical Rescue Team
- Both Hazardous Material Teams



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- Command Van
- Air Truck
- Rehab Unit

401.36.04 Responses

JIA

Alert 1

- Station 16 (Aircraft Investigative Assignment)
- F11 (Sig. 15 status)

Alert 2

- Fire Station 16
- Aircraft Full Assignment (Sig. 15 status)

Alert 3

- Station 16
- Aircraft Max Full Assignment
- Florida Air National Guard (FANG)

Cecil Airport

Alert 1

- Station 56
- Station 73 (Sig.15 status)
- F11 (Sig. 15 status)

Alert 2

- Station 56
- Station 73
- Aircraft Full Assignment (Sig.15 status)

Alert 3

- Station 56
- Station 73
- Aircraft Max Full Assignment

Craig Airport (Jax Executive)

Alert 1

- Aircraft Max Investigative Assignment

Alert 2

- Aircraft Max Investigative Assignment

Alert 3

- Aircraft Full Assignment



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Herlong Airport (Alert 1 not possible due to no tower)

Alert 2

- Aircraft Max Investigative Assignment

Alert 3

- Aircraft Full Assignment

Off Airport Property

Off-site

- Aircraft Full Assignment
- 1 - Brush Truck
- Consider DOF
- Consider JSO Aviation Unit

Naval Bases (NAS Jax or Mayport)

- Aircraft Full Assignment

If aircraft is reported to be a commercial aircraft, upgrade to the Aircraft Max Full Assignment.

If aircraft report to be in water, add JFRD Marine Unit(s), JSO Aviation, and USCG.

Aircraft 2nd Alarm

- If Aircraft Full Assignment previously dispatched, upgrade to the Aircraft Max Full Assignment
- If Aircraft Max Full Assignment already dispatched, increase to a Level 4 MCI response

401.37

MARINE INCIDENTS

Marine 21 (**M21**), Marine 32 (**M32**), Marine 34 (**M34**), Marine 42 (**M42**), and Marine 50 (**M50**) are aluminum Jon boats with small outboards that are kept on trailers. They can be dispatched to inland waterways (i.e., lakes, ponds, creeks) that are not accessible from a navigable waterway.

Rigid Hull Inflatable Boat (RHIB) 40 (**RHIB40**) is a 19 ft. ridged hull inflatable boat that can be dispatched to inland water ways and near shore incidents. RHIB40 is normally kept on a lift at Station 40.

MUD38 is an aluminum Jon boat with shallow water drives that make it capable of low water operation. MUD38 is kept on a trailer at Station 38.



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401.37.01 Marine Accident (accidents within a waterway involving a watercraft)

- 1 - Suppression Company
- 1 - Rescue Unit
- 2 - Marine Units
- F8

401.37.02 Marine Distress Incident

- 1 - Suppression Company
- 2 - Marine Units
- F8

401.37.03 Inland Water Sources

Assignments for all life-threatening incidents involving inland water sources (i.e., lakes, retention ponds, and other areas not accessible from a navigable water way) shall be as follows:

- 1 - Suppression Company
- 1 - Jon Boat or RHIB
- 1 - Suppression Chief
- F8
- 1 - Rescue Unit

401.37.04 Jumper (Suicide Attempt)

Assignments for incidents where an individual has jumped, or is threatening to jump, into the waterway shall be as follows:

- 1 - Suppression Company
- 2 - Marine Units
- 1 - Rescue Unit
- 1 - Suppression Chief
- F8

401.37.05 Offshore Response

Requests for assistance offshore may include sinking vessels, boat fires, search, and rescue, etc. In cases where M40 and/or M38 are dispatched to an incident offshore, F8 should always be consulted prior to dispatch and consider responding to Station 40 to establish command. Station 40 has a VHF (marine) radio base station that is capable of long-distance offshore communication.



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401.37.06 Flooding

Any standard EMS or Fire-related incident in an area known to be flooded will require one Jon Boat or RHIB in addition to the appropriate EMS or Suppression assignment.

401.37.07 Body Recovery (obvious death)

Assignments for incidents involving body recovery (usually assisting other agencies) shall be as follows:

- 1 - Suppression Company
- 1 - Marine Unit (Jon Boat or RHIB depending upon waterway accessibility)

401.37.08 Special Detail

Requests for assistance by stranded boaters or assignments to clear debris from waterways will receive a special detail assignment of 1 Marine Unit.



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APPENDIX C

NOT TESTABLE

EMS ASSIGNMENTS

401.38 STANDARD ASSIGNMENT

The standard assignment for an EMS incident will consist of 1 Rescue Unit and 1 Suppression Company (two-person minimum). Engines/Squads will be the primary Suppression response to EMS incidents within their *first-due territory*.

The assignment for vehicle accidents will require 1 Suppression apparatus with a minimum of 250 gallons of water, if not included in the initial dispatch. In all cases, the nearest apparatus will be in the initial dispatch (Tankers, Brush Trucks, etc., if appropriate).

401.39 EXTRICATION ASSIGNMENT

Assignments for incidents requiring extrication shall consist of the following:

- 2 - Engines
- 1 - Ladder
- 2 - Suppression Chiefs
- 1 - Rescue Chief
- 2 - Rescue Units

If the vehicle is submerged in water, dispatch appropriate marine unit(s).

401.40 CARDIAC/TRAUMA RED

The assignment for a confirmed Cardiac or Trauma Red, CPR in progress, or call in which the victim is reported to be not breathing (respiratory arrest), shall consist of the following:

- 2 - Suppression Companies
- 1 - Rescue Unit
- 1 - Rescue Chief

OR

- 1 - Suppression Company
- 2 - Rescue Units
- 1 - Rescue Chief



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401.41 ACTIVE SHOOTER

This assignment is intended to be an initial response to an active assailant incident where the number of patients is unknown. Once a more definitive patient count is determined, the correct MCI Level can be declared as appropriate.

- 4 - Rescue Units
- 4 - Engines
- 1 - Ladder
- 1 - Squad
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs

401.42 MASS CASUALTY INCIDENT (MCI) ASSIGNMENTS

If appropriate MCI Level Assignment was not sent on the initial dispatch, the balance of the assignment will be dispatched along with the original assignment.

401.42.01 Level I (5 - 10 patients)

- 4 - Rescue Units
- 2 - Engines
- 1 - Ladder
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs
- FRCC will notify the 2 closest hospitals to the incident and the 2 closest Trauma Centers

401.42.02 Level II (11 - 20 patients)

- 6 - Rescue Units
- 4 - Engines
- 2 - Ladders
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs
- FRCC will notify the 3 closest hospitals to the incident and all the local Trauma Centers

401.42.03 Level III (21 -100 patients)

- 8 - Rescue Units
- 6 - Engines
- 2 - Ladders
- 2 - Suppression Chiefs
- 3 - Rescue Chiefs
- MCI-59



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- RHB-5
- FRCC will notify the 4 closest hospitals to the incident and all the local Trauma Centers

401.42.04 Level IV (101-1000 patients)

- Level III assignment
- MCI-1
- Mutual Aid from surrounding agencies and private services

401.42.05 Level V (more than 1000 patients)

- Level IV assignment
- State and Regional Mutual Aid may be needed

401.43 **AUTOMATED SKYWAY EXPRESS**

EMS response to the Automated Skyway Express is as follows:

401.43.01 Passenger Loading Station

- Standard EMS Assignment

401.43.02 Any Other Location

- Full assignment

401.44 **AIR TRANSPORT UNIT (ATU) ASSIGNMENTS**

An ATU may be placed on standby status based upon information received and at the discretion of the FRCC Supervisor, or at the request of responding field personnel.

FRCC shall advise responding units of the ATU's standby status and dispatch a unit to establish a landing zone.

If field personnel request an ATU to respond, the following units will be assigned:

- 1 - Suppression unit (Engine, Ladder, Brush, or Tanker) for Landing Zone (if not already dispatched)
- 1 - Suppression Chief
- 1 - Rescue Chief

Other Agency/Off Duty personnel request for ATU

An ATU may be launched at the request of off-duty JFRD personnel and other reliable authorized personnel (FHP, local police agencies, other fire departments, physicians, other medical personnel, etc.) as outlined in SOG 415. Should another authorized agency on scene request to launch an ATU prior to the arrival of JFRD, the requesting agency assumes responsibility for establishing the landing zone. If JFRD arrives before the ATU, they may assist.



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APPENDIX D

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MUTUAL AID

401.45 DEFINITION

Mutual Aid – a request for assistance from agencies of surrounding counties, municipalities, and military facilities.

401.46 SUPPRESSION MUTUAL AID

401.46.01 Small fire (auto, woods, etc.):

- Dispatch units as requested
- Notify appropriate Suppression Chief

401.46.02 Structure Fire or larger incident:

Dispatch at least the following:

- 2 - Engines
- 1 - Ladder
- 1 - Squad
- 1 - Tanker (if appropriate)
- 2 - Suppression Chiefs
- Notify the appropriate Suppression Battalion Chief, if not assigned to the incident

401.46.03 Request for Suppression Company(s) to Distant Locations

- Contact Chief of Operations for instructions and notify Director/Fire Chief of incident
- Dispatch according to Chief of Operations instructions
- Notify the appropriate Suppression Battalion Chief, if not assigned

401.47 EMS MUTUAL AID

401.47.01 Requests for one or two Rescue Units

- Dispatch as requested
- Notify the appropriate Rescue Chief if two are dispatched



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401.47.02 Requests for more than two Rescue Units

- Dispatch 2 Rescue Units, including appropriate Rescue Chief
- Contact Division Chief of Rescue for decision concerning additional units and notify the Director/Fire Chief of the incident
- Dispatch the balance of the request based on decision from Division Chief of Rescue
- Notify appropriate Rescue Battalion Chief, if not assigned

401.47.03 Requests for Rescue Unit(s) to Distant Locations

- Contact Division Chief of Rescue for instructions and notify the Director/Fire Chief of incident
- Dispatch according to Chief of Rescue's instructions
- Notify the appropriate Rescue Battalion Chief, if not assigned



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APPENDIX E
NOT TESTABLE

ST JOHNS COUNTY FIRE/RESCUE

JFRD Radios

SJCFR Dispatch channel is located on the InterOp flight. This is their primary channel for routine EMS and suppression calls.

SJCFR TAC1, TAC2, TAC3, and TAC4 are located on the InterOp flight. These are used for large assignments.

SJCFR Radios

They have our B1, B5, B9, B13, A1, A2, and A3. They do not have our A4.

ATLANTIC BEACH PD, JACKSONVILLE BEACH PD, NEPTUNE BEACH PD

JFRD and JBPD Radios

A **NIMS** channel (our C6, C7, C8, or C9) can be used to facilitate communications.

JACKSONVILLE SHERIFF'S OFFICE

JFRD and JSO Radios

A **NIMS** channel (our C6, C7, C8, or C9) can be used to facilitate communications.

Our A10 is permanently patched to JSO's Marine Operations channel.

JACKSONVILLE BEACH OCEAN RESCUE

JFRD Radios

Jacksonville Beach Ocean Rescue operates on our **C2**.

Jacksonville Beach Ocean Rescue Radios

They have "Lifeguard Dispatch" which is our C2.

CLAY COUNTY FIRE/RESCUE

JFRD Radios

CCFR Primary channel is located on our InterOp flight. This is their primary channel routine EMS and suppression calls.

CCFR TAC1, TAC5, TAC9, and TAC12 are located on the InterOp flight. These are used for large assignments.

CCFR Radios

They have our B1, B5, B9, B13, A1, A2, A3, and A4.



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NAVY FIRE (NAS & MAYPORT)

JFRD Radios

We don't have their channels programmed.

Navy Radios

They have all our channels and will switch to a JFRD channel when working with us.

NASSAU COUNTY FIRE/RESCUE

JFRD Radios

NCFR Channel 1 and Channel 2 are on our InterOp flight. These are their primary channels for routine EMS and Suppression calls.

NCFR Radios

They have our B1, B5, B9, B13, A1, A2, A3, and A4.

BAKER COUNTY FIRE/RESCUE & MACCLENNY FD

Baker County and MacClenny Radios

We can't communicate because they have VHF radios. Dispatch centers will relay info.

MARINE CHANNEL (A10)

JFRD Radios

Our Marine channel is **A10**. You can communicate with the marine agencies listed below.

Various Agencies Radios

Coast Guard, FWC, JSO, Nassau, St. Johns, and Clay, all have it but under varying names.

OTHER HELPFUL INFORMATION

If utilizing another department's (Clay, St John's) radio channel, you are keying up on a radio tower in their county. This means that you must be close to that county before achieving reception.

If utilizing another department's (Clay, St John's) radio channel, FRCC is not able to monitor. Should you need to communicate with FRCC, you'll need to either switch back to a JFRD channel or maintain JFRD communications on a second radio.

The NIMS channels are a reliable means of communication in this region if bordering departments switch to the same NIMS channel, except in Baker County as noted above.

The simplex channels are A11 & A12. These are very short range. They are ideal for deployments when units are within a few miles of each other. FRCC can't monitor.

If you operate on a JFRD Bravo channel in another county, be aware that you are utilizing radio towers in Duval County. Get very deep into the other county and you will lose reception.



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APPENDIX F

NOT TESTABLE

RADIO TERMINOLOGY

401.47

STANDARD PHRASES

The following are standardized phrases to be used in JFRD radio transmissions:

- ***Acknowledge*** – (message understood)
- ***Affirmative*** – (yes/correct)
- ***All Clear*** – Indicates Primary or Secondary Search is complete
- ***Available***
- ***ASAP*** (As Soon As Possible)
- ***Can you copy?***
- ***Cancel***
- ***Change to Talk Group***
- ***Completed Assignment***
- ***Did you receive the message?***
- ***Disregard***
- ***Emergency Traffic***
- ***End of message***
- ***ETA (Estimated Time of Arrival)***
- ***In Quarters***
- ***Location?***
- ***Loud and Clear***
- ***Message Delivered***
- ***Negative***
- ***On-Scene***
- ***Out-of-Service***
- ***Rapid Response***
- ***Receiving Poorly***
- ***Relayed Information***
- ***Repeat***
- ***Responding***
- ***Returning/Return to Quarters***
- ***Situation Under Control*** – During structure fires, indicates forward progression of fire is stopped. During other incidents, this statement indicates field personnel are not involved in a life-threatening situation.



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- *Slow response*
- *Standby*
- *Visitors/Officials*
- *What is my CCR number?*

401.48

STANDARD ABBREVIATIONS

The following standard abbreviations will be used by FRCC in the additional information field:

ABD – Abdomen

ADV – Advised

ALM – Alarm

ATC – Attempting to Contact

BF – Black Female

BLDG – Building

BLK – Black

BM – Black Male

BRN – Brown

BYF – Boyfriend

CMP – Complainant

CO – Company

CR – Cardiac Red

DOT – Department of Transportation

EB – East Bound

ELD – Elderly

ENR – En-Route

EOC – Emergency Operations Center

F – Female

FOR – Forestry

FRM – From

FRT – Front

GAL – Gallon



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GF – Girlfriend
HTL – Hotel
INJ – Injury
JEA – Jacksonville Electric Authority
JSO – Jacksonville Sheriff's Office
KH – Key Holder
LSH- Last Seen Heading
LEO- Law Enforcement Officer
M – Male
NAT UNK – Nature Unknown
NB – North Bound
NOI- No Other Information
OD – Overdose
PED – Pedestrian
PL – Parking Lot
POSS – Possible
PP – Payphone
PRIV PROP – Private Property
PU – Pickup
SB – South Bound
SIG – Signal
THRU – Through
TRL – Trailer
UNK – Unknown
WB – West Bound
WF – White Female
WM – White Male
VEH – Vehicle
VS – Versus
YO – Years Old



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE COMMUNICATIONS**

CREATED: 06/25

**TITLE: FRCC CALL
HANDLING**

SOP: 202

202.00

PURPOSE

To provide all Emergency Dispatchers (ED) with approved procedures for obtaining initial case information and appropriate verifications for all emergency cases including cases where PDS interrogation is deemed necessary.

202.01

POLICY

When an emergency call is received via voice or non-voice, the ED shall obtain all initial case information including the detailed location, call back number, and the nature of the emergency as described below. It is the intent of this policy that the Call Handling Process, including Priority Dispatch System (PDS) Case Entry must be strictly adhered to at all times, except for fourth-party calls.

The International Academies of Emergency Dispatch Case Entry Standards require the address and phone number to be obtained and verified at the beginning of the call following the Academies' script for all emergency calls.

202.02

INITIAL CALL HANDLING PROCESS (VOICE)

202.02.01

Initial Information—Case Entry Standards

For all emergency calls, the address and phone number must be obtained and verified at the beginning of the call, following the Academies' script.

Initial information will be gathered from the voice caller using the following phrase and order:

1. "(Fire and Rescue surname), what is the address of the emergency?"
— including verification as described in section 202.02.04.
 - a. Supervisors will include their rank with surname
2. Is this a house, apartment, or business?
3. "What is the phone number you are calling from, including the area code?"—including verification as described in section 202.02.04.
4. "What is your name?" NOTE: This question is not specifically listed in the current version of EMD Case Entry, but is required to comply with Fire and Rescue Communications policy.
5. "Okay, tell me exactly what happened."



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

**TITLE: FRCC CALL
HANDLING**

CREATED: 05/25

REVISED: 06/25

SOP: 202

202.02.02 Initial Answer Phrase and Location Determination

1. All 9-1-1 and administrative phone lines will be answered using the standardized answer phrase: “(Fire and Rescue surname), what is the address of the emergency?”
 - a. Supervisors will include their rank with surname.
2. If the caller is unable to provide a numeric address, the ED will say, “Please give me the best location you have for the incident.”
 - a. If the caller is still unable to provide a location, the call taker may ask a clarifying question to identify the caller’s location such as intersection, landmark, business name, etc.
3. The ED will enter the address or location provided by the caller into the CAD incident using the most accurate information available from the caller (this could be a numeric address, intersection, business, landmark, etc.).
4. Verification will be completed as described in section 202.02.04.

202.02.03 Callback Number

1. The call taker will ask, “What is the telephone number you are calling from including the area code?”
2. If the caller is unable to provide their telephone number, the ED will refer to the telephone number displayed in the ANI/ALI window of the emergency telephone system.
3. Callback telephone number information will be entered into the CAD incident in the appropriate field.
4. Verification will be completed as described in section 202.02.04.

202.02.04 Verification Process

1. Where ANI/ALI information is available:
 - a. If the caller is calling from the exact location where help is needed, the ED will verify the address information obtained by using the ANI/ALI card and/or address point displayed on the emergency call handling map, accepting the address given by the caller only when the ANI/ALI information matches the caller’s information.
2. Where ANI/ALI information is not available or the caller is not at the actual location where help is needed, the ED will verify the address (or location) by stating the following: “Please repeat the address/location for verification.”



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

**TITLE: FRCC CALL
HANDLING**

CREATED: 05/25

REVISED: 06/25

SOP: 202

3. If a wireless, first, or second party caller is unable to provide address or location information, the ED shall utilize the ALI map and RapidSOS application to attempt a GPS location.
4. If the attempt is unsuccessful in locating the incident, the ED shall notify the Supervisor for further assistance.
5. For all residential locations such as apartments, condos, assisted living facilities, etc., the ED will obtain all necessary access information which may include location name, building letter/number, and apartment/room number. The ED will then accurately enter this information in the CAD incident.
6. For all non-residential locations, the ED will obtain all necessary access information, which may include building name, business name, floor number, office or suite number, specific entrance instructions, and intersection or street segment (for roadway incidents). The ED will then accurately enter this information in the CAD incident.
7. Callback information will be considered verified if it matches ANI/ALI information.
8. Where ANI/ALI information or call back number is not available, the ED will verify the telephone number by stating the following: "Please repeat the phone number for verification."
9. If the ED needs to call the caller back for additional location information, they must accurately record all received details in the CAD incident. The ED will then notify the appropriate dispatcher, who will ensure the information is accurately relayed to responders.
10. After entering the address/location into the CAD incident, the ED must geo-verify it by confirming that CAD returns a valid address/location. Additionally, the ED must ensure the entered information matches the details provided by the caller.

202.02.05 **Caller's Name**

1. The ED will obtain the caller's name as described in step 4. of section 202.02.01.
2. The caller's name will be entered into the CAD incident in the appropriate field.

202.02.06 **Complaint Description**

1. The call taker must assess the caller's response to the question, "Okay, tell me exactly what happened?" to determine the following:



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

**TITLE: FRCC CALL
HANDLING**

CREATED: 05/25

REVISED: 06/25

SOP: 202

- a. The most appropriate CAD signal to assign to the incident.
 - i. Once a signal is assigned, the incident should be immediately sent for dispatch.
- b. Which PDS protocols should be applied.
 - i. The PDS protocol is required, and EMD or EFD must be used for first, second, and third-party callers. The call taker will immediately launch ProQA for the appropriate discipline (Medical or Fire) and enter the reported information in the corresponding field and continue with PDS protocol interrogation.
 - ii. The PDS protocol is not required for fourth-party callers, i.e., law enforcement or supporting agencies. The call taker will enter the reported information directly into the CAD incident in the appropriate field and continue with agency approved questioning process including scene safety questions.

202.03 INITIAL CALL HANDLING PROCESS (NON-VOICE, TEXT TO 9-1-1, SHORT MESSAGE SERVICE SMS CALLER)

202.03.01 Initial information—Case Entry Standards

For all emergency calls the address and phone number must be obtained and verified at the beginning of the call following the Academies' script.

1. All communications with the non-voice, text to 9-1-1 caller shall be in clear text. The ED shall avoid using text shortcuts, lingo and acronyms. If the non-voice caller elects to use texting shortcuts which are difficult to understand by the ED, then the ED shall ask if he/she can call in by voice instead.
2. The Jacksonville Sheriff's Office Communications Center will receive the initial non-voice, text to 9-1-1 call for help and will transfer the non-voice emergency call to the Fire and Rescue Communications Center if the incident relates to a medical or fire emergency.
3. Initial information will be gathered from the non-voice text to 9-1-1 caller by the Fire and Rescue Communications ED using the following phrases and order:
 - a. "(Fire and Rescue surname), what is the address of the emergency?"
 - b. Supervisors will include their rank with surname.
4. Is this a house, apartment or business?



**STANDARD OPERATING PROCEDURES
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5. "What is the phone number you are calling from including the area code?"
6. "What is your name?" NOTE: This question is not specifically listed in the current version of EMD Case Entry, but is required to comply with Fire and Rescue Communications policy.
7. "Okay, tell me exactly what happened?"
8. "We need to gather further information, are you available to receive a voice telephone call?"
 - a. If yes, the Emergency Dispatcher shall initiate a voice telephone call to the phone number provided by the emergency caller and complete the EMD/EFD protocol.
 - b. If no, the Emergency Dispatcher shall continue completing the applicable EMD/EFD protocol as best as practicable via non-voice communication, text to 9-1-1.

202.03.02 Initial Answer Phrase and Location Determination:

1. All non-voice, text to 9-1-1 calls will be answered using the standardized answer phrase "(Fire Rescue surname), what is the address of the emergency?"
 - a. Supervisors will include their rank with surname.
2. If the non-voice, text to 9-1-1 is unable to provide a numeric address, the ED will say, "Please give me the best location you have for the incident."
3. The ED will enter the address or location provided by the caller into the CAD incident using the most accurate information available from the text to 9-1-1 caller (this could be a numeric address, intersection, business, landmark, etc.).
4. Verification will be completed as described in section 202.03.04.

202.03.03 Call Back Number

1. The ED will ask, "What is the telephone number you are texting from including the area code?"
2. If the non-voice, text to 9-1-1 caller is unable to provide their telephone number, then the ED will refer to the telephone number displayed in the web portal application.
3. Callback number information will be entered into the CAD incident in the appropriate field.
4. Verification will be completed as described in section 202.03.04.



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
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202.03.04 Verification Process

1. Where RapidSOS information is available:
 - a. If the caller is texting from the exact location where help is needed, the ED will verify the address information obtained by using the RapidSOS map, accepting the address given by the caller only when the information matches the caller's information.
 - b. Where RapidSOS information is not available or the caller is not at the actual location where help is needed, the ED will verify the address (or location) by texting the following: "Please repeat the address/location for verification."
 - c. If a wireless, first, or second party caller is unable to provide address or location information, the ED shall utilize the RapidSOS application to attempt a GPS location.
 - d. If the attempt is unsuccessful in locating the incident, the ED shall notify the Supervisor for further assistance.
 - e. For all residential locations such as apartments, condos, assisted living facilities, etc., the ED will obtain all necessary access information which may include location name, building letter/ number, and apartment/room number. The ED will then accurately enter this information in the CAD incident.
 - f. For all non-residential locations, the ED will obtain all necessary access information, which may include building name, business name, floor number, office or suite number, specific entrance instructions, and intersection or street segment (for roadway incidents). The ED will then accurately enter this information in the CAD incident.
 - g. Callback information will be considered verified if it matches the RapidSOS information.
 - h. Where RapidSOS information or call back number is not available the ED will verify the telephone number by stating the following: "Please repeat the phone number for verification."
 - i. If the ED needs to text the caller back for additional location information, they must accurately record all received details in the CAD incident. The ED will then notify the appropriate dispatcher, who will ensure the information is accurately relayed to responders.



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

**TITLE: FRCC CALL
HANDLING**

CREATED: 05/25

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SOP: 202

2. After entering the address/location into the CAD incident, the ED must geo-verify it by confirming that CAD returns a valid address/location. Additionally, the ED must ensure the entered information matches the details provided by the caller.

202.03.05 **Caller's Name**

1. The ED will obtain the caller's name as described in step 6. of section 202.03.01.
2. The caller's name will be entered into the CAD incident in the appropriate field.

202.03.06 **Complaint Description**

1. The call taker must assess the caller's response to the question, "Okay, tell me exactly what happened?" to determine the following:
 - a. The most appropriate CAD signal to assign to the incident.
 - i. Once a signal is assigned, the incident should be immediately sent for dispatch.
 - b. Which PDS protocols should be applied.
 - i. The PDS protocol is required, and EMD or EFD must be used for first, second, and third-party callers. The call taker will immediately launch ProQA for the appropriate discipline (Medical or Fire) and enter the reported information in the corresponding field and continue with PDS protocol interrogation.
 - ii. The PDS protocol is not required for fourth-party callers, i.e., law enforcement or supporting agencies. The call taker will enter the reported information directly into the CAD incident in the appropriate field and continue with agency approved questioning process including scene safety questions.



POLICY

This policy is intended to provide FRCC Fire Rescue Emergency Dispatchers (FRED's) with the ability to offer immediate video/phone interaction with a Board-Certified Emergency Medicine Physician via RightSite for specific Alpha and Omega determinant codes within the Priority Dispatch Emergency Medical Dispatch Protocol (EMD).

OVERVIEW

RightSite is a telehealth service that connects 9-1-1 callers with emergency physicians via on-demand navigators. In the setting of a non-emergent complaint (as detailed below), these on-demand navigators work with the FRED and caller to provide a connection to an online physician to determine if a caller can be evaluated and treated via telemedicine, referred to an urgent care site or to an Emergency Department (ED). RightSite arranges for the activation of the 9-1-1 system.

SCOPE

All FRED's that have completed the RightSite training are able to initiate this option when the call type is appropriate for RightSite. The program hours will be limited to Monday-Friday, 0700-2300, including holidays.

FRCC maintains authority over the call until released by the caller and navigator. If the caller changes their mind or the physician requires the patient to be transported to the ED at any time during the call, RightSite will immediately send the call back to FRCC to dispatch an immediate response by JFRD.

ACTIVATION

A caller with a profile deemed by EMD as an appropriate match for RightSite will have the ability to ask the caller if they would like to speak with the ED doctor instead of dispatching JFRD to their location. All call types are approved by JFRD Medical Director Bradley Elias.

APPROVED EMD CALL TYPES:

- **ALPHA Determinant Codes for protocols: 1, 3, 5, 7, 10, 11, 13, 14, 16, 19, 20, 21, 26, 27, 30,**
- **All OMEGA Determinant Codes for protocol: 26**



PROCEDURE

Once the FRED completes the interrogation process and EMD determines the call type is an Alpha or Omega determinant code as listed above, the FRED can offer the patient the option to connect them with RightSite.

Should the caller agree to engage with RightSite, proceed as follows:

1. Call RightSite and connect patient with the on-demand navigator (**must be a first party caller**).
2. Remain on the call until the caller gives consent to the navigator to speak with the ED physician and FRCC is released by the navigator.
3. The FRED will then hang up the phone and leave the call open in CAD.
4. RightSite will then call FRCC when the caller and the ED physician have agreed to a treatment plan; at that time the FRED will close out the call in CAD.
5. If the caller changes their mind at any time during the call, including while talking with the ED physician, RightSite will transfer the call back to FRCC and we will dispatch JFRD personnel immediately.
6. If the ED physician determines that the caller needs to be transported to the ED, RightSite will transfer the caller back to FRCC and we will dispatch JFRD personnel immediately.

Should the caller decline to engage with Right Site,

1. FRCC will follow our normal dispatch procedures and make a note in CAD that the caller declined RightSite.

EMERGENCY MEDICAL SERVICES

The Jacksonville Fire and Rescue Emergency Communications Center is required to follow Federal and State Laws when it comes to disclosing 9-1-1 Emergency Calls and strict adherence must be assured at all times.

With limited exceptions, s. 401.30(4), F.S., provides, in relevant part, that "[r]ecords of emergency calls which contain patient examination or treatment information are confidential and exempt from the provisions of s. 119.07(1) and may not be disclosed without the consent of the person to whom they pertain."



205.00 **PURPOSE**

To establish procedures for identifying, documenting, and notifying emergency personnel responding to incidents involving high-risk communicable diseases to safeguard responder health and operation effectiveness.

205.01 **POLICY**

The Jacksonville Fire Rescue Communications Center (FRCC) shall designate patients confirmed to have active Tuberculosis (TB), Meningitis, or Viral Hemorrhagic Fever (VHF) as a "Signal 13."

This designation ensures appropriate notification of emergency responders and adherence to enhanced personal protective equipment (PPE) protocols beyond standard universal precautions.

205.02 **SCOPE**

This policy applies to all FRCC personnel involved in the call-taking and dispatching process for patients who meet the criteria for Signal 13.

205.03 **DEFINITIONS**

205.03.01 Signal 13: A designation used in radio communication and CAD comments indicating a patient with a high-risk communicable disease.

205.03.02 High-Risk Communicable Diseases: Active Tuberculosis (TB), Meningitis, and Viral Hemorrhagic Fever (VHF), including Ebola, Marburg, Lassa, Yellow Fever, and Dengue Virus.

205.04 **PROCEDURE**

205.04.01 Identification of Signal 13 Patients

1. FRCC personnel shall document a "Signal 13" status in CAD comments upon receiving confirmation of a patient's communicable disease status from credible sources (e.g., the patient, medical professionals, hospital staff, official reports).
2. If patient status is unknown but symptoms are consistent with TB, Meningitis, or VHF, dispatchers shall notify emergency responders to exercise caution and apply full PPE precautions.



STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE COMMUNICATIONS

TITLE: SIGNAL 13

CREATED: 06/25

SOP: 205

- a. Common Symptoms for Active TB:
 - Persistent cough lasting three weeks or longer
 - Coughing up blood
 - Night sweats
 - History typically includes communal living (homeless shelter, jail, group home, etc.)
- b. Common Symptoms for Meningitis in Adults and Children:
 - Severe headache and vomiting with fever
 - Stiff neck
 - Sensitivity to light (photophobia)
 - Skin rash
- c. Common Symptoms for VHF
 - High fever
 - Severe weakness
 - Bloody vomit and/or diarrhea
 - Bleeding (from gums, nose, or internal bleeding)
 - Bruising or rash
 - History includes recent travel out of the country

205.04.02 Notification Protocol

1. Upon dispatching a unit to an incident involving a "Signal 13" patient, FRCC personnel shall:
 - a. Verbally communicate "Signal 13" designation to responding personnel via radio and confirm their acknowledgement.
 - b. Ensure the CAD comments clearly indicate "Signal 13" status for responders reviewing incident details.

205.04.03 Documentation and Follow-Up

1. FRCC personnel must ensure accurate documentation of "Signal 13" cases, including symptoms, within CAD comments.
2. FRCC supervisors shall periodically review compliance with notification and safety procedures to optimize response protocols.

205.04.04 Compliance & Enforcement

1. All personnel must adhere to this policy to ensure responder safety and operational efficiency.
2. Non-compliance may result in corrective actions and additional training requirements.

This policy ensures consistent identification, notification, and precautionary measures for emergency responders handling high-risk communicable disease cases.



FIRE AND RESCUE DEPARTMENT

February 06, 2024

INSTRUCTIONAL BULLETIN **#24-03**

TO: All Fire and Rescue Personnel

FROM: Jacob W. Blanton, Division Chief/Rescue *J. Blanton*
Daniel R. Guthrie, Deputy Division Chief/Rescue *D. Guthrie*
Brad Elias, Medical Director *Brad Elias MD*

RE: BAPTIST MEDICAL CENTER CLAY COUNTY – PRIMARY STROKE CENTER

Baptist Medical Center Clay County is now operating a **Primary** Stroke Center as authorized by the State of Florida Agency for Health Care Administration (AHCA).

The *Hospital Capabilities Chart for JFRD* located on the JFRD File Share site (formerly FTP site) has already been updated. Laminated copies of the revised chart will also be delivered to every Rescue unit in the coming days.

Any questions should be directed to your respective District/Battalion Chief.

Thank you.

A NEW DAY.



FIRE AND RESCUE DEPARTMENT

February 22, 2024

INSTRUCTIONAL BULLETIN #24-04

TO: All Fire and Rescue Personnel

FROM: Jacob W. Blanton, Division Chief/Rescue

A handwritten signature in black ink, appearing to read "Jacob W. Blanton".

Daniel R. Guthrie, Deputy Division Chief/Rescue

A handwritten signature in black ink, appearing to read "Daniel R. Guthrie".

Brad Elias, Medical Director

A handwritten signature in black ink, appearing to read "Brad Elias M.D.".

M.D.

RE: MEMORIAL HOSPITAL – THROMBECTOMY CAPABLE STROKE CENTER

Memorial Hospital is now operating as a ***Thrombectomy Capable Stroke Center*** as authorized by the State of Florida Agency for Health Care Administration (AHCA).

This new certification/capability allows the Neurovascular team at Memorial Hospital's main campus to perform thrombectomies on patients suffering from acute large vessel occlusions.

In terms of determining the appropriate hospital destination for our Stroke patients, this new "Thrombectomy Capable Stroke Center" should be regarded the same as a Comprehensive Stroke Center.

The *Hospital Capabilities Chart for JFRD* located on the JFRD File Share site (formerly FTP site) has already been updated to reflect this important change.

Any questions, contact your District/Battalion Chief.

A NEW DAY.



FIRE AND RESCUE DEPARTMENT

July 1, 2024

INSTRUCTIONAL BULLETIN #24-07 *Amended*

TO: All Fire and Rescue Personnel

FROM: Jacob W. Blanton, Division Chief/Rescue *J. W. Blanton*
Daniel R. Guthrie, Deputy Division Chief/Rescue *D. R. Guthrie*
Brad Elias, Medical Director *Brad Elias M.D.*

RE: Ascension St. Vincent's St. Johns – PRIMARY STROKE CENTER

Ascension Saint Vincent's St. Johns is now operating a **Primary** Stroke Center as authorized by the State of Florida Agency for Health Care Administration (AHCA).

The *Hospital Capabilities Chart for JFRD* located on the JFRD File Share site (formerly FTP site) has already been updated. Laminated copies of the revised chart will also be delivered to every Rescue unit in the coming days.

Any questions should be directed to your respective District/Battalion Chief.

Thank you.



FIRE AND RESCUE DEPARTMENT

March 7, 2025

INSTRUCTIONAL BULLETIN #25-03 **RESCINDED**

TO: All Fire and Rescue Personnel

FROM: Jacob W. Blanton, Division Chief/Rescue *J. W. Blanton*
Daniel R. Guthrie, Deputy Division Chief/Rescue *D. R. Guthrie*
Brad Elias, Medical Director *Brad Elias M.D.*

RE: NAVY HOSPITAL JACKSONVILLE – REDUCED OPERATING HOURS

Navy Hospital Jacksonville has announced a change to their Emergency Room operating hours. Beginning next week, the ER will no longer be open 24/7.

Effective March 10, 2025, JFRD will only transport to Navy Hospital from 6 a.m. to 4 p.m.

The *Hospital Capabilities Chart for JFRD* located on the JFRD File Share site (formerly FTP site) has been updated to reflect this important change. Laminated copies of this revised document will also be delivered to each Rescue Unit.

Any questions should be directed to your respective District/Battalion Chief.

Thank you.



Hospital Capabilities for JFRD (Rev. 7/25)

	DOOR CODE	PHONE NUMBER	STEMI	COMPREHENSIVE STROKE CENTER	PRIMARY STROKE CENTER	PEDIATRICS	LABOR & DELIVERY	ADULT TRAUMA CENTER (≥16 y/o)	PEDIATRIC TRAUMA CENTER (≤15 y/o)	VENTRICULAR ASSIST DEVICE	OPIOID RECOVERY PROGRAM
Baptist Medical Center – Beaches	#1097H	627-2999			✓		✓				
Baptist Medical Center Clay	#1097H	516-1100			✓	1300-2000					
Baptist Medical Center - Downtown (includes Wolfsons)	1097#	adult 202-2046 ped 202-9000	✓	✓	✓	✓	✓		✓		✓
Baptist Medical Center - Nassau	1097*	321-3561			✓						
Baptist Medical Center North - Stand Alone ER	#1097H	202-6890				1400-2200					✓
Baptist Medical Center Oakleaf - Stand Alone ER	#1097H	516-1620				0800-2100					
Baptist Medical Center - South	#1097H	adult 271-6100 ped 271-6060	✓		✓	0800-0000	✓				
Baptist Medical Center Towncenter - Stand Alone ER	1097#	202-6790				0800-0000					
Ed Fraser Memorial Hospital		259-3151 x2240									
Mayo Clinic	1094	956-0033	✓	✓	✓					✓	
Memorial Hospital	1911*	702-6089	✓	✓	✓	Mon-Fri 1400-2000 Sat-Sun 1600-2000	✓	✓			✓
Memorial Atlantic - Stand Alone ER	1911*	998-5001									
Memorial Julington Creek - Stand Alone ER	1911*	730-5001									
Memorial Mandarin - Stand Alone ER	1911*	407-8520									
NAS Naval Hospital	911911#	542-7340					✓				
Normandy Park - Stand Alone ER	1097	378-7301									
Orange Park Medical Center	1097	639-3971	✓	✓	✓		✓	✓			
Park West - Stand Alone ER	1097	772-3311									✓
St. Vincent's Medical Center Arlington - Stand Alone ER	1097#	450-6740									
St. Vincent's Medical Center - Clay	#1670H	602-1402	✓		✓		✓				
St. Vincent's Medical Center - Riverside	104#	308-5055	✓		✓						✓
St. Vincent's Medical Center - Southside	1097#	296-3784	✓		✓		✓				✓
St. Vincent's Medical Center - St. John's	1097#	691-1400			✓						
St. Vincent's Medical Center Westside - Stand Alone ER	1097#	450-6760									
UF Health Hospital	1097#	244-8703 Trauma 244-6993	✓	✓	✓	✓	✓	✓	✓		✓
UF Health Hospital North	1223*	427-7777					✓				
UF Health Baymeadows - Stand Alone ER	1097	427-7254									
UF Health Lane Ave - Stand Alone ER	1097	427-7252									
UF Health New Kings Rd - Stand Alone ER	1097	427-6150									

Stand Alone ERs - NOT to be transported to a Stand-Alone ER: Chest pain, Post-Cardiac Arrests with ROSC, STEMI Alerts, Stroke Alerts, COVID Alerts, Trauma Alerts, Trauma Reds, Pregnancies, Baker Acts, Pediatrics (except as listed above), and those patients expected to be admitted or require specialized services.

Nelson, Shannon - FRFO

Subject: FW: PATH Unit Information

Importance: High

From: Blanton, Jake - FROD

Sent: Friday, November 22, 2024 11:11 AM

To: Fire <Fire@coj.net>; FireandRescueStations <FireandRescueStations@coj.net>; FRCC Supervisors <FRCCSupervisors@coj.net>

Subject: PATH Unit Information

All,

Regarding JFRD's new Providing Assistance to The Homeless (PATH) unit/program, here is some helpful information.

PATH1 goes into service this Saturday, 11/23/24, riding out of Station 27.

- Landline phone: 255-3899
- Cell phone: **630-PATH (7284)**
- Team email: JFRDPATH@coj.net

This program is still very much a work in progress. In this early stage, the PATH team will largely be focusing on educational outreach and engagement.

For now, field units are **not** to request a PATH1 response. Should you encounter a homeless individual who may benefit from the team's outreach/education, you can make a referral to the PATH team for a potential follow-up by contacting them by phone or email. Again, field units should **not** request a PATH unit response over the radio, nor should units remain at a scene while attempting to make a referral.

Going forward, this team's scope of work will certainly expand. As this occurs, follow-up information will be shared with everyone.

Thank you,

Jake Blanton

Chief of Rescue

Jacksonville Fire & Rescue Department

515 N Julia St

Jacksonville, FL 32202

904-255-3302 (office)

904-654-6351 (cell)

EMAIL: jblanton@coj.net



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RIGHTSITE PROJECT TRIAL GUIDELINES JACKSONVILLE FIRE AND RESCUE DEPARTMENT

CREATED: 8/23

PURPOSE

This policy is intended to provide guidance to those JFRD members participating in the telehealth project trial. This trial is being conducted to determine the potential value of utilizing a telehealth referral system, versus hospital transportation, in specific non-emergent patient situations.

OVERVIEW

RightSite is a telehealth service that connects EMS with emergency physicians via on-demand navigators. In the setting of a non-emergent complaint (as detailed below), these on-demand navigators work with the JFRD Rescue Officer and an online physician to determine if a patient can be evaluated and treated at a site other than the Emergency Room. If so, RightSite arranges for transportation, when necessary, to and from the patient's location.

SCOPE

Only designated Rescue units staffed with personnel who have received the JFRD/RightSite training will participate in this trial. The program hours will be limited to Monday-Friday, 0700-1900.

JFRD maintains authority over the scene. If JFRD personnel believe the advice being given may not be in the best interest of the patient and/or places the JFRD in a position of potential liability, JFRD personnel should resume patient engagement and manage the scene per current JFRD practice.

ACTIVATION

A patient who is deemed stable after a complete assessment, and who also has a minor chief complaint that does not meet the requirements specified in Section 1140 of the EMS SOG 430, **may** be appropriate for a telehealth referral.

APPROPRIATE FOR REFERRAL:

- Med Refill
- Dental pain/fracture
- Stable illness (sinusitis, pharyngitis, bronchitis, earaches, conjunctivitis, etc.)
- Simple UTI, not pyelonephritis (no fever or flank pain)
- Extremity injuries without deformity
- Mild hypertension (systolic ≤ 180 , diastolic ≤ 110)
- Mild hyperglycemia < 200
- Abrasions
- Isolated rashes without fever and stable vitals



RIGHTSITE PROJECT TRIAL GUIDELINES **JACKSONVILLE FIRE AND RESCUE DEPARTMENT**

CREATED: 8/23

NOT APPROPRIATE FOR REFERRAL:

- 15 years of age or less
- All of the mandatory transport criteria as listed in Section 1140 of the EMS SOG
- Abnormal vital signs: Temp ≥ 102 , Heart Rate ≥ 120 , O2 Sat $< 95\%$
- Open fractures
- Dislocations
- Vision loss
- Eye pain
- Severe pain
- Heat illness
- Urinary retention
- Traumatic neck and/or back pain
- Lacerations
- Intoxication
- Drug or alcohol withdrawal

PROCEDURE

Should the patient agree to engage with RightSite, proceed as follows:

1. Log into the RightSite link and connect patient with the on-demand navigator.
2. Remain with the patient until the telehealth assessment is complete.
3. If the RightSite physician has agreed that non-emergent care is appropriate, ask the patient if they are agreeable to the arranged care.
4. If patient agrees to the non-emergent care arranged by RightSite, complete a full patient care report (PCR) utilizing "Evaluation Only" as the disposition.
5. Have patient sign the "Non-Emergency/Non-Transport" option within the signature section.
6. JFRD departs the scene.

Should the patient not want to engage with RightSite or should RightSite determine the patient is not appropriate for a RightSite referral, JFRD will manage the scene/documentation according to current JFRD practice.



**STANDARD OPERATING GUIDELINES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

TITLE: Communications

CREATED: 08/89

REVISED: 5/23

SOG: 401

401.00 PURPOSE

Establish guidelines for radio operations between field personnel and Fire Rescue Communications Center (FRCC) during emergency and non-emergency incidents.

Define JFRD Suppression/EMS assignments.

401.01 800 MHz RADIO

The JFRD performs radio communications on the *First Coast Radio System* (FCRS), an 800 MHz trunked radio system, using mobile and handheld portables.

There are six *Flights* available to the JFRD on the FCRS:

- ***A-Flight***
- ***B-Flight***
- ***C-Flight***
- ***Inter Op***
- ***Hospitals 1***
- ***Hospitals 2***

401.02 ASSIGNMENT OF 800 MHz RADIO FLIGHTS

Assigning incidents to Flights and Talk Groups is the responsibility of FRCC. Units may request to isolate an incident on an alternate Flight and Talk Group, when necessary, by notifying FRCC after dispatch.

FRCC may designate a Flight and Talk Group for the following:

- Incidents requiring 5 or more units
- Isolation of an Air Transport Unit (ATU) with Landing Zone Unit
- Mutual Aid assignments
- Special Event radio communications
- Non-emergency field communications
- Multi-department/agency communications
- Field training exercises



**STANDARD OPERATING GUIDELINES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

TITLE: Communications

CREATED: 08/89

REVISED: 5/23

SOG: 401

401.03 A-FLIGHT

401.03.01 A1 (EMS-EAST)

A1 is the primary Talk Group for EMS incidents occurring East or South of the St. John's River requiring dispatch of four or less units. After dispatch, responding units will place their radios on A1.

Incidents assigned to A1 that require additional units which result in an assignment of 5 or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A1 will be monitored by FRCC at all times.

401.03.02 A2 (DISPATCH)

A2 is the dispatch Talk Group for both Suppression and EMS.

FRCC will simultaneously broadcast dispatches across A1, A2, A3, and A4 for the benefit of all units.

Available Suppression and EMS units are required to monitor A2 at all times.

After dispatch, all relayed incident information and field requests shall be conducted on the assigned Flight and Talk Group. After completing the incident, units shall advise their disposition on the assigned Talk Group prior to returning to A2.

All non-emergency status changes (*Available, In-Quarters, En-Route to Tactical Support*, etc.) shall be conducted on the PMDC or A2.

Units advising "*Available*" on A2 without identifying destination will be assumed *Available* in *first-due* territory.

A2 will be monitored by FRCC at all times.

401.03.03 A3 (EMS-WEST)

A3 is the primary Talk Group for EMS incidents occurring West or North of the St. John's River requiring dispatch of four or less units. After dispatch, responding units will place their radios on A3.

Incidents assigned to A3 that require additional units which result in an assignment of five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A3 will be monitored by FRCC at all times.



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401.03.04 A4 (SUPPRESS)

A4 is the primary Talk Group for Suppression incidents requiring dispatch of four or less units. After dispatch, responding units will place their radios on A4. Incidents assigned to A4 that require additional units which result in an assignment of five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.

A4 will be monitored by FRCC at all times.

401.03.05 A5 (SP EVENT 1) and A6 (SP EVENT 2)

Special Event teams will communicate on and monitor either A5 or A6, unless directed by FRCC to an alternate Talk Group. These channels are encrypted.

Units dispatched to assist Special Event teams with emergency incidents will be instructed by FRCC to change to either A5 or A6. If upgraded to include five or more units, the incident may be isolated on B-Flight by FRCC or by field request.

FRCC will monitor A5 and A6 when in use.

401.03.06 A7 (REPEATER7)

DVRS assigned to F7.

401.03.07 A8 (SUPPORT)

A8 shall be used for non-emergency communications between field personnel and Tactical Support personnel.

Units shall return to A2 and notify FRCC when placed *Out-of-Service* or when advised to respond to a service facility.

A8 is not routinely monitored by FRCC.

401.03.08 A9 (REPEATER9)

DVRS assigned to F9.

401.03.09 A10 (MARINE)

A10 is primarily used on marine incidents involving multiple agencies. It is permanently patched to JSO and FWC.

A10 is not monitored by FRCC.



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401.03.10 A11 (TALK 1) and A12 (TALK 2)

A11 and A12 are conventional, simplex radio frequencies used for short-range communication within distances of approximately one mile. These channels may be useful for deployments, company training, or any non-emergency close range communications.

A11 and A12 are not monitored by FRCC.

401.03.11 A13 (HANNA)

A13 belongs to Hanna Park. It is commonly used by Ocean Rescue staff assigned to Hanna Park, call sign OCEAN 72.

A13 is not monitored by FRCC.

401.03.12 A14 (HUGUENOT)

A14 belongs to Huguenot Park. It is commonly used by Ocean Rescue staff assigned to Huguenot Park, call sign OCEAN 73.

A14 is not monitored by FRCC.

401.03.13 A15 (ATU)

A15 is used for communication between JFRD and Air Transport Units.

A15 is monitored by FRCC when in use.

401.03.14 A16 (TRAINING)

A16 is used for communication between units engaged in training exercises.

A16 is not monitored by FRCC.

401.04 **B-FLIGHT**

There are four Talk Groups located on B-Flight for isolating major incidents (B1, B5, B9, and B13).

EMS and Suppression incidents requiring five or more units will be isolated on B-Flight and assigned a Talk Group by FRCC.



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FRCC will rebroadcast the assigned Talk Group 15 seconds after initial dispatch for the benefit of responding units.

All the Talk Groups have expansion capabilities, in addition to the *Main / Sector Fire Group*:

- 2 Expansion Fire Groups (Sector)
- 1 Announcement Group (AG)

Responding units will initially be assigned to the Main group. Incident Commanders (IC) will use expansion groups at their discretion. The Announcement Group (AG) is used for simultaneously broadcasting information across the assigned Talk Group as well as both its expansion groups. The AG cannot receive transmissions. Radio channels must be returned to *Main* or one of the other expansion groups in the assigned Talk Group to have two-way communications.

B-1 Talk Group	B-5 Talk Group
B1 (main/sector)	B5 (main/sector)
B2 (sector)	B6 (sector)
B3 (sector)	B7 (sector)
B4 (Announcement Group)	B8 (Announcement Group)
B-9 Talk Group	B-13 Talk Group
B9 (main/sector)	B13 (main/sector)
B10 (sector)	B14 (sector)
B11 (sector)	B15 (sector)
B12 (Announcement Group)	B16 (Announcement Group)

401.05 C-FLIGHT

The C-Flight is a shared system throughout City agencies, but some *Talk Groups* (specific channels within the Flight) are specific to an agency/department.

- **C1 - RPTR1** DVRS assigned to Fire 1
- **C2 - JB OR** Jacksonville Beach Ocean Rescue
- **C3 - CECIL OPS** Cecil Field Operations
- **C4 - JAA OPS** Jacksonville Airport Authority Operations
- **C5 - RPTR5** DVRS assigned to Fire 5
- **C6 - NIMSN** National Incident Management North Branch
- **C7 - NIMSS** National Incident Management South Branch



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- **C8 - NIMSE** National Incident Management East Branch
- **C9 - NIMSW** National Incident Management West Branch
- **C10 – JFRD/JSO** Common channel for JFRD/JSO joint operations
- **8TAC94 (C11)** National Mutual Aid Tactical 4, **Fire 8 Repeater**
- **8TAC93 (C12)** National Mutual Aid Tactical 3
- **8TAC92 (C13)** National Mutual Aid Tactical 2
- **8TAC92 (C14)** National Mutual Aid Tactical 1
- **8TAC92 (C15)** National Mutual Aid Tactical 0
- **MA - FLA (C16)** Florida Mutual Aid

401.05.01 National Mutual Aid Communications

C11 through C15 are the National Mutual Aid and Tactical Talk Groups used during incidents requiring assistance across county/state lines.

401.05.02 State Mutual Aid Communications

C16 (MA–FLA) is the Florida Mutual Aid Channel designated for use during a major incident within the state requiring statewide Mutual Aid.

401.06 **INTEROP**

The InterOp-Flight is dedicated to surrounding county Fire and Rescue agencies and the Emergency Operations Center.

401.07 **Hospital Flight 1**

Hospital Flight 1 is dedicated to area hospitals for unit to hospital communication, with each hospital having a dedicated channel.



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401.08 Hospital Flight 2

Hospital Flight 2 is dedicated to area hospitals and future hospitals for unit to hospital communication, with each hospital having a dedicated channel.

401.09 MUTUAL AID COMMUNICATIONS

When responding to immediate surrounding counties and municipalities, the means to communicate with other departments will vary. See Appendix E for detailed information.

At times, it may require FRCC or the other department to “patch” a radio channel between JFRD and that department. When a patch occurs, you will be able to use the assigned channel to communicate with both FRCC and the surrounding county’s units.

401.10 DIGITAL VEHICULAR REPEATER SYSTEM (DVRS)

The DVRS is a small rugged, self-contained radio base station that improves portable radio coverage in challenging structure types, such as high-rises. When utilized, the appropriate chief will announce for crews to switch to the appropriate radio channel (C1, C5, A7, or A9).

Fire 1, Fire 5, Fire 7, and Fire 9 currently have these devices in their vehicles.

Fire 8 is equipped with a standard conventional repeater that utilizes the **C11-8TAC94** channel. No specialized/dedicated channel is needed.

401.11 FLORIDA INTEROPERABILITY NETWORK (FIN)

FRCC is equipped with a *Florida Interoperability Network* (FIN) radio to communicate with other county agencies directly.

The FIN may be patched directly into the 800 MHz radio system, allowing JFRD field personnel to communicate with Mutual Aid counties, if necessary.

FRCC will notify JFRD units participating in a Mutual Aid incident of the designated Talk Group.



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401.12 METRO-JAX TALKGROUP

FRCC is equipped with the Metro-Jax Talkgroup. It is designed to allow for emergency dispatch centers to immediately communicate with the other public safety communication centers in the region when a major incident occurs.

This channel will be used to coordinate needs and responses among the communication centers.

401.13 EQUIPMENT PROBLEMS

Telephone, computer, printer, or software problems shall be relayed to ITD (Information Technologies Division). Requests for station equipment problems shall be submitted through the Tivoli system or by calling 255-1818. Urgent repairs occurring outside normal business hours that require overtime must be authorized by the FRCC shift supervisor.

Power failures at the station shall be reported to FRCC. Field personnel are responsible for monitoring the radio until the power is restored. Field personnel shall inform FRCC as soon as the power is restored.

401.14 FIRE RESCUE COMMUNICATIONS CENTERS

The Fire Rescue Communications Center (FRCC) has two locations. The Primary center is located at JFRD Headquarters (515 N Julia St), and the Back-Up Communications Center (BUCC) is located at Cecil Airport (5847 Aviation Ave).

Both Communications Centers are fully equipped for continuous JFRD operations and therefore may be used interchangeably or simultaneously. FRCC will keep personnel updated as to which is center is active and serving as the main dispatch center.

401.14.01 Fire Alarms and Investigations at FRCC

Should a Fire Alarm, investigation, or an unconfirmed fire occur at a FRCC location that is actively operating as the main dispatch center, the following shall apply:

- The first arriving unit must report to the Communications Center to determine if it is safe for FRCC staff to remain in place
- If deemed safe, the IC or Company Officer shall assign someone to remain in FRCC until the incident is under control



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401.15 FIELD RADIO OPERATION PROCEDURES

Unit identification will precede all field radio transmissions.

To facilitate field communications, units requesting location or status of another unit will be directed to the appropriate Talk Group by FRCC.

Units shall attempt to clear Talk Groups A1, A2, A3, and A4 after hearing emergency dispatch tones (Alert 3, three short beeps in succession) transmitted by FRCC.

Non-essential field communication, personal statements, and catcalls are not permitted.

FRCC shall repeat the following transmissions from field units, including pertinent additional information received from on-scene personnel:

- Disposition updates ("*Available*," "*On-Scene*," etc.)
- EMS Alerts (Trauma Alert, Cardiac Red, etc.)
- W Signals
- Maydays
- Signal 34s

FRCC will not acknowledge units advising "*En-Route*," as this statement is an acknowledgement of dispatch. If units advise "*En-Route*" from a specific location, FRCC will acknowledge the unit and repeat the location.

401.15.01 Unit Status Updates

In an effort to reduce radio traffic, units shall conduct all status changes via the PMDC without the involvement of FRCC. This includes both, dispositions (*Romeo, India, etc.*) and non-emergency status updates (*Available, In quarters, etc.*).

Units en-route to maintenance facilities or other non-emergency operations will advise FRCC when *Out-of-Position, On-Scene, Assignment Complete, and Back-In-Position*.

Upon returning to service in *first-due* territory (from maintenance, assigned incidents, etc.) units will be notified by FRCC of incidents in progress that the unit would normally be assigned to for response.



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401.15.02 Non-Emergency Field Requests

Units requesting to leave *first-due* territory while remaining in service will:

- Secure permission from the appropriate Chief
- Coordinate through FRCC

Units will coordinate with FRCC any unscheduled training or apparatus/equipment testing which may result in a delayed response.

401.15.03 Field Communications During Emergency Response

On-scene units shall directly inform responding units of response status when applicable ("*Cancel*," "*Rapid Response*," etc.) without involving FRCC.

On all EMS Alerts and W Signals, units shall include all pertinent information necessary for relay by FRCC.

Units shall relay any posted or key holder information to FRCC in order to assist in notifications.

Units shall immediately advise FRCC of changes in location or Call Description.

During multi-unit assignments, companies staging at hydrants will advise their location for the benefit of the IC. FRCC will repeat the unit and location.

Units shall notify FRCC immediately when emergency responses are delayed (slow moving train, road blockages, road obstructions, vehicle malfunctions, etc.). FRCC will dispatch the next closest available unit (assisted by the next-due fully staffed/ equipped unit, if applicable) immediately after receiving notification. Units may advise alternate routes and alternate units for dispatch to offset response delay. Units shall advise FRCC immediately when clear of delay and if continuing response.

The following notifications shall generate the 10-minute increment notification from FRCC: Incident Command, Signal 34, Mayday, STEMI Alert, Stroke Alert, Trauma Alert, and Trauma Red. FRCC will broadcast on the Talk Group involved, the location and duration of the incident in 10-minute increments. The 10-minute increments will begin when the applicable command or notification is advised, except for structure fires. The 10-minute increment timer for structure fires shall begin upon dispatch of the incident.

The 10-minute notifications will continue until FRCC has been advised that the situation is under control or patient transport is in progress. The 10-minute increments will be acknowledged by the person in charge.



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Cardiac Reds will generate a 20-minute timer.

When Incident Command is established, personnel establishing and assuming Command will utilize "*Command*" as their radio designation for the duration of the incident or until relieved of Command by another JFRD officer.

During multi-unit responses, units (including those equipped with PMDC's) shall report all *On-Scenes* directly to FRCC.

401.15.04 Hospital Communications

FRCC will advise Rescue Units when a hospital is unable to accept patients due to an *Internal Disaster* (e.g., power failure, water leak, fire).

Units advising Trauma Alert, Stroke Alert, STEMI Alert, Cardiac Red, or Trauma Red will do so as soon as practical, giving:

- Criteria if applicable
- Hospital destination
- ETA to hospital

After receiving a Trauma Alert, Stroke Alert, STEMI Alert, Cardiac Red, or Trauma Red notification, FRCC will contact the appropriate hospital emergency facility relaying all information received.

401.15.05 Other Agency Requests

FRCC shall note all other agencies contacted to assist JFRD units on initial dispatch in the additional information field (JEA en-route, JSO responding, Pop-A-Lock en-route, etc.). If the supporting agency(s) are not required, units should advise FRCC as soon as possible to cancel them.

Units requesting assistance from other agencies (JEA, JSO, Pop-a-Lock, etc.) shall specify the nature at the time of request. Just as is the case with JFRD, these other agencies need detailed information so that they can dispatch appropriately.

401.15.06 Apparatus Problems

Units with vehicle maintenance issues shall contact the Tactical Support Facility during business hours via A8. After hours or holidays, units shall contact FRCC.

401.15.07 Systemwide Radio Failure

Should a systemwide radio failure occur, on-duty personnel must return to their assigned station immediately.



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FRCC will continue to dispatch units via the CAD/PMDC, and Red Phone, as necessary.

Field units must make status updates (i.e., enroute, on-scene, available, etc.) via the PMDC. If unable to do so, or for other critical messaging, FRCC should be contacted by Red Phone or their direct line at 630-0522.

As a last resort, and for the benefit of being able to communicate with nearby units, the following conventional simplex channels shall be utilized. These channels will allow units that are within close range, approximately one mile, of each other to communicate.

- A11 for units East and South of the St. Johns River
- A12 for units West and North of the St. Johns River

Meanwhile, FRCC must also complete the following tasks as soon as possible:

- Contact the Radio Shop to determine the situation and expected length of outage
- Email "FIRE" advising of the situation and the need for on-duty units to return to their assigned station ASAP
- Issue BOLO message to all PMDCs advising of the situation and the need for all units to return to their assigned station ASAP
- Issue message to all Stations via the Purvis Station Alerting System advising of the situation and the need to remain at the station unless dispatched on a call
- Notify the JFRD Admin Group via the Ready Op messaging
- Notify all hospitals about the temporary inability to transmit Med Reports

401.16 DISPATCHED UNITS

401.16.01 Units Responding from Quarters

All dispatches of units in quarters will be preceded by an *Alert 1* (single alert tone of at least a 1-second duration), followed by all applicable dispatch information. It is the responsibility of field personnel to notify FRCC immediately if the unit dispatched:

- Is not in quarters
- Is not appropriately staffed to handle incident
- Has limited capabilities and is unable to handle incident

401.16.02 Available Units

All dispatches of units on an *Available* status will be preceded by an *Alert 2* (alternating "hi-low" alert tone of at least a 1-second duration), followed by all applicable dispatch information.



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If a response is not received from a dispatched unit within 15 seconds of initial dispatch, FRCC will attempt to contact the unit directly by radio and/or red phone. If the unit fails to respond after the second attempt, the next closest available unit will be dispatched and assisted by a fully staffed and equipped unit if applicable. FRCC will contact the appropriate Suppression or Rescue Chief and relay the unit's failure to respond.

It is the responsibility of field personnel to notify FRCC immediately if the unit dispatched:

- Is not closest responder at its current location
- Is not appropriately staffed to handle incident
- Has limited capabilities and is unable to handle incident

401.17 ACKNOWLEDGEMENT OF DISPATCH

401.17.01 Units Responding from Quarters

Units in quarters will acknowledge receipt of dispatch by performing one of the following in descending order:

- Pressing station FSAS confirmation button. This action by itself does not confirm you are enroute
- Confirming dispatch via red phone
- Advising Enroute on appropriate Talk Group
- Pressing the Enroute button on PMDC if equipped

401.17.02 Available Units

Available units shall acknowledge dispatch by advising "*En-Route*" and their current location on the appropriate Talk Group (this includes apparatus equipped with PMDC's) for the benefit of surrounding units. FRCC will acknowledge "*En-Route*" by repeating the unit's current location only.

Available units hearing dispatch of an incident or advised of an incident near their current location will briefly confer with initially dispatched unit to determine which is closer. The responding unit must advise FRCC of the decision.

When an incident is dispatched near their current location, *Out-of-Position* units that are on an *Available* status shall advise FRCC if they are closer than the responding units.



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401.18 FRCC DISPATCH PROTOCOL

The type and amount of information received will dictate the initial assignment dispatched.

The closest available unit will be dispatched to an incident and, if necessary, supported by the next available appropriately equipped and staffed company.

401.18.01 Diverting Units

FRCC shall divert units to other incidents based on the criteria that life takes precedence over property. If units are diverted, the next closest available unit will be dispatched to the first incident and assisted by a fully staffed/equipped unit, if applicable.

Responding units may divert to a second incident, which exceeds the initial assignment in priority after advising they are closer and receiving approval from FRCC. A second unit will be dispatched to the first incident, as FRCC is notified of such.

401.18.02 Cancellations

Only the patient or complainant may request cancellation of responding units prior to the arrival of JFRD or JSO personnel. Upon FRCC relaying complainant/patient request, units may cancel at their discretion.

FRCC will relay cancellation requests from units on-scene or JSO personnel to responding units. Responding units may advise "*Available*" or proceed at their discretion.

401.18.03 Fire Alarms/False Alarms

FRCC will relay all pertinent information received from alarm companies whether the units are en-route or on-scene. Field personnel will utilize this information at their discretion.

401.18.04 Downgrading/Upgrading Alarms

During multi-unit responses, the downgrading of an initial assignment may occur if an on-scene unit provides an initial report, a fire classification, and the appropriate Chief acknowledges the report. Chief Officers or FRCC may then direct responding units to utilize PMDC's or A2 to go available. Units on scene are not included.



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Companies that possess special or prior knowledge of a dispatched location or situation may alter an assignment (upgrade or downgrade) at any time by immediately notifying FRCC of their decision.

When information is received that would increase the amount and type of apparatus/equipment needed, assignments will be upgraded immediately.

FRCC shall upgrade an assignment based upon information received from a complainant, another agency, or field personnel, provided responding units have not arrived.

401.18.05 Limited Jurisdiction Areas

When an incident occurs near a county line or military base, FRCC personnel shall automatically contact the adjacent county or agency and inquire on the availability of emergency units for assistance.

JFRD Suppression apparatus will not be assigned to an EMS incident at NAS JAX or NAS Mayport unless specifically requested by the naval facility.

Misrouted emergency rescue requests from on-base naval housing received by FRCC will be relayed to the Navy Regional Dispatch Center. FRCC will dispatch units when assistance is requested by the naval facility.

FRCC shall contact UNF police for assistance at all incidents occurring on the University of North Florida Campus.

FRCC shall notify Atlantic Beach Police and Neptune Beach Police of all life-threatening incidents occurring within their jurisdiction.

401.18.06 Law Enforcement Dispatched for Scene Safety

The appropriate police agency will be dispatched to bars, lounges, or any high-risk location where JFRD field personnel may be in danger.

Responding units will be advised immediately as to any unusual or dangerous circumstances (fights in progress, suspect on scene, etc.)

The appropriate police agency will be dispatched for traffic control on the initial dispatch of commercial structure fires, apartment fires, hazardous material incidents, and mass casualty incidents.



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401.18.07 Automated Skyway Express

FRCC shall notify the Skyway Control Center Operator via the Red Phone if any incident involves the Skyway. FRCC shall instruct the operator to de-energize the rail system until verification of the incident location has been established.

If an emergency occurs outside normal Skyway hours of operation, FRCC will contact the Skyway Operations Manager to meet the awaiting Suppression Company at the Control Center.

401.18.08 Tankers

Tankers will automatically be assigned when they appear in the suggested assignments and upon field request.

401.18.09 Ladders

Ladder companies are the primary dispatch to all special details, low hanging wires, wires down, wires arcing or sparking, and children locked in vehicles when they are the closest available unit.

401.18.10 Squads

Squads are defined as an engine in their 1st, 2nd, and 3rd due territories. On all other assignments, their main duty is to establish a Rapid Intervention Team (RIT) with a focus on rapid intervention and firefighter survival.

All structure fires, Hazardous Materials incidents, and Special Operations incidents will require *at least* one Squad assigned as RIT.

401.18.11 Chiefs

The appropriate Chief will automatically be assigned when they appear in the suggested assignments, upon field request, or at the discretion of the FRCC Supervisor.

The Technical Rescue Team Chief (Fire 4) will respond to:

- Special Operations incidents
- Incidents requiring deployment of the Technical Rescue Team

The Firefighting/Marine Operations Chief (F8) will respond to:

- Significant ship/boat accidents and other marine incidents



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The Hazardous Materials Chief (Fire 9) will respond to:

- Hazardous Materials incidents requiring a full team

The Aircraft Rescue and Fire Fighting (ARFF) Chief (Fire 11) will respond to:

- Alerts at JAA operated airports (JIA, Cecil, Craig, and Herlong)
- Any incidents involving aircraft, regardless of location

401.18.12 Command Van

The Command Van will be assigned at the request of the Incident Commander or when they appear in the suggested assignments,

401.18.13 Air Truck

The Air Truck will be assigned to all confirmed W3s, when they appear in the suggested assignments, or upon request by field personnel.

401.18.14 Rehab Unit

The Rehab Unit serves as the primary apparatus for delivering rehabilitation equipment and supplies to an emergency scene.

The Rehab Unit will be assigned to all confirmed W3s, when they appear in the suggested assignments, or upon request by field personnel.

401.19 **FIELD REPORTS / BENCHMARKS**

401.19.01 Initial Report

The first-arriving unit of a multi-unit response shall transmit a brief initial radio report including:

1. Unit identification on-scene
2. Building/incident description (occupancy, size, construction)
3. Obvious conditions and initial tactics

401.19.02 Fire Classifications

Any fire that involves FLAME damage to the structure will require the response of a Suppression District/Battalion Chief.

- **W1** - One Suppression unit required to handle incident (see SOG 406, Appendix B for full description)
- **W2** - Two or more Suppression units required to handle incident (see SOG 406, Appendix B for full description)



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- **W3** - Full Assignment or Maximum Full Assignment required to handle incident (see SOG 406, Appendix B for full description)
- **2nd Alarm, 3rd Alarm, 4th Alarm, 5th Alarm** – See section 401.31

401.19.03 Suppression Benchmarks (see SOG 406.09.05)

- Primary Search Complete
- *Situation Under Control*
- *Secondary Search Complete*
- **W4**

401.19.04 EMS Alerts

- MCI Level I (5-10) victims
- MCI Level II (11-20) victims
- MCI Level III (21-100) victims
- MCI Level IV (101-1000) victims
- MCI Level V (over 1000) victims
- Trauma Alert
- Stroke Alert
- STEMI Alert
- Cardiac Red
- Trauma Red

401.20 **FIELD PERSONNEL EMERGENCIES**

401.20.01 Emergency Alarm Button

If an emergency arises that may compromise the health, safety, or welfare of on-duty JFRD personnel, the orange *Emergency Alarm Button* located on the portable radio should immediately be activated. Depending on whether it is a Mayday or Signal 34 situation, personnel should clearly state:

- Unit identification
 - “Mayday! Mayday! Firefighter down/missing!”
 - Present location of missing/trapped personnel, if known
- OR
- Unit identification
 - “Signal 34”
 - Present location

Activating the orange Emergency Alarm Button sets off an alarm and displays the unit’s portable radio ID on all radio positions in FRCC.



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Activating the orange Emergency Alarm Button will automatically lock down the channel and open the mic for 20 seconds, after that the mic must be physically keyed for Communications to receive any radio traffic.

Not all ID numbers reflect a company or unit's portable radio. The ID number displayed in FRCC may belong to the portable radio itself. Therefore, if possible, it is imperative each company or unit in distress announce their Unit name, number, and location. The Radio Shop programs the radio IDs.

The Emergency Alarm Button must be reset after the emergency has ended. To reset, the user must hold the button down until receiving a long steady tone (approximately five seconds), then release. Should there be difficulty in resetting the alarm, advise FRCC over the radio that the situation is under control, and you are attempting to reset.

401.20.02 Mayday

A "Mayday" is a transmission announced over the air by any firefighter that has or is in danger of becoming lost, disorientated, trapped, and or disabled during a fire or other emergency.

FRCC will activate *Alert 3* tone (three short beeps in succession) and repeat transmission including "Emergency Traffic Only!" on the assigned isolated Talk Group.

If multiple Talk Groups are in use for an incident, FRCC will also activate Alert 3 and repeat the transmission including "*Emergency Traffic Only!*" on the additional *Announcement Group(s)*.

Units should follow procedures outlined in Personnel Accountability SOG 404 - Procedures for Lost/Missing Firefighters.

In the event of a mayday or lost/trapped firefighter, Command will begin a Roll Call by requesting an *Alert 3* (short rapid tones) from FRCC. Following the Alert 3, FRCC will announce: "***All companies, stand-by for a Roll Call.***"
FRCC will await further instructions from the Incident Commander.

401.20.03 Signal 34

Signal 34 is utilized in the event of a firefighter(s) in a potentially life-threatening situation. This signal can be announced over the radio or indicated by pressing the *Emergency Alarm Button*.

FRCC will attempt to contact the unit by radio to verify the emergency and location by repeating the transmission and receiving acknowledgement from the unit. If attempt is unsuccessful, FRCC will activate an Alert 3 tone for at least 1-second duration and broadcast the following on Talk Groups A1, A2, A3, and A4 simultaneously for the benefit of *Available* units:



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- “*Emergency Alarm activation for (unit name and number).*”
- “*Emergency traffic only!*”

Upon hearing an *Alert 3* tone and the broadcast of “*Emergency Traffic Only*” from FRCC, field units shall do the following:

- Units on *Available* status shall maintain radio silence and await instructions from FRCC
- Non-emergency status changes shall be advised by red phone or PMDC
- FRCC shall dispatch an *Emergency Assistance Request* Assignment to the last known location of the unit. If a unit is on *Available* status and does not advise their present location with the *Signal 34*, FRCC will continue attempting to contact the unit and notify the applicable Chief of the situation.

An Emergency Assistance Request Assignment shall consist of a Maximum Investigative Assignment (in addition to on-scene units) as well as the following:

- Rescue Unit
- Rescue Chief
- Appropriate law enforcement agency

The unit in need of emergency assistance must notify FRCC immediately once the situation is *Under Control* or *All Clear*. FRCC will repeat transmission for the benefit of units maintaining radio silence during the alert.

Note:

To maintain communication with the unit in distress, FRCC will not designate an alternate Talk Group until additional units arrive on scene and assess the situation.

401.21

COMPANY/UNIT TRANSFERS

To maintain sufficient coverage and decrease response time, units shall be transferred by FRCC into depleted areas when necessary.

401.21.01 Coverage

Stations **40, 48, and 55** shall always be covered.

Stations 16 does not require a transfer Engine for coverage as long as the Crash Units are available to respond.

Crash units shall not leave their assigned airport without approval from F11.

The suppression apparatus assigned to the Technical Rescue Team (Station 4), Hazardous Materials Teams (Stations 7 and 21), and the ARFF stations (Stations 16 and 73) shall not be used as transfer companies but may conduct standbys within their first-due territory on an *Available* status.



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In the combined territories of Stations 1, 2, 4, 5, and 9, two fully staffed Engine Companies and one fully staffed Ladder Company shall always be maintained.

In the combined territories of Stations 60 and 71, one fully staffed suppression apparatus with a pump shall always be maintained.

Field Chiefs may suggest and coordinate with the FRCC Supervisor for unit transfers to depleted areas and for *stand-by* assignments.

401.21.02 **Transfer Guidelines**

Units shall conduct transfers based on the following guidelines:

- Officers will ensure transfers are performed immediately but on a non-emergency status, unless otherwise advised
- Units must remain in transfer area until notified by FRCC to return to quarters

401.22 **SPECIALIZED RESPONSE TEAMS**

401.22.01 **Hazardous Materials (HazMat) Teams**

- **Station 7** - (Engine 7, Hazmat 7, Rescue 7, Tower Ladder 7)
- **Station 21** - (Engine 21, Hazmat 21 Rescue 21, Tower Ladder 21)

The Haz Mat Rescues are part of the Haz Mat Team when dispatched as part of a Haz Mat assignment. An additional Rescue Unit will be dispatched to satisfy various assignments.

401.22.02 **Decontamination Unit (Decon)**

The Decontamination Team is comprised of Fire Station 21 and will be dispatched at the request of the IC when information is received indicating numerous persons are ill and are experiencing the same type of symptoms. Fire 9 and a Hazardous Materials Team will be assigned to all incidents involving the Decon Unit.

401.22.03 **Technical Rescue Team (TRT)**

The Technical Rescue Team is compromised of all apparatus assigned to Station 4 and will respond *together* on all incidents involving:

- Confined Space Rescue Operations
- High Angle Rescue Operations
- Trench Collapse Rescue Operations
- Industrial machinery incidents involving entrapment



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- Structural Collapse
- Extrications involving Tractor Trailers, Buses, Trains or Multiple Vehicles
- High Rise Structure Fires
- Confirmed W-3's involving commercial buildings (IC should consider using the TRT as RIT)

F4 will be assigned to all incidents involving the Technical Rescue Team.

401.22.04 **Secondary Rapid Intervention Team (RIT) Assignment**

A secondary RIT consisting of the TRT will automatically be assigned on all W-3's involving large commercial structures (i.e., warehouse, strip mall, enclosed mall, office building, etc.). Fire 4 will be assigned with the secondary RIT to assist the on-scene Incident Commander with this expanded assignment. The Incident Commander can alter this assignment as needed.

401.23 **DEPLOYMENT TEAMS**

401.23.01 **Urban Search and Rescue (USAR) Team**

A team combined of all members of the Specialized Response Teams, on or off duty. The USAR Team will be activated by administrative request to assist with urban search and rescue deployments.

401.23.02 **Deployment Trailer**

The Deployment Trailer is a semi-tractor trailer mobile communication center utilized primarily for long-term, out-of-town deployment.

401.24 **AFTER HOURS NOTIFICATIONS**

The Duty Division Chief will be the primary administrative contact for serious and/or unusual events or incidents after normal working hours. If the Duty Division Chief is unreachable contact the applicable Division Chief or Deputy Division Chief.



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STANDARD SUPPRESSION ASSIGNMENTS

401.24 INVESTIGATIVE ASSIGNMENTS / SPECIAL DETAIL

401.24.01 Units

An *Investigative Assignment* consists of:

- Suppression Unit (Ladder or Engine)

Ladders are the primary response to the following incident types/call descriptions when they are the closest available unit.

401.24.02 Incident Types / Call Descriptions

- ****Assist a Citizen or Special Detail**
- ****Calls in which information received indicates a non-serious nature or the caller is convinced it is not serious**
- ****Tree Incident (fallen without injury)**
- Child locked in vehicle
- Elevator Incident with no injuries
- Low hanging wires, wires down, arcing, or sparking
- Wires burning

401.25 SINGLE ENGINE RESPONSE

Incident Types / Call Descriptions

- Brush fire (no potential for extension or life hazard exists (non-emergency))
- Chemical Leak/Spill (single family dwelling)
- Dumpster
- Electrical, gas, or chemical odor/investigation (single family dwelling or outside area)
- Fire (must specify - shopping carts, bikes, trees, etc.)
- Fuel Leak Vehicle (no more than 4 wheels)
- Grass Fire (no potential for extension or life hazard exists)
- Heater Malfunction
- Investigation (must specify)
- Mailboxes (commercial and residential)



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- Outdoor LP Gas Leak (20 lb. cylinder or less)
- Pleasure Boat Docked/Inland water source, lakes, ponds, nonnavigable waterways, etc.
- Private Dock (Inland water source, lakes, ponds, non-navigable waterways, etc.)
- Residential Fire Alarms (single family dwelling)
- Smoke Odor (single family dwelling or in the area)
- Transformer Fire
- Trash Fire (no potential for extension or life hazard (non-emergency)
- Unverified 911
- Vehicle Fire (autos, vans, pickups)
- **Bomb Threat (assist law enforcement)
- **Civil Disturbance
- **Land Clearing (no potential for extension or life hazard)
- **Oil Spill (less than 20 gallons)

** = Respond signal 15 status – no lights and sirens

401.26 MAXIMUM INVESTIGATIVE ASSIGNMENT

401.26.01 Units

A Maximum Investigative Assignment consists of:

- 1 - Engine
- 1 - Ladder
- 1 - Suppression Chief

401.26.02 Incident Types / Call Descriptions

- Appliance Fires - contained
- Chemical Leak/Spill Multi-Family Residence, Commercial
- Chemical Odor Multi-Family, Commercial
- Commercial Vehicle (smoking or on fire)
- Commercial Fire Alarms (includes apartments)
- Electrical, gas, or chemical odor/investigation (apartments, commercial building, daycare, enclosed mall, high life hazard, high rise, hospital, hotel, industrial, mercantile, motel, nursing home, restaurant, school, service station, strip mall, warehouse)
- Passenger Bus (smoking or on fire)
- Recreational Vehicle (smoking or on fire)



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- Smoke Odor (apartments, commercial building, daycare, enclosed mall, high life hazard, high rise, hospital, hotel, industrial, mercantile, motel, nursing home, office, restaurant, school, service station, strip mall, warehouse.)
- Tractor Trailer (smoking or on fire) (See Commercial)
- Vehicle Fire (commercial and recreational)

401.27 SPECIALIZED MAXIMUM INVESTIGATIVE ASSIGNMENT

A Specialized Maximum Investigative Assignment will consist of a ***Maximum Investigative Assignment*** plus the following additional field personnel or specialized apparatus or teams:

401.27.01 Barricaded or Hostage Incident (when requested by law enforcement)

- 1 - Rescue Unit

401.27.02 Bridge Collapse

- Maximum Investigative Assignment from each side of the river
- Technical Rescue Team
- Fire 4
- Fire 8
- 2 - Marine Units
- 1 - Squad
- 2 - Rescue Units from each side of the river
- 1 - Rescue Chief
- Command Van

401.27.03 Chemical Leak/Spill within a commercial building

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit

401.27.04 Chemical Leak/Spill involving a Tanker

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit



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- 401.27.05 Confirmed Bomb/WMD Threat
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 – Squad
 - 1 - Rescue Unit
- 401.27.06 Construction/Industrial Incident
- Technical Rescue Team
 - Fire 4
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief
 - 1 - Squad
- 401.27.07 Dock Fire (public/private in navigable waterways)
- 2 - Marine Units
 - F8
- 401.27.08 Emergency Assistance Request (Signal 34)
- 1 - Rescue Unit
 - 1 - Rescue Chief
 - Appropriate law enforcement agency
- 401.27.09 Gas Cylinder Fire (outside and < 100lb)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
- 401.27.10 Gas Cylinder Leak (outside and > 100 lb)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.11 Gasoline Leak (involving a Tanker)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit



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- 401.27.12 Gas Line Cut/Severed
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.13 Hostage Situation (Multi Family/Commercial Building)
- 1 - Rescue Unit
- 401.27.14 Industrial/Machinery Incident (Entrapment/Multiple Victims/etc.)
- Technical Rescue Team
 - Fire 4
 - 1 - Squad
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief
- 401.27.15 Passenger Bus Fire
- 1 - Rescue Unit
- 401.27.16 Radiation Incident (No WMD)
- Hazardous Materials Team
 - Fire 9
 - 1 additional Suppression Chief
 - 1 - Squad
 - 1 - Rescue Unit
- 401.27.17 RV/Commercial Vehicle
- 1 - Tanker
- 401.27.18 Railroad Incident – Freight Train
- Maximum Investigative Assignment from each side of RR tracks
 - Both Hazardous Materials Teams
 - Fire 9
 - Technical Rescue Team
 - Fire 4
 - 1 - Squad
 - 1 - Rescue Unit
 - 1 - Rescue Chief
 - 1 additional Suppression Chief



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401.27.19 **Railroad Incident – Passenger Train**

- Maximum Investigative Assignment from each side of RR tracks
- Hazardous Materials Team
- Fire 9
- Technical Rescue Team
- Fire 4
- 1 - Squad
- 3 - Rescue Units
- 1 - Rescue Chief

401.27.20 **Train Fire – Freight Train**

- Maximum Investigative Assignment from each side of RR tracks
- Both Hazardous Materials Teams
- Fire 9
- Technical Rescue Team
- Fire 4
- 1 - Squad
- 2 - Rescue Units
- 1 - Rescue Chief
- 1 additional Suppression Chief

401.27.21 **Train Fire – Passenger Train**

- Maximum Investigative Assignment from each side of RR tracks
- Fire 4
- Technical Rescue Team
- 1 - Squad
- 2 - Rescue Units
- 1 - Rescue Chief

401.27.22 **WMD Investigations involving, chemical, biological, radiological/nuclear, high yield explosive weapons (includes “White Powder” investigations)**

- Hazardous Materials Team
- Fire 9
- 1 additional Suppression Chief
- 1 - Squad
- 1 - Rescue Unit



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401.28 FULL ASSIGNMENT

401.28.01 Units

Full Assignment consists of:

- 4 - Engines
- 2 - Ladders
- 3 - Suppression Chiefs
- 1 - Squad
- 1 - Rescue Chief
- 2 - Rescue Units
- 3 - Tankers

If confirmed W3:

- 1 - Rehab Unit
- 1 - Air Truck (Sig. 15 response unless directed otherwise)

401.28.02 Incident Types / Call Descriptions

- All Structure Fires, excluding hospitals, nursing homes, convalescent centers, high rises, high-life hazard occupancies
- Gas cylinder leaks – inside a structure and < 100 lb
- Fire-related incidents involving the **Automated Skyway Express** (excluding trash receptacles)

401.29 SPECIALIZED FULL ASSIGNMENT

A Specialized Full Assignment consists of a **Full Assignment** plus the **following** field personnel or specialized apparatus or teams:

401.29.01 Building Collapse

- Technical Rescue Team
- Fire 4
- 2 - Rescues
- 1 - Tanker
- Command Van
- Air Truck

401.29.02 Chemical Leak/Spill (occurring within an industrial site)

- Hazardous Materials Team
- Fire 9



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- 401.29.03 Confined Space Rescue
- Technical Rescue Team
 - F4
 - 1- Rescue Unit
 - Command Van
 - Air Truck
- 401.29.04 Elevator Incident (Structural Failure)
- Technical Rescue Team
- 401.29.05 Fire JEA/Electrical Substation
- Hazardous Materials Team
 - Fire 9
- 401.29.06 Fire Tanker Truck
- Hazardous Materials Team
 - Fire 9
- 401.29.07 Gas Cylinder Fire (within a structure)
- Hazardous Materials Team
 - Fire 9
- 401.29.08 Gas Cylinder Fire (outside a structure and > 100 lb)
- Both Hazardous Materials Teams
 - Fire 9
- 401.29.09 Gas Cylinder Leak (within a structure)
- Hazardous Materials Team
 - Fire 9
- 401.29.10 Ship/Boat/Barge Fire or Incident
- Both Hazardous Materials Teams
 - Fire 9
 - Fire 4
 - Fire 8
 - 2 - Marine Units
 - Technical Rescue Team



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401.29.11 Storage Tank Fire

- Both Hazardous Materials Teams
- Fire 9
- Command Van
- Foam Unit

401.29.12 Structural Collapse

- Technical Rescue Team
- Fire 4
- Command Van
- Air Truck

401.29.13 Trench Collapse

- Technical Rescue Team
- Fire 4
- Command Van
- Air Truck

401.30 **MAXIMUM FULL ASSIGNMENT**

A Maximum Full Assignment will be dispatched to structure fires involving hospitals, nursing homes, convalescent centers, and high-rise buildings. The assignment will consist of a ***Full Assignment*** plus the following:

- 1 - Engine
- 1 - Ladder
- 1 - Tanker
- 1 - Suppression Chief
- 2 - Rescue Units
- 1 - Suppression Chief with mobile repeater system (F1, F5, F7, F9), if not already assigned

401.30.01 Additional units for High-Rise Building

- 1 - Engine
- 1 - Squad
- 1 - Rescue Unit
- Technical Rescue Team
- Fire 4



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401.31 ADDITIONAL ALARM ASSIGNMENTS (2ND, 3RD, 4TH, 5TH)

Each additional alarm will consist of:

- 2 - Engines
- 1 - Ladder
- 1 - Suppression Chief (at least 1 Suppression Battalion Chief must be assigned to any multi-alarm assignment)
- 1 - Rescue

If a Full Assignment or Maximum Full Assignment, depending on the type of structure involved, was not sent on the initial dispatch, the balance of the appropriate assignment will be dispatched along with the 2nd Alarm Assignment.

2nd Alarm Assignments shall be dispatched when advised by JFRD field personnel only.

For notification purposes only, FRCC will notify all stations of additional Alarm Assignments by activating the *All Stations* tones and broadcasting alarm, location, and Talk Group.

401.32 GENERAL ALARM

General alarms are events of such magnitude that the IC must consider calling in off-duty firefighters and mutual aid from surrounding counties. Once the General Alarm has been sounded, call back procedures and all future equipment requests will be tailored to the event.

401.33 W4

The W4 signal is not a tactical signal but a *health & safety* one. It can be declared before or after the signal 77 (under control) is given.

Once a W4 is declared, the following apparatus will be dispatched at a minimum:

- 1 - Engine
- 1 - Ladder
- 1 - Rescue
- Rehab Unit
- Air Truck



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SPECIFIED SUPPRESSION ASSIGNMENTS

401.34 ELECTRIC VEHICLE FIRES

401.34.01 Passenger vehicle

- 1 - Engine
- 1 - Suppression Chief
- 1 - Tanker
- Hazardous Materials Team
- F9

401.34.02 Commerical vehicle (bus, cargo truck, etc.)

- 2 - Engines
- 1 - Ladder
- 2 - Tankers
- 1 - Suppression Chief
- Hazardous Materials Team
- F9

401.35 WILDLAND FIRES

Response assignments to brush fires shall be determined by the Fire Readiness Level (FRL) provided daily by the Division of Forestry (DOF). FRCC shall obtain and advise field personnel of the daily FRL. The FRL definitions and assignments are as follows:

401.35.01 FRL 1 (Little to no fire activity)

- 1 - Engine
- 1 - Brush Truck

401.35.02 FRL 2 (Routine fire anticipated)

- 1 - Engine
- 1 - Brush Truck
- 1 - Tanker



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401.35.03 **FRL 3 (Fire occurrence above average)**

- 2 - Engines
- 1 - Brush Truck
- 2 - Tankers
- 2 - Suppression Chiefs

401.35.04 **FRL 4/5 (Fire occurrence high/extreme)**

- 3 - Engines
- 2 - Brush Trucks
- 2 - Tankers
- 2 - Suppression Chiefs
- 1 - Rescue Unit

401.36 **AIRCRAFT INCIDENTS**

401.36.01 **Alert Definitions**

The term "ALERT" is airport terminology for an aircraft incident. The pilot announces the emergency, and the alert level is determined by the air traffic control tower or the ARFF crew. Alert 1's and 2's should be expected at airports only.

- **Alert 1** - Aircraft is approaching the airport and is experiencing a **MINOR** issue.
- **Alert 2** - Aircraft is approaching the airport and is experiencing a **MAJOR** issue.
- **Alert 3** - Aircraft has crashed at an airport or off-site, is parked and is endangered by fire or explosives, aircraft is involved in a collision, or any emergency that the pilot in command requests immediate ARFF response.



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401.36.02 Aircraft Alert Assignments

401.36.03 Units

Aircraft Investigative Assignment

- ARFF Station only

Aircraft Maximum Investigative Assignment

- ARFF Station(s) if applicable
- 1 - Engine
- 1 - Ladder
- 1 - Suppression Chief
- F11
- 1 - Rescue Chief
- 1 - Rescue

Aircraft Full Assignment

- ARFF Station(s) if applicable
- 4 - Engines
- 1 - Ladder
- 1 - Squad
- 2 - Suppression Chiefs
- F11
- 2 - Rescue Chiefs
- 4 - Rescues
- 3 - Tankers
- Rehab Unit

Aircraft Max Full Assignment

- ARFF Station(s) if applicable
- 6 - Engines
- 2 - Ladders
- 1 - Squad
- 2 - Suppression Chiefs
- F11
- F4
- F9
- 3 - Rescue Chiefs
- 10 - Rescues
- 4 - Tankers
- Technical Rescue Team
- Both Hazardous Material Teams



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- Command Van
- Air Truck
- Rehab Unit

401.36.04 **Responses**

JIA

Alert 1

- Station 16 (Aircraft Investigative Assignment)
- F11 (Sig. 15 status)

Alert 2

- Fire Station 16
- Aircraft Full Assignment (Sig. 15 status)

Alert 3

- Station 16
- Aircraft Max Full Assignment
- Florida Air National Guard (FANG)

Cecil Airport

Alert 1

- Station 56
- Station 73 (Sig.15 status)
- F11 (Sig. 15 status)

Alert 2

- Station 56
- Station 73
- Aircraft Full Assignment (Sig.15 status)

Alert 3

- Station 56
- Station 73
- Aircraft Max Full Assignment

Craig Airport (Jax Executive)

Alert 1

- Aircraft Max Investigative Assignment

Alert 2

- Aircraft Max Investigative Assignment

Alert 3

- Aircraft Full Assignment



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Herlong Airport (Alert 1 not possible due to no tower)

Alert 2

- Aircraft Max Investigative Assignment

Alert 3

- Aircraft Full Assignment

Off Airport Property

Off-site

- Aircraft Full Assignment
- 1 - Brush Truck
- Consider DOF
- Consider JSO Aviation Unit

Naval Bases (NAS Jax or Mayport)

- Aircraft Full Assignment

If aircraft is reported to be a commercial aircraft, upgrade to the Aircraft Max Full Assignment.

If aircraft report to be in water, add JFRD Marine Unit(s), JSO Aviation, and USCG.

Aircraft 2nd Alarm

- If Aircraft Full Assignment previously dispatched, upgrade to the Aircraft Max Full Assignment
- If Aircraft Max Full Assignment already dispatched, increase to a Level 4 MCI response

401.37

MARINE INCIDENTS

Marine 21 (**M21**), Marine 32 (**M32**), Marine 34 (**M34**), Marine 42 (**M42**), and Marine 50 (**M50**) are aluminum Jon boats with small outboards that are kept on trailers. They can be dispatched to inland waterways (i.e., lakes, ponds, creeks) that are not accessible from a navigable waterway.

Rigid Hull Inflatable Boat (RHIB) 40 (**RHIB40**) is a 19 ft. ridged hull inflatable boat that can be dispatched to inland water ways and near shore incidents. RHIB40 is normally kept on a lift at Station 40.

MUD38 is an aluminum Jon boat with shallow water drives that make it capable of low water operation. MUD38 is kept on a trailer at Station 38.



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401.37.01 Marine Accident (accidents within a waterway involving a watercraft)

- 1 - Suppression Company
- 1 - Rescue Unit
- 2 - Marine Units
- F8

401.37.02 Marine Distress Incident

- 1 - Suppression Company
- 2 - Marine Units
- F8

401.37.03 Inland Water Sources

Assignments for all life-threatening incidents involving inland water sources (i.e., lakes, retention ponds, and other areas not accessible from a navigable water way) shall be as follows:

- 1 - Suppression Company
- 1 - Jon Boat or RHIB
- 1 - Suppression Chief
- F8
- 1 - Rescue Unit

401.37.04 Jumper (Suicide Attempt)

Assignments for incidents where an individual has jumped, or is threatening to jump, into the waterway shall be as follows:

- 1 - Suppression Company
- 2 - Marine Units
- 1 - Rescue Unit
- 1 - Suppression Chief
- F8

401.37.05 Offshore Response

Requests for assistance offshore may include sinking vessels, boat fires, search, and rescue, etc. In cases where M40 and/or M38 are dispatched to an incident offshore, F8 should always be consulted prior to dispatch and consider responding to Station 40 to establish command. Station 40 has a VHF (marine) radio base station that is capable of long-distance offshore communication.



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401.37.06 Flooding

Any standard EMS or Fire-related incident in an area known to be flooded will require one Jon Boat or RHIB in addition to the appropriate EMS or Suppression assignment.

401.37.07 Body Recovery (obvious death)

Assignments for incidents involving body recovery (usually assisting other agencies) shall be as follows:

- 1 - Suppression Company
- 1 - Marine Unit (Jon Boat or RHIB depending upon waterway accessibility)

401.37.08 Special Detail

Requests for assistance by stranded boaters or assignments to clear debris from waterways will receive a special detail assignment of 1 Marine Unit.



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EMS ASSIGNMENTS

401.38 STANDARD ASSIGNMENT

The standard assignment for an EMS incident will consist of 1 Rescue Unit and 1 Suppression Company (two-person minimum). Engines/Squads will be the primary Suppression response to EMS incidents within their *first-due territory*.

The assignment for vehicle accidents will require 1 Suppression apparatus with a minimum of 250 gallons of water, if not included in the initial dispatch. In all cases, the nearest apparatus will be in the initial dispatch (Tankers, Brush Trucks, etc., if appropriate).

401.39 EXTRICATION ASSIGNMENT

Assignments for incidents requiring extrication shall consist of the following:

- 2 - Engines
- 1 - Ladder
- 2 - Suppression Chiefs
- 1 - Rescue Chief
- 2 - Rescue Units

If the vehicle is submerged in water, dispatch appropriate marine unit(s).

401.40 CARDIAC/TRAUMA RED

The assignment for a confirmed Cardiac or Trauma Red, CPR in progress, or call in which the victim is reported to be not breathing (respiratory arrest), shall consist of the following:

- 2 - Suppression Companies
- 1 - Rescue Unit
- 1 - Rescue Chief

OR

- 1 - Suppression Company
- 2 - Rescue Units
- 1 - Rescue Chief



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401.41 ACTIVE SHOOTER

This assignment is intended to be an initial response to an active assailant incident where the number of patients is unknown. Once a more definitive patient count is determined, the correct MCI Level can be declared as appropriate.

- 4 - Rescue Units
- 4 - Engines
- 1 - Ladder
- 1 - Squad
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs

401.42 MASS CASUALTY INCIDENT (MCI) ASSIGNMENTS

If appropriate MCI Level Assignment was not sent on the initial dispatch, the balance of the assignment will be dispatched along with the original assignment.

401.42.01 Level I (5 - 10 patients)

- 4 - Rescue Units
- 2 - Engines
- 1 - Ladder
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs
- FRCC will notify the 2 closest hospitals to the incident and the 2 closest Trauma Centers

401.42.02 Level II (11 - 20 patients)

- 6 - Rescue Units
- 4 - Engines
- 2 - Ladders
- 2 - Suppression Chiefs
- 2 - Rescue Chiefs
- FRCC will notify the 3 closest hospitals to the incident and all the local Trauma Centers

401.42.03 Level III (21 -100 patients)

- 8 - Rescue Units
- 6 - Engines
- 2 - Ladders
- 2 - Suppression Chiefs
- 3 - Rescue Chiefs
- MCI-59



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- RHB-5
- FRCC will notify the 4 closest hospitals to the incident and all the local Trauma Centers

401.42.04 Level IV (101-1000 patients)

- Level III assignment
- MCI-1
- Mutual Aid from surrounding agencies and private services

401.42.05 Level V (more than 1000 patients)

- Level IV assignment
- State and Regional Mutual Aid may be needed

401.43 **AUTOMATED SKYWAY EXPRESS**

EMS response to the Automated Skyway Express is as follows:

401.43.01 Passenger Loading Station

- Standard EMS Assignment

401.43.02 Any Other Location

- Full assignment

401.44 **AIR TRANSPORT UNIT (ATU) ASSIGNMENTS**

An ATU may be placed on standby status based upon information received and at the discretion of the FRCC Supervisor, or at the request of responding field personnel.

FRCC shall advise responding units of the ATU's standby status and dispatch a unit to establish a landing zone.

If field personnel request an ATU to respond, the following units will be assigned:

- 1 - Suppression unit (Engine, Ladder, Brush, or Tanker) for Landing Zone (if not already dispatched)
- 1 - Suppression Chief
- 1 - Rescue Chief

Other Agency/Off Duty personnel request for ATU

An ATU may be launched at the request of off-duty JFRD personnel and other reliable authorized personnel (FHP, local police agencies, other fire departments, physicians, other medical personnel, etc.) as outlined in SOG 415. Should another authorized agency on scene request to launch an ATU prior to the arrival of JFRD, the requesting agency assumes responsibility for establishing the landing zone. If JFRD arrives before the ATU, they may assist.



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APPENDIX D

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MUTUAL AID

401.45 DEFINITION

Mutual Aid – a request for assistance from agencies of surrounding counties, municipalities, and military facilities.

401.46 SUPPRESSION MUTUAL AID

401.46.01 Small fire (auto, woods, etc.):

- Dispatch units as requested
- Notify appropriate Suppression Chief

401.46.02 Structure Fire or larger incident:

Dispatch at least the following:

- 2 - Engines
- 1 - Ladder
- 1 - Squad
- 1 - Tanker (if appropriate)
- 2 - Suppression Chiefs
- Notify the appropriate Suppression Battalion Chief, if not assigned to the incident

401.46.03 Request for Suppression Company(s) to Distant Locations

- Contact Chief of Operations for instructions and notify Director/Fire Chief of incident
- Dispatch according to Chief of Operations instructions
- Notify the appropriate Suppression Battalion Chief, if not assigned

401.47 EMS MUTUAL AID

401.47.01 Requests for one or two Rescue Units

- Dispatch as requested
- Notify the appropriate Rescue Chief if two are dispatched



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401.47.02 Requests for more than two Rescue Units

- Dispatch 2 Rescue Units, including appropriate Rescue Chief
- Contact Division Chief of Rescue for decision concerning additional units and notify the Director/Fire Chief of the incident
- Dispatch the balance of the request based on decision from Division Chief of Rescue
- Notify appropriate Rescue Battalion Chief, if not assigned

401.47.03 Requests for Rescue Unit(s) to Distant Locations

- Contact Division Chief of Rescue for instructions and notify the Director/Fire Chief of incident
- Dispatch according to Chief of Rescue's instructions
- Notify the appropriate Rescue Battalion Chief, if not assigned



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APPENDIX E

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ST JOHNS COUNTY FIRE/RESCUE

JFRD Radios

SJCFR Dispatch channel is located on the InterOp flight. This is their primary channel for routine EMS and suppression calls.

SJCFR TAC1, TAC2, TAC3, and TAC4 are located on the InterOp flight. These are used for large assignments.

SJCFR Radios

They have our B1, B5, B9, B13, A1, A2, and A3. They do not have our A4.

ATLANTIC BEACH PD, JACKSONVILLE BEACH PD, NEPTUNE BEACH PD

JFRD and JBPD Radios

A **NIMS** channel (our C6, C7, C8, or C9) can be used to facilitate communications.

JACKSONVILLE SHERIFF'S OFFICE

JFRD and JSO Radios

A **NIMS** channel (our C6, C7, C8, or C9) can be used to facilitate communications.

Our A10 is permanently patched to JSO's Marine Operations channel.

JACKSONVILLE BEACH OCEAN RESCUE

JFRD Radios

Jacksonville Beach Ocean Rescue operates on our **C2**.

Jacksonville Beach Ocean Rescue Radios

They have "Lifeguard Dispatch" which is our C2.

CLAY COUNTY FIRE/RESCUE

JFRD Radios

CCFR Primary channel is located on our InterOp flight. This is their primary channel routine EMS and suppression calls.

CCFR TAC1, TAC5, TAC9, and TAC12 are located on the InterOp flight. These are used for large assignments.

CCFR Radios

They have our B1, B5, B9, B13, A1, A2, A3, and A4.



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NAVY FIRE (NAS & MAYPORT)

JFRD Radios

We don't have their channels programmed.

Navy Radios

They have all our channels and will switch to a JFRD channel when working with us.

NASSAU COUNTY FIRE/RESCUE

JFRD Radios

NCFR Channel 1 and Channel 2 are on our InterOp flight. These are their primary channels for routine EMS and Suppression calls.

NCFR Radios

They have our B1, B5, B9, B13, A1, A2, A3, and A4.

BAKER COUNTY FIRE/RESCUE & MACCLENNY FD

Baker County and MacClenny Radios

We can't communicate because they have VHF radios. Dispatch centers will relay info.

MARINE CHANNEL (A10)

JFRD Radios

Our Marine channel is **A10**. You can communicate with the marine agencies listed below.

Various Agencies Radios

Coast Guard, FWC, JSO, Nassau, St. Johns, and Clay, all have it but under varying names.

OTHER HELPFUL INFORMATION

If utilizing another department's (Clay, St John's) radio channel, you are keying up on a radio tower in their county. This means that you must be close to that county before achieving reception.

If utilizing another department's (Clay, St John's) radio channel, FRCC is not able to monitor. Should you need to communicate with FRCC, you'll need to either switch back to a JFRD channel or maintain JFRD communications on a second radio.

The NIMS channels are a reliable means of communication in this region if bordering departments switch to the same NIMS channel, except in Baker County as noted above.

The simplex channels are A11 & A12. These are very short range. They are ideal for deployments when units are within a few miles of each other. FRCC can't monitor.

If you operate on a JFRD Bravo channel in another county, be aware that you are utilizing radio towers in Duval County. Get very deep into the other county and you will lose reception.



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APPENDIX F

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RADIO TERMINOLOGY

401.47

STANDARD PHRASES

The following are standardized phrases to be used in JFRD radio transmissions:

- ***Acknowledge*** – (message understood)
- ***Affirmative*** – (yes/correct)
- ***All Clear*** – Indicates Primary or Secondary Search is complete
- ***Available***
- ***ASAP*** (As Soon As Possible)
- ***Can you copy?***
- ***Cancel***
- ***Change to Talk Group***
- ***Completed Assignment***
- ***Did you receive the message?***
- ***Disregard***
- ***Emergency Traffic***
- ***End of message***
- ***ETA (Estimated Time of Arrival)***
- ***In Quarters***
- ***Location?***
- ***Loud and Clear***
- ***Message Delivered***
- ***Negative***
- ***On-Scene***
- ***Out-of-Service***
- ***Rapid Response***
- ***Receiving Poorly***
- ***Relayed Information***
- ***Repeat***
- ***Responding***
- ***Returning/Return to Quarters***
- ***Situation Under Control*** – During structure fires, indicates forward progression of fire is stopped. During other incidents, this statement indicates field personnel are not involved in a life-threatening situation.



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- *Slow response*
- *Standby*
- *Visitors/Officials*
- *What is my CCR number?*

401.48

STANDARD ABBREVIATIONS

The following standard abbreviations will be used by FRCC in the additional information field:

ABD – Abdomen

ADV – Advised

ALM – Alarm

ATC – Attempting to Contact

BF – Black Female

BLDG – Building

BLK – Black

BM – Black Male

BRN – Brown

BYF – Boyfriend

CMP – Complainant

CO – Company

CR – Cardiac Red

DOT – Department of Transportation

EB – East Bound

ELD – Elderly

ENR – En-Route

EOC – Emergency Operations Center

F – Female

FOR – Forestry

FRM – From

FRT – Front

GAL – Gallon



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GF – Girlfriend
HTL – Hotel
INJ – Injury
JEA – Jacksonville Electric Authority
JSO – Jacksonville Sheriff's Office
KH – Key Holder
LSH- Last Seen Heading
LEO- Law Enforcement Officer
M – Male
NAT UNK – Nature Unknown
NB – North Bound
NOI- No Other Information
OD – Overdose
PED – Pedestrian
PL – Parking Lot
POSS – Possible
PP – Payphone
PRIV PROP – Private Property
PU – Pickup
SB – South Bound
SIG – Signal
THRU – Through
TRL – Trailer
UNK – Unknown
WB – West Bound
WF – White Female
WM – White Male
VEH – Vehicle
VS – Versus
YO – Years Old



416.00

PURPOSE

To define and establish guidelines for response to a patient(s) confirmed with or suspected to have an emerging Infectious Disease (i.e., COVID-19, H1N1, etc.) that may directly impact public health.

To provide a standardized procedure for disinfecting and decontaminating equipment and Rescue unit after transportation of an emerging Infectious Disease patient; and for documenting an unprotected exposure.

To identify special circumstances where emerging Infectious Disease patient(s) may present to JFRD and potentially challenge or overwhelm its local resources.

416.01

CONFIRMATION OF EMERGING INFECTIOUS DISEASE

The FRCC call-taker will first attempt to identify that the patient is suspected to have an Infectious Disease through a range of predetermined questions. Some of the questions may include, but are not limited to the following:

- Is the patient experiencing fever, difficulty breathing, cough, congestion, body aches, chills, headaches, sore throat, nausea/vomiting, runny nose, or diarrhea?
- Has the patient recently traveled (within the reported incubation period) to the area of origin for the Infectious Disease outbreak?
- Has the patient had close contact with persons diagnosed with or who are under investigation for the identified Infectious Disease?

If any of the predetermined questions are confirmed by the FRCC call-taker, FRCC will advise the responding units that the patient is suspected "Signal 13" and that "PPE is advised." This message will be relayed in the PMDC primary dispatch notes AND over the radio to ensure receipt of this important information.

416.02

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Appropriate PPE will be strictly dictated by the severity level of the identified Infectious Disease. Some examples of appropriate PPE are listed below:

- NIOSH-certified Respirator (N95 or higher)
- Powered Air-Purifying Respirator (PAPR)
- Eye/Facial Protection (Goggles, Face Shield)
- Disposable Gown
- Fluid Resistant Gown
- Disposable Gloves



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In ANY circumstance(s) where a patient suspected or diagnosed with a **Highly** Infectious Disease (Ebola, SARS, etc.) may be encountered, JFRD personnel from Station 7 and 21, who are members of the Florida Infectious Disease Transport Network (FIDTN) with specialized PPE will be selected by FRCC for primary response, initial patient contact, and transport; **No Exceptions.**

416.03 RESPONSE

Unit response to a single patient with a suspected emerging Infectious Disease will typically be dispatched by FRCC as a standard EMS assignment with one Rescue Unit and One Suppression Company (two-person minimum).

416.03.01 Scene Arrival

Responding units, both Suppression and Rescue, will don the appropriate PPE upon arrival at the scene. All personnel on the scene will also ensure that PPE is donned PRIOR to entering the patient's location and PRIOR to patient contact.

In the event that NIOSH-certified respirators are in short supply, if available, Suppression personnel shall utilize their assigned MSA facepiece only with CBRNE or P-100 Filter attached. Rescue personnel will utilize the NIOSH-certified respirators to facilitate optimal communication with the patient.

Exposure to the patient's immediate location should be limited to the absolute minimum number of personnel required to safely evaluate and transfer the patient to the stretcher; one paramedic is recommended to limit exposure.

A disposable surgical mask should be immediately placed over the patient's nose/mouth and maintained throughout initial assessment, treatment, and transport to the hospital. If required, a nasal cannula may be placed under the surgical mask to provide oxygen to the patient or, if clinically indicated, a non-rebreather mask may be utilized in lieu of the surgical mask.

Once patient contact is made, all caregivers should avoid touching their own face (eyes, nose, or mouth).

416.03.02 Patient Transport

Patients who present with common symptoms of and who are suspected to have an emerging Infectious Disease do not routinely require specialized care and may be transported to ANY local hospital within the unit's response territory.

Stand-Alone ED's are **EXCLUDED** as transport destinations for patients with a suspected emerging and/or pandemic Infectious Disease.



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Prior to transport and before entering an isolated driver's compartment, the Engineer should remove and dispose of PPE and perform hand hygiene to avoid soiling the driver compartment.

In the absence of an isolated driver's compartment, the Engineer should continue to wear the NIOSH-certified respirator.

If a transport unit without an isolated driver's compartment and ventilation must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting. This will create a negative pressure gradient in the patient area.

Before initiating transport the Engineer should accomplish the following:

- If possible, provide a sealed barrier between the driver's compartment pass-through window and the patient compartment with visqueen plastic and tape, supplied to all Rescue units for this specific purpose
- Place the ventilation settings in both compartments to "non-circulation mode" to maximize air changes that reduce potentially infectious particles in the unit
- Turn on the rear exhaust fan to draw air away from the cab, toward the patient-care area, and out of the rear of the unit

Requests for transport to a patient's hospital of record may be honored and are at the discretion of the Officer-in-Charge (OIC) with consideration of hemodynamic stability (Refer to EMS SOG 430 for guidance).

Family members and other contacts of patients with a suspected Infectious Disease should NOT routinely ride as passengers in the Rescue unit.

The receiving hospital must receive advanced notification of the patient's suspected illness from FRCC. In addition, the transporting unit should notify the hospital via med report about the nature of the patient as soon as possible and PRIOR to arrival to provide adequate time to prepare an isolation room and have medical staff donned in appropriate PPE.

Upon arrival at the receiving facility, it may be necessary to maintain isolation of the patient in the Rescue unit until direct transfer to an isolation room can be coordinated with hospital staff.

Once the patient is removed, the rear doors of the Rescue unit should be left OPEN to allow for sufficient air changes to remove potentially infectious particles.



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Per the Ryan White Act 1990 Part G, the JFRD Health & Safety Officer (HSO) will act as the JFRD *Designated Officer* and shall maintain contact with the receiving hospital to closely follow the evaluation and testing of the patient, including confirmation of the suspected Infectious Disease.

416.04 UNIT AND EQUIPMENT DECONTAMINATION

416.04.01 Contaminated PPE/Clothing

PPE utilized for any suspected Infectious Disease patient should be considered BioHazardous and be properly cleaned or disposed of immediately after doffing.

PPE that is considered “single patient use” and disposable should be sealed inside two bio-waste red bags and properly disposed of at the hospital.

Under no circumstances should bio-waste from a suspected Infectious Disease patient be placed back into a sterilized Rescue unit and taken back to the station.

In accordance with SOG 422 *Infection Control*, contaminated uniforms are to be placed in two bio-waste red bags and cleaned in a designated JFRD commercial extractor one time on a 30 cycle for decontamination. Proper PPE shall be worn at all times while handling contaminated clothing.

416.04.02 Contaminated Unit/Equipment

Immediately after completion of the transport, the Rescue Unit will be taken out-of-service and the JFRD HSO notified to coordinate decontamination of the unit and equipment with an AeroClave Decontamination System utilizing EPA-registered Vital Oxide, regardless of time of day.

The appropriate Rescue District/Battalion Chief and FRCC shall also be notified of the unit’s availability status.

In the event the AeroClave is not available or out-of-service, manual unit decontamination is required and appropriate PPE must be worn at all times.

The patient compartment area and all contaminated equipment and surfaces must be thoroughly disinfected. Allow disinfectant to sit on surfaces and equipment for a **minimum of 10 minutes** prior to wiping clean.

All surfaces that may have come in contact with the patient or materials contaminated during patient care (i.e., stretcher, rails, control panels, floors, walls, seats, work surfaces, etc.) should be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant.



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416.04.03 Unprotected Exposure

Any unprotected exposure (i.e., not wearing recommended PPE) of JFRD personnel to a suspected emerging or pandemic Infectious Disease patient should be immediately reported to the HSO, in accordance with SOG 423 *Infectious Exposure*.

416.05 SPECIAL CIRCUMSTANCES

Situations may arise where patient(s) confirmed with or suspected to have an emerging Infectious Disease present to JFRD as a result of commercial travel or mass transit into Jacksonville (i.e., Commercial Aircraft, Cruise or Cargo Ship, etc.). These special circumstances mandate the official notification of specified outside federal agencies, such as the Centers for Disease Control (CDC).

416.05.01 Commercial Aircraft (JIA)

The following process has been outlined by the Department of Transportation (DOT) when a commercial aircraft reports a suspected pandemic patient on board a flight in bound to Jacksonville International Airport (JIA):

- Pilot notifies the Federal Aviation Administration (FAA) Air Traffic Control Tower (ATCT)
- The FAA ATCT notifies the Airport Operations Control Center (AOCC) via 904-741-2040
- The AOCC notifies JFRD Station 16 and FRCC
- JFRD notifies the Miami Quarantine Station
- The Miami Quarantine Station makes a phone assessment
- The Miami Quarantine Station decides whether to quarantine the aircraft or request JFRD to board the aircraft using PPE
- The aircraft may be isolated depending on situation
- If a quarantinable disease emergency is suspected, the captain of the arriving aircraft will be directed by FAA or JIA to secure the doors of the plane until emergency medical response/CDC personnel arrive
- The ability to quarantine on-site is airport dependent, but ultimately at the discretion of CDC

416.05.02 Cruise Ship/Cargo Vessel (JaxPort)

Seagoing vessel representatives are required to report sick passengers/crew within the last 15 days to the CDC under 42 CFR 71.21. Regional CDC quarantine station points of contact can be found at :

<http://www.cdc.gov/quarantine/QuarantineStationContactListFull.html>



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The US Coast Guard (USCG) will continue to review all "Notice of Arrivals" in accordance with current policies and will communicate any concerns stemming from sick passengers or crew to their USCG chain of command and the CDC quarantine station, which will coordinate with local health authorities and EMS.

Vessel masters shall inform USCG boarding teams of any ill passengers or crewmembers on board their vessel prior to the USCG embarking. Boarding Teams will verify any suspected vessel illnesses with the CDC.

The U.S. Customs and Border Protection (CBP) agency serves to facilitate the CDC's enhanced health screening of passengers and crew entering the U.S.

Passengers or crewmembers identified with symptoms of Infectious Disease may be provided with a surgical mask and referred to EMS personnel for additional treatment and health screening.



Medical Authorization

AUTHORIZATION

These treatment guidelines were developed under the authorization of the below-signed Medical Director in accordance with Florida Statute 401, Chapter 64J-1 and 64J-2 of the Florida Administrative Code. Changes to these guidelines can only be made with the authorization of the Jacksonville Fire and Rescue Department Medical Director, Division Chief of Rescue and Fire Chief.

Bradley J. Elias, M.D.
Medical Director

A handwritten signature in black ink that reads "Bradley J. Elias M.D." The signature is written in a cursive, flowing style.

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Last Revision 08/25



Medical Authorization

A special *Thank You* to the following individuals for their contributions, talent, and time during this latest revision of the Jacksonville Fire/Rescue EMS SOG:

Medical Director Brad Elias, M.D.
Deputy Director/Fire Chief Jake Blanton
Division Chief M. Dallas Cooke

Deputy Division Chief Daniel Guthrie
Deputy Division Chief James Schaudel
District Chief Christopher Perrotta

Captain Lawrence Mack
Captain Cameron Chadwick
Lieutenant Benjamin Hodge



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Administrative Policy

Chapter 1

Administrative Policies



Administrative Policy

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Introduction

Medical Director Review Date 08/2025

Purpose

The guidelines and treatments contained within this document are intended to ensure uniform treatment for all patients who receive pre-hospital care by JFRD personnel and auxiliary affiliations.

Scope

These guidelines have been written to cover all medical emergencies; however, the Medical Director realizes that unforeseen scenarios or situations may arise. In these cases, JFRD personnel should attempt to follow the most appropriate intervention and contact online medical control (receiving physician) for treatment recommendations outside the scope of these guidelines.

Medical Direction

Providing Emergency Medical Services is the responsibility of all members of the JFRD. All EMTs and Paramedics must function under the direction of a Medical Director as mandated by F.S. 401.265 and F.A.C. 64J-1.004. The Medical Director functions autonomously as administrator of clinical care and medical ethics for the Fire and Rescue personnel who work under his medical license.

Standard of Care

It is the philosophy of the JFRD that the well-being of the patient is our primary concern. This is accomplished by practicing the highest standard of care as defined by current medical science and treatment guidelines, as well as federal, state, and local laws.

The standard of care is dynamic, changing and improving regularly. Every member of the JFRD is responsible for maintaining their EMT and Paramedic skills to meet the current standard of care. All members will function at the highest level of license granted by the State of Florida Department of Health.

Ocean Rescue (COJ Lifeguards)

Personnel will operate within these treatment guidelines and initiate treatment only within their scope of practice.

First Responders will perform those procedures they are credentialed and/or have been trained to perform such as blood pressure check, CPR, glucose check, spinal immobilization, tourniquet application, splinting, etc.

Mutual Aid/Deployment

JFRD treatment guidelines are permitted in mutual aid jurisdictions. Deployments using JFRD treatment guidelines will be approved on an as needed basis by the Medical Director and Division Chief of Rescue.



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Introduction

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Scope of Practice

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All JFRD Field Personnel

EMTs and Paramedics are trained in basic and advanced emergency medical procedures and licensed by the Florida Department of Health.

- Responsibilities (not inclusive):
 - Perform scene assessments for safety
 - Perform primary and secondary patient assessments as appropriate, including obtaining vital signs
 - A primary assessment consists of general appearance with initial emphasis on airway, breathing, and circulation. This is accomplished with a full head to toe assessment.
 - A secondary assessment consists of a focal exam of the affected body systems, with a detailed history
 - A complete set of vital signs includes the following: blood pressure, heart rate, pulse oximetry, respirations, blood sugar (when indicated), and temperature (when indicated)
 - Be familiar with all equipment and procedures as listed in this document
 - Be familiar with and provide appropriate treatment as listed in this document
 - Utilize appropriate infection control practices to reduce risk of exposure(s)
 - Be familiar with and comply with various reporting requirements as listed in this document
 - Be familiar with and follow the instructions found in F.A.C. 64J-(1)(2)
 - Always display professional conduct, which includes providing full name, rank, and assignment when requested
 - Comply with all EMS related laws, regulations, and policies
 - Comply with the patient care report (PCR) signature requirements as set forth by the Centers for Medicare & Medicaid Services (CMS)
 - **Complete all PCRs by the end of shift**



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Scope of Practice

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Consent and Capacity

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Patients and Patient Encounters

A **patient** shall be defined as: a person who presents with subjective and/or objective signs and/or symptoms or a complaint which results in evaluation and/or treatment.

- Someone who arrives at a fire station requesting a blood pressure check and also verbalizes a medical complaint will be considered a patient and a full patient care report must be completed

A **patient encounter** does not require treatment, transport, or cooperation from the patient. If a technician perceives a medical problem that requires evaluation, a patient encounter has been made and a full patient care report must be completed.

If JFRD units arrive at a crash scene and those involved indicate they are "ok" and the technician sees no signs or symptoms that would warrant evaluation or treatment, **no** patient encounter has been made

Capacity versus Competency

Medical decision-making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment). Capacity is the basis of informed consent. Patients have medical decision-making capacity if they can demonstrate understanding of the situation, the consequences of their decision, reasoning in their thought process, and if they can communicate their wishes.

Competency is a global assessment and legal determination made by a judge in court.

Informed Consent

A patient with medical decision-making capacity is considered to give informed consent when any of the following occur:

- Patient gives verbal permission to treat
- Patient gives written permission to treat
- Patient does not object as you begin assessment

To give informed consent, a patient must be legally allowed to act as an adult. This means that the patient must be:

- At least 18 years of age
- **OR**
- Emancipated
 - Less than 18 and married or legally released from custody of parent or guardian
- **Exceptions**
 - An unmarried pregnant minor may consent to or refuse treatment for medical problems related to her pregnancy only
 - An unmarried minor mother may consent to or refuse treatment for her child



Consent and Capacity

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Withholding Consent for Treatment

An adult with medical decision-making capacity may withhold consent to treat. A parent with medical decision-making capacity may withhold consent to treat their child. This shall be documented in the patient care report. Personnel shall obtain the patient/parent signature on the refusal form. If the patient/parent refuses to sign, have a witness of the refusal sign the refusal form and select "Not Signed – Unwilling/Refused to Sign."

- Patients/parents are not considered to have medical decision-making capacity if any of the following are present:
 - Significant mental impairment (e.g., alcohol, drugs, head injury or significant illness)
 - Resident in a memory care facility
 - At risk for self-harm, suicide, or homicide

Treatment of Children

In the case of children under the care of a parent or legal guardian, consent must be obtained from the parent or legal guardian. If consent cannot be obtained, follow Florida Statute 743.064

If medical personnel are concerned for the safety of a minor and the parent or legal guardian refuses treatment and transport, contact the Rescue District/Battalion Chief and law enforcement for guidance.

Florida Statute 743.064

Emergency medical care or treatment to minors without parental consent

- (1) Emergency medical care or treatment may also be rendered in the pre-hospital setting by paramedics, emergency medical technicians, and other emergency medical services personnel, provided such care is rendered consistent with the provisions of chapter 401. These persons shall follow the general guidelines and notification provisions of this section.
- (2) This section shall apply only when parental consent cannot be immediately obtained for one of the following reasons:
 - (a) The minor's condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the minor to the hospital.
 - (b) The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.
- (3) Notification shall be accomplished as soon as possible after the emergency medical care or treatment is administered. The hospital records shall reflect the reason such consent was not obtained and shall contain a statement by the attending physician that immediate medical care or treatment was necessary for the patient's health or physical well-being. The hospital records shall be open for inspection by the person legally responsible for the minor.
- (4) No person as delineated in subsection (1), hospital, or college health service shall incur civil liability by reason of having rendered emergency medical care or treatment pursuant to this section, provided such treatment or care was rendered in accordance with acceptable standards of medical practice.



Consent and Capacity

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Approved Health Care Agents

A health care agent is an individual authorized to make medical decisions on behalf of an incapacitated patient. There are three types (as listed below) recognized by the State of Florida which may impact JFRD operations. **If any unusual circumstances arise, contact the Rescue District/Battalion Chief for guidance.**

Durable Power of Attorney (Florida Statute 709)

A Durable Power of Attorney form authorizes a designated individual to handle affairs and conduct business on a patient's behalf. This form is completed in advance of a patient becoming incapacitated. In Florida, the Durable Power of Attorney may include language that allows the designated decision-maker to also make medical decisions. However, because the Durable Power of Attorney is often a lengthy detailed document that includes financial considerations, the Health Care Surrogate form is more commonly utilized in these situations. Should a patient be alert and oriented, they maintain the right to override the form.

Health Care Surrogate (Florida Statute 765.202)

A Health Care Surrogate form authorizes a designated individual to make health care decisions on a patient's behalf. This form is completed in advance of a patient becoming incapacitated. Should a patient be alert and oriented, they maintain the right to override the form.

The Proxy (Florida Statute 765.401)

If an individual is incapacitated and did not previously complete an advance directive (as listed above), decisions regarding the patient's medical treatment are made by a designated Proxy. Because these types of situations often occur unexpectedly, a completed Proxy Form may not be present. Regardless, any of the following individuals, in order of priority, may make health care decisions on the patient's behalf:

- The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment
- The patient's spouse
- An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation
- A parent of the patient
- The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation
- An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs
- A close friend of the patient
- A clinical social worker licensed pursuant to chapter 491



Consent and Capacity

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If there is any doubt as to the authenticity of any of the above documents, JFRD members should provide examination and treatment of the mentally incapacitated in accordance with this SOG and Florida Statute 401.445.

An approved health care agent may verbally revoke a Do Not Resuscitate Order (DNRO) if their signature is appropriately listed on the yellow DNRO form (see Guideline 1130, page 4). However, a healthcare agent **may not** verbally withhold consent for CPR in the absence of a DNRO. Resuscitation may only be withheld or withdrawn upon presentation of a valid DNRO as described in JFRD Resuscitation Guideline 1130.

Florida Patient's Bill of Rights – Information Request

In accordance with Florida Statute 381.026, a patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. JFRD members must provide such information when requested.

Baker Act

In accordance with Florida Statute 394.463, a Baker Act is an involuntary mental health commitment by law enforcement when the patient does not have the capacity to make a medical decision and is believed to be a danger to themselves and/or others.

- If JFRD members feel that a Baker Act is warranted, law enforcement must be contacted
- A Baker Act will not be used as a pretext to provide medical treatment/transportation to an individual who refuses treatment
- JFRD members are not legally authorized to execute a Baker Act
- Baker Act patients will **not** be transported to stand-alone emergency departments or mental health facilities



Controlled Substance

Medical Director Review Date 08/2025

Responsibility

The Logistical Support Facility will be responsible for the procurement, storage, dispensing and disposal of controlled substances. Logistical Support will disperse controlled substances to individual ALS companies through the Rescue District/Battalion Chiefs as directed by the Division Chief of Rescue and the JFRD Medical Director.

Medication Errors

Medication errors and reactions while the patient is under the care of JFRD shall be reported immediately to the receiving physician and the appropriate District/Battalion Chief. The District/Battalion Chief shall then notify the JFRD Medical Director and the Division Chief of Rescue within 24 hours.

- Mandated by F.A.C. 64J-1.014(7)
- Such notification shall be documented in the PCR

Controlled Substance Inventories:

- May be amended based on drug availability (e.g., national backorder)
- **ALS Suppression Units**
 - Minimum
 - Midazolam - 5 mg
- **Rescue Units**
 - Minimum
 - Etomidate/Amidate - 60 mg
 - Fentanyl - 200 mcg
 - Ketamine - 500 mg
 - Midazolam - 15 mg
- **Rescue District/Battalion Chiefs**
 - As determined and authorized by the Division Chief of Rescue and the Medical Director

Inventory and Documentation

- Controlled Substance Daily Checklists are official records that must be completed with blue or black ink
- These forms are maintained for a minimum of 5 years and are subject to inspection by governing agencies
- Completed JFRD Controlled Substance Daily Checklists will remain with the notebook until collected by the District/Battalion Chiefs and forwarded to the Quality Improvement Officer
- Each controlled substance page has a serial number that denotes the year, unit, and page number. Therefore, a page should not be removed
- On the first of each month, a new JFRD Controlled Substance Daily Checklist shall be started
 - An inspection of the vault is not necessary



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- Any errors made on the JFRD Controlled Substance Daily Checklist will be noted by placing a single line through the error and initialed by the person correcting the error (erasures are inappropriate). White out will not be used on these documents

Dispensed to a Company

- The controlled substance inventory will be checked and documented on the JFRD Controlled Substance Daily Checklist
- The dispensing will be documented on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time of dispensing
 - Total quantity of each controlled substance
 - Inspect the controlled substances for expiration date and damage
 - New seal Number
 - Printed name and signature of the Rescue District/Battalion Chief dispersing the controlled substance
 - Printed name and signature of Paramedic Officer-in-Charge of the ALS company (or the paramedic assigned to the ALS company, if Officer is not a paramedic)
 - Explanation: Dispensing to appropriate company
 - Do not write "SEALED" in the log

Daily Inspections

- Daily and anytime the Paramedic-in-Charge is relieved
- The Paramedic Officer-in-Charge or Paramedic assigned to the ALS Company will, with a witness present, verify that the numbered seal is intact. This applies to the Rescue Chiefs' inventory also
 - If the seal is not broken
 - Document on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Seal Number
 - Printed name and signature of the Paramedic Officer-in-Charge or paramedic assigned to the ALS company
 - Witness' printed name and signature
 - Explanation: Daily Seal Inspection
 - Do not write "SEALED" in the log
 - If the seal is broken
 - Document on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Inspect the controlled substances for expiration date and damage
 - Total quantity of each controlled substance
 - New seal Number
 - Printed name and signature of the Paramedic Officer-in-Charge or paramedic assigned to the ALS company



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- Witness' printed name and signature
- Explanation: As appropriate
- On the first of each month, a new JFRD Controlled Substance Daily Checklist shall be started
 - An inspection of the vault is not necessary
- If a stocked spare unit is not staffed for the day, the Officer-in-Charge or Paramedic assigned to a staffed ALS unit within the station will, with a witness present, verify that the numbered seal is intact, and document accordingly as listed above. If the seal is broken, contact the appropriate Rescue District/Battalion Chief
- The company Captain's and Chief's signature is verification that all shifts have accurately completed the daily controlled substance log. If any errors or missing information is found, have crew promptly correct the issue

End of Year (12/31) Inspection

- Inspect inventory to verify accuracy of controlled substances prior to submitting completed logs to QI

First of Year (1/1) Inspection

- Inspect inventory to verify accuracy of document counts and expiration dates

All Advanced Life Support (ALS) Companies

- **Storage**
 - Each ALS vehicle is equipped with a permanently mounted, locking, metal safe for storage of controlled substances. The safe must be fitted with shock absorbent materials for controlled substance storage
 - Controlled substances will always be stored in the locked storage safe mounted in each ALS vehicle with a numbered seal
 - Each ALS vehicle is equipped with a notebook containing the JFRD Controlled Substance Daily Checklist
 - Access to the storage safe can be achieved by breaking the seal, then use the appropriate key or entering the individual paramedic's PIN number and pressing the pound key
 - Access to the locked storage safe will be limited to the:
 - Paramedic Officer-in-Charge of the ALS company
 - OR** (if Officer is not a paramedic)
 - Paramedic assigned to the ALS company
 - Any access to the safe will be witnessed by appropriate individuals:
 - Engineer will witness for the Paramedic Officer-in-Charge
 - OR** (if Officer is not a paramedic)
 - Officer-in-Charge will witness for the paramedic assigned to the ALS company
- **Each time a controlled substance is administered**



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- The controlled substance inventory will be checked and documented on the JFRD Controlled Substance Daily Checklist
- Inspect the controlled substances for expiration date and damage
- The administration will be documented on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time of administration
 - Total quantity of each controlled substance
 - Earliest Expiration Date of each controlled substance
 - New seal Number
 - Printed name and signature of the Paramedic Officer-in-Charge or paramedic assigned to the ALS company
 - Witness' printed name and signature
 - Explanation: CCR Number, Medication, Amount Administered, Amount Wasted
- **Discrepancies**
 - Reported to Rescue District/Battalion Chief
 - Relayed to oncoming shift
 - Documented in the Explanation section of the JFRD Controlled Substance Daily Checklist
 - Investigated by the Quality Improvement Officer and Rescue District/Battalion Chief with a discrepancy report provided to the Division Chief of Rescue and the JFRD Medical Director
- **Restocking**
 - The Rescue District/Battalion Chiefs will restock all controlled substances
 - Restocking should occur when:
 - Minimum ALS Engine inventory is reached
 - Minimum Rescue inventory is reached
 - Prior to expiration date
 - Prior to holiday or weekend when stock is close to minimum Rescue inventory
 - Each time a controlled substance is restocked:
 - The controlled substance inventory will be checked and documented on the JFRD Controlled Substance Daily Checklist
 - Inspect the controlled substances for expiration date and damage
 - The restocking will be documented on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Total quantity of each controlled substance
 - Earliest Expiration Date of each controlled substance
 - New Seal Number
 - Printed name and signature of the Paramedic Officer-in-Charge or Paramedic assigned to the ALS Company
 - Witness' printed name and signature
 - Explanation: Restocking from (R-103, etc.)



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- Rescues may swap inventory with a suppression apparatus when the suppression's medication is getting close to expiration
 - ALS apparatus may also restock each other in cases of emergency
- **Expired or damaged controlled substances**
 - Until returned any expired or damaged controlled substances will be labeled "DO NOT USE", remain in the locked safe, and be included in the total count
 - A note will be made in the comment section of the Controlled Substance Log indicating the amount and name of the expired medication
 - Any expired or damaged controlled substances shall be reported to the Rescue District/Battalion Chief

Rescue District/Battalion Chiefs

- **Storage**
 - Controlled substances will be stored in a locked safe in a climate-controlled location
 - Access to the Rescue Chiefs' safes require concurrent use of a key and PIN. A seal on the hinge of the safe must be broken to remove the key. The seal and required key must be replaced each time the safe requires access
- **Daily inspections**
 - Daily and anytime the Rescue District/Battalion Chief is relieved
 - The Rescue District/Battalion Chief, with a witness present, verify that the numbered seal is intact
 - If the seal is not broken
 - Document on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Seal Number
 - Printed name and signature of the Rescue District/Battalion Chief
 - Witness' printed name and signature
 - Explanation: Daily Seal Inspection
 - Do not write "SEALED" in the log
 - If the seal is broken
 - Document on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Total quantity of each controlled substance
 - Inspect the controlled substances for expiration date and damage
 - New Seal Number
 - Printed name and signature of the Rescue District/Battalion Chief
 - Witness' printed name and signature
 - Explanation: As appropriate
- **Discrepancies**
 - Discrepancies concerning controlled substances will be:
 - Reported to the Division Chief of Rescue and the JFRD Medical Director



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Controlled Substance

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- Investigated by the Quality Improvement Officer and the Deputy Division Chief of Rescue with a discrepancy report provided to the Division Chief of Rescue and the JFRD Medical Director
- **Restocking**
 - The Logistical Support Facility will disperse controlled substances to the Rescue District/Battalion Chiefs during normal business hours.
 - The controlled substance inventory will be checked and documented on the JFRD Controlled Substance Daily Checklist
 - The restocking will be documented on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Total quantity of each controlled substance
 - Inspect the controlled substances for expiration date and damage
 - New seal Number
 - Printed name and signature of the Rescue District/Battalion Chief
 - Witness' printed name and signature
 - Explanation: Restocking from Logistical Support
- **Expired or damaged controlled substances**
 - Until returned any expired or damaged controlled substances will be labeled "DO NOT USE" and will remain in the locked safe
 - Rescue District/Battalion Chiefs do not include expired controlled substances in their total count. Expired controlled substances have a separate log and are secured in a separate location inside the safe. Expired or damaged controlled substances will be turned in to the Logistical Support Facility during normal business hours

Rescue and Suppression District/Battalion Chiefs

- **Monthly (23rd, 24th or 25th) Chief inspection of ALS companies:**
 - These dates were chosen so that any medications set to expire the following week will be identified and restocked prior to their actual expiration date
 - Suppression Chiefs shall notify the appropriate Rescue Chief whenever the need for a restock is identified
 - The District/Battalion Chief with the Paramedic Officer-in-Charge or the paramedic assigned to the ALS company will
 - Audit the JFRD Controlled Substance Daily Checklist, ensuring that the actual count and the documented count are the same, and page serial numbers are in sequential order
 - Inspect the controlled substances for expiration date and damage
 - Document the audit on the JFRD Controlled Substance Daily Checklist, annotating:
 - Date/Time
 - Total quantity of each controlled substance
 - Earliest Expiration Date of each controlled substance



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- New Seal Number
- Printed name and signature of the Paramedic Officer-in-Charge or paramedic assigned to the ALS company
- District/Battalion Chief's printed name and signature
 - The District/Battalion Chief's signature is verification that all signatures, inventory, amount used and wasted are correct since the last audit.
Explanation: Inspection by District/Battalion Chief



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Controlled Substance

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IV Fluids/Medications

Medical Director Review Date 08/2025

Responsibility

The Logistical Support Facility will be responsible for the procurement, storage and dispensing to individual JFRD companies of all IV fluids and medications (except controlled substances) as directed by the Division Chief of Rescue and JFRD Medical Director.

Medication Errors

Medication errors and reactions while the patient is under the care of JFRD shall be reported immediately to the receiving physician and the appropriate District/Battalion Chief. The District/Battalion Chief shall then notify the JFRD Medical Director and the Division Chief of Rescue within 24 hours.

- Mandated by F.A.C. 64J-1.014(7)
- Such notification shall be documented in the PCR

Storage

IV fluids and medications will be stored at the station in a climate controlled secure location. Access to this area will be limited to the appropriate JFRD personnel.

Inventory

On the first day of each month, all IV fluids and medications will be inventoried and inspected for expiration date and damage by the Officer-in-Charge or designee.

Medications with a specific expiration date (e.g., 4/1/2013) expire on that date. Medications that have an expiration date of a month and a year (e.g., 4/2013) expire at the end of that month.

Additions to the inventory of IV fluids and medications will be procured from the Logistical Support Facility Manager in amounts authorized by the Division Chief of Rescue and JFRD Medical Director.

Restocking

The Logistical Support Facility will disperse IV fluids and medications during normal business hours.

Dispensing of IV fluids or medications from the Logistical Support Facility will be documented on a JFRD Logistical Support Requisition, signed by the requesting Company Captain or designee.

In the event a JFRD Company requires restocking of IV fluids or medications after business hours, they will temporarily restock from inventory of the closest JFRD Company after consulting with the company officer.



IV Fluids/Medications

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Disposal of Expired or Damaged IV Fluids/Medications

Expired or damaged IV fluids or medications (except controlled substances) will be properly bagged and sealed in the red biowaste bags; sharps shall be placed in red sharps boxes.

Secure sharps boxes with an "X" of tape, sealing the lid to the box. Red biowaste bags and sharps boxes shall then be labeled with the work location generating the waste and the date the waste was readied for disposal (e.g., Rescue 1, 611 N. Liberty St., Jacksonville, FL 32202, 04/01/2022). Red biowaste bags and sharps boxes shall then be placed into a large, red biowaste bag for storage inside the red biowaste container at the fire station

Unauthorized Use of IV Fluids/Medications

Excluding rehab and emergent treatment the use of IV fluids and medications will not occur unless approved by the HSO or Medical Director and proper protocols and documentation must be followed.



Cooperation with Law Enforcement

Medical Director Review Date 08/2025

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Responsibilities

- JFRD personnel are to cooperate with law enforcement
- The JFRD is responsible for the welfare of the patient and all medical treatment at the scene of an emergency. Law enforcement is responsible for traffic control and general scene management

Patients in police custody (includes incarceration)

- Patients with mental capacity in police custody can still make decisions about their medical treatment and sign an AMA Refusal or Non-Emergency/Non-Transport Waiver if allowed by law enforcement. If Law enforcement refuses to remove the handcuffs to allow the patient to sign, document in the Narrative section of the PCR that the patient verbalized a refusal of treatment. Select "Not Signed – In Law Enforcement Custody" under the Signature Type tab when selecting Refusal of Assessment/Care/Transport. Have the law enforcement officer sign the Witness signature in the PCR. Also include the officer's ID number
- Transport Destination
 - If the patient is unstable (includes any Alert), transport to the closest most appropriate hospital
 - If the patient is stable, law enforcement will dictate the hospital destination



Cooperation with Law Enforcement

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Evidentiary Blood Draw

Medical Director Review Date 08/2025

Introduction

Jacksonville Fire Rescue paramedics will comply with all law enforcement agencies requests for blood draws under the specific conditions set forth in Florida Statutes Chapters 316.1932, 316.1933, 322.63, 327.352 and 327.353.

Indications

When a law enforcement officer is at an incident involving a vehicle/vessel crash or vehicle/vessel stop, and the officer has probable cause to believe that a person involved is under the influence of alcohol or controlled substances, they may request a JFRD rescue to draw a blood sample for testing. This request is valid and must be complied with, performed in a reasonable manner and within the parameters established by Florida Statutes and this procedure.

Priority must be given to the examination and treatment of all injured persons. If a person is injured or has a potential medical emergency, the person (patient) is to be treated and transported according to the appropriate guideline.

If the suspect refuses the blood draw, it is the law enforcement officer's responsibility to inform the suspect of the provisions in Florida Statutes 316.1932 and 316.1933.

Blood draw on patients being transported

The following process shall be followed for blood draw requests on patients being transported by Rescue:

- Initiate medical care as per the appropriate guideline
- "Any person who is incapable of refusal by reason of unconsciousness or other mental or physical condition is deemed not to have withdrawn his or her consent to such test" (F.S. 316.1932)
- **Do not delay transport of an unstable patient to perform a blood draw**
- Draw blood per instructions in the blood draw kit
- All items except the needle will be returned to the kit with the Betadine prep pad being sealed in the plastic bag provided
- The investigating officer will seal the blood collection kit, maintain the chain of custody and complete the documentation
- In your report, record the date printed on the blood draw kit and the investigating officer's name and ID number



Evidentiary Blood Draw

Medical Director Review Date 08/2025

Blood draw on patients not transported

The following process shall be followed for blood draw requests on patients who refuse treatment and/or transport:

- A patient with mental capacity may refuse the test
- If agreeable to the test, draw blood per instructions in blood draw kit
- All items except the needle will be returned to the kit with the Betadine prep pad being sealed in the plastic bag provided
- The investigating officer will seal the blood collection kit, maintain the chain of custody and complete the documentation
- In your report, record the date printed on the blood draw kit and the investigating officer's name and ID number
- A full patient care report must be completed
 - Capture a refusal signature as necessary and have the investigating officer witness the refusal. If the patient refuses to sign, follow Guideline 1090 for documentation requirements



Patient Restraints

Medical Director Review Date 08/2025

Patients who may be physically restrained

- Patient restraints are to be utilized only when necessary, and in those situations where the patient is exhibiting behavior deemed to present a danger to themselves or to others
- Post intubation non-cardiac arrest patients

Approved methods of restraint

- **Law enforcement**
 - Handcuffs
 - Plastic ties
 - "Hobble" restraints
 - If Law Enforcement restrains the patient, ensure they accompany in the back of the rescue or follow behind in case the restraints need to be removed
- **JFRD personnel**
 - Consider appropriate sedative, as necessary. See Guideline 6030
 - Soft limb restraints
 - Stretcher straps/harness
 - Wide cloth restraints

Care of restrained patients

- **No patient will be restrained in the prone or "hogtied" position**
- Restraints shall not prohibit evaluation of the patient's medical status or injure the patient in any way
- Frequently assess the patient to ensure that the airway is patent, distal limb circulation is adequate and that restraints can be released quickly should the patient's condition deteriorate
- When restraints are in use, circulation to the extremities shall be evaluated at least every 5 minutes
- JFRD personnel shall never leave the restrained patient unattended
- **Patients requiring restraints will not be transported to Stand-alone Emergency Departments**

Documentation of patient restraint

Documentation of the use of restraints on the EMS field copy report and PCR shall include:

- The patient's behavior necessitating placement of restraints
- The type of restraint used
- Status of circulation distal to restraints at least every 5 minutes



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Patient Restraints

Medical Director Review Date 08/2025

This page is for formatting only



Patient Care Report

Medical Director Review Date 08/2025

Patient Care Reports (PCR)

The primary purpose of a PCR (electronic or field copy) is to document the clinical care provided to a patient. The PCR is a legal medical record and must be treated with the same degree of confidentiality as other medical records. The PCR documentation must also satisfy billing processes required for reimbursement. Accurate and legible signatures are critically important in both transport and non-transport reports.

Properly documenting the patient assessment, treatment, interventions, reassessment after interventions and the patient's response to treatment will reduce your liability and ultimately improve the overall patient care and outcome. Proper documentation also results in more accurate and timely billing.

General

- All patient care reports should be completed as soon as possible and are always required to be completed **by the end of the shift**
 - This is governed by F.A.C. 64J-1.014(14)
 - ANY EXCEPTIONS (e.g., CAD links, disposition code(s), etc.) shall be immediately relayed to QI and the appropriate District/Battalion chief
- All chief officers and captains must review E-Pro daily for outstanding reports to ensure that all reports have been completed on time
- The Suppression Officer will provide the completed EMS field copy to the Rescue Officer
 - This is governed by F.A.C. 64J-1.014(4)
- The Rescue Officer will ensure the EMS field copy is completed and provide the white copy to the hospital
 - This is governed by F.A.C. 64J-1.014(2)
- All EMS field copies must be shredded after completion of the electronic PCR
- The Emergency Pro report system is designed to recognize the report writer as the lead crew member. The proper procedure is for all report authors to ensure their name is listed in the first (top) position on the sign-in roster
- Anytime an ALS procedure is performed, the paramedic's name (unit number is not acceptable) that performed the procedure must be listed in the flow sheet
- Avoid phrases that do not add value
- Always document objectively
- Below is the ONLY approved JFRD format for your PCR Narrative
 - CC: (Chief Complaint)
 - The patient's main complaint (e.g., chest pain)
 - HPI: (History of Present Illness)
 - Exactly how the patient was presented to JFRD personnel (e.g., upon arrival at the patient's residence, the patient was found lying on the bedroom floor...)
 - Complete description of why the patient called 911 (e.g., onset of symptoms and activity related to the complaint)
 - Include a detailed description of the patient's complaints



Patient Care Report

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- PE: (Physical Exam)
 - Evaluate objective anatomic findings through observation, palpation, percussion, and auscultation
 - For any complaints of pain, document: Onset, Provocation, Quality, Radiation, Severity and Time (OPQRST)
 - Include any associated signs or symptoms that relate to the present illness
 - List any pertinent positive and negative findings
- TX: (Treatment)
 - Describe patient's condition and any changes that occurred during transport and transfer of care at the hospital
 - Document the interventions performed (paint the picture)
 - Document how the patient was moved to the JFRD stretcher (e.g., assisted, carried, sheeted, stair-chaired, etc.) and to the hospital bed, including that a hospital staff member was at the bedside upon patient transfer
 - Unsuccessful interventions must also be documented
- NOTE:
 - This section should be used for any unusual circumstances that occur during the entire duration of the incident. (e.g., patient contact delays, scene delays, patient/family issues, equipment issues, transfer of care issues, etc.)

TRANSPORT DOCUMENTATION

- Record assessments and document appropriate vital signs based on patient complaint every 5 minutes if the patient is unstable or every 15 minutes if the patient is stable. Minimum of two required for all transported patients (one at or near patient contact and one at or near arrival at the hospital)
- Record assessments and document vital signs for all "ALERT" patients (Stroke, STEMI, Trauma) every 5 minutes
- **For all patients with an advanced airway, document ETCO2 and SpO2 values post procedure and confirmation of tube placement by hospital staff**
- Parent/Guardian information must be added in the billing section under "responsible party" for all pediatric patients
- Acquire the patient's health insurance information (when available), hospital number, and medical record number from the hospital's facesheet. Document this information in the appropriate section
- Enter auto insurance information in the billing section when applicable
- **TRANSPORT SIGNATURE REQUIREMENTS**
 - Title 42 – Public Health, Chapter IV – Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services requires a patient's own signature on a claim unless the patient has died or is physically or mentally incapable of signing. All transport reports require a legible signature from either the **responsible party** or a **hospital representative**. Signatures must be



Patient Care Report

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captured prior to announcing the disposition code and departing the medical facility. Any issues concerning the signatures must be detailed in the narrative section of the PCR

- **RESPONSIBILITY** (only a single signature is required)
 - If the patient is awake, alert and oriented, and able to sign, you must obtain their signature
 - Obtaining the patient's own signature should occur in most cases
 - If the patient is unable to sign because of a mental or physical condition, the following individuals (patient representative) may sign the report on behalf of the patient:
 - The patient's legal guardian/POA
 - A relative or other person who receives social security or other governmental benefits on behalf of the patient
 - A relative who arranges their care
 - A representative of an agency that provided other care to the patient
 - If a patient is less than 18 years of age, the parent/legal guardian must sign if they are available. Select the appropriate relationship from the drop-down options
 - If the laptop is not functioning following a transport, the appropriate signatures must be captured on paper. A paper "responsibility" signature form is located on the back of the field copy report
 - The paper signature form must be scanned and emailed to JFRDQI@coj.net before shift completion. If this is not possible, the form must be delivered to the Rescue District/Battalion Chief
- **PATIENT UNABLE TO SIGN ("NOT SIGNED")** (multiple signatures are required)
 - This option is designed for those patients who are physically or mentally unable to sign for themselves and no patient representative is present. When this occurs, it must be detailed in the narrative section of the PCR. Examples include:
 - Mentally incapable
 - Physically unable (e.g., hand injury)
 - Severe distress
 - Language barrier
 - Visual impairment
 - Handcuffed
 - Uncooperative patient
 - Pediatric patient where the parent/legal guardian is not available
 - When executing a PUTS report, a representative of the receiving ER/facility must sign the report in addition to the JFRD provider (JFRD member's PIN counts as a signature)



Patient Care Report

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- If a patient refuses to sign the report, the corresponding drop-down selection must be chosen
 - **When a patient refuses to sign, they are billed directly rather than their insurance. Informing your patient of this fact may encourage them to sign**

NON-TRANSPORT DOCUMENTATION (AMA REFUSAL & NON-EMERGENCY)

- If permitted, perform a physical examination
- Assess and document the mental capacity of the patient, to ensure **all** of the following criteria are met:
 - Awake, alert, and fully oriented to person, place, time, and event
 - Is greater than or equal to 18 years of age or a court certified emancipated minor.
 - Is not intoxicated and under the influence of drugs, or otherwise incapable of providing informed consent
 - Assess for any trauma or medical illness that may represent a threat to well-being of the patient or alter their ability to make decisions and document findings
 - Assess for psychiatric illness (e.g., suicidal/homicidal behavior, hallucinations, delusions, etc.) and document findings
 - Assess for the presence of a toxic ingestion or exposure (e.g., alcohol, drugs, narcotics, or CO) and document findings
- If the patient does **not** have the mental capacity to refuse transport:
 - Explain to the patient (or parent/legal guardian), the need for transport
 - Reassure the patient that no harm will result from transport but complications, up to and including death, may result from a delay in treatment
- If the patient continues to refuse care and satisfies Florida Statute 401.445 "Emergency examination and treatment of incapacitated persons":
 - Enlist the aid of law enforcement personnel for patient and crew safety
 - Proceed with transport of the patient
- If the patient (or parent/legal guardian) has the mental capacity to refuse transport, emphasize:
 - The need for treatment/transportation
 - The risks of refusal of care (including death and disability)
 - The willingness of EMS to transport the patient
 - The patient or parent/legal guardian should call 911 again if there are any changes in their condition
- Document on the patient care report:
 - Details concerning the assessment of mental capacity
 - The following statement must be included in the narrative section:
 - "The patient/parent/guardian was advised multiple times that they needed treatment/transport to the emergency department for evaluation by a physician. The patient/guardian was also advised of the consequences, up to and including death if treatment/transport was refused. The patient/guardian



Patient Care Report

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- verbalized understanding of the instructions and refused treatment/transport as indicated on the signed AMA refusal. The patient/guardian was advised to call us back if anything changes in their condition.”
- A full assessment and at least one complete set of vital signs for each patient (If unobtainable, justify reason on report)
 - Any improvement from initial complaint
 - **Care may be refused for a minor (less than 18 years of age) only when all the following criteria are met:**
 - The patient exhibits no historical or physical findings of potentially life, limb, organ threatening injury or illness
 - The patient is not intoxicated and has no alterations in mental status, level of consciousness or vital signs
 - The responsible parent/legal guardian is present and has mental capacity
 - **REFUSAL SIGNATURE REQUIREMENTS**
 - The JFRD member executing the refusal must read the statement below aloud to the patient. The individual serving as the witness must observe this statement being read aloud and then sign acknowledging the same in the appropriate section of the refusal form
 - **“You have a health condition that needs to be evaluated by a physician and you need to be transported to the hospital. If you are not transported to the hospital, you may die or be severely disabled.”**
 - Obtain signature of patient (or parent/legal guardian or medical power of attorney if applicable). The officer (regardless of apparatus type) that performed the assessment and obtained the verbal refusal is responsible for acquiring all signature(s) and completing the electronic PCR.
 - No one else can sign for an adult patient with mental capacity (e.g., spouses, relatives, friends, etc.)
 - If patient refuses to sign, then document “Refused to Sign”
 - Printed name and signature of witness(es) with mental capacity
 - Appropriate witnesses (in order of preference)
 - Spouses, relatives, law enforcement, friends, other fire/rescue personnel
 - **Fellow fire/rescue personnel are an absolute last resort**
 - The documented refusal is only valid with an appropriate witness signature
 - The JFRD member who is documenting and executing the legal refusal CANNOT sign as the witness
 - Patients with medical decision-making capacity in police custody can still make decisions about their medical treatment and sign an AMA Refusal or Non-Emergency/Non-Transport Waiver if allowed by law enforcement. If Law enforcement refuses to remove the handcuffs to allow the patient to sign, document in the Narrative section of the PCR that the patient verbalized a refusal of treatment. Select “Not Signed – In Law Enforcement Custody” under the Signature Type tab when selecting Refusal of Assessment/Care/Transport. Have



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Patient Care Report

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the law enforcement officer sign the Witness signature in the PCR. Also include the officer's ID number.

- All signatures shall be acquired on the laptop
 - Any circumstance in which the laptop is unavailable or not functioning, the Officer-in-Charge will select "Laptop Technical Issue" as the reason for not obtaining a signature. If a laptop technical issue occurs:
 - Every field on the **field copy report** must be completed
 - Ensure signature on back of form is in **appropriate** area (AMA refusal or non-emergency non-transport)
 - Include an explanation of the technical issue in the narrative
 - Witness name and signature
 - Signed refusals on the EMS field copy (laptop failure only) will be completed and filed at the station
 - Monthly, completed paper refusals will be forwarded to the Quality Improvement Office

DOS DOCUMENTATION

- A patient care report will be completed on any DOS patient
- Include as much information as possible to include:
 - Criteria met to be called DOS
 - Any patient information that could be gathered
 - A narrative describing the conditions found
 - Any extraordinary findings
 - Any interventions done prior to calling DOS (i.e., fast patches, BVM)



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Radio Report Format

Medical Director Review Date 08/2025

JFRD Radio report format

Radio reports to the receiving hospital should be transmitted according to the following format within **one minute**:

- Unit identification
- Any applicable "Alerts" that were called
- Patient's age
- Length based tape color for pediatrics
- Gender
- Chief complaint
- Brief history of the present illness
- Vital signs (e.g., pulse, respiratory rate, blood pressure, pulse oximetry, BGL, cardiac rhythm, ETCO2 for all patients with an advanced airway and GCS for all trauma patients)
- General appearance that includes level of consciousness and pertinent physical findings
- Pertinent care provided (e.g., intubated, medications, defibrillated, etc.)
- If applicable, request for physician orders
- Provide ETA

If requested by receiving hospital, the patient's name and date of birth shall be provided.

When transporting an Alert or otherwise critical patient, **transmit the med report to the receiving facility as soon as possible.**

Unable to reach hospital via medical radio

- Stable patient
 - Proceed to the hospital and give a verbal report upon arrival
- Unstable patient
 - Relay **brief** radio report through FRCC



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Radio Report Format

Medical Director Review Date 08/2025

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Quality Improvement

Medical Director Review Date 08/2025

JFRD Quality Improvement Program

Purpose

The purpose of Quality Improvement is to promote practices that will provide the highest quality pre-hospital emergency care by utilizing the most well-trained, courteous employees for the benefit of all residents and visitors of the Jacksonville area.

Intent

The Intention of Quality Improvement will be to train. The program will identify individual and system weaknesses and will develop plans to improve patient care.

Authority

The Authority for the continuous Quality Improvement program comes from the Director/Fire Chief in addition to the Medical Director as mandated by F.S. 401 and F.A.C. 64J-1

Annual Review

The program will review present standards of practice at least annually so that they reflect currently accepted medical practices that are of the highest quality.

Administration

Administration of the continuous Quality Improvement Program will be the responsibility of the:

- Medical Director
- Division Chief of Rescue
- Deputy Division Chief/ Rescue
- Quality Improvement Officer

The Director/Fire Chief will appoint the Quality Improvement Officer after receiving recommendations from the Division Chief of Rescue.

Quality Improvement Meetings

The Medical Director and Quality Improvement Officer will communicate on a weekly basis.



Quality Improvement

Medical Director Review Date 08/2025

The Quality Improvement process

The Quality Improvement program will be a dynamic process, changing with the identified needs of the department and consisting of the following three aspects:

- Proactive
- Concurrent
- Retrospective

Proactive Quality Improvement

Proactive Quality Improvement will consist of evaluation and training of practices that promote high quality patient care, **prior** to the delivery of patient care by JFRD personnel.

The Quality Improvement Officer, Division Chief of Rescue, and Medical Director will apply an Accepted Standard of Care (ASC) with benchmarks based upon JFRD Rules, this Emergency Medical Services SOG and national standards.

Concurrent Quality Improvement

Concurrent Quality Improvement will consist of supervision and evaluation of practices for quality **during** the delivery of patient care by JFRD personnel. This will be accomplished by the Rescue District/Battalion Chiefs and the Medical Director.

Retrospective Quality Improvement

Retrospective Quality Improvement will consist of the evaluation of practices for quality **after** the delivery of patient care by JFRD personnel.

The Division Chief of Rescue will appoint select individuals to the Quality Improvement Review Committee. The committee will meet as needed.

Practices which deviate from the SOG or the ASC, will be identified by:

- PCR database queries
- Concerns regarding the delivery of patient care
- Patient outcome reports from the area hospitals
- Patient care complaints



Quality Improvement

Medical Director Review Date 08/2025

Emergency-Pro Review Process

The primary purpose of a patient care report (PCR) review is to verify that the clinical care provided to the patient meets the established standards set forth in this EMS SOG. In addition, the report review must also verify that the documentation itself satisfies both legal and billing processes required for reimbursement, up to and including, the presence of a legal and legible signature(s) captured and documented on the PCR prior to departing the medical facility (as noted by the time stamp).

Rescue Captains

- Must review the following reports monthly:
 - **20** PCRs per month to include a sampling from all report authors assigned to that unit during the month, either permanently or temporarily, with an emphasis on refusals and calls of a critical nature
 - All "Alerts" (Trauma, STEMI, Stroke, etc.)

Rescue District/Battalion Chiefs

- Must review all of the following reports monthly, if not already reviewed by a Captain:
 - All Cardiac/Trauma Arrest reports
 - All "Alerts" (Trauma, STEMI, Stroke, etc.)
 - All advanced airways
 - All controlled substance administration
 - **Minimum of 30** PCRs per month to include a sampling from all report authors assigned to their district. This number of reviews may have already been accomplished with the criteria above
 - Specific reports identified by the Medical Director

Daily Emergency-Pro PCR Signature Audits

As part of ongoing and continuous improvement in EMS documentation, the Quality Improvement (QI) Office will conduct daily audits of Emergency-Pro patient care reports (PCR) to ensure that the documentation satisfies the legal and billing processes required, up to and including the presence of a legal and legible responsibility signature captured PRIOR to departing the medical facility (as noted by the time stamp in the PCR).

The QI Office receives automated daily queries of Emergency-Pro PCRs that have a responsibility signature timestamp notated **AFTER** the transport unit has gone available from the medical facility. The purpose of the query is not to suggest that the report author acquired a false or inappropriate signature. Rather, the daily query is a means by which the QI Office can determine the signature's appropriateness and validity by further review of the PCR including, but not limited to, the patient's condition and Glasgow Coma Score (GCS); justification provided for a patient not signing the PCR; review of the signature image; and review of the unit's geographical location at the time the signature time-stamp is notated utilizing AVL and GPS software.



Quality Improvement

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The QI Office will subsequently forward any PCR populated in the automated daily query to the report author for notification that the report was audited by the QI office, with the District/Battalion Chief copied on the email. All PCRs populated in the automated daily query will also be forwarded to the JFRD EMS Billing Manager and will not be processed for billing/reimbursement until such time confirmation is received by the QI Office that the PCR contains explicit documentation in the narrative section that the following occurred: *The Rescue unit returned to the medical facility to legally obtain the patient or receiving facility representative signature **AND** the AVL data confirms the same*, if data is available.

If, after review of the PCR by the QI Office, there is no documentation or notation in the narrative by the report author that the Rescue unit returned to the medical facility to legally obtain an appropriate signature on the PCR **AND** the AVL data confirms that the Rescue unit was not at the medical facility when the responsibility signature time-stamp was captured on the PCR, a formal request for investigation will be immediately forwarded to the appropriate District/Battalion chief, with Rule Infraction Charges to follow when necessary. Copies of the PCR and supporting AVL data shall be forwarded to the appropriate District/Battalion chief to assist with their investigation.

EMS Documentation Training

ALL **paramedics** permanently assigned to the Rescue Division shall receive formal EMS Documentation and Navigation Training class taught by the QI Office.

Rescue personnel are not permitted to author an electronic patient care report without first receiving this class. This does not preclude the officer-in-charge from providing introductory report writing training to a new engineer. It is preferred that introductory report writing training is done by the officer-in-charge prior to the new engineer's formal EMS Documentation Training and Navigation class taught by the QI Office.

EMS Documentation Training shall be comprehensive in nature covering all medical-legal aspects of proper, accurate, and legible documentation on the PCR. Annual refresher training will be required to be completed via Vector Solutions.

Medical Director Clearance

Prior to being approved by the Medical Director to ride as the officer in charge of a Rescue unit, individuals shall complete the **Rescue Engineer Task Booklet** and formal EMS Documentation Training.



Reporting Abuse/Neglect

Medical Director Review Date 08/2025

Policy

This policy requires reporting of all known or suspected cases of abuse or neglect to a child or vulnerable adult where such knowledge is the result of employment with the City of Jacksonville.

A vulnerable adult is defined as one who, due to their age or disability, may be unable to adequately provide for their own care or protection.

All employees are required to report known or suspected child or vulnerable adult abuse, abandonment, or neglect. Anyone who knowingly and willfully fails to do so, or who knowingly and willfully prevents another person from doing so, commits a felony of the third degree, punishable as provided in Florida Statutes.

Anyone who knowingly and willfully makes a false report of child or vulnerable adult abuse, abandonment, or neglect, or who advises another to make a false report, is guilty of a felony of the third degree, punishable as provided in Florida Statutes.

No JFRD member shall use the threat of filing a report of abuse or neglect as deterrent from calling 911.

Anyone making a report who is acting in good faith is immune from any liability per FL Statute.

Suspected Abuse

- When JFRD personnel suspect that abuse or neglect of a child or vulnerable adult has taken place, they shall initiate the following:
 - Treat related injuries
 - Transport all suspected cases
 - If transport is refused:
 - Request law enforcement at scene
 - Stay with patient until law enforcement arrival
 - Notify the Rescue District/Battalion Chief

Reporting Abuse

- In addition to the above, JFRD personnel shall also report the abuse/neglect according to the following procedure:
 - **Immediately report the actual or suspected child abuse, neglect or abandonment to the central abuse hotline maintained by the Department of Children and Family Services (DCF)**
 - The officer-in-charge shall make the initial verbal report by calling the statewide toll-free number **(1-800-962-2873)** or by submitting an online report at **reportabuse.myflfamilies.com**



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Reporting Abuse/Neglect

Medical Director Review Date 08/2025

- If making a verbal report obtain name and ID Number from the contact person
- Report suspicions to emergency department physician
- Notify the Rescue District/Battalion Chief
- Notify the Division Chief of Rescue via email within 24 hours indicating that you have reported the case to the FL Abuse/Neglect Registry
 - If making a verbal report, include **ONLY** the **first name** (agency gives a first name only) and **ID number** of the contact person
 - If submitting an online report, provide the Case number
 - **Do not** provide any patient information in the email (HIPAA concern) or CCR number
- Document in the PCR narrative the circumstances and reporting of abuse



Resuscitation Guideline

Medical Director Review Date 08/2025

Application

This guideline is to assist JFRD personnel in making resuscitation decisions. All resuscitations will follow JFRD EMS guidelines.

Unquestionable Death Criteria

Patients meeting the criteria listed below shall be considered DOS (**criteria must be documented in the narrative**):

- Unresponsive
- Apneic
- Pulseless
- **In addition to the above**, the patient shall meet **at least one** of the following criteria:
 - The patient has lividity (discoloration of dependent parts of the body by gravitation of blood)
 - The patient has clear signs of body decay or visible decomposition
 - The patient has rigor mortis (rigidity)
 - The patient has an open cranium with exposed brain matter
 - The patient is decapitated or has a severed trunk
 - The patient has full thickness burns to the entire body

Trauma Death Criteria

Blunt chest trauma or multi-system trauma patients meeting the following criteria shall be considered DOS:

- Unresponsive
- Apneic
- Pulseless
- If cardiac rhythm is asystole or wide complex ventricular rhythm of 30 or less without a pulse, document time and pronounce death

Medical Asystole

The following applies to patients who are apneic, pulseless and asystolic that do not meet the unquestionable death criteria. Remember to use situational awareness prior to making this decision. If in doubt, follow the appropriate arrest guideline and transport the patient.

Resuscitation efforts may be terminated **only when all the following criteria exist**:

- Patient is at a long-term care medical facility
- Arrest was not witnessed
- No shocks provided prior to JFRD arrival or at any time during the resuscitation
- Patient is ≥ 18 years old
- Rhythm remains asystole after providing 3 rounds of full ACLS
- Advanced airway in place (endotracheal intubation is preferred)

Acutely hypothermic patients in cardiac arrest shall be treated and transported.

- Includes submersion victims < 60 minutes



Resuscitation Guideline

Medical Director Review Date 08/2025

Florida Statute 401.45

Denial of emergency treatment; civil liability—

- (1)(a) Except as provided in subsection (3), a person may not be denied needed pre-hospital treatment or transport from any licensee for an emergency medical condition.
- (b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.
- (2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.
- (3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 609. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.
- (b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.
- (c) The department, in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration, shall develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a patient for whom a physician has issued an order not to administer cardiopulmonary resuscitation. The department may charge a reasonable fee to cover the cost of producing and distributing such identification devices. Use of such devices shall be voluntary.
- (4) Any licensee or emergency medical technician or paramedic who in good faith provides emergency medical care or treatment within the scope of their employment and pursuant to oral or written instructions of a medical director shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2)(b).
- (5) The department shall adopt and enforce all rules necessary to implement this section.



Resuscitation Guideline

Medical Director Review Date 08/2025

Death Scene Procedure

Except for healthcare facilities, a JFRD unit shall remain on scene until law enforcement arrives. Control of death scenes is the responsibility of law enforcement. Generally, law enforcement officers voluntarily defer to the EMS provider for resuscitation decisions; however, ultimate responsibility for control of death scenes rests with law enforcement. If a law enforcement officer denies you access to the scene, they are assuming full responsibility and acting within the law to preserve evidence. You must obtain the law enforcement officer's name and ID number, explaining to them that you are required to document in the patient care report that they assumed the responsibility for the pronouncement of death and that they denied you access to the scene.

Do Not Resuscitate Orders

The State of Florida's "Do Not Resuscitate Order" (DNRO) form will be honored per the requirements of Florida Statute 401.45(3)(a) and Florida Administrative Code 64J-2.018. If there is any doubt of the authenticity of the form, resuscitation will be performed. Key points listed in the rule:

- According to the Florida Department of Health (DOH), the 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
- 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, which is defined by the state of Florida as the bottom detachable portion of the official DNRO form as notated on the following page, is voluntary and is intended to provide a convenient and portable DNRO which travels with the patient
- The DNRO form and patient identification device must be signed by the patient's physician
- There will be times when family/caregivers call 911 for a variety of reasons. In those cases, the EMS provider shall provide comforting, pain relief and any other medically indicated care, short of respiratory or cardiac resuscitation. **A DNRO only means that in the event of cardiac or pulmonary arrest, that CPR will not be initiated.**
- During each transport, the EMS provider shall ensure that a copy of the DNRO form or the patient identification device accompanies the live patient
- 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



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Resuscitation Guideline

Medical Director Review Date 08/2025


State of Florida
DO NOT RESUSCITATE ORDER
(please use ink)

Patient's Full Legal Name: _____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT
Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT
I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(Signature of Physician) (Date) Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

OH Form 1-89G, Revised December 2002

PHYSICIAN'S STATEMENT
I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(Signature of Physician) (Date) Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

OH Form 1-89G, Revised December 2002

 **State of Florida**
DO NOT RESUSCITATE ORDER

Patient's Full Legal Name (Print or Type) _____ (Date) _____

PATIENT'S STATEMENT
Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. (If not signed by patient, check applicable box):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)



Transport/Destination

Medical Director Review Date 08/2025

General

Transportation to the appropriate facility of those patients requiring further medical care is the final step in assuring the continuity of patient care. Patient care and well-being must be the overriding consideration in every case.

All patients will be transported based on patient assessment in the most appropriate manner consistent with their condition. Deviations will be documented on the patient care report.

Transportation and destination must be determined from specific guidelines and free from the influence of ability to pay, social status, convenience of personnel or other discriminatory factors. In those situations where extraordinary circumstances exist, as in multiple patient incidents, the Incident Commander, or Transport Officer, may elect to deviate from existing guidelines in determining destination of patients.

Patients who will be transported by rescue (with proper consent)

The following situations require **transport**:

- Life-threatening emergencies and those situations which could become life-threatening
- Chest pain/cardiac signs and symptoms/epigastric discomfort
- Systolic B/P greater than 180 mmHg OR Diastolic B/P greater than 110 mmHg
- Systolic B/P less than 90 mmHg
- Abdominal pain
- Reported loss of consciousness
- Report of blood in stool or vomit
- Severe sudden onset headache, light intolerance and/or neck stiffness
- Difficulty breathing
- Pregnancy
- Diabetic emergencies
- Altered mental status
- Suspected or known overdoses
- Suicidal (attempted or suspected) patients unless transported by law enforcement
- All non-fatal drowning patients
- Patients who meet Trauma, STEMI, or Stroke Alert status
- Patients who require or have received Advanced Life Support treatment and/or medications
- Patient's injury or condition that might be exacerbated by improper handling or transport by privately owned vehicle (POV) or other means of transportation
- Pediatric patients **12 years of age or less** who are symptomatic
 - Exceptions are superficial injuries when a parent or legal guardian with mental capacity is on-scene or documented signed refusal of treatment/transportation



Transport/Destination

Medical Director Review Date 08/2025

- Elderly patients **70 years of age or greater**
 - Exceptions are non-symptomatic patients with mental capacity without a documented chief complaint or documented signed refusal of treatment/transportation

Transport after administration of medications

- Patients will not be given medications in the field and then released or allowed transport by private vehicle
- Prior to medication administration, patient condition permitting, the patient should be informed that if JFRD personnel administer medication, the patient must be transported by JFRD for physician evaluation
- Even if the patient's condition improves, the patient should still be transported by Rescue for evaluation

Non-transport situations

The following situations will not require transportation of the patient to the hospital by Rescue: (Complete signed AMA or non-emergency/non-transport refusal when appropriate).

- Situations where no emergency exists
- Injuries of a superficial or minor nature
- Situations where transport would endanger the safety of rescue crew members
- Patients, otherwise stable, who require transport to a mental health resource or Detox facility
- Situations where patient requests private provider or private vehicle transportation
- DOS victims will not be transported
- Patients who refuse transport

Transport of passengers

Various circumstances (e.g., elderly spouse, medical POA, etc.) warrant consideration for allowing passengers to accompany the patient during transport, utilizing common sense and a customer service approach. However, transport of passengers is at the sole discretion of the officer in charge of the rescue unit.

- Exceptions
 - Pediatric patients requiring a parent or guardian
 - School representative when a parent or guardian is not available
 - Geriatric patients requiring a guardian or caregiver
 - Patients with language barriers requiring a translator
 - Patients with speech disabilities requiring someone proficient in sign language

Transport of multiple patients

Many times, JFRD personnel are faced with the situation of transporting more than one patient to the hospital via one Rescue Company. In these situations, no patient shall be left unattended in the back of the rescue unit, under any circumstances.



Transport/Destination

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When transporting more than one patient to the hospital, the Officer-in-Charge of the Suppression Company will provide personnel to ride along to assist in patient care and monitor the patient until they can be taken into the emergency room.

The District/Battalion Chief may wave the maximum of two patients per Rescue Company in extenuating circumstances.

Transports of unstable patients should begin within 10 minutes when possible.

Adult destination determination policy

The officer-in-charge will determine the transport destination after considering the following:

- Refer to the most recent *Hospital Capabilities Chart for JFRD* as needed to assist with determining a hospital's capabilities
- Patients who are **unstable or in cardiac arrest** will be transported to the closest most appropriate emergency department
- Patients who are **stable** will generally be transported to the hospital where the patient is usually seen or has been recently discharged. However, the patient's choice will be the overriding factor in determining transport destination.
- Special Transport Circumstances:
 - Patients who meet Stroke Alert status will be transported to the most appropriate State of Florida approved Comprehensive or Primary Stroke Center (See Stroke SOG)
 - Patients who meet Trauma Alert status will be transported in accordance with Trauma Transport Guidelines
 - Patients who meet STEMI Alert status should be transported to a facility with interventional cardiac catheterization capability (See *Hospital Capabilities Chart*)
 - Patients with pregnancy-related complaints will be transported to a facility with obstetric (OB) capability

Pediatric destination determination policy

The officer-in-charge will determine the transport destination after considering the following:

- Refer to the most recent *Hospital Capabilities Chart for JFRD* as needed to assist with determining a hospital's capabilities
 - Adhere to the facility's specific pediatric coverage hours
- Pediatric patients who are **unstable or in cardiac arrest** should be transported to the closest approved Pediatric Emergency Department
 - Transport to an alternate hospital should only take place if that hospital is closer to the scene of the incident and the patient's immediate condition is such that the patient's life will be endangered if care is delayed by proceeding directly to an approved pediatric emergency department (i.e., impending airway closure)
- Patients who are **stable** should be transported to the hospital where the patient is usually seen and has the patient's medical records



Transport/Destination

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- Stable pediatric with a simple injury or complaint and no hospital affiliation: Transport to the closest approved Pediatric Emergency Department. If the parent/guardian insists on their child being transported to a hospital without pediatric capabilities, the details of your attempt to encourage transport to a pediatric facility must be documented in the PCR
- Stable pediatric with a complex complaint and/or medical history (e.g., congenital cardiac, neurologic, or endocrine abnormalities): Transport to Baptist Medical Center-Downtown (Wolfson Children's Hospital) or UF Health Jacksonville

Pediatrics should be secured to the stretcher with the Pediatric Restraint Device (Appendix L) (if size appropriate) or their own car seat.

- Exceptions may be made for level of distress and/or treatment. However, use of the Pediatric Restraint Device (Appendix L) or car seat is optimal

Patients transported by Rescue will normally be transported to the emergency department.

- Exceptions:
 - Obstetric patients may be taken directly to labor & delivery from the ED. An escort from the ED may be requested
 - Obstetric patients may be taken directly to Baptist Pavilion, Baptist Beaches OB, or St. Vincent's Southside Women's Center after consultation with the ED via radio
 - STEMI alerts may be taken directly to the cardiac catheterization lab when accompanied by an RN, PA, or Physician
 - Stroke alerts may be taken directly to radiology when accompanied by an RN, PA, or Physician

Emergency inter-facility transfer procedures

- **The transferring physician will determine the hospital destination**
- Inter-facility transfers should be taken to the emergency department, with rare exception, the patient may be brought to the Cath lab, ICU, etc., with the appropriate medical escort by hospital staff
- Equipment and/or staff may be requested from the transferring facility, this will be required if the patient is on a ventilator and/or has IV infusions running via IV pump, and the unit personnel are not trained/competent on the use of the equipment

Stand-alone emergency departments

Most patients can be transported to a Stand-alone ED. **Exceptions include:**

- **Those patients expected to be admitted or require specialized services** (e.g., OR, ICU, Cath Lab, GI suite)
- Cardiac Arrest with shockable rhythm and/or ROSC
- Pediatric (except during designated hours as defined on the *Hospital Capabilities Chart*)
- Pregnancy
- Baker Act
- Trauma Red
- Psychiatric illness (use of Ketamine, restraints, psychosis, suicide attempt)
- CPAP



Transport/Destination

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- Chest pain
- All Alerts (Trauma, STEMI, Stroke)

Approved Adult Hospitals

- See most recent *Hospital Capabilities Chart for JFRD*

Approved Pediatric Hospitals - Hours may vary, see most recent *Hospital Capabilities Chart*

- See most recent *Hospital Capabilities Chart for JFRD*

Transports to more distant Emergency Departments may occur after consultation with the Rescue District/Battalion Chief.

Deviations from the transportation guidelines must be documented and justified on the patient care report.

Arrival at receiving facility

- If patient not assessed by staff within 15 minutes of arrival (sooner if the patient is unstable), consult with Charge Nurse or Nurse Manager for guidance; if there is an issue contact your District/Battalion Chief
- Rescue personnel will transfer patient to the hospital stretcher in a timely and expedient manner. If the transfer is delayed more than 30 minutes notify FRCC
- Once inside the emergency department, the patient will not be removed

Departing receiving facility

- Ensure any patient or receiving facility signatures have been acquired prior to departing the hospital
- Ensure the Rescue Unit is returned to a state of readiness prior to departing the hospital, if unable to immediately return to readiness declare code Hotel to accomplish decon, mandatory restocking, etc. and then notify FRCC of availability upon completion
- Prior to departing, the Officer in Charge shall notify FRCC via MDT or radio with an India status, indicating that patient transport is complete and the unit is back in service



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Transport/Destination

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Transport of Patients With Service Animal

Medical Director Review Date 08/2025

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Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. Pets not defined as Service Animals will not be transported.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

A service animal, utilized by a patient for a disability, shall be permitted to accompany a patient or guardian of a minor patient in the rescue unless the presence of the service animal will disrupt patient care, the patient is unstable or there is some basis for the crew members to believe that the safety of the crew, the patient or others would be compromised by the presence of the service animal in the rescue.

- Growling may be considered a threatening behavior in which case the service animal may be transported by other means. Barking may also be considered threatening; however, specific service animals are required to bark to get their owner's attention

When transporting a patient with a service animal, every effort should be made to do so in a safe manner for the patient, the animal, and the crew members. If possible, the animal should be secured in some manner to prevent injury to either the animal or the crew during transport. The patient should be loaded into the rescue first, and then the service animal. Whenever possible, the receiving hospital should be notified that you are in route with a service animal.

When the presence of a service animal in the rescue might interfere with patient care, jeopardize the safety of the crew, the patient or others, personnel should make other arrangements for simultaneous transport of the service animal to the receiving facility.

- Acceptable alternative methods of transporting a service animal to the receiving facility include, but are not limited to, family members, friends or neighbors of the patient, animal control, a District/Battalion Chief, or a law enforcement official

Personnel should document on the Patient Care Report (PCR) instances where the patient or guardian accompanying a minor patient utilizes a service animal and note whether the service



Transport of Patients With Service Animal

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animal was transported with the patient. If the service animal was not transported in the rescue with the patient, the PCR should contain the reason(s) and how the animal was transported.

When it is not obvious what service an animal provides, only limited inquiries are allowed.

Personnel may ask **only** two questions:

1. Is the dog a service animal because of a disability?
2. What work or task has the dog been trained to perform?

Personnel **cannot** ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals.

In addition to the provisions about service dogs, the Department's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 60 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether or not the miniature horse's presence will compromise legitimate safety requirements necessary for safe operation of the facility.



Transport of Injured Police Canines (K9)

Medical Director Review Date 08/2025

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Introduction

As authorized by Florida Statute, Chapter 401.254, JFRD may provide treatment and transport of injured "police canines." F.S. 401.254 also states, "A paramedic or an emergency medical technician who acts in good faith to provide emergency medical care to an injured police canine (K9) is immune from criminal or civil liability."

Under **no circumstances** are JFRD personnel and/or units authorized to transport any other animal (domestic pet, animal, etc.) outside the scope of this specific statutory authority.

Police Canine Defined (per F.S. 401.254)

"Any canine that is owned, or the service of which is employed, by a federal, state or local law enforcement agency, a fire department, a special fire district, or the State Fire Marshal for the principal purpose of aiding in the detection of criminal activity, flammable materials, or missing person; the enforcement of laws; the investigation of fires; or the apprehension of offenders."

Treatment

Initial priority must be given to the examination, treatment, and transport of any injured persons on the scene.

JFRD personnel must operate within these guidelines and only initiate treatment within their scope of practice, which includes basic medical procedures such as oxygen administration, tourniquet application (must be high on the extremity), splinting, and bandaging.

The canine handler may possess additional specialized veterinary training. JFRD personnel shall allow such treatment and may assist when necessary.

Transport (approved veterinary clinics)

When possible, the canine should be secured to the stretcher with the handler sitting alongside on the bench. The handler will place a safety muzzle on the dog when necessary.

If the canine is with the Jacksonville Sheriff's office (JSO), the transport destination shall be the clinic listed below as they provide 24/7 emergency veterinary care and are also contracted by the JSO. As soon as feasible, on-scene personnel should notify the receiving clinic of the in-bound injured canine and approximate eta.

- First Coast Vet 301 Jacksonville, Dr. Jacksonville Beach 32250
 - (904) 853 6310

The destination facility for non-JSO law enforcement canines will be determined after consultation with the K9 handler. There may be agency specific existing contracts, or the handler may have a preference based upon the injuries present.



Transport of Injured Police Canines (K9)

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Trauma Transport

Medical Director Review Date 08/2025

Service Description

The Jacksonville Fire and Rescue Department (JFRD) is a state licensed Advanced Life Support (ALS) provider of pre-hospital emergency care. The JFRD is the primary provider of pre-hospital EMS in Duval County.

Communications Procedures

For each EMS call, Fire Rescue Communications Center (FRCC) shall obtain the following information:

- Address or location of the incident
- Nature of emergency
 - Number of patients
 - Type and severity of injury(s)
- Type of location (house, apartment, street, or highway, etc.)
- Complainant's name
- Complainant's phone number

Using the Computer Aided Dispatch (CAD) system, the Emergency Medical Dispatcher (EMD) shall ensure dispatch of the closest available ALS unit. The CAD system will display the appropriate apparatus that normally responds to the listed address in order of priority.

Outside Agency Assistance

While at the scene of an emergency, personnel may request assistance from other emergency response agencies (Air Transport Unit, law enforcement, etc.) by contacting FRCC via radio or telephone. FRCC will forward the request to the appropriate agency and advise on-scene personnel of the disposition of the request and ETA of the required agency.

Pre-hospital Procedures

Upon arrival at the location of the incident, the EMT or Paramedic shall assess the condition of each trauma patient using the Trauma Scorecard Methodology as outlined in F.A.C. 64J-2.004 for adults and F.A.C. 64J-2.005 for pediatrics to determine if the patient meets "Trauma Alert" criteria. Transport destination of trauma patients shall be determined by this assessment.



Trauma Transport

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Assessing **ADULT** Trauma Patients:

The EMT or Paramedic shall assess all adult trauma patients using the following Trauma Scorecard Methodology in the order presented. If any **ONE** of the following conditions is identified, the patient shall be considered a trauma alert patient:

- **Airway** – The patient receives active airway assistance beyond the administration of O₂
- **Circulation** –
 - The patient lacks a radial pulse with a sustained heart rate greater than 120 beats per minute
 - Has a systolic blood pressure of less than 90 mmHg
- **Best Motor Response (BMR)** – The patient exhibits a score of four or less on the motor assessment component of the Glasgow Coma Scale
- **Spinal** – There is the presence of paralysis; or loss of sensation; or there is the suspicion of a spinal cord injury
- **Cutaneous** –
 - The patient has 2nd or 3rd degree burns to 15% or more of total body surface area
 - Amputation proximal to the wrist or ankle
 - Any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined)
- **Long bone Fracture** – The patient reveals signs or symptoms of two or more long bone fracture sites (humerus, femur, radius/ulna, or tibia/fibula). The radius/ulna and tibia/fibula each count as only one fracture when isolated to the same extremity.

Should the trauma patient not be identified as a trauma alert using the previous criteria, they shall be further assessed using the following criteria and shall be considered a trauma alert patient when any **TWO** of the following conditions are identified:

- **Airway** – The patient has a respiratory rate of 30 or greater
- **Circulation** – The patient has a sustained heart rate of 120 beats per minute or greater
- **BMR** – The patient has a BMR of 5 on the motor component of the GCS
- **Cutaneous** –
 - The patient has soft tissue loss from either a major degloving injury or a major flap avulsion greater than 5 inches
 - Sustained a gunshot wound to the extremities of the body
- **Long bone Fracture** –
 - The patient reveals signs or symptoms of a single long bone fracture resulting from a motor vehicle collision
 - Fall from an elevation of 10 feet or greater
- **Age** – The patient is 55 years of age or older
- **Mechanism of Injury** –
 - The patient has been ejected from a motor vehicle (excluding any motorcycle, moped, all-terrain vehicle, bicycle, or the open body of a pick-up truck)
 - The driver of the motor vehicle has impacted with the steering wheel causing steering wheel deformity



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Trauma Transport

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If, after evaluating the patient using the previous criteria, the patient is not identified as a trauma alert patient, they will be evaluated using all elements of the Glasgow Coma Scale. If the patient's score is **12 or less**, the patient shall be considered a trauma alert patient (excluding patients whose normal Glasgow Coma Scale Score is 12 or less, as established by the patient's medical history or preexisting medical condition when known).

If the patient meets none of the aforementioned trauma alert criteria, the EMT or Paramedic can call a trauma alert if, in his or her judgment, the patient's condition warrants such action. Where EMT or Paramedic judgment is used as the basis for calling a trauma alert, it shall be documented as required in section F.A.C. 64J-2.002(5).



Trauma Transport

Medical Director Review Date 08/2025

Assessing **PEDIATRIC** Trauma Patients:

Trauma patients with the anatomical and physical characteristics of a person **fifteen years of age or less** will be assessed as pediatric patients using the following Trauma Scorecard Methodology. If any **ONE** of the following conditions are identified, the patient shall be considered a pediatric trauma alert patient:

- **Airway** – In order to maintain optimal ventilation, the patient is intubated; or the patient's breathing is assisted through such measures as manual jaw thrust, continuous suctioning, or through the use of other adjuncts to assist ventilatory efforts
- **Circulation** –
 - The patient has a faint or non-palpable carotid or femoral pulse
 - The patient has a systolic blood pressure of less than 50 mmHg
- **Consciousness** – The patient exhibits an altered mental status that includes drowsiness, lethargy, the inability to follow commands, unresponsiveness to voice, totally unresponsive, or is in a coma
- **Spinal** – There is the presence of paralysis; or loss of sensation; or there is the suspicion of a spinal cord injury
- **Fracture** – There is evidence of an open long bone (humerus, radius, ulna, femur, tibia, or fibula) fracture; or there are multiple fracture sites or multiple dislocations (except for isolated wrist or ankle fractures or dislocations)
- **Cutaneous** –
 - The patient has a major soft tissue disruption including major degloving injury or major flap avulsion
 - 2nd or 3rd degree burns to 10% or more of the total body surface area
 - Amputation proximal to the wrist or ankle
 - Penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined)

Should the pediatric trauma patient not be identified as a trauma alert using the previous criteria, they shall be further assessed using the following criteria and shall be considered a pediatric trauma alert patient when any **TWO** of the following conditions are identified:

- **Consciousness** – The patient exhibits symptoms of amnesia; or there is loss of consciousness
- **Circulation** –
 - The carotid or femoral pulse is palpable, but the radial or pedal pulses are not palpable
 - The systolic blood pressure is less than 90 mmHg
- **Fracture** – The patient reveals signs or symptoms of a single closed long bone fracture (does not include isolated wrist or ankle fractures)
- **Size** – Pediatric trauma patients weighing 11 kilograms or less, or the body length is equivalent to this weight on a pediatric length and weight emergency tape (the equivalent of 33 inches in measurement or less)



Trauma Transport

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If the patient meets none of the aforementioned trauma alert criteria, the EMT or Paramedic can call a trauma alert if, in his or her judgment, the patient's condition warrants such action. Where EMT or Paramedic judgment is used as the basis for calling a trauma alert, it shall be documented as required in section F.A.C. 64J-2.002(5).

Issuing a Trauma Alert:

Upon determining that a trauma patient meets either Adult or Pediatric Trauma Scorecard Methodology, that patient will be classified as a "Trauma Alert" patient. JFRD personnel will issue a trauma alert using the words "Trauma Alert," state the criteria, and announce the destination, this includes trauma patients in cardiac arrest.

The "Trauma Red" declaration is a JFRD specific term that represents a "Trauma Alert" patient who is in cardiac arrest. For state data collections, trauma patients in cardiac arrest shall still be classified a "Trauma Alert" and documented accordingly.

FRCC shall notify the State-Approved Trauma Center (SATC), State-Approved Pediatric Trauma Center (SAPTC), or receiving hospital that they will be receiving a "Trauma Alert" patient.

The **Medical Director** of the EMS provider issuing the trauma alert or the **physician** at the receiving trauma center or hospital, are the only people authorized to change the trauma alert status, as documented in F.A.C. 64J-2.002(5).

Documentation of Trauma Patients

JFRD personnel will provide required trauma information to the receiving facility in accordance with F.A.C. 64J-2.004 for adults and F.A.C. 64J-2.005 for pediatrics, and F.A.C. 64J-2.002(5).

A JFRD EMS patient care record will be completed as required in F.A.C. 64J-1.014 (3).

Transporting to SATC or SAPTC

All patients meeting Adult or Pediatric Trauma Scorecard Methodology will be transported by JFRD ground transport to a SATC or SAPTC nearest to the location of the incident.

Other patients that don't meet Trauma Alert criteria but should still be considered for transport to a SATC or SAPTC include the following: high speed MVC, significant intrusion from an MVC (roll-over, T-bone, etc.), motorcycle accident, chest or abdominal injury, open fractures, and patients on anticoagulants. Special considerations should also be given to elderly patients with significant traumatic mechanisms.



Trauma Transport

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Critical Care Paramedic Units (CCP)

When a trauma patient may benefit from blood products (tachycardia, hypotension, etc.) and/or rapid sequence intubation (decreased LOC, inability to protect airway, etc.), units should request availability and/or response of a CCP unit. If anticipated arrival of a CCP unit is greater than 10 minutes, field units should initiate transport to the closest most appropriate trauma center.

Air transport units (ATU)

- Air Transport Units (ATU) should be considered for critically ill, injured, or burned patients any time ground transport time to the closest appropriate hospital exceeds 20 minutes
- Patients in cardiac or traumatic arrest are not appropriate for an ATU

Receiving Facilities

A receiving facility is one which is identified in these guidelines, and which meets the requirements of F.A.C. 64J-2.002.

- **State-Approved Trauma Centers (SATC)**
 - UF Health Hospital Jacksonville
 - Memorial Hospital
 - Orange Park Medical Center
- **State-Approved Pediatric Trauma Centers (SAPTC)**
 - UF Health Hospital Jacksonville
 - Wolfson Children's Hospital

Transporting to Other Than SATC or SAPTC

A trauma alert patient may be transported to a receiving facility other than a SATC or SAPTC under the conditions listed below. Such variances must be documented in Emergency-Pro in the "Trauma section of the Incident Tab." Under "Trauma Protocol Exception," select "Yes."

- Transport to a SATC or SAPTC is impractical due to unforeseen events (MCI, natural disaster, or another catastrophic event, etc.)
- The patient's immediate condition is such that the patient's life may be endangered if care is delayed by proceeding directly to a SATC or SAPTC
- If, after informing patient of the state guidelines, the patient still insists on transport to another facility, transport will proceed according to patient's wishes.
 - In this rare circumstance, immediate consultation with the appropriate District/Battalion Rescue Chief must occur
 - In the Narrative of the PCR, document that the JFRD Trauma Transport protocols were explained to the patient, including limited trauma/surgical capabilities, potential need for transfer, and delaying definitive care, and that the patient verbalized understanding of the protocols and refused transport to the trauma center



Protocol Approval

Medical Director Review Date 12-7-2022

MEDICAL DIRECTOR APPROVAL

I, **Bradley J. Elias, M.D.**, Medical Director for the Jacksonville Fire/Rescue Department, certify that I have reviewed and approved the Trauma Transport Guidelines.

Bradley J. Elias, M.D.
Medical Director

A handwritten signature in black ink that reads "Bradley J. Elias M.D." The signature is written in a cursive, flowing style.



Protocol Approval

Medical Director Review Date 12-7-2022

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Trauma

Chapter 2

Trauma



Trauma

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Trauma

Adult Glasgow Coma Score		
RESPONSE		VALUE
Eye Opening	Spontaneous	4
	To Speech	3
	To Pain	2
	None	1
Best Verbal Response	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	None	1
Best Motor Response	Obeys	6
	Localizes	5
	Withdraws	4
	Abnormal flexion	3
	Abnormal extension	2
	None	1
Total Score		3-15



Trauma

PEDIATRIC GLASCOW COMA SCORE				
RESPONSE	ADOLESCENT	CHILD	INFANT	VALUE
Eye Opening	Spontaneous	Spontaneous	Spontaneous	4
	To Speech	To speech	To speech	3
	To Pain	To pain	To pain	2
	None	None	None	1
Best Verbal Response	Oriented	Oriented, appropriate	Coos and babbles	5
	Confused	Confused	Irritable, cries	4
	Inappropriate words	Inappropriate words	Cries in response to pain	3
	Incomprehensible sounds	Incomprehensible words or nonspecific sounds	Moans in response to pain	2
	None	None	None	1
Best Motor Response	Obeys	Obeys commands	Moves spontaneously and purposely	6
	Localizes	Localizes painful stimulus	Withdraws in response to touch	5
	Withdraws	Withdraws in response to pain	Withdraws in response to pain	4
	Abnormal flexion	Flexion in response to pain	Abnormal flexion in response to pain	3
	Abnormal extension	Extension in response to pain	Abnormal extension in response to pain	2
	None	None	None	1
Total Score				3-15



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Trauma Arrest

Medical Director Review Date 08/2025

If patient does not meet unquestionable death criteria as listed in Guideline 1130, follow this guideline.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- The Lucas Device is permitted in trauma
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Penetrating chest trauma
 - Needle decompression procedure (Appendix J) on affected side(s)
- Refer to appropriate medical cardiac arrest and advanced airway guidelines
- Provide spinal immobilization if indicated



2010

Trauma Arrest

Medical Director Review Date 08/2025

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2020

Multi-System Trauma

Medical Director Review Date 08/2025

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- Provide spinal immobilization
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain adequate oxygen saturation of 95% or greater
 - Tension pneumothorax
 - Needle decompression procedure (Appendix J)
 - Refer to Advanced Airway Guideline 9020 as indicated
- Consider SAM pelvic splint (Appendix N) for unstable pelvis
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Bleeding from the nose and/or ears should not be stopped, but a sterile dressing should be placed over the nose and/or ears
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO Access
 - Up to 20 mL/kg intravenous fluids to achieve Systolic BP of 90 mmHg; maximum 2L
 - Therapeutic goal is **Systolic 90 mm/Hg**
 - If IO used for access, the humerus is the preferred site, especially in pelvic trauma
- Determine Blood Glucose Level



2020

Multi-System Trauma

Medical Director Review Date 08/2025

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Head Trauma

Medical Director Review Date 08/2025

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Transport to a Trauma Center when there is decreased LOC, severe headache, or repeated vomiting. Elderly patients on anticoagulants should also be transported to a Trauma Center**
 - Consider Trauma Alert based on EMT/Paramedic judgement
- Provide spinal immobilization if indicated (Appendix O)
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
 - **A C-collar must be placed on all elderly fall patients with altered mental status including dementia**
- Airway/breathing management
 - **It is critically important to avoid hypoxia in the head trauma patient**
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9020 as indicated
 - The head injured patient with a decreased LOC is more likely to suffer airway compromise than the standard trauma patient
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Bleeding from the nose and/or ears should not be stopped, but a sterile dressing should be placed over the nose and/or ears
- Establish IV/IO Access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - It is critically important to avoid hypotension in a head trauma patient
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Determine Blood Glucose Level



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Head Trauma

Medical Director Review Date 08/2025

- **Protective helmets** (e.g., motorcycle, bicycle) should be removed
- **Sporting helmet** removal:
 - The face mask should always be removed for airway access
 - Helmets and shoulder pads should be left in place except in the following situations:
 - Helmet in place and no shoulder pads
 - Head/facial trauma
 - Face mask cannot be removed
 - Cervical/spinal regions are unstable because the helmet fits poorly
 - Airway management cannot be achieved with just face mask removal
 - Patient is in cardiac arrest (requires removal of shoulder pads)
 - If the helmet is removed, the shoulder pads also need to be removed. It is an “all or nothing” principle
- Refer to Appendix Q for Helmet Removal Procedure



Spinal Trauma

Medical Director Review Date 08/2025

In cases of isolated spinal injuries, scene time is less critical, and care should be taken in performing proper spinal immobilization.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Provide spinal immobilization if indicated (Appendix O)
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Protective helmets** (e.g., motorcycle, bicycle) should be removed
- **Sporting helmet** removal:
 - The face mask should always be removed for airway access
 - Helmets and shoulder pads should be left in place except in the following situations:
 - Helmet in place and no shoulder pads
 - Head/facial trauma
 - Face mask cannot be removed
 - Cervical/spinal regions are unstable because the helmet fits poorly
 - Airway management cannot be achieved with just face mask removal
 - Patient is in cardiac arrest (requires removal of shoulder pads)
 - If the helmet is removed, the shoulder pads also need to be removed. It's an "all or nothing" principle
- Refer to Appendix Q for Helmet Removal Procedure
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - High cervical injury may cause apnea
 - Refer to Advanced Airway Guideline 9020 as indicated
- Consider SAM pelvic splint (Appendix N) for pelvic fractures
- Establish IV/IO Access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is the preferred site
 - If hypotension persists after 1L and neurogenic shock is suspected, administer **Dopamine 5-15 mcg/kg/min IV/IO**
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



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Spinal Trauma

Medical Director Review Date 08/2025

- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway



Chest Trauma

Medical Director Review Date 08/2025

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Transport to a Trauma Center when discoloration, severe tenderness, crepitus, respiratory distress, or decreased breath sounds are present. Elderly patients on anticoagulants should also be transported to a Trauma Center**
 - Consider Trauma Alert based on EMT/Paramedic judgement
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9020 as indicated
- All patients in trauma arrest from penetrating chest injury
 - Needle decompression procedure (Appendix J)
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Treatments based on injuries:
 - Sucking Chest Wound
 - Apply vented Halo Chest Seal if available
 - Otherwise, apply Vaseline-type occlusive dressing(s) to cover the wound(s)
 - Cover the occlusive dressing with sterile 4X4s
 - Tape the dressing on three sides
 - Tension Pneumothorax
 - Unilateral absent breath sounds **with** severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, and hypoxia
 - Needle decompression procedure (Appendix J)
- Establish IV/IO Access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - Therapeutic goal is **Systolic 90 mm/Hg**
 - If IO used for access, the humerus is the preferred site



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Chest Trauma

Medical Director Review Date 08/2025

- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed



Abdominal Trauma

Medical Director Review Date 08/2025

Mechanism of injury is the most important indicator of abdominal trauma.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Transport to a Trauma Center when discoloration and/or severe tenderness are present. Elderly patients on anticoagulants should also be transported to a Trauma Center**
 - Consider Trauma Alert based on EMT/Paramedic judgement
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9020 as indicated
- Immobilize impaled objects in place
- Consider SAM pelvic splint (Appendix N) for unstable pelvis
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Apply hemostatic gauze if available for life-threatening hemorrhage
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - Therapeutic goal is **Systolic 90 mm/Hg**
 - If IO used for access, the humerus is the preferred site
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Abdominal Evisceration
 - Never replace abdominal viscera
 - Cover with sterile dressing and moisten with intravenous fluid (may need to periodically remoisten)
 - Secure the wet dressing in place if possible



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Abdominal Trauma

Medical Director Review Date 08/2025

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Trauma Pregnancy

Medical Director Review Date 08/2025

Signs and symptoms of shock may be delayed due to increased maternal blood volume.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Transport to a trauma center if patient is experiencing vaginal bleeding or abdominal pain and is greater than 20 weeks gestation**
- Provide spinal immobilization if indicated (Appendix O)
 - Immobilizing a pregnant patient greater than **20 weeks** may cause supine hypotension syndrome from pressure on the inferior vena cava and may also impair ventilation as the fetus and the uterus press against the diaphragm
 - After immobilization is complete and patient is secure, elevate the patient's right side of the long spine board (LSB) approximately 6 inches. This will displace the uterus and fetus to the left side and off the inferior vena cava
 - If the long spine board (LSB) cannot be elevated, manually displace the uterus to the left as much as possible without causing spinal movement and maintain this displacement throughout the transport
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9020 as indicated
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Apply hemostatic gauze if available for life-threatening hemorrhage
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - Therapeutic goal is **Systolic 90 mm/Hg**
 - If IO used for access, the humerus is the preferred site
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Determine Blood Glucose Level



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Trauma Pregnancy

Medical Director Review Date 08/2025

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Extremity Trauma

Medical Director Review Date 08/2025

This guideline does NOT apply to a multi-system trauma patient.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- **Transport to a Trauma Center when open fractures are present**
- Provide spinal immobilization if indicated (Appendix O)
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Consider SAM pelvic splint (Appendix N) for pelvic fractures
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Splint all areas of tenderness or deformity
 - May consider pain management prior to patient movement or splinting
 - Splint dislocations and joint injuries in the position found
 - Consider ice pack to reduce swelling and pain
 - Reduce fractures (open or closed) by axial traction if absence of distal pulses
 - Consider traction splint (Appendix C) for presumed femur fracture
 - Elevate the extremity when practical
 - Locate, mark, and monitor distal pulses before and after splinting. Record sensation and motor function before and after splinting
- Amputation
 - Place the amputated part in sterile gauze, moisten with intravenous fluids
 - Keep amputated part cool
 - Dress and splint partial amputations in alignment with the extremity, being careful to avoid torsion
 - Do not clamp vessels



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Extremity Trauma

Medical Director Review Date 08/2025

- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - Therapeutic goal is **Systolic 90 mm/Hg**
 - If IO used for access, the humerus is the preferred site
- Assess patient for injuries and provide pain management, if appropriate
 - Adult and pediatric, **Fentanyl 1 mcg/kg slow IVP only; maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total maximum dose 200 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity



Crush Injury

Medical Director Review Date 08/2025

The patient's overall health status, total amount of entrapped body surface area, length of the entrapment and weight of the object dictate the extent of the symptoms. Crush injury is to be distinguished from a simple entrapment.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access. Initiate fluid resuscitation prior to removal of compression force if possible
 - **Adult** - 20 mL/kg IV/IO intravenous fluids; maximum 2L
 - If IO used for access, the humerus is the preferred site
 - **Pediatric** – 20 mL/kg IV/IO intravenous fluids; maximum 2L
- Life threatening dysrhythmias, peaked T waves or widening QRS complex (see image example on next page)
 - **Calcium Chloride 1g** IV/IO over 5-10 minutes (**Adults Only**)
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate. Must flush line if using same site for other medication(s)
 - Administer bolus of **Sodium Bicarbonate** IV/IO by a separate line or flush line as mentioned above
 - **Adult - Sodium Bicarbonate 1 mEq/kg**
 - **Pediatric - Sodium Bicarbonate 1 mEq/kg; maximum dose 50mEq**

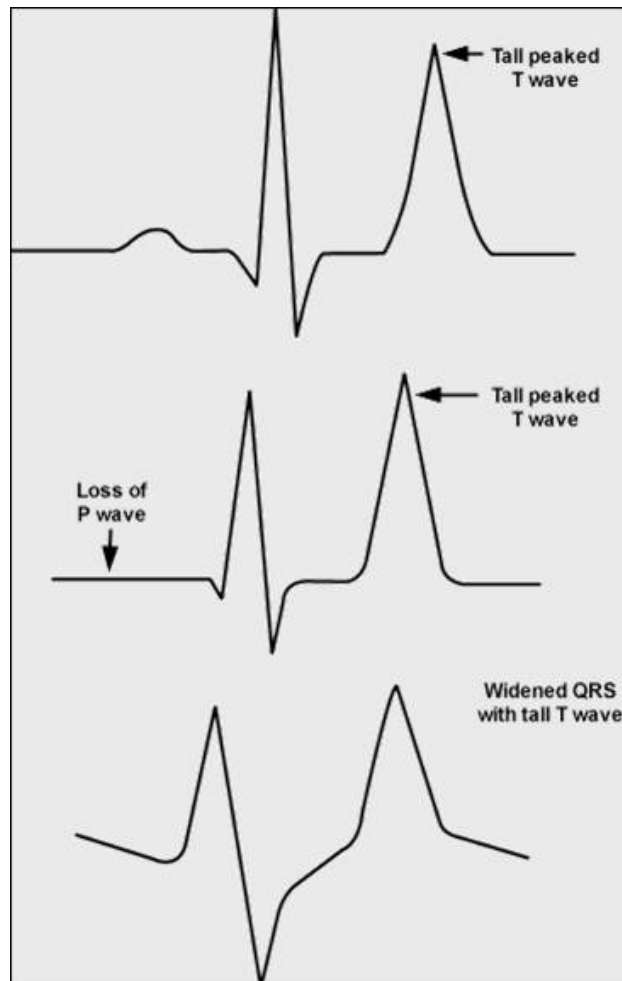


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Crush Injury

Medical Director Review Date 08/2025

- Adult and pediatric pain management
 - **Fentanyl 1 mcg/kg** slow IV/IO only; **maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total maximum dose 200 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity





Taser Trauma

Medical Director Review Date 08/2025

Only law enforcement officers are permitted to remove probe(s).

Patient Transport

- The patient should be transported to the hospital if any of the following underlying circumstances apply:
 - History of delirium, mania, or irrational bizarre behavior before being tased
 - Abnormal vital signs
 - History or physical findings consistent with amphetamine or hallucinogenic drug use
 - Cardiac history
 - Altered level of consciousness or aggressive, violent behavior including resistance to evaluation
 - Evidence of hyperthermia
 - JSO unable or unwilling to remove probe(s)
 - Any patient that meets the JFRD transport criteria

TREATMENT

- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level



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Taser Trauma

Medical Director Review Date 08/2025

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Burns

Medical Director Review Date 08/2025

Burns are classified according to type (Thermal, Electrical, and Chemical) and thickness. Use the Rule of Nines or the “palm of hand method” (palm of the patient’s hand including the fingers is 1% of body surface area) to estimate burn area.

ASSESSMENT

Burn Trauma Alert Criteria:

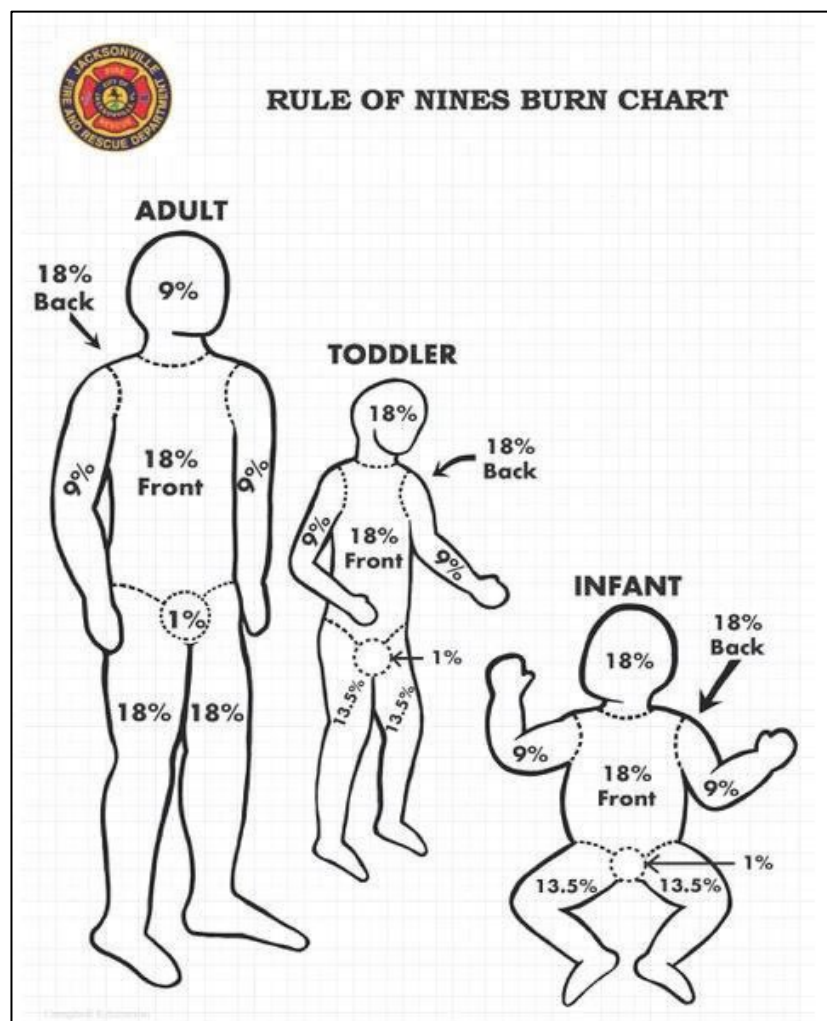
- Adult
 - Partial/full thickness (2nd/3rd degree) burns to 15% or more BSA
- Pediatric
 - Partial/full thickness (2nd/3rd degree) burns to 10% or more BSA

Trauma alert burn patients should be transported to the nearest Trauma Center

Entire Adult Head 9%
Entire Adult Arm 9%
Entire Adult Torso 36%
Entire Adult Leg 18%
Entire Adult Genitalia 1%

Entire Toddler Head 18%
Entire Toddler Arm 9%
Entire Toddler Torso 36%
Entire Toddler Leg 13.5%
Entire Toddler Genitalia 1%

Entire Infant Head 18%
Entire Infant Arm 9%
Entire Infant Torso 36%
Entire Infant Leg 13.5%
Entire Infant Genitalia 1%





Burns

Medical Director Review Date 08/2025

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- Airway/breathing management
 - Patients with known inhalation injury or with signs of potential airway burns who are in respiratory distress should be intubated early to prevent airway collapse
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9020 as indicated
 - Refer to Carbon Monoxide/Cyanide Exposure 6080 as indicated
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO Access
 - If IO used for access, the humerus is the preferred site
 - For partial/full thickness (2nd/3rd degree) burns to 20% or more body surface area (BSA), 20 mL/kg intravenous fluids; maximum 2L
 - Inform hospital of total IV fluid administered for their burn formula calculations
- Remove all clothing, jewelry or constricting items from the burned area unless adhered to the patient
- Request HAZMAT Team when appropriate
- Treatment
 - Chemical burns (not involving Lime, Carboic Acid, Sulfuric Acid, Solid Potassium or Sodium metals)
 - Irrigate with intravenous fluid for 20 minutes
 - Chemical burns involving Lime, Carboic Acid, Sulfuric Acid, Solid Potassium or Sodium metals
 - Do not flush wound(s) with water, intravenous fluids, sterile water, etc.
 - Contact receiving physician for treatment
 - Superficial burns
 - Apply burn gel dressing(s) if needed



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Burns

Medical Director Review Date 08/2025

- Partial-Thickness/Full-Thickness burns
 - Apply dry, sterile dressing(s)
 - Leave blisters intact
 - Adult and pediatric pain management
 - **Fentanyl 1-2 mcg/kg slow IV/IO only; maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total maximum dose 400 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity



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Burns

Medical Director Review Date 08/2025

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Electrical Trauma

Medical Director Review Date 08/2025

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment and consider warm IV fluids
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO Access
 - 20 mL/kg intravenous fluids; maximum 2L
- In electrocutions that involve multiple patients, reverse triage shall be applied and patients in cardiac arrest shall be worked **first**
- Assess patient for injuries and provide pain management, if appropriate
 - **Fentanyl 1-2 mcg/kg slow IV/IO only; maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total Maximum dose 400 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity



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Electrical Trauma

Medical Director Review Date 08/2025

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Eye Trauma

Medical Director Review Date 08/2025

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- **Transport to a Trauma Center when penetrating eye trauma is present**
- Remove contact lenses when applicable
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess nature of ophthalmologic emergency
 - Direct Trauma
 - Patch both eyes gently without pressure to the globes
 - Maintain patient in supine position to reduce leakage of fluids from the eye
 - If blood is noted in anterior chamber, place the patient in semi-Fowler's
 - Immobilize any impaled object and cover both eyes
 - Dim lights for patient comfort
 - Chemical/Irritant Exposure (e.g., pepper spray, tear gas)
 - **Tetracaine 2 drops** to each eye before and after irrigation
 - May be repeated every 10 minutes
 - Contraindications
 - Open ocular trauma
 - Irrigate affected eye with intravenous fluids during transport
 - Apply dry sterile dressings to both eyes
 - Dim lights for patient comfort
 - Atraumatic
 - Patch both eyes gently without pressure to the globes
 - Dim lights for patient comfort



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Eye Trauma

Medical Director Review Date 08/2025

- Assess patient for injuries and provide pain management, if appropriate
 - Adult and pediatric, **Fentanyl 1 mcg/kg slow IVP only; maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total maximum dose 200 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity



2140

Hemorrhage Control

Medical Director Review Date 08/2025

Bleeding to extremity

- Life-threatening (Signs/Symptoms include amputation, profuse pulsating bleeding, blood soaking through pressure bandage and signs of shock with continuous bleeding)
 - Immediately apply tourniquet (Appendix M)
 - Transport to a trauma center
- Non-life-threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing

Bleeding to Head, Neck, or Torso

- Life-threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply Hemostatic gauze if available. Otherwise, apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing
- Non-life threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing



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Hemorrhage Control

Medical Director Review Date 08/2025

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Cardiovascular Emergencies

Chapter 3

Cardiovascular Emergencies



Cardiovascular Emergencies

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3010

Chest Pain

Medical Director Review Date 08/2025

JFRD STEMI ALERT POLICY

CRITERIA #1

Zoll ***ACUTE MI*** or ***STEMI*** message

CRITERIA #2

The patient has symptoms consistent with an Acute Coronary Syndrome such as active /recent chest pain/discomfort, unexplained difficulty breathing, unexplained weakness, syncope, near-syncope, dizziness, diaphoresis, or nausea and/or vomiting **AND** has 12 lead ECG with ST segment elevation in **two anatomically contiguously leads**:

- Greater than or equal to 1.5mm in V2 and V3
or
- Greater than or equal to 1mm in all other leads

If the patient meets **either** of the above criteria:

- Identify a STEMI approved hospital destination
 - See most recent *Hospital Capabilities Chart for JFRD*
- Notify FRCC of "STEMI Alert," destination and ETA
- Transmit 12 lead ECG to receiving facility **as soon as possible** with the patient's name entered
 - Other life-threatening or questionable ECGs may also be transmitted
- **Apply fast patches so that rapid defibrillation is readily available should a shockable rhythm occur**

TREATMENT

- Vitals should be obtained before and in between each administration of nitroglycerin
- If life-threatening arrhythmias are present, refer to appropriate guideline
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Perform 12 lead ECG. If tracing quality is poor with a wavy baseline, make necessary adjustments to improve tracing quality, and repeat interpretation as necessary. If pain persists despite interventions, cases of clinical deterioration, or ECG changes, repeat as necessary.
 - The receiving hospital must receive a hard copy of any 12 lead ECG that is performed. The patient's name must be entered on the ECG
 - No medications except O₂ and aspirin should be given prior to the completion of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed



Chest Pain

Medical Director Review Date 08/2025

- Establish IV access
 - In the setting of Inferior STEMI, initiate 20 mL/kg intravenous fluids prior to considering **NTG**; maximum 2L
- Treatment situations:
 - Patients presenting with chest pain should receive Aspirin unless contraindicated or previously taken within 2 hours
 - **Aspirin 324 mg PO**
 - Contraindications
 - Allergies to salicylates
 - Active GI bleeding
 - **Aspirin 81 mg PO**
 - Pregnant patients will only be given ASA in the presence of a STEMI
 - History of GI bleeding
 - Use of anticoagulants
 - Normotensive (SBP $\geq$ 100 mmHg) and evidence of Acute Coronary Syndrome
 - Only one dose of **NTG** can be given without IV access when systolic $\geq$ 140 mmHg
 - **NTG 0.4 mg** SL should be administered every 5 minutes until pain is resolved or systolic BP drops below 100 mmHg
 - Contraindications
 - Systolic BP less than 100 mmHg
 - Hypovolemia
 - Precaution
 - Consider withholding for patients 30 years of age and younger without Acute Coronary Syndrome symptoms
 - In the setting of an Inferior MI (ST elevation in leads II, III, aVF), **NTG** administration may result in hypotension
 - If hypotension develops, be prepared to administer a fluid challenge and elevate the patient's legs. Patient must be closely monitored
 - A drop in the systolic BP of 20 mmHg or more, consider withholding repeat doses
 - If the patient has used erectile dysfunction medications (Viagra, Levitra, Cialis) within 48 hours



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Chest Pain

Medical Director Review Date 08/2025

- Pain management for **STEMI** patients **only**, **Fentanyl 1 mcg/kg slow IV only**; **maximum single dose 100 mcg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May be repeated every 5-10 minutes
 - **Total maximum dose 200 mcg**
 - Contraindications
 - Hypotension (systolic blood pressure less than 90 mmHg)
 - Respiratory depression
 - Precaution
 - Rapid administration may cause chest wall rigidity
- Hypotensive (SBP<90 mmHg)
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If patient develops pulmonary edema stop IV fluid administration and administer, **Dopamine 5-15mcg/kg/min** IV and titrate to effect
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



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Chest Pain

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Acute Stroke

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JFRD STROKE ALERT POLICY

Scene time should be limited to under 10 minutes, perform rapid assessment using BE-FAST obtaining a LAMS score, and provide early notification to the Stroke Center.

1. Assess patient using the BE-FAST algorithm to **IDENTIFY** the presence of a stroke

- **Balance** – Sudden dizziness, loss of balance or coordination
- **Eyes** – Sudden trouble seeing out of one or both eyes
- **Face** – Facial Weakness, uneven smile
- **Arm** – Weakness to one side, with drift or paralysis
- **Speech** – Impaired, slurred, difficulty repeating simple phrases
- **Time** - Last seen normal?

If any positive finding, there is a possibility of a stroke and Stroke Alert should be issued.

2. Perform the *Los Angeles Motor Scale* (LAMS) assessment to determine the **SEVERITY** of the stroke. LAMS of 3, 4, or 5 are indicative of a potential large vessel occlusion that requires transport to a Comprehensive/Thrombectomy Capable Stroke Center.

Los Angeles Motor Scale (LAMS)		
Face	0	Both sides move normally
	1	One side is weak or flaccid
Arm	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Grip	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Total	0 - 5	



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3. If the patient's blood glucose is ≥ 60 mg/dL, proceed with assessment. Otherwise, administer **12.5 grams** of Dextrose IV/IO. If stroke symptoms persist despite treatment, continue with assessment.
4. After identifying stroke alert criteria, determine closest, most appropriate Stroke Center per parameters below. If symptoms present greater than 24 hours, any hospital is appropriate, and a Stroke Alert is not indicated.
 - **Comprehensive/Thrombectomy Capable Stroke Center**
 - **All LAMS scores of 3, 4, or 5** with onset up to 24 hours
 - LAMS score of 0, 1, or 2 when that facility is the closest Stroke Center
 - All suspected strokes with onset greater than 3 hours and less than 24 hours
 - Patient wakes up with stroke symptoms
 - History of previous strokes or brain tumor
 - Suspicion of subarachnoid hemorrhage/intracranial hemorrhage, sudden severe headache ("Thunderclap Headache") or sudden decrease in LOC
 - Patients on anti-amyloid infusions
 - Current or recent GI bleeding
 - Trauma, surgery, or invasive procedure within past 2 months
 - Currently on anticoagulants
 - Bleeding disorders (e.g., low platelets, cirrhosis)
 - **Primary Stroke Center**
 - LAMS score of 0, 1, or 2 with onset up to 3 hours when that facility is the closest Stroke Center

Notify FRCC of Stroke Alert, destination, LAMS score, last know well time, and ETA.

Obtain contact information from the family (name, phone number etc.) for hospital history verification and possible procedural consents. This information should be noted on the field copy and relayed to hospital staff.

Comprehensive/Thrombectomy Capable Stroke Centers

- See most recent *Hospital Capabilities Chart for JFRD*

Primary Stroke Centers

- See most recent *Hospital Capabilities Chart for JFRD*



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TREATMENT

- Place patient on the stretcher in semi-Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Establish IV/IO access
 - 18 gauge in the antecubital if possible
 - The unaffected side is preferred but the affected side may be used
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Initiate cardiac monitoring
 - Perform 12 lead ECG (do not delay transport). The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Consider alternate diagnosis based on clinical presentation (e.g., seizure, bilateral weakness or symptoms, fever with hypotension, prolonged mental status changes, etc.)
- Determine Blood Glucose Level
 - Treat if indicated (should be performed **BEFORE** issuing Stroke Alert)
 - Hypoglycemia (<60 mg/dL)
 - **Dextrose 12.5 grams** IV/IO. Repeat BGL by finger stick in 5 minutes
 - If no improvement and BGL <60 mg/dL, repeat **Dextrose 12.5 grams**
 - Without IV/IO access
 - **Glucagon 1 mg IM** (repeat BGL after 15 minutes)
 - Considerations
 - Onset in 1 minute with a peak onset time of 30 minutes
 - The hypoglycemic patient will usually awaken within 15 minutes



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Acute Stroke

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Acute Heart Failure/ Pulmonary Edema

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TREATMENT

- Place the patient in full Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - **Consider early use of the CPAP (Appendix H) to treat pulmonary edema**
 - Refer to Advanced Airway Guideline 9010 as indicated
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
- Treatment situations:
 - Normotensive (SBP $\geq$ 100 mmHg) or hypertensive
 - **NTG 0.4 mg SL** every 5 minutes until systolic BP drops below 100 mmHg
 - First dose of **NTG** can be given without IV/IO access when systolic $\geq$ 140 mmHg
 - **Additional doses of NTG require IV/IO access**
 - If possible, administer NTG SL prior to CPAP application
 - If CPAP in place, apply **1 inch of Nitropaste** to the patient's left anterior chest
 - Contraindications
 - Systolic BP < 100 mmHg
 - Hypovolemia
 - Precaution
 - In the setting of an Inferior STEMI (ST elevation in leads II, III, aVF), **NTG** administration may result in hypotension
 - If hypotension develops, be prepared to administer a fluid challenge and elevate the patient's legs. Patient must be closely monitored
 - A drop in the systolic BP of 20 mmHg or more, consider withholding repeat doses of **NTG**
 - If the patient has used erectile dysfunction medications (Viagra, Levitra, Cialis, etc.) within 48 hours
 - If patient becomes hypotensive after applying **Nitropaste**, wipe away paste
 - Hypotensive (SBP < 90 mmHg) may indicate cardiogenic shock
 - **Dopamine 5-15mcg/kg/min** IV/IO and titrate to effect
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



Acute Heart Failure/ Pulmonary Edema

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Hypertension

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Hypertensive Urgency (systolic BP greater than 220 mmHg and diastolic BP greater than 120 mmHg) can present with or without symptoms. If stroke, cardiovascular, or respiratory symptoms are present with an abnormally elevated BP, refer to the appropriate guideline.

TREATMENT

- Place patient in semi-Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access



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Hypertension

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V-Fib/Pulseless V-Tach

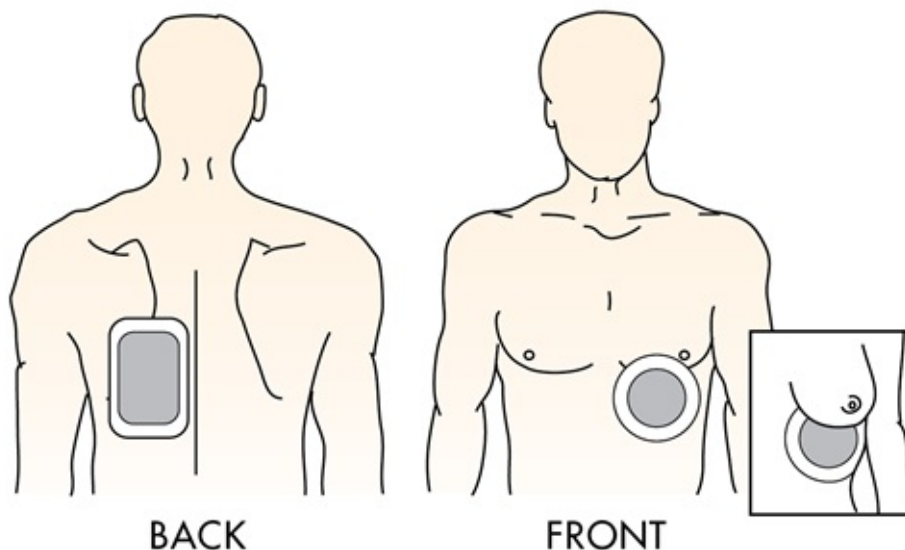
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The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions and defibrillation as outlined in Appendix S. Initial defibrillation should occur wherever the patient is found.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (Should not take more than 10 seconds)
- Initiate CPR and apply monitor/defibrillator pads as soon as possible, anterior/posterior placement is preferred

ADULT ANTERIOR/POSTERIOR



- If an unwitnessed arrest or no bystander CPR, perform 2 minutes of CPR prior to defibrillation
- If witnessed arrest by JFRD or bystander CPR in progress, analyze and defibrillate **immediately**, if indicated
 - If shockable, give **1 defibrillation at 200J**
 - Continue to provide defibrillation every two minutes (all subsequent defibrillations should be at 200J) if shockable rhythm is noted upon reassessment
 - The time from the last compression to defibrillation should be minimized
 - After each defibrillation, **IMMEDIATELY** continue CPR, starting with compressions for 2 minutes then reassess



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V-Fib/Pulseless V-Tach

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- If no shock advised, **IMMEDIATELY** continue CPR, starting with compressions, for 2 minutes then reassess
- Utilize Lucas CPR device (Appendix A) as early as possible
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Airway/breathing management
 - Refer to Advanced Airway Guideline 9010 as indicated
 - **If unable to intubate patient after two attempts, with minimal interruptions to chest compressions (maximum of 10 seconds per attempt), insert supraglottic airway (Appendix D)**
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the tibia is the preferred site
- Determine Blood Glucose Level
- Administer **Epinephrine 1 mg (1:10,000) IV/IO**
 - Repeat Epinephrine every 3 to 5 minutes
- Administer **Amiodarone 300 mg IV/IO**
 - Repeat **Amiodarone once at 150 mg IV/IO** at 5 minutes for refractory shockable rhythm
- **For Torsades de Pointes** (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - Instead of Amiodarone, administer **Magnesium Sulfate 2g IV/IO** over 1-2 minutes
- Consider the following possible causes of cardiac arrest, H's and T's, and their appropriate treatments:
 - Hyperkalemia - Dialysis patients
 - **Calcium Chloride 1g IV/IO** over 2 minutes
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
 - Hypovolemia
 - Fluid challenge with 2L maximum



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V-Fib/Pulseless V-Tach

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- Hypoxia
 - Provide 100% O₂ with use of BVM and appropriate airway adjunct
- Acidosis caused by extended down time greater than **15 minutes**
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
- Hyperthermia/Hypothermia
 - Cool or warm as needed
- Tension pneumothorax
 - Needle decompression procedure (Appendix J)
- Toxins/Tablets
 - Suspected narcotic overdose
 - **Narcan 4mg IV/IO**
 - Calcium Channel blocker overdose
 - **Calcium Chloride 1g IV/IO over 2 minutes**
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate
 - Tricyclic Antidepressant overdose (e.g., Amitriptyline, Amoxapine, Desipramine, Doxepin, Imipramine, Nortriptyline, Protriptyline, Trimipramine, etc.)
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
- Any patient considered to be unstable, (e.g. hypotension, cardiac dysrhythmias, declining mental status or respiratory distress), shall remain on the cardiac monitor until transfer to the receiving medical team is completed



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V-Fib/Pulseless V-Tach

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Asystole/Pulseless Electrical Activity

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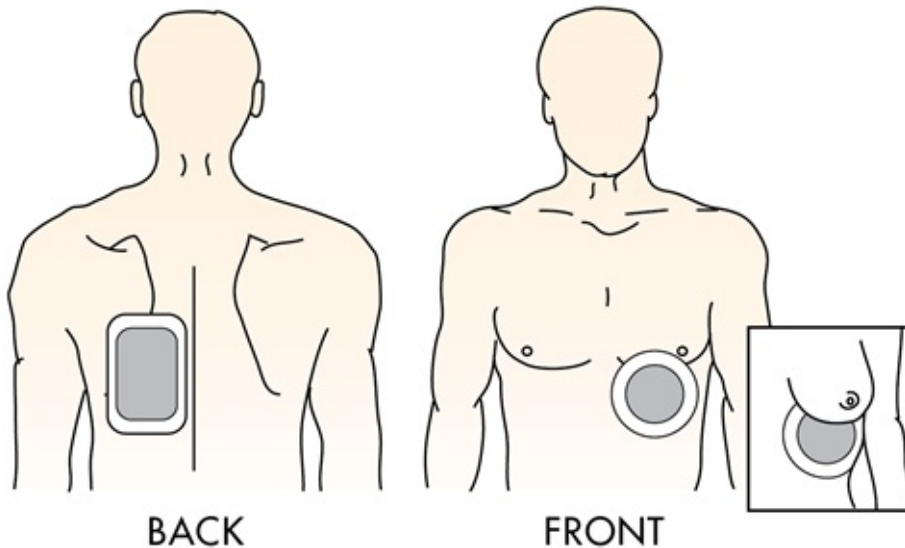
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The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions as outlined in Appendix S.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
- Initiate CPR and apply monitor/defibrillator pads as soon as possible, anterior/posterior placement is preferred

ADULT ANTERIOR/POSTERIOR



- Utilize Lucas CPR device (Appendix A) as early as possible
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Airway/breathing management
 - Refer to Advanced Airway Guideline 9010 as indicated
 - If unable to intubate patient after two attempts, with minimal interruptions to chest compressions (**maximum of 10 seconds per attempt**), insert supraglottic airway (Appendix D)



Asystole/Pulseless Electrical Activity

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- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the tibia is the preferred site
- Determine Blood Glucose Level
- Administer **Epinephrine 1 mg (1:10,000)** IV/IO
 - Repeat Epinephrine every 3 to 5 minutes
- Consider the following possible causes of cardiac arrest, H's and T's, and their appropriate treatments:
 - Hyperkalemia - Dialysis patients
 - **Calcium Chloride 1g** IV/IO over 2 minutes
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate
 - **Sodium Bicarbonate 1 mEq/kg** IV/IO
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
 - Hypovolemia
 - Fluid challenge with 2L maximum
 - Hypoxia
 - Provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Acidosis caused by extended down time greater than **15 minutes**
 - **Sodium Bicarbonate 1 mEq/kg** IV/IO
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
 - Hyperthermia/Hypothermia
 - Cool or warm as needed
 - Tension pneumothorax
 - Needle decompression procedure (Appendix J)
 - Toxins/Tablets
 - Suspected narcotic overdose
 - **Narcan 4mg** IV/IO
 - Calcium Channel blocker overdose
 - **Calcium Chloride 1g** IV/IO over 2 minutes
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate



Asystole/Pulseless Electrical Activity

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- Tricyclic Antidepressant overdose (e.g., Amitriptyline, Amoxapine, Desipramine, Doxepin, Imipramine, Nortriptyline, Protriptyline, Trimipramine, etc.)
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
- Any patient considered to be unstable, (e.g. hypotension, cardiac dysrhythmias, declining mental status or respiratory distress), shall remain on the cardiac monitor until transfer to the receiving medical team is completed



Asystole/Pulseless Electrical Activity

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Post-Resuscitation Care

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Patients may display a wide range of responses to resuscitation from being awake and alert with adequate spontaneous respirations and hemodynamic stability to unconscious and NOT breathing with hemodynamic instability.

TREATMENT

- Patients with ROSC should only be transported to STEMI capable facilities
- Reassess airway
 - Provide 100% oxygen with appropriate airway adjunct
 - **Monitor ETCO₂ and SpO₂ values for all patients that have an advanced airway in place**
 - Normal readings are 35 to 45 mmHg in a healthy patient
 - Assure correct wave form
 - Consider sedation in the intubated patient
 - **If systolic BP >100, Midazolam 2mg IV/IO**, may repeat every 5 minutes
 - **If systolic BP <100, Ketamine 0.5mg/kg IV/IO**; maximum single dose 50mg, may repeat once in 5 minutes
- Consider soft restraints for patients in ROSC that have been intubated
- Establish IV/IO access if not already done
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Initiate cardiac monitoring
 - Perform 12 lead ECG if time permits. The receiving hospital must receive a hard copy of any 12 lead ECG that is performed
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Determine Blood Glucose Level
- Consider specific treatments:
 - Hypotension without bradycardia
 - If hypotension persists after fluid bolus, consider **Dopamine 5-15 mcg/kg/min IV/IO**
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



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Post-Resuscitation Care

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- Tachycardia
 - Wide regular QRS (V-Tach or runs of V-Tach identified as ≥ 6 consecutive PVCs)
 - **Amiodarone 150 mg in 100 mL intravenous fluid bag over 10 mins**
 - **No need for Amiodarone drip after ROSC unless there is V-Tach or runs of PVCs**
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Bradycardia with hypotension (systolic BP <90 mmHg)
 - Administer **Atropine 1 mg** IV/IO every 3 to 5 minutes; **maximum total dose 3 mg**
 - Precaution
 - Wide complex atrio-ventricular blocks
 - Consider transcutaneous pacing (Appendix B) if refractory to Atropine or severe symptoms
 - If bradycardia persists after atropine, consider **Dopamine 5-15 mcg/kg/min** IV/IO
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR



Tachycardia

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When treating tachycardia, it is important to first consider a compensatory cause. The increased heart rate may be compensating for an underlying cause (e.g., fever, sepsis, hypovolemia, etc.)

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - **Apply fast patches**
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Repeat as necessary if pain persists despite interventions, cases of clinical deterioration, or ECG changes
 - Do not delay treatment or transport
 - Life-threatening ECGs should also be transmitted
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Determine Blood Glucose Level
- Consider specific treatment based on evaluation of patient and QRS
 - **Stable** patient
 - Wide regular QRS (V-Tach or runs of V-Tach identified as ≥ 6 consecutive PVCs)
 - **Amiodarone 150 mg in 100 mL intravenous fluid bag over 10 mins**
 - Torsades de Pointes (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - **Magnesium Sulfate 2g IV/IO** IV in small intravenous fluid bag (100-250cc) over **10 mins**, smaller bag is preferred
 - **Deterioration to cardiac arrest is likely**



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Tachycardia

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- Narrow regular QRS (SVT)
 - **Adenosine 6 mg rapid IV** (may attempt vagal maneuvers before administration of Adenosine). If **Adenosine 6mg** unsuccessful, administer **Adenosine 12 mg rapid IV**
 - Contraindication
 - Known WPW syndrome
 - Precaution
 - Patients taking Digoxin and/or Verapamil
- **Unstable** patient. Symptoms include severe CP or SOB, hypotension, and altered mental status
 - Synchronized Cardioversion. May consider brief trial of Adenosine while preparing for cardioversion
 - As patient is unstable, perform cardioversion without pre-medication
 - Narrow regular QRS (SVT) - Synchronized cardioversion at 50 J
 - Repeat as needed with escalating doses up to 100 J
 - Narrow irregular QRS (A-fib)– Synchronized cardioversion at 120 J
 - Repeat as needed with escalating doses up to 200 J
 - Wide regular QRS (V-tach)– Synchronized cardioversion at 100 J
 - Repeat as needed with escalating doses up to 200 J
- **Torsades de Pointes** (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - **Magnesium Sulfate 2g IV/IO** slow push over **2 mins**
 - **Deterioration to cardiac arrest is likely**
 - Attempt synchronized cardioversion at 100J
 - May have to change to defibrillation if patient is in extremis, as the monitor may not synch due to varying QRS axis



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Bradycardia

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Symptomatic bradycardia is a combination of slow heart rate with symptoms such as altered mental status, ongoing chest discomfort, hypotension, or signs of shock.

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Do not delay treatment or transport
 - Life-threatening ECGs may be transmitted
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- **Stable** patient with bradycardia, first degree block or second-degree type I heart block without significant clinical symptoms. A normotensive patient typically does not require treatment
- **Unstable** patient with bradycardia. Presenting with poor perfusion evidenced by slow heart rate and **hypotension (systolic <90 mmHg)**.
 - Administer **Atropine 1 mg** IV/IO every 3 to 5 minutes; **maximum total dose 3 mg**
 - Precaution
 - Wide complex atrio-ventricular blocks
 - Consider **Transcutaneous Pacing** (Appendix B). May be appropriate prior to Atropine if severity dictates (e.g., second degree type II, **third degree heart block**) or IV/IO delayed
 - If patient is unstable, initiate pacing without sedation
 - If a patient is uncomfortable after capture achieved with clinical improvement and systolic >90 mmHg, administer **Ketamine 0.3 mg/kg** IV/IO (no repeat dose)
 - If Atropine or Transcutaneous Pacing does not improve blood pressure (systolic <90 mmHg), administer **Dopamine 5-15 mcg/kg/min** IV/IO and titrate to effect
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



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Bradycardia

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Respiratory Emergencies

Chapter 4

Respiratory Emergencies



Respiratory Emergencies

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Respiratory Distress

Medical Director Review Date 08/2025

In the patient with severe respiratory compromise, treatment should be aggressive to prevent respiratory arrest. Lung sounds and degree of distress should guide treatment.

TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Apply nasal capnography for moderate to severe distress
 - Normal values should range between 35-45 mmHg
 - Values above 45 mmHg may indicate respiratory failure potentially requiring ventilatory assistance (e.g. BVM)
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Refer to Advanced Airway Guideline 9010 as indicated
 - If unable to intubate patient after two attempts, insert supraglottic airway (Appendix D)
- Consider possible treatment situations and refer to appropriate guideline
 - Clear lung sounds with difficulty breathing
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Known or suspected pneumonia (fever, decreased lung sounds, and/or cough)
 - **Albuterol 5 mg** and **Atrovent 0.5 mg nebulized**. May repeat as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
- If respiratory distress due to Asthma, COPD, Shock, or Acute Heart Failure, refer to appropriate guideline
- Initiate cardiac monitoring
 - Consider performing a 12 lead ECG if possible cardiac issue. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Determine Blood Glucose Level



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Respiratory Distress

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Respiratory Arrest

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TREATMENT

- Provide 100% oxygen via BVM with an airway adjunct(s) (oropharyngeal airway and/or nasopharyngeal airway)
- Provide suction as needed
- Airway/breathing management
 - Refer to Advanced Airway Guideline 9010 as indicated
 - If unable to intubate patient after two attempts, insert supraglottic airway (Appendix D)
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess Blood Glucose Level



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Respiratory Arrest

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Reactive Airway Disease (Asthma, COPD)

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TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - **Consider early use of the CPAP (Appendix H)**
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Refer to Advanced Airway Guideline 9010 as indicated
 - If unable to intubate patient after two attempts, insert supraglottic airway (Appendix D)
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Treatment should be based on lung sounds and level of distress
 - **Mild Distress** - Wheezes only
 - **Albuterol 5 mg** and **Atrovent 0.5 mg nebulized**. May repeat as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Moderate Distress** - Wheezes/decreased breath sounds/accessory muscle use
 - **Albuterol 5 mg** and **Atrovent 0.5 mg nebulized**. May be repeated as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Magnesium Sulfate 2 grams** IV in small intravenous fluid bag (100-250cc) over 10 mins. Smaller bag is preferred
 - **Solu-Medrol 125 mg** slow IV push



Reactive Airway Disease (Asthma, COPD)

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- **Severe Distress** - Wheezes/stridor/decreased breath sounds with little or no air movement/accessory muscle use/tripoding
 - **Epinephrine 1:1000 0.3 - 0.5 mg IM** (0.3 mg appropriate for ≥ 50 years old)
 - Administer only in the case of asthma exacerbation
 - **Continuous Positive Airway Pressure (CPAP) (Appendix H) in conjunction with an in-line Albuterol/Atrovent nebulizer**
 - **Albuterol 5 mg** and **Atrovent 0.5 mg nebulized**. May be repeated. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Magnesium Sulfate 2 grams IV** in small intravenous fluid bag (100-250cc) over 10 mins. Smaller bag is preferred.
 - **Solu-Medrol 125 mg IV/IO push**



Foreign Body Airway Obstruction

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TREATMENT

- Foreign Body Airway Obstruction (FBAO) maneuvers as indicated below:
 - **Conscious**
 - Mild Obstruction (with good air exchange)
 - Encourage patient's own spontaneous coughing and breathing efforts
 - Severe Obstruction
 - Abdominal Thrusts (Heimlich maneuver)
 - If patient is pregnant or obese, perform chest thrusts instead of abdominal thrusts
 - **Unconscious**
 - Reposition airway and remove object by direct or video laryngoscopy with Magill forceps
 - Begin CPR as indicated
 - Suction as indicated
 - Assist ventilations with appropriate BVM with a nasopharyngeal airway
 - Consider Mechanical Airway Clearance Device (Appendix U)
 - If foreign body cannot be removed, attempt to bypass by pushing the obstruction into one bronchus with the ET tube and then intubating the other bronchus
 - Supraglottic airway is contraindicated in this situation
 - If unable to bypass obstruction, consider cricothyrotomy (Appendix K)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Auscultate lung sounds
 - Determine respiratory rate, depth, and quality
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access



Foreign Body Airway Obstruction

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Hyperventilation

Medical Director Review Date 08/2025

Many serious medical problems can cause hyperventilation. Consider possible underlying causes (e.g. DKA, metabolic acidosis, sepsis).

TREATMENT

- Airway/breathing management
 - Administer O₂ via NRB until hyperventilation has resolved, then administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Auscultate lung sounds
 - Determine respiratory rate, depth, and quality
 - Do not administer CO₂ re-breathing techniques
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
- Determine Blood Glucose Level
- Establish IV access if indicated



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Hyperventilation

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Medical Emergencies

Chapter 5

Medical Emergencies



Medical Emergencies

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5010

Abdominal/Flank Pain

Medical Director Review Date 08/2025

TREATMENT

- Place patient in position of comfort
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - **Perform 12 lead ECG for patients 40 years old and greater**
 - The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Assess temperature



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Abdominal/Flank Pain

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Alcohol Related Illness

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TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation 95% or greater
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050
 - For malnourished patients, especially alcoholics, that require dextrose. Do not delay administering dextrose
 - **Thiamine 100 mg** IV/IM
 - Contraindication
 - Known hypersensitivity
 - If suspected narcotic use
 - If respiratory depression present or unable to protect airway
 - **Narcan 0.4 mg** IV/IO/IM
 - May repeat **Narcan** dose every 2 minutes; **maximum total dose 4 mg**



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Alcohol Related Illness

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Allergic Reaction/Anaphylaxis

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TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Refer to Advanced Airway Guideline 9010 as indicated
 - Anticipate rapid deterioration and the need for intubation
 - If unable to intubate patient after two attempts, insert supraglottic airway (Appendix D)
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assist with administration of patient's Auto-Injector Epinephrine if respiratory compromise present
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Assess temperature
- Treatment based on assessment and patient's level of distress:
 - **Mild/Moderate** reaction without respiratory compromise
 - **Benadryl 25 mg IV/IM**
 - **Solu-Medrol 125 mg IV**
 - **Moderate** reaction with respiratory compromise
 - **Benadryl 25 mg IV/IM**
 - **Albuterol 5 mg** and **Atrovent 0.5 mg**. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Solu-Medrol 125 mg IV**



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Allergic Reaction/Anaphylaxis

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- **Severe** reaction/**Anaphylaxis** (severe respiratory distress and/or cardiovascular compromise)
 - **Epinephrine 1:1,000 0.3 - 0.5 mg IM.** (0.3 mg appropriate for ≥ 50 years old)
 - May repeat once after 10 minutes if needed, at different site
 - **Albuterol 5 mg** and **Atrovent 0.5 mg**. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Benadryl 25 mg IV/IO/IM**
 - **Solu-Medrol 125 mg IV/IO**
 - If hypotensive after fluid administration, administer:
 - **Dopamine 5-15 mcg/kg/min IV/IO** and titrate to systolic BP of 90 mmHg
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach



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Altered Consciousness

Medical Director Review Date 08/2025

TREATMENT

- Prevent aspiration by placing patient in the recovery position
- Determine Blood Glucose Level. If BGL less than 60 mg/dL, refer to Diabetic Guideline 5050
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - If GCS ≤ 8 or inability to protect airway, refer to Advanced Airway Guideline 9010
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Treatment based on underlying cause:
 - Narcotic use/exposure
 - Refer to Overdose/Poisoning Guideline 6070
 - Unknown etiology
 - Consider other treatable neurological or metabolic disorders and if identified follow the appropriate guideline
 - **Assess for head trauma and consider use of a C-collar**



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Altered Consciousness

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Diabetic

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TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Look for underlying causes
- **Treatments based on blood glucose level and level of consciousness:**
 - Hypoglycemia
 - Decreased LOC with BGL <60 mg/dL
 - **Dextrose 25 grams** slow IV push over 2 minutes (D₅W 12.5 grams is an acceptable alternative if D₅₀W is not available)
 - Repeat BGL by finger stick in 5 minutes
 - If no IV access, **Glucagon 1mg** IM
 - Repeat BGL after 15 minutes
 - Considerations
 - Onset in 1 minute with a peak onset time of 30 minutes
 - The hypoglycemic patient will usually awaken within 15 minutes
 - Glucagon may not be effective in patients with liver disease
 - Unconscious or unresponsive with BGL <60 mg/dL
 - **Dextrose 25 grams** IV/IO slow push over 2 minutes (D₅W 12.5 grams is an acceptable alternative if D₅₀W is not available)
 - Repeat BGL by finger stick in 5 minutes
 - If no improvement and BGL is still <60 mg/dL, administer an additional **Dextrose 12.5 grams**



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Diabetic

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- Conscious and alert patient ($GCS \geq 14$) with BGL < 60 mg/dL, administer oral **Glucose paste 15 grams** (1 tube)
 - May repeat once in 10 minutes if BGL still < 60 mg/dL
 - Contraindications
 - Altered level of consciousness
 - Difficulty swallowing
- Hyperglycemia
 - BGL > 300 mg/dL, administer 20ml/kg intravenous fluids; maximum 2L
 - If no IV access and $GCS \leq 8$, establish IO



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Nosebleed

Medical Director Review Date 08/2025

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Look for underlying causes
- If other injuries do not exist, prevent aspiration of blood by placing the patient in a sitting position with their head leaning forward
 - Suction the airway as required if unable to position the patient
 - Encourage patient not to swallow blood as it could precipitate vomiting
- Control hemorrhage by pinching the nostrils
 - To facilitate clotting instruct the patient to hold pressure for at least 20 minutes and not to sniff, blow or manipulate the nasal passages in any way
- Consider the use of hemostatic gauze for bleeding control



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Nosebleed

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Headache

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TREATMENT

- If sudden severe headache (“Thunderclap Headache”) or sudden decrease in LOC, refer to Acute Stroke Guideline 3020
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
 - Headaches with elevated temperature, nausea/vomiting and/or altered mental status may indicate meningitis or neurological event
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Look for underlying causes



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Headache

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Nausea/Vomiting

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TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
- Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - **Perform 12 lead ECG for patients 40 years old and greater**
 - The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- The primary treatment for the patient with gastrointestinal related signs and symptoms is to rehydrate them with IV fluids
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
- Gastrointestinal related nausea and vomiting
 - **Adult – Zofran 4 mg IV**
 - No repeat doses
 - **Pediatric – Zofran 0.15 mg/kg IV; maximum total dose 4mg**
 - No repeat doses



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Nausea/Vomiting

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Seizures

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TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- If trauma suspected, immobilize patient using proper technique
- If the patient is actively seizing, protect the patient from further injury
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050
 - Assess temperature
- Active seizures
 - **Midazolam 2-5 mg** IV/IO/IM for active seizures. Consider small doses of Midazolam, preferable to give smaller more frequent doses. If active seizing persists or returns, after 5 minutes, may repeat doses up to a total **maximum of 10 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
 - Potential side effect is hypotension, treat with intravenous fluids as necessary



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Seizures

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Shock Medical

Medical Director Review Date 08/2025

Shock patients may deteriorate rapidly. Signs of poor perfusion include cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds), tachycardia AND systolic BP less than 90 mm/hg.

TREATMENT

- Place patient in supine position with legs elevated
- Maintain body warmth
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is the preferred site
 - If hypotensive after fluid administration, administer:
 - **Dopamine 5-15 mcg/kg/min** IV/IO and titrate to systolic BP of 90 mmHg
 - Contraindications
 - Hypovolemic shock
 - A-Fib/A-Flutter with RVR
 - V-Tach
- For patients confirmed to have Acute Adrenal Insufficiency by either the presence of a medical alert bracelet, designation of medical records, patient, family, or medical confirmation
 - Assist with administration of patient's **Solu-Cortef** IM if present (adult dose is 100mg)
 - If Solu-Cortef not available, **Solu-Medrol 125 mg** slow IV/IO push
- Assess temperature
 - If patient is febrile, apply cooling measures
- Look for underlying causes



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Shock Medical

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Syncope/Near Syncope

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TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature



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Syncope/Near Syncope

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Special Emergencies

Chapter 6

Special Emergencies



Special Emergencies

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6010

Non-Fatal Drowning

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TREATMENT

- If suspected trauma, immobilize patient using proper technique
- Determine submersion time
- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Apply nasal capnography for moderate to severe distress
 - Normal values should range between 35-45 mmHg
 - Values above 45 mmHg may indicate respiratory failure potentially requiring ventilatory assistance (e.g. BVM)
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Consider CPAP (Appendix H) for patients with pulmonary edema
 - Refer to Advanced Airway Guideline 9010 as indicated
 - If unable to intubate patient after two attempts, insert supraglottic airway (Appendix D)
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
 - Maintain body warmth and correct as necessary
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Do not transport to a Stand-alone ED



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Non-Fatal Drowning

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Decompression Sickness

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Medical Director Review Date 08/2025

TREATMENT

- Place patient in recovery position (left side)
- Airway/breathing management
 - Monitor SpO₂ and provide 100% O₂ via NRB
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Assess temperature
 - Maintain body warmth and correct as necessary
- Retrieve dive computer (if appropriate) and ensure transport with patient or try to obtain depth and length of dive from patient or bystanders
- Tension Pneumothorax
 - Needle decompression procedure (Appendix J)
- Determine Blood Glucose Level
- Do not transport to a Stand-alone ED
- Transport to the closest most appropriate emergency department
 - **There is currently no emergent hyperbaric treatment chamber in Duval County**



Decompression Sickness

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Combative Patient

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Request law enforcement if they are not already on scene.

A wide variety of medical conditions can cause a patient to become combative.

Agitated Delirium, previously known as Excited Delirium, can mimic several medical conditions including hypoxia, hypoglycemia, stroke, or intracranial bleeding. All patients suspected of experiencing agitated delirium must be transported.

- Physical signs of agitated delirium include:
 - Unfounded fear and panic
 - Shouting/irrational speech
 - Bizarre behavior (hallucinations/paranoia)
 - Hyperactivity and thrashing about (especially after restraint)
 - Unexplained strength/endurance
 - Shedding clothes/nudity (due to increased body temperature)
 - Profuse diaphoresis
 - Decreased sensitivity to pain

A previously combative patient who suddenly becomes quiet should raise a red flag.

TREATMENT

- Attempt to calm patient
 - Move patient to a calm, quiet environment
 - Respond in a confident, supportive manner
 - Inquire about resolving the cause of anger
 - Express sympathy and concern
- Apply restraints if needed and not already in place by law enforcement (e.g., handcuffs, flex cuffs)
 - Approved JFRD physical restraints include:
 - Soft limb restraints
 - Stretcher straps/harness
 - Wide cloth restraints
 - **No patient will be restrained in the prone or “hogtied” position**
 - Restraints shall not prohibit evaluation of the patient’s medical status or injure the patient in any way
 - Frequently assess the patient to ensure that the airway is patent, distal limb circulation is adequate and that restraints can be released quickly should the patient’s condition deteriorate
 - When restraints are in use, circulation to the extremities shall be evaluated at least every 5 minutes
 - JFRD personnel shall never leave the restrained patient unattended



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Combative Patient

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- Document the following in the patient care report:
 - The patient's behavior necessitating placement of restraints
 - The type of restraint used
 - Status of circulation distal to restraints at least every 5 minutes
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
- Look for underlying causes
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- If medication is required to calm the patient

Ketamine and Midazolam should only be administered to patients ≥ 13 years of age in this protocol for combative patient

 - If IV unobtainable
 - Administer **Ketamine 4 mg/kg IM; maximum dose 400 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - IM volumes greater than 2 mL should be administered in the thigh or buttocks
 - After 15 minutes, if sedation is still needed, administer **Midazolam 2-5 mg IM**
 - Precaution
 - Accuracy in weight estimation is critically important to avoid excessive dosing
 - If IV in place
 - **Midazolam 2-5 mg IV**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - May repeat one dose in 10 minutes
 - Precaution
 - Hypotension
 - **Airway assistance will be required if both Ketamine and Midazolam are administered based on LOC, respiratory effort, and airway patency**
 - **Airway assistance may still be required if only one medication is used**
- Do not transport to a Stand-alone ED



Hyperthermia

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TREATMENT

- Move patient to cooler environment and remove any clothing or gear
- Assess temperature
 - Oral and/or tympanic readings are typically less accurate and lower than actual body core temperature
 - Reduce temperature in patient compartment
- Treat heat stroke aggressively
 - Apply and practice cooling measures (application of ice packs/wet towels to neck, axillae, groin, etc. and fanning the skin) to reduce body temperature to less than 104 degrees as quickly as possible
 - **If ice water immersion cooling has been initiated by health care professionals or athletic trainers, consider allowing continued treatment for up to an additional 10 minutes after arrival**
 - When removing patient from ice bath, place some of the ice on the stretcher around the patient. A drag blanket or tarp may prove beneficial in this scenario
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - 20 mL/kg intravenous fluids; maximum 2L



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Hyperthermia

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Hypothermia

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TREATMENT

- Place patient in supine position
- Move patient to warmer environment
- Handle patient gently
 - The hypothermic heart is irritable; excessive movement may result in ventricular arrhythmias
- Assess temperature
 - Rewarming is the priority
 - Remove any wet clothing
 - Increase core temperature with blankets
 - Increase temperature in patient compartment to at least 85°
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg warmed intravenous fluids; maximum 2L



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Hypothermia

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Bites and Stings

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If signs of allergic reaction noted, follow Allergic Reaction/Anaphylaxis Guideline (Guideline 5030).

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Insects and Spiders
 - Remove stinger if present and cleanse with peroxide
- Marine Stings
 - Remove any clinging tentacles by saltwater rinse (if unavailable, intravenous fluids) or by using a gloved hand
 - Avoid rinsing with fresh water
- Stings involving the eye(s)
 - Irrigate affected eye with intravenous fluids
 - **Tetracaine 2 drops** to each eye before and after irrigation
 - May be repeated every 10 minutes
 - Contraindications
 - Open ocular trauma
- Snake Bites
 - Remove any constricting bands
 - Immobilize extremity
 - Mark initial edematous area with pen and note time
 - Attempt to identify type of snake
 - If venomous, have FRCC contact potential receiving facilities to determine if they have anti-venom on hand
 - Do not transport to a Stand-alone ED
- Apply sterile dressing



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Bites and Stings

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Overdose/Poisoning

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TREATMENT

- If substance is known, contact Poison Control at **1-800-222-1222**. Provide all information requested by poison control representative
- Do not delay treatment or transport, but if possible, bring medication or substance ingested
- Wear appropriate personal protective equipment
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Determine blood glucose Level
- Seizures may develop in many overdose/poison/ingestion situations
 - **Midazolam 2-5 mg** IV/IO/IM for active seizures. Consider small doses of Midazolam, preferable to give smaller more frequent doses. If active seizing persists or returns, after 5 minutes, may repeat doses up to total **maximum of 10 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
 - Potential side effect is hypotension, treat with intravenous fluids as necessary
- Narcotic use
 - If respiratory depression present or unable to protect airway
 - **Narcan 0.4 mg** IV/IO/IM
 - May repeat **Narcan** dose every 2 minutes; **maximum total dose 4 mg**
 - If nasal Narcan administered prior to JFRD arrival, transport shall be encouraged
 - If no improvement, consider nasal capnography (Appendix F) to help guide airway management



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Overdose/Poisoning

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- Organophosphate exposure
 - For all suspected organophosphate exposures, notify Haz Mat Team
 - Signs and symptoms include Diarrhea, Urination, Miosis, Bradycardia, Bronchorrhea, Bronchospasm, Emesis, Lacrimation and Salivation
 - Mild symptoms
 - Administer **one (1) Duodote Kit** (injection). If symptoms worsen, administer two (2) additional doses
 - Severe symptoms
 - Administer **three (3) Duodote Kits** (injections). No more than three (3) doses should be administered
 - **Atropine 2 - 4 mg** IV/IO every 3 to 5 minutes until secretions dry; **no max dose**
 - Precaution
 - Acute myocardial infarction
 - Wide complex atrio-ventricular blocks
 - **Midazolam 2-5 mg** IV/IO/IM for active seizures. Consider small doses of Midazolam, preferable to give smaller more frequent doses. If active seizing persists or returns, may repeat doses up to **total maximum of 10 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
 - Potential side effect is hypotension, treat with intravenous fluids as necessary
 - Duodote Kits are currently carried by the Haz Mat Teams
- Acute Dystonic Reaction to anti-psychotics (e.g., Haldol)
 - Signs and symptoms include painful muscle spasms of the face, neck and back
 - **Benadryl 25 mg** IV/IM
- Beta-Blocker overdose
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - If indicated (e.g., tachycardia, hypotension), up to 20 mL/kg intravenous fluids; maximum 2L
 - If hypotensive after 500 mL fluid administration
 - **Dopamine 5-15 mcg/kg/min** IV/IO and titrate to systolic BP of 90 mmHg
 - First line medication for cardiogenic shock (pulmonary edema/hypotension)



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Overdose/Poisoning

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- Calcium Channel Blocker toxicity
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - **Calcium Chloride 1g** IV/IO over 5-10 minutes
 - Precaution
 - Possible crystallization when mixed with Sodium Bicarbonate. Must flush line if using same site for other medication(s)
 - If indicated (e.g., tachycardia, hypotension), up to 20 mL/kg intravenous fluids; maximum 2L
 - If hypotensive after 500 mL fluid administration
 - **Dopamine 5-15 mcg/kg/min** IV/IO and titrate to systolic BP of 90 mmHg
 - First line medication for cardiogenic shock (pulmonary edema with hypotension)
- Tricyclic Antidepressant overdose (e.g., Amitriptyline, Amoxapine, Desipramine, Doxepin, Imipramine, Nortriptyline, Protriptyline, Trimipramine, etc.) with hypotension, ALOC, tachycardia, seizures, ventricular arrhythmias or a wide QRS complex:
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - **Sodium Bicarbonate 1 mEq/kg** IV/IO



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Overdose/Poisoning

Medical Director Review Date 08/2025

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Carbon Monoxide/Cyanide Exposure

6080

Medical Director Review Date 08/2025

TREATMENT

- Request the HAZMAT team when appropriate
- Wear appropriate personal protective barrier
- Remove the patient to an environment with fresh air
- Determine the carboxyhemoglobin saturation (SpCO) if possible
 - Abnormal values
 - Non-smoker
 - Greater than 5%
 - Smoker
 - Greater than 10%
- Airway/breathing management
 - **Administer 100% O₂ via NRB on ALL suspect carbon monoxide/cyanide exposures**
- Suspected Cyanide poisoning
 - Smoke inhalation is the most common source
 - Signs/symptoms include headache, confusion, dyspnea, chest tightness, nausea, ALOC, seizure, vomiting, hypertension (early), hypotension (late), tachypnea (early), apnea (late), dilated pupils
 - **Cyanokit IV/IO infused over 15 minutes. Must be diluted with 200 mL intravenous fluid, as directed on package**
 - **Adult – 5g**
 - Cyanokits are currently carried by Haz Mat Rescues, Critical Care Rescues, and the Rescue Chiefs
- Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Do not transport to a Stand-alone ED
- **There is currently no emergent hyperbaric treatment chamber in Duval County**



Carbon Monoxide/Cyanide Exposure

6080

Medical Director Review Date 08/2025

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Left Ventricular Assist Device (LVAD)

6090

Medical Director Review Date 08/2025

An LVAD is a mechanical pump that is used to support heart function and blood flow in people who have weakened hearts. The device takes blood from the lower chamber of the heart and helps pump it to the body and vital organs just as a healthy heart would. A properly functioning device produces a continuous whirling sound, which can be heard with auscultation of the chest.

This protocol applies to the management of all patients who have an LVAD implanted. Please remember that these patients, along with their families, have been well trained in the care of themselves and their devices. **LISTEN TO THEM!** Patients always carry a "backup bag" which contains 2 extra fully charged batteries, a second controller, and an emergency guide. Make sure to always bring this emergency backup equipment with them to the hospital.

Call the number listed on the device for the on-call LVAD coordinator and you must transport to Mayo Clinic.

TREATMENT

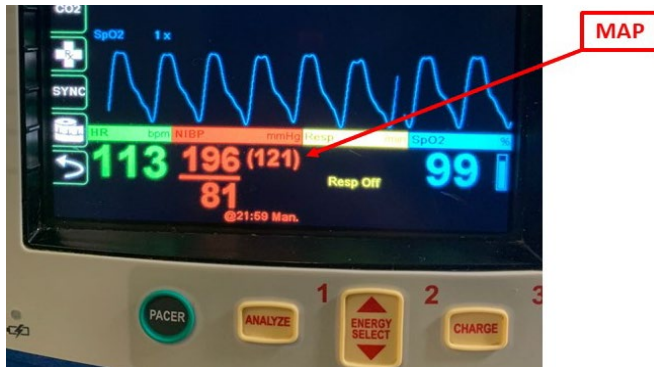
- Auscultate for heart sounds to determine if LVAD is operating
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9010 as indicated
- Obtain vital signs:
 - In most of these patients, a **pulse** will not be palpable. This is because the LVAD unloads the ventricle in a continuous fashion and therefore the aortic valve may not open with each contraction
 - A manual **blood pressure** may not be obtainable. An automated cuff should be used and is likely to measure a narrow pulse pressure
 - Your treatment of the patient will be based on the mean arterial pressure. In these patients, the normal range for the MAP is greater than 60 and less than 90
 - **Pulse oximetry** may not be accurate due to the continuous flow nature of the LVAD
- Initiate cardiac monitoring
 - Perform 12 lead ECG if chest pain or ischemic equivalent symptoms present. The receiving hospital must receive a hard copy of the 12 lead ECG
 - If patient meets STEMI criteria on 12 lead ECG, follow STEMI procedures (Guideline 3010)
 - All dysrhythmias should be treated in accordance with appropriate protocols
 - Defibrillation, cardioversion, and pacing is permitted
 - **Determine Mean Arterial Pressure (MAP)**



Left Ventricular Assist Device (LVAD)

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- Establish IV/IO Access
 - Administer up to 20 mL/kg if the LVAD is alarming with a red light and a steady audio alert. These alarms indicate that the device is in a low flow state of less than 2.5 lpm
- Cautions
 - The most common complications associated with an LVAD patient are the increased risks for stroke, bleeding disorders, arrhythmias, dehydration, and right sided heart failure
 - Ensure modular cable connections are tight as shown below. If the yellow line is showing, turn the connector to the locked position



- If the patient is unconscious, unresponsive to stimuli, and pulseless:
 - **If LVAD is operating** (able to auscultate whirling sound) **with MAP ≥ 50 mmHg, DO NOT PERFORM CPR**
 - The LVAD device has been surgically placed into the left ventricle and CPR could dislodge this device, causing death
 - **If LVAD is NOT operating, perform CPR** per cardiac arrest protocol
 - **If LVAD is operating** (able to auscultate whirling sound) **with MAP < 50 mmHg, refer to Shock Medical Guideline 5100. DO NOT PERFORM CPR**
- **All patients with an LVAD implanted must be TRANSPORTED TO MAYO CLINIC regardless of specific complaint.** Alert hospital early in the transport



Obstetrical/Gynecological

Chapter 7

Obstetrical/Gynecological



Obstetrical/Gynecological

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7010

Vaginal Bleeding

Medical Director Review Date 08/2025

TREATMENT

- Determine last menstrual period (LMP)
- Place patient in position of comfort
 - If pregnant and greater than 20 weeks, place patient in recovery position (left side)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Apply trauma pads to vaginal area for significant bleeding
- Pregnancy and post-partum bleeding should not be transported to Stand Alone EDs



7010

Vaginal Bleeding

Medical Director Review Date 08/2025

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7020

Pre-Eclampsia/Eclampsia

Medical Director Review Date 08/2025

**Transport to Emergency department with L&D capabilities (See most recent
Hospital Capabilities Chart for JFRD)**

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
- Assess temperature
- Place patient in recovery position (left side)
- **Pre-eclampsia**
 - Disorder of pregnancy **after 20 weeks** characterized by the onset of fluid retention and high blood pressure
 - Physical exam may reveal blood pressure greater than 140/90 mmHg, tachycardia, tachypnea, pulmonary edema, confusion, and generalized edema
- **Eclampsia/Severe Pre-eclampsia**
 - Further complication of the pre-eclampsia patient
 - Defined by altered LOC and a blood pressure greater than 160/110 mmHg
 - Can occur postpartum (up to six weeks after delivery)
 - This condition is life-threatening to the mother and baby if not treated promptly
 - With 2 consecutive blood pressure readings greater than 160/110 mmHg over 10-minute period
 - **Magnesium Sulfate 4 grams IV over 20 minutes**
 - Considerations
 - Hypotension
 - Respiratory depression
 - **In presence of seizure activity, shorten infusion to 10 minutes**



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Pre-Eclampsia/Eclampsia

Medical Director Review Date 08/2025

- **Midazolam 2-5 mg** IV/IO/IM for seizure activity persisting greater than 5 minutes after initiation of Magnesium Sulfate infusion. If active seizing persists or returns, may repeat dose once in 5 minutes. **Do not discontinue Magnesium Sulfate infusion.**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
- Potential side effect is hypotension, treat with intravenous fluids as necessary



7030

Imminent Delivery

Medical Director Review Date 08/2025

Transport to the nearest Emergency Department with L&D capabilities, preferably where the patient has received their prenatal care (see Hospital Capabilities Chart for JFRD)

TREATMENT

- Provide rapid transport
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
- **Delivery – without complications**
 - Apply gentle perineal pressure to allow a slow, controlled delivery of the head
 - Observe for meconium staining, suctioning is imperative
 - Gently guide the head downward to allow delivery of the upper shoulder. Do not pull on the newborn to facilitate delivery
 - Gently guide the head upward and allow delivery of the lower shoulder
 - Once the shoulders are delivered, the newborn's trunk and legs will follow rapidly. Be prepared to grasp and support the newborn as it emerges
 - Once the newborn is delivered, maintain body position at the same level as the vagina to prevent blood drainage from the umbilical cord
 - Wipe any blood or mucus from the newborn's nose and mouth with a sterile gauze
 - Use a bulb syringe to suction the mouth and nostrils **only** when the newborn is having difficulty clearing the airway, if secretions are obstructing the airway, or if BVM ventilation is necessary
 - Dry the newborn and wrap in dry blanket
 - Record the time of birth
 - Apply 2 clamps (2 to 3 inches apart), 7 to 10 inches from abdomen of the neonate
 - Cut cord between clamps
 - Closely monitor the cut umbilical cord for bleeding
- Maintain body temperature of neonate post delivery
- Assess and record APGAR at one minute and five minutes post delivery



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Imminent Delivery

Medical Director Review Date 08/2025

- Placenta must be brought to the hospital for evaluation
- Postpartum
 - Assess for postpartum hemorrhage
 - Gently massage uterus until firm
 - **Nuchal Cord**
 - Feel for the cord around the neck as soon as the head is delivered
 - Gently remove the cord from around the neck
 - If unable to remove, clamp and cut the cord
 - Use extreme caution when cutting the cord
 - **Breech Delivery**
 - If delivery is not immediate:
 - Place the mother in the knee-chest position
 - If delivery is immediate:
 - Allow the buttocks or feet to deliver on their own and support the trunk
 - Check for the umbilical cord around the neonate's neck and allow the head to deliver
 - If the head does not deliver within 3 minutes, use a gloved hand to make an airway for the neonate, using the fingers to make airspace
 - **Limb or Brow Presentation**
 - Place the mother in the knee-chest position
 - **Prolapsed Cord**
 - Assessment should focus on the presence of pulses in the umbilical cord and relief of the pressure obstructing the blood flow within the cord
 - Place the mother in the knee-chest position or supine with hips elevated
 - Relieve pressure from the prolapsed cord if no pulses are detected in the cord
 - Use gloved hand to gently but firmly push the neonate's head back into the vagina; avoid pushing on the fontanelles
 - Stop pushing upon the return of pulses in the cord
 - Do not push the cord back into the vagina, but keep moist with soaked towels
 - **Abruptio Placenta or Placenta Previa**
 - Treat for shock if indicated (Guideline 5100)



Newborn Stabilization/Resuscitation

Medical Director Review Date 08/2025

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The majority of newborns require no stabilization beyond drying, warming, positioning, suctioning, and tactile stimulation. More invasive procedures may be required for multiple births, pre-mature birth, or there is meconium staining.

ASSESSMENT

APGAR Score	0	1	2
Appearance	Blue all over	Acrocyanosis	Pink all over
Pulse	Absent	<100	≥100
Grimace/Irritability	No response or none	Grimace Weak cry	Sneeze Cough Vigorous cry
Activity/Muscle Tone	Limp/flaccid	Some motion / flexion of extremities	Active motion
Respirations	None	Slow/irregular	Vigorous cry or Normal respirations



Newborn Stabilization/Resuscitation

Medical Director Review Date 08/2025

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TREATMENT

- If complications are present with mother or child, request a second rescue if necessary
- An additional PCR must be completed for the newborn
- Wipe any blood or mucus from the newborn's nose and mouth with a sterile gauze
- Use a bulb syringe to suction the mouth and nostrils **only** when the newborn is having difficulty clearing the airway, if secretions are obstructing the airway, or if BVM ventilation is necessary
- Thoroughly dry the newborn with towels or blankets. Wrap newborn in a dry blanket
- Administer tactile stimulation, if required, by tapping soles of feet
- Assess and record APGAR at one minute and five minutes post delivery
- Position the infant in the supine position with the neck in a neutral position. A 1" blanket roll under the shoulders will help maintain head position, if aggressive airway management is needed
- Re-assess newborn every 30 seconds
- Determine BGL by heel stick
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Airway/breathing management
 - Assess respiratory rate and effort
- Establish IV/IO access only if neonate is in distress, do not delay transport for vascular access
 - If indicated (e.g., tachycardia, hypotension), 10 mL/kg intravenous fluids
- Consider specific treatment situations:
 - Pre-viable delivery is defined as 24 weeks or less
 - Resuscitation should not be initiated
 - Any treatment should be comfort only



Newborn

Stabilization/Resuscitation

Medical Director Review Date 08/2025

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- Cyanosis isolated to the extremities (acrocyanosis)
 - Saturation may remain less than normal for up to 10 minutes after birth
 - Administer blow-by O₂
- Heart rate less than 100 with labored breathing, apnea, persistent central cyanosis, and/or no muscle tone
 - Provide 100% O₂ at 40 to 60 ventilations/minute via infant BVM
- Heart rate less than 60
 - Administer chest compressions/ventilations
 - A **3:1 ratio of compressions to ventilation**, with 90 compressions and 30 breaths to achieve approximately **120 events per minute** to maximize ventilation at an achievable rate is recommended. Compressions and ventilations should be coordinated to avoid simultaneous delivery. The chest should be allowed to re-expand fully during relaxation (after each compression), but the rescuer's thumbs should not leave the chest.
 - **Epinephrine 1:10,000 0.01 mg/kg** every 3 to 5 min IV/IO
 - Precaution
 - Do not mix with any other drug
 - **Narcan 0.1 mg/kg** IV/IO - Administer to improve respiratory depression in a newborn of a mother suspected of narcotic use within 4 hours of delivery
- Blood sugar <45 mg/dL
 - **D₁₀W at 5mL/kg** IV/IO slow push over 2 minutes
 - To make D₁₀W, discard 40ml out of one amp of D50 then draw 40ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution
 - Precaution
 - Dextrose causes tissue necrosis and adequate vascular access must be ensured prior to administration



Newborn Stabilization/Resuscitation

Medical Director Review Date 08/2025

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Pediatric Emergencies

Chapter 8

Pediatric Emergencies



Pediatric Emergencies

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Pediatric Assessment

Medical Director Review Date 08/2025

A pediatric patient is 17 years of age or less. The only exception is the pediatric trauma alert patient, which is 15 years of age or less (as defined by the Florida Administrative Code).

Pediatric assessment

- Identify parent, care giver or legal guardian
- Identify signs of abuse/neglect (observe patient's surroundings)
- Ensure medications or accurate medication list is available for receiving facility
- Assessment of pediatric patient requires observation, auscultation and palpation

Abnormal findings:

- Appearance
 - Decreased response to parents or environmental stimuli
 - Rigid or poor muscle tone or not moving
- Breathing
 - Abnormal or no cry or speech
 - Increased/excessive nasal flaring
 - Retractions or abdominal muscle use
 - Decreased or no respiratory effort
 - Noisy breathing (wheezing, grunting, gasping, or gurgling)
 - Respiratory rate outside normal range
- Circulation
 - Abnormal skin color (cyanosis, mottling, or paleness)
 - Obvious significant bleeding
 - Capillary refill >2 seconds with other abnormal findings

Normal vital signs:

<u>Normal Respiratory Rate</u>		<u>Normal Pulse Rate</u>	<u>Lower Limit of Normal Systolic BP</u>		
Infant (<1yr):	30- 53	Infant:	100-180	Infant:	>72 (or strong pulses)
Toddler (1-3yr):	22 -37	Toddler:	98-140	Toddler:	>86 (or strong pulses)
Preschooler(4-5yr):	20-28	Preschooler:	80-120	Preschooler:	>89
School-age(6-12yr):	18 -25	School-age:	75-118	School-age:	>97
Adolescent(13-17yr):	12 -20	Adolescent:	60-100	Adolescent:	>110
		Pulses slower in sleeping child/athlete			



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Pediatric Assessment

Medical Director Review Date 08/2025

PEDIATRIC GLASCOW COMA SCORE				
RESPONSE	ADOLESCENT	CHILD	INFANT	VALUE
Eye Opening	Spontaneous	Spontaneous	Spontaneous	4
	To Speech	To speech	To speech	3
	To Pain	To pain	To pain	2
	None	None	None	1
Best Verbal Response	Oriented	Oriented, appropriate	Coos and babbles	5
	Confused	Confused	Irritable, cries	4
	Inappropriate words	Inappropriate words	Cries in response to pain	3
	Incomprehensible sounds	Incomprehensible words or nonspecific sounds	Moans in response to pain	2
	None	None	None	1
Best Motor Response	Obeys	Obeys commands	Moves spontaneously and purposely	6
	Localizes	Localizes painful stimulus	Withdraws in response to touch	5
	Withdraws	Withdraws in response to pain	Withdraws in response to pain	4
	Abnormal flexion	Flexion in response to pain	Abnormal flexion in response to pain	3
	Abnormal extension	Extension in response to pain	Abnormal extension in response to pain	2
	None	None	None	1
Total Score				3-15



Pediatric Bradycardia

Medical Director Review Date 08/2025

Symptomatic pediatric bradycardia: cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds). Pediatric bradycardia is frequently caused by a respiratory disorder (hypoxia).

TREATMENT

- Airway/breathing management
 - Monitor SpO₂ and administer 100% O₂ via NRB
 - Refer to Advanced Airway Guideline 9030 as indicated
- If signs of severe cardiopulmonary compromise are present
 - Ventilate with BVM
 - If patient 8 years old or less and has signs of poor perfusion (as described above) with a heart rate <60 despite 100% O₂ and ventilation for 2 minutes, initiate chest compressions according to Pediatric Asystole/Pulseless Electrical Activity Guideline 8080
- Look for signs of airway obstruction:
 - No breath sounds
 - Tachypnea
 - Intercostal and suprasternal retractions
 - Stridor
 - Choking
 - Cyanosis
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - A 4 lead ECG is acceptable for an infant
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - If indicated (e.g., hypotension), up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants



8010

Pediatric Bradycardia

Medical Director Review Date 08/2025

- If heart rate remains <60 with signs of poor perfusion despite previous interventions
 - **Epinephrine 1:10,000 0.01 mg/kg** every 3 to 5 min IV/IO; **maximum dose 1 mg**
 - Precaution
 - Do not mix with any other drug
 - Refractory to Epinephrine or increased vagal tone
 - **Atropine 0.02 mg/kg IV/IO; maximum single dose 1 mg**
 - **Minimum dose 0.1 mg**
 - **May repeat dose once in 5 minutes**
- Determine Blood Glucose Level
- Assess temperature
 - Hypothermia – Rewarm patient, ensure patient compartment is warm and administer warm IV fluids



Pediatric Tachycardia

Medical Director Review Date 08/2025

Symptomatic pediatric tachycardia: cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds).

Sinus Tachycardia = Infant <220 or Child (1-17 years) <180 with narrow QRS

Symptomatic Tachycardia = Infant ≥ 220 or Child (1-17 years) ≥ 180 with signs of poor perfusion

TREATMENT

- **If the patient is asymptomatic look for underlying causes** (fever, dehydration, pain etc.)
- Airway/breathing management
 - Monitor SpO₂ and administer 100% O₂ via NRB
 - Refer to Advanced Airway Guideline 9030 as indicated
- Initiate cardiac monitoring
 - Perform 12 lead ECG. The receiving hospital must receive a hard copy of the 12 lead ECG
 - A 4 lead ECG is acceptable for an infant
 - Evaluate width of QRS
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Determine Blood Glucose Level
- Assess temperature
- Consider specific treatment based on evaluation of patient and QRS
 - Apply fast patches
- **Stable**
 - Narrow QRS (≤ 0.08) and infant rate ≥ 220 /minute or child rate ≥ 180 /minute (Supraventricular Tachycardia)
 - **Adenosine 0.1 mg/kg IV (maximum 1st dose 6 mg)** rapid bolus, followed by intravenous fluids bolus, may repeat once at **0.2 mg/kg; maximum 2nd dose 12 mg**



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Pediatric Tachycardia

Medical Director Review Date 08/2025

- **Torsades de Pointes** (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - **Magnesium Sulfate 50 mg/kg IV/IO** in small intravenous fluid bag (100-250cc) over **10 mins**, smaller bag is preferred; **maximum single dose 2 grams**
 - **Deterioration to cardiac arrest is likely**
- **Unstable**
 - Narrow QRS (≤ 0.08) and infant rate ≥ 220 /minute or child rate ≥ 180 /minute (Supraventricular Tachycardia)
 - **If vascular access is available, administer Adenosine 0.1 mg/kg IV/IO (maximum dose 6 mg)** rapid bolus, followed by intravenous fluids bolus
 - **Synchronized cardioversion 0.5 - 1 J/kg; if not effective increase to 2 J/kg**
 - Wide QRS (> 0.08 in younger children, > 0.10 in adolescents) Ventricular tachycardia
 - **Synchronized cardioversion 0.5 - 1 J/kg; if not effective increase to 2 J/kg**
 - **Torsades de Pointes** (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - **Magnesium Sulfate 50 mg/kg IV/IO** slow push over 2 mins; **maximum single dose 2 grams**
 - **Deterioration to cardiac arrest is likely**
 - Attempt synchronized cardioversion at 1J/kg
 - May have to change to defibrillation if patient is in extremis, as the monitor may not synch due to varying QRS axis



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Pediatric Shock

Medical Director Review Date 08/2025

Shock patients may deteriorate rapidly. Signs of shock include hypotension, cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds) and tachycardia.

TREATMENT

- Place patient in supine position
- Maintain body warmth
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9030 as indicated
- Assess temperature
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- For patients with Acute Adrenal Insufficiency, as confirmed by patient/family/medical professional or noted by the presence of a medical alert bracelet or record
 - Assist with administration of patient's **Solu-Cortef** IM if present
 - **≤3 years: 25mg**
 - **4-12 years: 50mg**
 - **13 years and older: 100mg**
 - If Solu-Cortef not available, **Solu-Medrol 2 mg/kg slow IV/IO push; maximum dose 125 mg**



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Pediatric Shock

Medical Director Review Date 08/2025

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Pediatric Foreign Body

Airway Obstruction

Medical Director Review Date 08/2025

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TREATMENT

- Airway/breathing management
 - Foreign Body **AIRWAY OBSTRUCTION MANEUVERS** as indicated below:
 - **Infant (less than 1 year)**
 - **Conscious**
 - Mild Obstruction with good air exchange
 - Do not interfere with patient's own attempts to expel the obstruction
 - Monitor closely for signs of worsening
 - Attempt to keep patient calm
 - Severe Obstruction
 - If possible, bare the infant's chest
 - Support the infant in prone position, deliver up to 5 back blows in the middle of the upper back
 - Continuing to support the infant, rotate to a supine position with the head lower than the trunk
 - Deliver up to 5 quick downward chest thrusts in the same location as chest compressions
 - Repeat sequence until obstruction is cleared, or the infant becomes unconscious
 - **Unconscious**
 - Reposition airway and attempt to remove object by direct laryngoscopy with Magill forceps
 - Begin CPR as indicated
 - Suction as indicated
 - Refer to Advanced Airway Guideline 9030 as indicated
 - If unable to clear airway and adequately oxygenate/ventilate, perform age appropriate cricothyrotomy (Appendix K)
 - **Child (1-17 years)**
 - **Conscious**
 - Mild Obstruction with good air exchange
 - Encourage patient's own spontaneous coughing and breathing efforts
 - Attempt to keep patient calm
 - Severe Obstruction:
 - Abdominal thrusts (Heimlich maneuver)
 - **Unconscious**
 - Reposition airway and attempt to remove object by direct or video laryngoscopy with Magill forceps Begin CPR as indicated
 - Suction as indicated
 - Consider Mechanical Airway Clearance Device (Appendix U)
 - Refer to Advanced Airway Guideline 9030 as indicated



Pediatric Foreign Body Airway Obstruction

Medical Director Review Date 08/2025

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- If unable to clear airway and adequately oxygenate/ventilate, perform age appropriate cricothyrotomy (Appendix K)
- Airway/breathing management
 - Once obstruction is removed, administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9030 as indicated
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access only if obstruction cannot be relieved
 - If IO used for access, the humerus is contraindicated in newborns and infants



Pediatric Respiratory Distress

Medical Director Review Date 08/2025

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The following signs and symptoms will be treated as Respiratory Distress: increased respiratory rate, increased work of breathing, retractions, nasal flaring, SpO₂ <95%.

- Normal Respiratory Rates
 - Infant (<1yr): 30- 53
 - Toddler (1-3yr): 22 -37
 - Preschooler (4-5yr): 20-28
 - School-age (6-12yr): 18 -25
 - Adolescent (13-17yr): 12 -20

TREATMENT

- Airway/breathing management
 - Assess breath sounds
 - Administer O₂ via NRB
 - If unable to maintain an oxygen saturation of $\geq 92\%$ with NRB, provide 100% O₂ with BVM and positive pressure ventilations
 - Refer to Advanced Airway Guideline 9030 as indicated
- If wheezing present, refer to Pediatric Asthma Guideline 8060
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assess temperature
- Establish IV/IO access only if medication administration is required
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Determine Blood Glucose Level
- Mild croup (barking cough)
 - **Intravenous fluid** 5 mL nebulized
- Moderate to severe croup (Inspiratory or expiratory stridor at rest)
 - Mix 0.5 mg of **Epinephrine 1:1000** in 5 mL of intravenous fluid in nebulizer
 - Single dose only
 - Possible Side Effects
 - Tachycardia
 - Tremors
 - Vomiting



Pediatric
Respiratory Distress
Medical Director Review Date 08/2025

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Pediatric Asthma

Medical Director Review Date 08/2025

TREATMENT

- Airway/breathing management
 - Assess breath sounds
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Refer to Advanced Airway Guideline 9030 as indicated
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access only if medication administration is required
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Treatment should be based on lung sounds and level of distress
 - **Mild** distress - Wheezes only
 - **Albuterol 5 mg and Atrovent 0.5 mg.** May be repeated as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Albuterol dose 2.5mg for patient less than 10kg, may be repeated**
 - **Moderate** distress - Wheezes/decreased breath sounds/accessory muscle use
 - **Albuterol 5 mg and Atrovent 0.5 mg.** May be repeated as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Albuterol dose 2.5mg for patient less than 10kg, may be repeated**
 - **Magnesium Sulfate 50 mg/kg IV** in 100-250 mL of intravenous fluid, infused over 10 minutes. Smaller bag is preferred
 - **Maximum dose 2 grams**
 - If patient ≥ 25 kg, dilution into 500 mL acceptable if smaller bag is not available
 - **Solu-Medrol 2 mg/kg IV; maximum dose 125 mg**
 - **Severe** distress - Wheezes/stridor/decreased breath sounds with little or no air movement/accessory muscle use/tripoding
 - **Epinephrine 1:1000 0.01 mg/kg IM only, maximum dose 0.5 mg**
 - **Continuous Positive Airway Pressure (CPAP) (Appendix H) in conjunction with an in-line Albuterol/Atrovent nebulizer**
 - **Albuterol 5 mg and Atrovent 0.5 mg.** May be repeated as needed. Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Albuterol dose 2.5mg for patient less than 10kg, may be repeated**



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Pediatric Asthma

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- **Magnesium Sulfate 50 mg/kg IV/IO** in 100-250 mL of intravenous fluid, infused over 10 minutes. Smaller bag is preferred
 - **Maximum dose 2 grams**
 - If patient weighs ≥ 25 kg, dilution into 500 mL is acceptable if a smaller bag is not available
 - **Solu-Medrol 2 mg/kg IV/IO; maximum dose 125 mg**
- Assess temperature
- Determine Blood Glucose Level



Pediatric

V-Fib/Pulseless V-Tach

Medical Director Review Date 08/2025

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Children usually experience cardiopulmonary failure secondary to respiratory failure or shock and rarely due to primary cardiac disease or primary cardiac arrest. The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions and defibrillation as outlined in Appendix T.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
 - Start cycles of 15 compressions to 2 breaths for 2 person CPR (with 100% O₂ and BVM)
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Continue CPR and apply monitor/defibrillator pads as soon as possible
 - If an unwitnessed arrest or no bystander CPR, perform 2 minutes of CPR prior to defibrillation
 - If witnessed arrest by JFRD or bystander CPR in progress, analyze and defibrillate immediately, if indicated
 - If shockable, give **1 shock at 2 J/kg**
 - Continue to provide defibrillation every two minutes (**subsequent shocks should be 4 J/kg**) if shockable rhythm is noted upon reassessment
 - The time from the last compression to defibrillation should be minimized
 - After each defibrillation, **IMMEDIATELY** continue CPR, starting with compressions for 2 minutes then reassess
- If no shock advised, **IMMEDIATELY** continue CPR, starting with compressions, for 2 minutes then reassess
- Utilize Lucas CPR device (Appendix A) as early as possible
 - If the patient is too small, the Lucas device will alert with 3 fast signals when lowering the Suction Cup and will not enter the PAUSE mode or ACTIVE mode
- Airway/breathing management
 - **Pediatrics under the age of 3 will not be intubated with an ETT**
 - BVM with NPA and/or OPA will be utilized for patients in this age group
 - Refer to Advanced Airway Guideline 9030 as indicated
 - Once an advanced airway is placed, provide continuous chest compressions and provide 1 breath every 6 seconds
 - Continue this compression to ventilation ratio until placement of an advanced airway



Pediatric

V-Fib/Pulseless V-Tach

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- Use of basic airway adjuncts (OPA and/or NPAs) should be utilized when ventilating the patient without an advanced airway in place
- Establish IV/IO access
 - 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Determine Blood Glucose Level
- Administer **Epinephrine 0.01 mg/kg (1:10,000) IV/IO; maximum dose 1mg**
 - Continue CPR
 - If shockable rhythm, repeat shock sequence
 - If not a shockable rhythm, continue CPR and change to appropriate treatment guideline
 - Repeat Epinephrine every 3 to 5 minutes (consistently)
 - Precaution
 - Do not mix with any other drug
- After administration of Epinephrine, circulate for two minutes before giving anti-arrhythmic
- Administer antiarrhythmic, **Amiodarone 5 mg/kg IV/IO** for recurrent VF/VT; **maximum single dose 300 mg**
 - Continue CPR
 - If shockable rhythm, repeat shock sequence
 - If not shockable rhythm, continue CPR and change to appropriate treatment guideline
 - Repeat dose of **Amiodarone 5 mg/kg IV/IO once; maximum repeat dose 150 mg**
- **For Torsades de Pointes** (polymorphic VT with prolonged QTc greater than 475 milliseconds)
 - Instead of Amiodarone, administer **Magnesium Sulfate 50 mg/kg IV/IO** over 1-2 minutes; **maximum single dose 2 grams**
 - Continue CPR
 - If shockable rhythm, repeat shock sequence
 - If not shockable rhythm, continue CPR and change to appropriate treatment guideline
- Consider the following less common causes of cardiac arrest, H's and T's and their appropriate treatments:
 - Hypovolemia
 - Give bolus of **intravenous fluid 20 mL/kg**, repeat once if needed
 - Hypoxia – provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Acidosis caused by extended down time greater than **15 minutes**
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**



Pediatric

V-Fib/Pulseless V-Tach

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- Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
- Hyperthermia/Hypothermia – cool or warm as needed
- Hypoglycemia – Appropriate dextrose concentration for the pediatric patient
 - Neonate (<3 month) **D₁₀W** at **5 mL/kg** IV/IO for BGL less than 45 mg/dL
 - To make D₁₀W, discard 40ml out of one amp of D50 then draw 40ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution
 - Infant/child (3 month – 12 years) **D₂₅W** at **2 mL/kg** IV/IO for BGL less than 60 mg/dL
 - To make D₂₅W, discard 25ml out of one amp of D50 then draw 25ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution
 - Adolescent (13-18 years) **D₅₀W** at **1 mL/kg** IV/IO for BGL less than 60 mg/dL;
maximum dose 25 grams
- Toxins/Tablets
 - **Narcan 0.1 mg/kg** IV/IO; **maximum dose 4 mg**
- Tension pneumothorax
 - Needle decompression procedure (Appendix J)
- Any patient considered to be unstable, (e.g. hypotension, cardiac dysrhythmias, declining mental status or respiratory distress), shall remain on the cardiac monitor until transfer to the receiving medical team is completed



Pediatric
V-Fib/Pulseless V-Tach
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Pediatric Asystole/PEA or Symptomatic Bradycardia (≤ 8 y/o)

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Medical Director Review Date 08/2025

Children usually experience cardiopulmonary failure secondary to respiratory failure or shock and rarely due to primary cardiac disease or primary cardiac arrest. The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions as outlined in Appendix T.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
- If **NO** pulse present, OR patient is 8 years or less and has a heart rate less than 60 with signs of poor perfusion (e.g., cool mottled skin, altered mental status) despite oxygenation and ventilation, initiate CPR.
 - Start cycles of 15 compressions to 2 breaths for 2 person CPR (with 100% O₂ and BVM)
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Apply monitor/defibrillator pads as soon as possible
- Utilize Lucas CPR device (Appendix A) as early as possible
 - If the patient is too small, the Lucas device will alert with 3 fast signals when lowering the Suction Cup and will not enter the PAUSE mode or ACTIVE mode
- Airway/breathing management
 - **Pediatrics under the age of 3 will not be intubated with an ETT.**
 - BVM with NPA and/or OPA will be utilized for patients in this age group
 - Refer to Advanced Airway Guideline 9030 as indicated
 - Once an advanced airway is placed, provide continuous chest compressions and provide 1 breath every 6 seconds
 - Continue this compression to ventilation ratio until placement of an advanced airway
 - Use of basic airway adjuncts (OPA and/or NPAs) should be utilized when ventilating the patient without an advanced airway in place
- Establish IV/IO access
 - 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Administer **Epinephrine 0.01 mg/kg (1:10,000) IV/IO; maximum dose 1mg**
 - Continue CPR



Pediatric Asystole/PEA or Symptomatic Bradycardia (≤ 8 y/o)

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- Repeat Epinephrine every 3 to 5 minutes (consistently)
 - Precaution
 - Do not mix with any other drug
- Determine Blood Glucose Level
- Consider the following less common causes of cardiac arrest, H's and T's and their appropriate treatments:
 - Hypovolemia
 - Give bolus of **intravenous fluid 20 mL/kg**, repeat once if needed
 - Hypoxia – provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Acidosis caused by extended down time greater than **15 minutes**
 - **Sodium Bicarbonate 1 mEq/kg IV/IO**
 - Precaution
 - Do not mix with other drugs and flush line well after injecting
 - Inactivates Epinephrine when mixed
 - Hyperthermia/Hypothermia – cool or warm as needed
 - Hypoglycemia – Appropriate dextrose concentration for the pediatric patient
 - Neonate (<3 month) **D₁₀W** at **5 mL/kg IV/IO** for BGL less than 45 mg/dL
 - To make D₁₀W, discard 40ml out of one amp of D50 then draw 40ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution
 - Infant/child (3 month – 12 years) **D₂₅W** at **2 mL/kg IV/IO** for BGL less than 60 mg/dL
 - To make D₂₅W, discard 25ml out of one amp of D50 then draw 25ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution
 - Adolescent (13-18 years) **D₅₀W** at **1 mL/kg IV/IO** for BGL less than 60 mg/dL
 - Maximum dose **25 grams**
 - Precaution
 - Dextrose causes tissue necrosis and adequate vascular access must be ensured prior to administration
 - Toxins/Tablets
 - **Narcan 0.1 mg/kg IV/IO; maximum dose 4 mg**
 - Tension pneumothorax
 - Needle decompression procedure (Appendix J)



Pediatric Allergic Reaction/Anaphylaxis

Medical Director Review Date 08/2025

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TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Anticipate rapid deterioration and the need to intubate
 - Refer to Advanced Airway Guideline 9030 as indicated
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Assist with administration of patient's Auto-Injector Epinephrine if present
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Determine Blood Glucose Level
- Assess temperature
- Treatment based on assessment and patient's level of distress:
 - **Mild/moderate reaction without respiratory compromise**
 - **Benadryl 1 mg/kg IV/IM; maximum dose 25 mg**
 - **Solu-Medrol 2 mg/kg IV; maximum dose 125 mg**
 - **Moderate reaction with respiratory compromise**
 - **Benadryl 1 mg/kg IV/IM; maximum dose 25 mg**
 - **Albuterol 5 mg and Atrovent 0.5 mg nebulized.** May be repeated as needed
Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Albuterol dose 2.5mg for patient less than 10kg, may be repeated**
 - **Solu-Medrol 2 mg/kg IV; maximum dose 125 mg**
 - **Severe reaction/ Anaphylaxis** (severe respiratory distress and/or cardiovascular compromise)
 - **Epinephrine 1:1,000 0.01 mg/kg IM only; maximum single dose 0.5 mg**
 - May repeat once after 10 minutes if needed, at different site
 - **Albuterol 5 mg and Atrovent 0.5 mg nebulized.** May be repeated as needed
Subsequent nebulizer treatments will contain only **Albuterol 5 mg**
 - **Albuterol dose 2.5mg for patient less than 10kg, may be repeated**
 - **Benadryl 1 mg/kg IV/IO/IM; maximum dose 25 mg**
 - **Solu-Medrol 2 mg/kg IV/IO; maximum dose 125 mg**



Pediatric Allergic Reaction/Anaphylaxis

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Pediatric Altered Consciousness

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TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Determine blood glucose level. If BGL is abnormal, refer to Pediatric Diabetic Guideline 8110
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - If GCS ≤ 8 or inability to protect airway, refer to Advanced Airway Guideline 9030
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Assess temperature
- Treatment based on underlying cause:
 - Narcotic use/exposure
 - Refer to Pediatric Overdose/Poisoning Guideline 8120
 - Unknown etiology
 - Consider other treatable neurological or metabolic disorders and, if identified, follow the appropriate guideline



Pediatric Altered Consciousness

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Pediatric Diabetic

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TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If the patient experiences a seizure due to hypoglycemia and IV access is unobtainable, establish IO
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Assess temperature
- Look for underlying causes
- **Treatments based on blood glucose level and level of consciousness:**
 - Hypoglycemia **WITH** vascular access
 - Less than 3 months: **D₁₀W at 5 mL/kg** slow IV push over 2 minutes for BGL less than 45 mg/dL
 - To make D₁₀W, discard 40ml out of one amp of D50 then draw 40ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution.
 - 3 month-12 years: **D₂₅W at 2 mL/kg** slow IV push over 2 minutes for BGL less than 60 mg/dL
 - To make D₂₅W, discard 25mL out of one amp of D50 then draw 25ml of intravenous fluid into the D50 amp. Agitate syringe to mix solution.
 - 13-17 years: **D₅₀W at 1 mL/kg** IV for BGL less than 60 mg/dL; **maximum dose 25 grams**
 - If no improvement and BGL is below **60** mg/dL
 - Repeat appropriate **Dextrose** concentration and dose for the pediatric patient



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Pediatric Diabetic

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- Hypoglycemia (BGL <60 mg/dL or altered mental status) **WITHOUT** vascular access
 - Altered level of consciousness or difficulty swallowing
 - Less than **20 kg: Glucagon 0.5 mg IM**
 - **20 kg or greater: Glucagon 1 mg IM**
 - Repeat BGL after 15 minutes
 - Considerations
 - Onset in 1 minute with a peak onset time of 30 minutes
 - The hypoglycemic patient will usually awaken within 15 minutes
 - Unconscious
 - Hypoglycemia (BGL <60 mg/dL) **without** vascular access and **unresponsive**
 - Establish IO and administer dextrose as listed above
 - Conscious and alert patient (GCS ≥ 14) with BGL <60 mg/dL, administer oral **Glucose paste 15 grams** (1 tube)
 - May repeat once in 10 minutes if BGL still <60 mg/dL
 - Contraindications
 - Patient less than 2 years old
 - Altered level of consciousness
 - Difficulty swallowing
- Hyperglycemia
 - BGL >300 mg/dL, administer **intravenous fluids 20 mL/kg**
 - If no IV access and GCS ≤ 8 , establish IO



Pediatric Overdose/Poisoning

Medical Director Review Date 08/2025

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TREATMENT

- If substance is known, contact Poison Control at **1-800-222-1222**. Provide all information requested by poison control representative
- Do not delay treatment or transport, but if possible, bring medication or substance ingested
- Wear appropriate personal protective equipment
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Determine Blood Glucose Level
- Active seizures
 - Treat status epilepticus aggressively. Administer **Midazolam 0.1 mg/kg IV/IO/IM**: **maximum single dose 5 mg**, consider small doses of Midazolam, preferable to give smaller more frequent doses. If active seizing persists or returns, after 5 minutes, may repeat dose up to total **maximum of 10 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
 - Potential side effect is hypotension, treat with intravenous fluids as necessary
- Consider specific treatment situations:
 - Narcotic use/exposure
 - **Narcan 0.1 mg/kg IV/IO/IM; maximum single dose 0.4 mg**
 - If no change in 5 minutes, may repeat **Narcan 0.1 mg/kg IV/IO/IM**
 - Maximum total dose 4 mg
 - Use in respiratory depression, unable to protect airway
 - The goal is to increase respirations, not LOC



Pediatric Overdose/Poisoning

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- Organophosphate exposure
 - For all suspected organophosphate exposures, notify HAZMAT Team
 - Signs and symptoms include Diarrhea, Urination, Miosis, Bradycardia, Bronchorrhea, Bronchospasm, Emesis, Lacrimation and Salivation
 - **Atropine 0.02 mg/kg is indicated in the unstable patient**
 - Minimum initial dose **0.1 mg IV/IO, maximum initial dose 2 mg**
 - Repeat every 3 to 5 min as needed until secretions dry
 - No maximum total dose
- Acute Dystonic Reaction to anti-psychotics (Haldol)
 - Signs and symptoms include painful muscle spasms of the face, neck and back
 - **Benadryl 1 mg/kg IV/IO/IM; maximum dose 25 mg**



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Pediatric Seizures

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TREATMENT

- Maintain aspiration precaution by placing the patient in the recovery position
- If trauma suspected, immobilize patient using proper technique
- If the patient is actively seizing, protect the patient from further injury
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Initiate cardiac monitoring
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- Establish IV/IO access
 - Up to 20 mL/kg intravenous fluids; maximum 2L
 - If IO used for access, the humerus is contraindicated in newborns and infants
- Look for underlying causes
 - Determine blood glucose level. If BGL is abnormal, refer to Pediatric Diabetic Guideline 8110
 - Assess temperature
 - Apply cooling measures (ice packs or wet towels to neck, axillae, groin, etc.) when the patient has a temperature ≥ 102 degrees
- Active seizures
 - Treat status epilepticus aggressively. Administer **Midazolam 0.1 mg/kg IV/IO/IM: maximum single dose 5 mg**, consider small doses of Midazolam, preferable to give smaller more frequent doses. If active seizing persists or returns, after 5 minutes, may repeat dose up to total **maximum of 10 mg**
 - Capnography is required after sedative/analgesic administration (Appendix F)
 - Airway assistance may be necessary after Midazolam administration
 - Potential side effect is hypotension, treat with intravenous fluids as necessary



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Pediatric Seizures

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Pediatric Fever

Medical Director Review Date 08/2025

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Assess temperature
 - Apply cooling measures (ice packs or wet towels to neck, axillae, groin, etc.) when the patient has a temperature ≥ 102 degrees
- Establish IV access only if medication administration is required
 - Up to 20 mL/kg intravenous fluids; maximum 2L
- Determine Blood Glucose Level
- Initiate cardiac monitoring
 - Expect increased heart rates in patients with a fever
 - Any patient considered to be unstable (e.g., hypotension, cardiac dysrhythmias, declining mental status or respiratory distress) shall remain on the cardiac monitor until transfer to the receiving medical team is completed
- If the pediatric patient has a temperature ≥ 102 degrees and the parent has Ibuprofen or Acetaminophen:
 - Administer **Ibuprofen 10 mg/kg** (not for children under 6 months) PO or **Acetaminophen 15 mg/kg** PO



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Pediatric Fever

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Advanced Airway

Chapter 9

Advanced Airway



Advanced Airway

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Advanced Airway – Adult

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Intubation of the patient should only occur if the patient is in severe respiratory failure that is refractory to medical intervention, unable to maintain pulse oximetry >88%, respirations less than 10/min or greater than 40/min, or a decreased LOC (GCS ≤8).

- If airway obstruction present and unable to oxygenate/ventilate, consider cricothyrotomy (Appendix K)
- Assess for tension pneumothorax (unilateral absent or decreased breath sounds with severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, JVD, and hypoxia)
 - In the non-trauma setting, only spontaneous pneumothorax is normally present. However, positive pressure ventilation can lead to tension pneumothorax
 - Needle decompression procedure (Appendix J)

PRIOR TO INTUBATION:

- Pre-oxygenate for 3 minutes
 - NRBM for spontaneous breathing
 - BVM with OPA/NPA for apnea/agonal respirations
 - All patients should simultaneously receive passive oxygenation via NC 8 LPM
- Prepare necessary equipment and ensure in working order (e.g., suction, laryngoscope light, failed airway adjunct(s), ETT holder, etc.)
- Suction as necessary
- If sedation required:
 - Administer **Etomidate 0.3 mg/kg IV/IO; maximum dose 40mg**
 - Peak effect: 1 minute, do not try to intubate for one minute
 - Duration: 3-5 minutes
 - Contraindications
 - Known sensitivity
 - **Cardiac/Trauma arrest**
 - If Etomidate is not successful at completing sedation (e.g., trismus, combative) and post Etomidate systolic BP is greater than 100 mm/Hg, administer **Midazolam 2-5 mg IV/IO**
 - In the setting of burns, asthma, anaphylaxis, and shock, consider **Ketamine 2mg/kg IV/IO; maximum 200mg** instead of Etomidate
 - Avoid Ketamine in patients with systolic BP >180 mmHg
- Consider use of the bougie (Appendix I) when the vocal cords are visualized but the ETT can't be passed through the cords
- **Each intubation attempt should be limited to a maximum of 10 seconds to minimize the interruption of chest compressions if CPR is being performed**



Advanced Airway – Adult

Medical Director Review Date 08/2025

UNABLE TO INTUBATE:

- After two unsuccessful intubation attempts, insert supraglottic airway (Appendix D).
 - If supraglottic airway unsuccessful, use a BVM with airway adjunct(s)
 - If unable to oxygenate/ventilate, proceed to cricothyrotomy (Appendix K)

AFTER INTUBATION or INSERTION OF SUPRAGLOTTIC AIRWAY:

- **All patients with an advanced airway must have continuous capnography**
- Confirm tube placement and constantly monitor adequacy of ventilations:
 - Assess and document ETCO₂ and SpO₂ values (Appendix F)
 - Normal readings are 35-45 mmHg
 - Higher values suggest hypoventilation and require an increased respiration rate
 - Lower values may be seen with hyperventilation or metabolic acidotic states like sepsis or poor perfusion
 - Typical cardiac arrest values with good CPR are 10-20 mmHg
 - If there is a sudden rise in end tidal, check for a pulse
 - Absence of gastric sounds with auscultation
 - Auscultating for the presence of bilateral breath sounds
 - Look for equal chest rise
- **If unable to capture ETCO₂ value or if vomit is forcefully coming from the ETT, esophageal placement is likely, remove ETT and place a King Tube or utilize a BVM**
- Secure tube with commercial tube holder (may use other means if necessary)
- Consider **Midazolam 2 - 5 mg** IV/IO to maintain sedation in the intubated patient, may repeat once in 10 minutes
 - Avoid use in hypotensive patients and beware that administration may cause a drop in the patient's blood pressure
 - Greater than 64 years old, administer in 2 mg increments
- Consider **Ketamine 0.5mg/kg max 100mg** for SBP <100, may repeat once in 5 minutes
- If wheezing present, consider in-line nebulizer (Appendix G or H)
- **DO NOT HYPERVENTILATE** patients with suspected Ischemic or Traumatic Brain Injury
 - Maintain end tidal value at least 35 mmHg

TUBE CONFIRMATION AT HOSPITAL:

- Prior to patient transfer, obtain snapshot of cardiac monitor to be attached to PCR (Appendix V)
- Cardiac monitor must be brought into the hospital for tube placement verification via ETCO₂ by staff (Physician, Respiratory Therapist, or RN preferred)
- Confirmation of tube placement must be documented in the PCR



Advanced Airway – Pediatric

Medical Director Review Date 08/2025

Intubation of the patient(>3y/o) should only occur if the patient is in severe respiratory failure that is refractory to medical intervention, has a decreased LOC (GCS ≤ 8), or if unable to maintain pulse oximetry >88%.

- If airway obstruction present and unable to oxygenate/ventilate, consider cricothyrotomy (Appendix K)
- Assess for tension pneumothorax (unilateral absent or decreased breath sounds with severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, and hypoxia
 - In the non-trauma setting, only spontaneous pneumothorax is normally present. However, positive pressure ventilation can lead to tension pneumothorax
 - Needle decompression procedure (Appendix J)

PRIOR TO INTUBATION:

- Pre-oxygenate for 3 minutes
 - NRB for spontaneous breathing
 - BVM with OPA/NPA for apnea/agonal respirations
 - Premature Neonate and Neonate: 40 to 60 per minute
 - Infants and Children: 12 to 20 per minute
 - All patients should simultaneously receive passive oxygenation via NC 8 LPM
- Prepare necessary equipment and ensure in working order (e.g., suction, laryngoscope light, failed airway adjunct(s), ETT holder, etc.)
- Suction as necessary
- If sedation required:
 - Administer **Etomidate 0.3 mg/kg IV/IO; maximum dose 40mg**
 - Peak effect: 1 minute, do not try to intubate for one minute
 - Duration: 3-5 minutes
 - Contraindications
 - Known sensitivity
 - Cardiac/Trauma arrest
 - If Etomidate is not successful at completing sedation (e.g., trismus, combative) and post Etomidate systolic BP is greater than 100 mm/Hg, administer **Midazolam 0.1mg/kg IV/IO maximum dose 5mg**
 - In the setting of burns, asthma, anaphylaxis, and shock, consider **Ketamine 2mg/kg IV/IO; maximum 200mg** instead of Etomidate
 - Avoid Ketamine in patients with systolic BP >180 mmHg
- Consider use of the bougie (Appendix I) when the laryngeal inlet cannot be completely visualized in patients 10 years and older
- **No endotracheal intubation attempts for patients less than 3 years old**
 - Neonate to 3 years: BVM with adjuncts only



Advanced Airway – Pediatric

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- Supraglottic airway (King Tube) may be first option for patients >8 years old or >4 feet tall
- Each intubation attempt should be **limited to a maximum of 10 seconds**
- **Only CUFFED endotracheal tubes are to be used for pediatric intubations.** Tube size will be based on a length-based measuring tape

UNABLE TO INTUBATE:

- After two unsuccessful intubation attempts, insert supraglottic airway (Appendix D)
 - If supraglottic airway unsuccessful, use a BVM with airway adjunct(s)
 - If unable to oxygenate/ventilate, proceed to cricothyrotomy (Appendix K)

AFTER INTUBATION or INSERTION OF SUPRAGLOTTIC AIRWAY:

- Confirm tube placement and constantly monitor adequacy of ventilations:
 - Assess and document both capnography waveform and ETCO₂ value (Appendix F)
 - Normal readings are 35-45 mmHg in a healthy patient
 - Higher values suggest hypoventilation and require an increased respiration rate
 - Lower values may be seen with hyperventilation or metabolic acidotic states like sepsis or poor perfusion
 - Typical cardiac arrest values with good CPR are 10-20 mmHg
 - If there is a sudden rise in end tidal, check for a pulse
 - Absence of gastric sounds with auscultation
 - Auscultating for the presence of bilateral breath sounds
 - Look for equal chest rise
- Consider **Midazolam 0.1 mg/kg IV/IO; maximum dose 5 mg** to maintain sedation
 - Avoid use in hypotensive patients and beware administration may cause a drop in the patient's blood pressure
- Consider **Ketamine 0.5mg/kg max 100mg** for SBP <100, may repeat once in 5 minutes
- If wheezing present, consider in-line nebulizer (Appendix G or H)
- DO NOT HYPERVENTILATE patients with suspected Ischemic or Traumatic Brain Injury
 - Maintain end tidal value at least 35 mmHg
- **If unable to capture ETCO₂ value or if vomit is forcefully coming from the ETT, esophageal placement is likely, remove ETT and utilize a BVM**
- Secure tube with commercial tube holder (may use other means if necessary)

TUBE CONFIRMATION AT HOSPITAL:

- Prior to patient transfer, obtain snapshot of cardiac monitor to be attached to PCR (Appendix V)
- Cardiac monitor must be brought into the hospital for tube placement verification via ETCO₂ by staff (Physician, Respiratory Therapist, or RN preferred)
- Confirmation of tube placement must be documented in the PCR



Drug Information

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Drug Information

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Drug Information

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Adenosine

Slows conduction through AV node and interrupts AV reentry pathways, which restore normal sinus symptoms. Adult dose 6mg then 12mg, peds 0.1 mg/kg (max 6mg and 12mg). Given as a rapid injection (1-3 sec) by peripheral IV route directly into IV line close (proximal) to patient and is followed by rapid NS flush after each injection (20 mL for adults, 5 mL or more for pediatrics).

Albuterol

Beta agonist. Produces bronchodilation through bronchial smooth muscle relaxation.

Amiodarone

Anti-arrhythmic inhibiting adrenergic stimulation by affecting sodium, potassium and calcium channels. Prolongs the action potential and repolarization and decreases AV conduction. Use in ACLS for ventricular Fibrillation and pulseless ventricular tachycardia 300mg and 150mg boluses. For stable ventricular tachycardia, 150mg infusion over 10 minutes. Pediatric dosing is 5mg/kg.

Aspirin

Antiplatelet therapy for cardiac ischemia. Standard dose is 324mg except in Pregnancy (with STEMI), history of GI bleeding or use of anticoagulants, then dose is 81mg.

Atropine

Antimuscarinic agent; inhibits action of acetylcholine at parasympathetic sites in smooth muscle, CNS, and secretory glands. Increases cardiac output and heart rate also dries secretions. 1 mg every 3 to 5 minutes, max dose is 3mg. Use caution with STEMI and unlikely to work third degree block and wide complex atrio-ventricular blocks.

Atrovent

Anticholinergic (parasympatholytic) agent; inhibits vagally mediated reflexes by antagonizing acetylcholine action; relaxing bronchial smooth muscles and drying secretions

Benadryl

Acts by competitively inhibiting histamine at the H1 receptor. This effect mediates bronchial constriction, mucus secretion, smooth muscle contraction, and edema. Sedation may be a side effect.

Calcium Chloride

Electrolyte to stabilize the cardiac membrane in hyperkalemia or to treat calcium channel overdose. 1000mg IV/IO infusion rate based on indication. Do not mix with Sodium Bicarb.



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Cyanokit

Intravenous infusion is indicated for the treatment of known or suspected cyanide poisoning. A cyanide antidote that contains hydroxocobalamin, a form of vitamin B₁₂. Hydroxocobalamin binds to cyanide, creating nontoxic cyanocobalamin, allowing the body to use oxygen again. The starting dose of CYANOKIT for adults is 5 g (contained in a single vial), administered by IV infusion over 15 minutes (approximately 15 mL/min). To reconstitute, place the vial in an upright position. Add 200 mL of 0.9% Sodium Chloride injection to the vial using the transfer spike. Fill to the line. Then mix, the vial should be repeatedly inverted or rocked, not shaken, for at least 60 seconds prior to infusion. Infuse vial using vented intravenous tubing. Hang and infuse over 15 minutes. Not for use in pediatric patients.

Dextrose

Essential source of energy for cell metabolism and function. Hypertonic solution that can cause skin necrosis if there is extravasation. Standard adult dose is 25g except with Stroke (12.5g). Pediatric concentration is age based and dosing is weight based.

Dopamine

Sympathomimetic vasopressor. Raises heart rate with increase in blood pressure. More Beta₁ with some alpha receptor function. Begin infusion of diluted solution at doses of 5 mcg/kg/minute and increase gradually to 15 mcg/kg/minute. Contraindications: Hypovolemic shock, A-Fib/A-Flutter with RVR, V-Tach. Use in bradycardia not responsive to atropine and if pacing is not required. Also, for hypotension not improving with fluid resuscitation or if fluids not tolerated as in CHF.

Epinephrine

Alpha- and beta-adrenergic vasopressor resulting in increased heart rate and contractility, with increased cardiac output. Vasoconstriction will raise the blood pressure. Beta₂ stimulation results in bronchodilation through bronchial smooth muscle relaxation. IM (1:1000) for severe asthma and allergic reactions. IV for ACLS cardiac arrest care.

Etomidate

Primary sedative for elective intubation. Etomidate acts on the CNS to stimulate gamma-aminobutyric acid (GABA) receptors and depresses the reticular activating system. 0.3mg/kg IV/IO, max 40mg. The drug reaches peak brain concentrations within 1 minute of IV administration and induces unconsciousness within 30 seconds. Its effects last less than 10 minutes after a single bolus dose. Myoclonic activity has been reported in approximately one third of cases and is believed to be caused by disinhibition of subcortical activity rather than CNS stimulation and does not represent seizure. Must be administered with appropriate monitoring in place and airway management is required.



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Fentanyl

Opioid Analgesic for pain control. 1.0 mcg/kg IV/IO slow push, Max dose single dose 100mcg. Max total dose 200mcg, 400mcg for burns and electrical trauma. May be repeated in 5-10 minutes. Requires monitoring of airway and breathing. Hold for BP below 90mmHg. Potential to cause respiratory depression and decreased level of consciousness. Rapid administration may cause chest wall rigidity. Reversed by narcan.

Glucagon

Corrects hypoglycemia when oral glucose and IV dextrose are not available. Causes hepatic glycogenolysis resulting in an increase in blood glucose levels. Onset 8-10min. Time for peak glucose concentration 30min. Standard dosing is 1mg IM, except patients less than 20 kg, then 0.5mg.

Ketamine

Sedative for combative patients and those requiring pacing. Also, for elective intubation in patients presenting with hypotension, severe asthma, anaphylaxis or with burns. Ketamine is a nonbarbiturate dissociative anesthetic. It selectively interrupts association pathways of the brain by producing a somesthetic sensory blockade. The onset of action, when given IV, is within seconds. When administered IM, the onset of action is approximately 4 minutes, with a duration of action from 15 to 30 minutes. Ketamine generally maintains normal pharyngeal and laryngeal reflexes and, therefore, permits spontaneous respiration. It enhances or maintains normal skeletal muscle tone and is associated with cardiovascular and respiratory stimulation. There may be transient respiratory depression if the medication is administered too rapidly or in too high a dose. The airway and breathing must be monitored closely and BVM or emergency intubation may be necessary. Dosage is weight based and dependent on the indication for use

Magnesium

Electrolyte that has anticonvulsant effects, stabilization of excitable membranes and smooth muscle relaxation. Used for bronchodilation, Torsades and pre-eclampsia/eclampsia. Dosing based on indication. May cause hypotension if administered quickly, and larger doses can cause decreased mental status and respiratory depression.

Midazolam

Sedative and anti-seizure. Binds receptors at several sites within the CNS, including the limbic system and reticular formation. Its effects may be mediated through GABA receptor system and increase in neuronal membrane permeability to chloride ions enhances the inhibitory effects of GABA. The shift in chloride ions causes hyperpolarization (less excitability) and stabilization of the neuronal membrane. Onset 1-3 min (IV) and 5-15 min (IM). Duration 30-80 min. Patient will require close monitoring for respiratory depression and hypotension. Use lower doses in elderly.



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Narcan

Opioid antagonist. Reverses the effects of opioids like heroin and fentanyl. Should improve mental status, level of consciousness and respiratory drive. May precipitate opioid withdrawal, agitation, nausea, cramping and sweating.

Nitroglycerin

Vasodilator for ischemic chest pain and congestive heart failure. Do not use with SBP less than 100 mmHg. Use caution with an inferior MI as the right heart is preload dependent. If patient has taken an erectile drug recently, consider withholding the nitroglycerin. SL will have an onset with minutes, paste at least 10 minutes. Make sure paste is wiped off if defibrillation must occur.

Sodium Bicarbonate

Neutralizes acidic state. Treatment of prolonged cardiac arrest, hyperkalemia, and TCA overdoses. Reacts with H⁺ ions to form water and carbon dioxide, acting as a buffer by raising blood pH. Do not mix with other drugs and flush line well after injecting. Inactivates Epinephrine when mixed

Solumedrol

Potent glucocorticoid steroid that controls or limits inflammation. Modulates the body's inflammatory response. Particularly useful with reactive airways disease and allergic reactions. Onset is in hours.

Thiamine

Essential B vitamin. Forms an essential coenzyme in carbohydrate metabolism. May be deficient in patients from alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders. Should be given to malnourished patients, especially alcoholics, if also receiving glucose. Do not delay giving dextrose to a symptomatic hypoglycemic patient, as thiamine can be given after.

Zofran

Anti-nausea medication. Is in a class of medications called serotonin 5-HT₃ receptor antagonists. It works by blocking the action of serotonin, a natural substance that may cause nausea and vomiting.



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Purpose

This portion of the EMS SOG is intended to provide supplemental treatments options to those members assigned to the Critical Care Team. The various treatment modalities listed below are meant to augment, not replace, the main body of SOG 430.

Scope

The members assigned to the Critical Care Team possess higher-level training than that of standard paramedics, and as a result will be equipped with more advanced level medications and equipment. The standards of care as it relates to JFRD's critical care program will expand over time, and as a result will likely require frequent expansions and revisions of this portion of SOG 430.

MEDICATIONS

Given the potency of these medications both critical care paramedics must be present in the patient compartment when administered. Both critical care paramedics must agree and verify drug selection and correct dose and this must be documented in the narrative section of the PCR.

Diltiazem

Indications: Atrial Fibrillation or Flutter with Rapid Ventricular Response (sustained HR greater than 120 bpm) or SVT unresponsive to adenosine

Dose: 0.25mg/kg, max dose 20mg, slow IVP over 2 minutes

Contraindications: WPW, SBP <100mmHg, pediatric patients

Additional info: This is a calcium channel blocker that inhibits extracellular calcium ion influx across membranes of myocardial cells and vascular smooth muscle cells, resulting in inhibition of cardiac and vascular smooth muscle contraction and thereby dilating main coronary and systemic arteries. Also has substantial inhibitory effects on cardiac conduction system, acting principally at AV node, with some effects at sinus node. Blocking the AV node in some patients may lead to impulses that are transmitted exclusively down the accessory pathway, and this can result in ventricular fibrillation. If this happens, the patient will require immediate defibrillation. Fast patches will be on when administering diltiazem. May also cause bradycardia and or hypotension. Requires refrigeration.

Ketamine

Indications: Additional critical care use of ketamine to include anxiety, pain management, and to provide sedation post intubation.

Dose: Anxiety while on BiPAP and pain management for the hypotensive patient, may administer **Ketamine 0.3mg/kg IV/IO, max dose 30mg**. Must monitor level of consciousness and manage appropriately (Appendix F). Post intubation sedation, use if patient is hypotensive



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or indication was burns or bronchospasms related, may administer **Ketamine 1mg/kg IV/IO, max dose 100mg**. If the patient's Shock Index-(HR/SBP) >1 or if the patient is on Norepinephrine 8mcg/min, then **Ketamine dose should be 0.5mg/kg, max dose 50mg**. Dose may be repeated once after 10 minutes.

Norepinephrine

Indications: MAP <65 mmHg or SBP <90 mmHg

Dose: Start with 2mcg/min and titrate up 2mcg/min every 2 minutes to a maximum of 10 mcg/min. Mix 4mg norepinephrine in 250 ml NS; final concentration yields 16 mcg/ml and must be administered via IV pump.

Contraindication: Pediatric patients

Additional info: This is a potent vasopressor that has strong alpha and beta1 adrenergic effects. Fluid resuscitation should be already initiated. Infusion must be via the IV pump. Slow and discontinue infusion if patient complains of pain at the IV site. It's best to use a good large bore IV **20 ga or larger** and watch for extravasation. Tissue necrosis could occur with extravasation and hospital needs to be notified if that occurs. Select IV site high on the extremity (i.e., forearm or antecubital fossa). **DO NOT INFUSE NOREPINEPHRINE THROUGH THE HAND.** May use humoral head site via IO

Nitroglycerin Drip

Indications: STEMI, Acute Heart Failure, CHF

Dose: 10 mcg/min titrated up 10 mcg/min every 5 minutes as needed for continued chest pain when blood pressure remains >100 mmHg. Maximum dose 60 mcg/min for STEMI, 80 mcg/min for CHF. Must be administered via IV pump. Must use vented IV tubing.

Contraindications: Same as SL NTG.

Succinylcholine (Succs)

Indication: Paralytic for rapid sequence intubation

Dose: 1.5mg/kg IV/IO

Contraindications: Avoid in patients with known hyperkalemia and renal failure patients. Succinylcholine should be avoided in patients with significant burns or traumatic injuries that are 24 to 72 hours post-injury due to the high probability of acute hyperkalemia that may occur. Avoid use in patients with known muscular dystrophy, spinal paralysis, nerve pathologies, (i.e., multiple sclerosis & ALS- (Amyotrophic lateral sclerosis, Lou Gehrig's disease).

Additional info: This is the primary paralytic to be used, unless contraindicated. An induction agent must be used prior to the administration of Succs. This is a short-acting depolarizing neuromuscular blockade. Adheres to post-synaptic cholinergic receptors of the motor endplate, inducing continuous disruption that results in transient fasciculations or involuntary muscle contractions and subsequent skeletal muscle paralysis. A rare complication is malignant hyperthermia presenting with rapid increase in heart rate and body temperature with tachypnea and muscle rigidity. Hospital must be notified if this occurs. Following intravenous administration



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of doses in recommended range, neuromuscular blockade develops in about 1 minute; maximum blockade in about 2 minutes, after which recovery takes place within 6 to 10 minutes. Airway must be managed after succinylcholine is administered. Requires refrigeration.

Rocuronium (Roc)

Indication: Paralytic for rapid sequence intubation

Dose: 1 mg/kg IV/IO

Additional info: Onset 1-2 minutes with a duration of 30-45 minutes. To be used in RSI when Succinylcholine is contraindicated. An induction agent must be used prior to the administration of Roc. This is a non-depolarizing neuromuscular blocker used to produce muscle relaxation. Airway must be managed after rocuronium is administered. Follow up sedation will be necessary. Requires refrigeration.

Tranexamic acid (TXA)

Indications: Adult Trauma Alert patients with non-compressible hemorrhage (head, chest, abdomen, or pelvis) and a HR greater than 110 bpm and/or systolic blood pressure less than 90mmHg that is not responding to initial crystalloid resuscitation (same indication if considering blood administration). Consider TXA for moderate/severe TBI (traumatic brain injury), defined as GCS 12 or less. Also consider for severe post-partum hemorrhage.

TXA should be administered anytime blood product is used and through a separate IV.

Dose: 2g IV/IO over 10 minutes in 100ml bag

Contraindications: Pediatric patients, GI (gastrointestinal) bleeds, and uncertainty regarding 3-hour window of bleeding onset.

Additional info: Must be administered within 3 hours of injury. This is an antifibrinolytic agent to be used in the setting of potential traumatic exsanguination. TXA is a synthetic reversible competitive inhibitor to the lysine receptor found on plasminogen. The binding of this receptor prevents plasmin (activated form of plasminogen) from binding to and ultimately destabilizing the fibrin matrix. Normally, the binding of plasmin to fibrin facilitates the breakdown of fibrin (i.e., clot dissolution). By preventing the attachment of plasmin to fibrin, TXA ultimately prevents fibrinolysis and reduces traumatic hemorrhage. Rapid infusion can cause hypotension and/or seizure activity.



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BLOOD PRODUCT ADMINISTRATION AND PROCEDURES

Blood product administration is indicated for suspicion of noncompressible hemorrhage (head, chest, abdomen, and pelvis) with a HR >110 bpm and/or a systolic BP <90 mmHg that has not responded to IV fluid resuscitation. Secondary inclusion criteria: diaphoresis, altered mental status and suspicion of ongoing hemorrhage and impending hemorrhagic shock.

Blood products will only be used on **Adult Trauma Alert patients (includes patients 16 years of age and older), significant GI (gastrointestinal) bleeds), dialysis access hemorrhages and severe post-partum hemorrhage.**

Exclusion criteria: Patients refusing blood or blood products and trauma/cardiac arrest on arrival.

Procedure:

1. Identify patients with signs/symptoms of acute hemorrhage
2. Establish two IV sites, preferably 20 ga or larger
3. Administer 500ml fluid bolus. May use pressure infuser for rapid administration, do not exceed 300mmhg. Use fluid/blood warmer device
4. Document patient name
5. Begin transfusion of Plasma first. Confirm product is within temperature range prior to administration. May use pressure infuser for rapid administration, do not exceed 300mmhg. Use fluid/blood warmer device
6. Document blood product type and infusion start time
7. Note completion time
8. Reassess vitals and temperature every 5 minutes
9. Infuse PRBCs (type O+). Confirm product is within temperature range prior to administration. May use pressure infuser for rapid administration, do not exceed 300mmhg. Use fluid/blood warmer device
10. Consider simultaneous administration of TXA through a separate IV
11. Document blood product type and infusion start time
12. Note completion time
13. Reassess vitals and temperature every 5 minutes
14. Document Rescue unit number
15. Document blood product expiration dates
16. Notify receiving facility about transfusion via radio report, especially when female patient is of child-bearing age
17. Once transfusions are complete, flush IV line with normal saline and note completion time.
Leave all transfused units of blood product with the receiving facility. Remove reference sticker(s) from all units that were transfused and add to hard and electronic copy to the PCR
18. Continue to monitor patient for any signs of a reaction
19. Additional medications **should not** be administered through the same line as blood products



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Each time a blood product is administered, the following must be documented: LifeSouth unit number, expiration date, infusion start time, and infusion complete time.

Transfusion Reactions (allergic, sudden drop in blood pressure, fever, chest pain or shortness of breath were not present prior to transfusion):

- STOP transfusion immediately
- Disconnect from IV/IO line, remove blood product bag and line, set aside for the receiving hospital
- Address reaction as necessary (allergic or hypotension)
- Notify receiving facility prior to arrival
- Notify R108 and Medical Director
- Complete LifeSouth Transfusion Reaction and Adverse Event Form

Blood products will be kept on the Rescue unit in the Credo cooler at a temperature between 2-8° C. Once the blood or plasma is removed from the cooler, it must be promptly prepared for infusion. Each time a unit of blood product is transfused, both critical care providers will verify patient's name, blood product temperature, expiration date(s), and check to ensure the product is free of any unusual color or appearance.

The quantum blood warmer must be used during administration of blood products. **If warmer malfunctions, the blood product will still be infused**, but the hospital must be made aware.

Daily Inspection

- **Temperature checks, visual inspections, blood product rotation and cooler rotation must be completed every 24 hours at the beginning of each shift, NO EXCEPTIONS.**
- At the beginning of every shift: credo cooling plates shall be exchanged for cold plates from the freezer. Used cooling plates shall be returned to the freezer. If cooler plates become contaminated, do not place in the freezer until properly decontaminated. Ensure temperature probe is inserted inside the cooler and monitoring properly. Ensure specialized blood tubing is in the rear pocket of the credo case.
- Both PRBC and Plasma shall be rotated from the Helmer blood fridge to the cooler at the beginning of every shift. Place both units of product in a zip-lock bag prior to sealing the cooler. Blood product that was previously in the credo cooler shall be returned to the Helmer blood fridge. Ensure blood products has been maintained at required temperature. **Assess blood products for contamination**: red cell mass appears purple, appearance of zone of hemolysis, visible clot(s) present, plasma is murky or has a purple, brown or red discoloration, signs of leakage or inadequate sealing (**immediately notify R108 if any sign of contamination is discovered**). Verify and document blood fridge is maintaining temperatures between 2-8° C. Ensure blood products are within administration range; verify expiration date. Ensure stylus is contacting the recorder chart



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- Document on provided forms in the binder, blood fridge temperature and recorder temperature at the beginning of every shift.
- Ensure each unit of blood product has a corresponding disposition log form in the binder and has proper documentation for each unit of blood product.

Weekly R108 Chief Inspection

- **Weekly Chief Inspections should occur EVERY Sunday, NO EXCEPTIONS.**
- Ensure and verify critical care units are following procedures and documenting appropriately.
- Ensure binder has all required forms and daily temperature checks are completed.
- Every Sunday, at the beginning of the shift, remove the wheel chart from the temperature recorder machine. Ensure that the date the chart was inserted and the date the chart was removed are written on the back of the wheel chart with R108 Chief's initials. Place new wheel chart in the recorder.
- Scan/photocopy the wheel chart, save to folder on the desktop computer at R108 quarters. Place used wheel chart in the binder.

Monthly R108 Chief procedures

- Collect all completed forms from the binders, scan/photocopy all forms, save to folder on the desktop computer at R108 quarters. File original forms at R108 quarters. **This should be done on the first day of each month.**
- Prepare electronic copy of forms and email to LifeSouth: QA@lifesouth.org. **This should be done on the first day of each month.**
- Ensure new monthly forms are inserted into the binder. **This should be done on the first day of each month.**
- Request delivery of blood products from LifeSouth if any blood products are approaching expiration or when inventory is at minimum.

Quarterly checks and procedures

- Perform alarm checks on the Helmer blood fridge. **Follow the alarm check procedure according to the instructions provided in the blood binder.**
 - High alarm should activate at 5.5° C
 - Low alarm should activate at 1.5° C
- Fill out quarterly report from in the blood binder. Scan/photocopy form and save to folder on desktop at R108 quarters. Submit forms quarterly via email to LifeSouth: QA@lifesouth.org
- Refill or replace glycerol if necessary.

R108 Chiefs procedures for ordering blood products

- **When minimum inventory is reached or when blood products are approaching expiration, initiate reorder procedures.**
- Use the online order program: donors@lifesouth.org
- If necessary, you may contact LifeSouth via phone at: (904) 365-6770. This may be necessary if you experience issues with the online ordering system.



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Delivery of blood products at stations

- LifeSouth will send units via courier and will notify the station of delivery of blood products.
- When new inventory is received at the station:
 - Verify each unit received matches the information on the packing/shipping form and disposition log (unit number, expiration date, etc.) **Insert corresponding disposition log and packing slip in the blood binder at the station.**
 - Verify PRBC units are O +Pos/O -Neg
 - Verify Plasma units are A (Rh can be +Pos or -Neg)
 - Verify temperature monitor device is within acceptable range
 - Verify the information on the Transfusion Report (TR), attached to the unit matches the unit

Return and disposal of blood products

- LifeSouth will be responsible for packing and transporting any returned blood products for consignment. All blood product that is to be returned shall remain in the blood fridge until obtained by LifeSouth courier. **Make every attempt to have unused Packed Red Blood Cells (PRBCs) returned to LifeSouth within 17 days of expiration.** This will be coordinated by R108 Chiefs.
- Blood products that are expired may be disposed of following bio-hazardous waste procedures (utilize red bio-waste bags).



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ADDITIONAL CRITICAL CARE SPECIFIC PROCEDURES

Controlled Hyperventilation

In the setting of head trauma or confirmed ICH on CT, with suspicion of brain herniation, suggested by signs and symptoms including decreasing mental status, asymmetric pupils, vomiting, bradycardia and hypertension

Procedure

Initiate mild hyperventilation to achieve ETCO₂ of 30-35mmHg

Double Sequential Defibrillation

The goal of double sequential defibrillation is to provide:

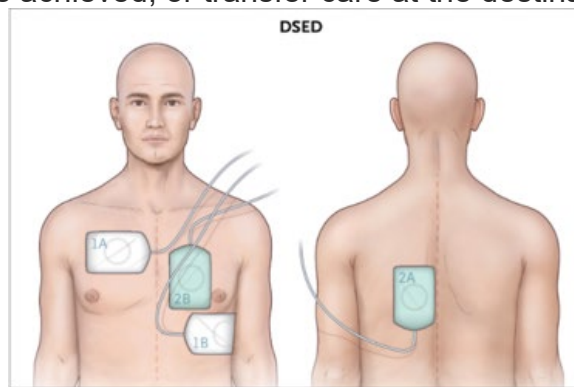
- A vector change in the direction of the energy across the heart
- Increased total energy across the heart
- Increased time the heart is exposed to energy

This approach is intended to provide complete resetting of all the myocardium. Unsuccessful defibrillation is a result of incomplete resetting of all the myocardial tissue, leaving some in fibrillation which then propagates through the rest of heart, preventing ROSC.

Procedure

- If the patient has remained in VF throughout the code despite 3 defibrillations, epinephrine & amiodarone, the 4th & subsequent defibrillations will be double sequential.
- The initial pad placement for the Fast Patches should have been in the Anterior/Posterior location. This will be attached to the engine's monitor and will stay with the patient.
- The second set of pads will now be placed in the upper right chest and left lateral chest. These pads are connected to the rescue monitor.
- The frequency of defibrillation will continue at every 2 minutes.
- The energy will be set at 200J for both devices. The patient will continue to receive ACLS medications and interventions as per 3050.
- At the time of the 4th and subsequent defibrillations, there will be count down, 3-2-1 and both monitor defibrillation buttons will be pressed at the same time. Resume CPR.

Continue following 3050 with double sequential defibrillation every 2 minutes while patient is in refractory VF, until ROSC is achieved, or transfer care at the destination.





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EQUIPMENT

DuCanto Catheter

The DuCanto Catheter is a single-use, non-sterile, rigid suction catheter specifically designed to aspirate liquids or semi-solids from a patient's upper airway. It has a larger inside diameter than a standard Yankauer suction tip which allows it to better remove fluids containing food particles.

The hyper curved catheter is shaped more like a patient's airway making it easy to position the catheter and work with other complementary devices used to clear a patient's airway. It is instrumental in performing the Suction Assisted Laryngoscopy and Airway Decontamination (SALAD) technique.

Ventilator (Allied AHP300) (**NOTE: To be used on ALL intubated patients not in arrest**)



1. Attach vent circuit
2. Connect O2 to vent from source using quick connect (main or portable)
3. Turn Power on
4. Set standard Initial vent settings manually or by using the quick start soft key:
 - Volume Mode Assist Control (AC)
 - Rate 14 BPM
 - PEEP 5
 - I Time 1.75 (I:E ratio should be around 1:2)
 - FIO2 1.0
 - Vt 6ml/kg based off patient's ideal/predicted body weight (IBW/PBW) – See chart attached to the vent for reference
5. Attempt to achieve End Tidal Capnography values of 35-45 mmHg
 - Adjust Respiratory Rate and Tidal Volume as necessary. End goal is to significantly change the minute ventilation in effort to affect ETCO2.
 - Adjust RR first in increments of 2-4 bpm



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- Increasing RR and Vt will lower end tidal values
- Decreasing RR and Vt will raise end tidal values
- 6. Adjust FiO2 and or PEEP to obtain adequate oxygenation (**SPO2 95% or greater**)
Asthmatics/COPD exacerbation
 - Consider lowering RR and Vt
 - Decrease I Time to increase I:E ratio to 1:3 if breath stacking occursHypotension
 - Decrease PEEP if possibleInterfacility transports
 - Match current vent settingsBiPAP
 - Set Mode to Non-invasive/CPAP
 - PEEP 5 (**should always be 4-5 lower than Pressure Support level**)
 - Pressure Support 10 (**should always be 4-5 higher than PEEP level**)
- 7. Alarms
 - System Failure, on start up or during operation
 - Perform manual ventilations with bag
 - Critical Battery - 20 minutes of power left
 - Plug into AC as soon as possible
 - Low O2 - Supply pressure is dropping, 2 minutes remaining
 - Switch to different O2 source
 - Apnea - 20 seconds with 0 breaths in CPAP/BiPAP mode
 - Begin BVM and airway management as necessary
 - High Airway Pressure - reassess patient, address as necessary:
 - Kinked line
 - Coughing/fighting breaths or biting tube
 - Provide further sedation
 - Mucus or secretion
 - Suction ETT
 - Reduced lung compliance
 - Evaluate for pneumothorax
 - Increased airway resistance
 - Start duoneb treatment
 - Low Airway Pressure
 - Check for disconnection

If unable to clear an alarm, disconnect patient from ventilator and ventilate via BVM.

If the patient is in cardiac/trauma arrest or if a king tube is utilized, disconnect patient from the ventilator and ventilate via BVM.



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Quantum Blood Warmer



Indication

- The Quantum Blood and IV Fluid Infusion Warmer is indicated for warming blood, blood products and intravenous solutions prior to administration in the adult trauma alert patient.
- Should be used anytime blood is transfused.

Contraindications

- **DO NOT** use components from other manufacturers. Only use quantum approved components (TTS-B transfusion set).
- **DO NOT** use a multiple socket power strip or extension cord when charging the device.
- **DO NOT** touch battery pins and the patient at the same time.
- Known malfunction of the device to include overheating or not heating.
 - **NOTE:** In the event the quantum warming device malfunctions or stops working, continue transfusion without the warming device. Ensure that the receiving facility is notified of the situation.

Daily Inspection

- Check battery status each morning during daily blood product inspection and rotation. (3 green LEDs = Fully charged, 2 green LEDs = 50% charged, 1 LED = low/insufficient charge). Allow battery to charge for 90 minutes if fully discharged.
- Ensure TTS-B transfusion sets are present, either in the rear pocket of the credo blood cooler or on the Rescue Unit.
- Ensure the controller cable remains with the battery pack



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Cautions

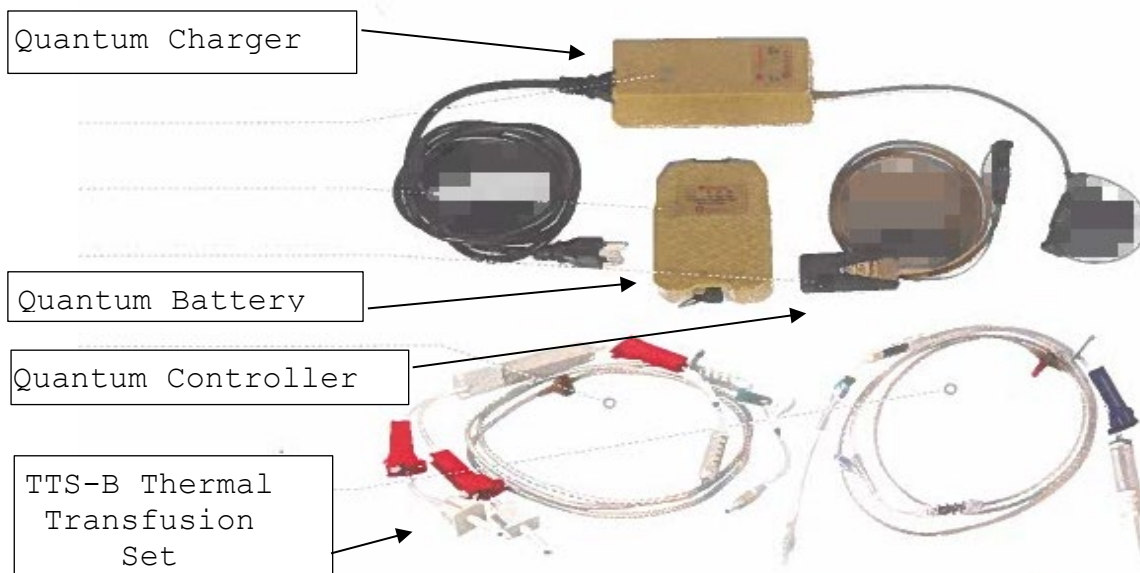
- Refrain from leaving the controller cable connected to the battery pack when there is NO primed TTS-B transfusion set connected. This will prevent the device from overheating and causing other malfunctions. The controller cable and battery should never be connected to and operating with a dry TTS-B transfusion set.
- Retrieve the quantum blood warmer and all components prior to leaving receiving facility.

Cleaning

- The battery pack and controller cable may be cleaned with a mild cleaning agent or disinfectant. DO NOT submerge any of the components in water. Allow to dry or manually dry with a towel prior to placing the device in its case.
- The used TTS-B transfusion set along with ALL units of blood product should be left with the receiving facility. DO NOT TRASH THESE ITEMS.

Procedure

- Step 1: Select TTS-B transfusion set. Tear pouch open where marked. Prime and purge all air from line. Invert the TTS-B drip chamber to facilitate priming.
- Step 2: Briefly press "Status" button once on battery pack to check charge status. If sufficiently charged connect controller cable to the battery.
- Step 3: Remove protective cap from circuit cartridge and connect the controller to the tubing by pressing the circuit cartridge into the connector slot. NOTE: The controller module/connector works in either orientation.
- Step 4: Adjust to desired flow rate with roller clamp on tubing. NOTE: Use pressure infuser for rapid administration. Controller turns on automatically. LEDs on controller indicate system status during operation.





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Controller Normal Operation Indicators

- Green flash every 4 seconds (not connected) Self-check OK, ready for use. **Action:** Connect to the primed tubing set
- Green flash every second (connected tubing) Stand-by mode, no flow or flow rate too slow to warm. **Action:** Increase flow rate
- Blue flashing-fluid warming, but temperature is $<36^{\circ}\text{C}$
- Green solid: fluid is warmed to $\geq 36^{\circ}\text{C}$ (in steady state)
- Yellow solid-low battery condition. **Action:** Change or replace battery

Alert Conditions on Controller, Battery and/or Charger

- Yellow flashing (Controller)- Dry line, poor connection/disconnection or tubing mechanical failure. **Action:** Disconnect controller from tubing set and ensure the tubing is completely primed and no air in line. If properly primed reattach controller to the tubing set and yellow flashing should stop.
 - If yellow flashing persists, tubing set may have a mechanical failure. Disconnect controller and tubing from the patient. Obtain a new tubing set. Prime and attach to patient.
- No LEDs on Controller-Poor connection to battery, battery dead or controller failure. **Action(s):** check battery connection, check battery charge status.
- Audible Alert and/or red strobe (on battery)- Infusion over temperature. **Action:** Stop fluid flow. Disconnect controller from battery and tubing. (Note: power is cut automatically as well). Check fluid source and line. If fluid source bag does not feel warm to the touch, reconnect to the patient.
- Blue Flashing LED (charger) indicates battery charging failure. **Action:** Disconnect battery from charger, wait 15 seconds and reconnect to charger.



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Sapphire IV Pump



Indications

- The Q Core Sapphire Infusion Pump is intended for controlled delivery through intravascular routes. The pump is designed to deliver saline and IV medications. The Sapphire Infusion Pump is intended to be used by both licensed health care professionals in a clinical environment, and in pre-hospital medical air and ground transportation.
- The dedicated Q Core administration sets for the Sapphire Infusion Pump are intended for single-patient use and single-use only.
- The Sapphire Infusion Pump is preconfigured to support the continuous delivery mode for prehospital use.
- The full manual for the Sapphire Infusion Pump is available on [Vector Solutions](#) via file center in the ***"JFRD Critical Care Team Documents and Training Aid"*** folder.

Precautions

- To ensure safety and proper operation, read the User Manual and any instructions accompanying disposables or accessories before operating the device.
- **DO NOT** operate the pump with the safety door open.
- ALL service procedures, including certification, calibration, part replacement and modification of equipment, should be carried out only by a qualified service technician. Detailed instructions are available in the service manual.
- Connect AC power to the pump only via a Q Core supplied power adapter.
- The Sapphire Infusion Pump IS NOT MRI compatible.
- **DO NOT** connect the administration set to the patient while priming. If it becomes necessary to re-prime the administration set while in use, pause the infusion and remove the cassette from the pump, disconnect from the patient and manually prime the administration set.
- **DO NOT** use force when connecting the administration set to the patient.



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- Address all alarms as they occur, (i.e., **occlusion, air detection, low battery**)
- DO NOT enter a volume to be infused greater than the amount of fluid available in the container.
- Always ensure that the administration set is primed before starting an infusion. Manual priming will be the fastest method over using the internal priming option available on the pump.

Procedure

- Prime the administration set by depressing the cassette clamp/Anti-Free-Flow Valve (AFFV) inward. Ensure all air is eliminated from the tubing
- Open the safety door using your thumb and press the door outwards and insert the cassette. Close the door once the cassette is loaded
- Turn the pump On by pressing the On/Off hard key at the lower right corner of the pump
- While the pump turns On, a system check is performed. If you do not hear a sound from the speaker, or if items on the screen do not display properly, do not use the pump
- Select "New Infusion"
- Enter the medication to be infused and follow the prompts. The pump has a drug library installed for your convenience. If it becomes necessary to input a drug that is not in the installed library, you will be required to enter the data manually by inputting the concentration (ex. Amount of medication and the amount of diluent)
- Enter the dose you intend to start infusing followed by the Volume To Be Infused (VTBI)
- Confirm all entries by selecting OK
- The Pump will display a final confirmation screen. Connect tubing to the pt. Ensure all clamps are released. Once you confirm all entered data, select OK and then select Start. A green flashing light on the right side of the pump indicates that the pump is running.
- Follow touch screen instructions when it becomes necessary to pause the pump
- Select/Touch the screen where the dose is displayed when it becomes necessary to titrate your dose up/down. Enter the new desired dose and then select ok. Follow on screen confirmations and restart the infusion.
- To turn the pump completely off simply hold down the ON/OFF button

Battery Care Information

- The Sapphire pump can operate on battery power, enabling operation of the pump during an electrical power failure, during transport or during ambulatory care.
- When working on battery power (disconnected from main power supply) the battery charge level icon, at the upper right corner of the indicators bar, indicates the remaining battery capacity. Check the status of the battery charge level icon regularly.
- Remaining battery capacity indicators- 5 Bars 100%, 4 Bars 75%, 3 Bars 50%, 2 Bars 25%, 1 Bar Low. You can also check the status of the battery using the Options menu.
- Battery operation time is dependent upon the condition of the battery, which varies according to temperature conditions, battery age, frequency of charging, and conditions of storage and use.



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- An alarm is triggered when there are 30 minutes left until battery depletion. This time may depend on the delivery rate, the frequency of pressing keys, and whether the backlight is On. When the Battery Depletion alarm sounds or following long periods of storage, connect the pump to the power supply.

Cleaning

- The pump may be cleaned with a mild cleaning wipe. **DO NOT use bleach or bleach wipes.** DO NOT submerge any component of the pump in water. Allow to dry or manually dry with a towel.



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Chapter 12

CORE Supplement



CORE Supplement

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CORE Supplement

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Purpose

This portion of the EMS SOG is intended to provide supplemental treatment options to those members assigned to the CORE Team.

Scope

The JFRD CORE Team will interact with OUD patients in various settings including hospitals, Gateway Community Services, the Sulzbacher Center, and other off-site locations that are prearranged by the JFRD CORE Team.

The roles and responsibilities of JFRD CORE Team members will evolve as the JFRD CORE Program develops. Therefore, the JFRD CORE Team members must stay flexible, recognizing that the CORE Network was created because standard treatment models were ineffective in achieving stable, long-term recoveries.

MEDICATION - ASSISTED TREATMENT (MAT)

Medications can be used to manage withdrawal symptoms, prevent relapses, and treat co-occurring conditions.

Withdrawal: Medications help suppress withdrawal symptoms during detoxification. Detoxification is not in itself "treatment," but only the first step in the process. Patients who do not receive any further treatment after detoxification usually resume their drug use.

Relapse prevention: Patients can use medications to help re-establish normal brain function and decrease cravings. Medications are available to treat opioid, tobacco, and alcohol addiction.

Buprenorphine is a partial opioid agonist. It produces effects such as euphoria or respiratory depression at low to moderate doses. With Buprenorphine, however, these effects are weaker than full opioid agonists such as methadone and heroin. When taken as prescribed, Buprenorphine is safe and effective. Buprenorphine has unique pharmacological properties that help diminish the effects of physical dependence to opioids, including withdrawal symptoms and cravings.



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COMFORT MEDICATIONS

Baclofen is a skeletal muscle relaxant. It can be used to treat muscle spasms sometimes associated with acute withdrawal.

Clonidine is an antihypertensive medication that centrally acts on alpha-adrenergic and imidazoline receptor agonists. It is indicated for an acute withdrawal patient suffering from elevated blood pressure (BP) as it works by decreasing the heart rate and relaxing blood vessels.

Zofran (Ondansetron) is a selective 5-HT₃ serotonin-receptor antagonist most commonly used for the empiric treatment of nausea and vomiting. It can be useful in reducing nausea and vomiting, both common side effects of opiate withdrawal.

CORE WORKFLOW

1. A patient arrives at the Emergency Department (ED) or is discharged from the hospital and is identified by a healthcare provider as having Opioid Use Disorder (OUD).
2. Healthcare provider notifies Project Save Lives (PSL). Where Project Saves Lives is not present, the healthcare provider will notify the JFRD CORE Team directly at (904) 575-0503.
3. OUD patient meets PSL Peer Support Specialist and is offered Hospital Bridge Program – PSL services.
 - If the patient declines entry into PSL program, the patient is offered JFRD CORE Program services.
 - If the patient accepts entry into the JFRD CORE Program, the PSL Peer Support Specialist contacts the JFRD CORE Team at (904) 575-0503 for a warm handoff of the patient.
4. The JFRD CORE Team member responds to the ED and meets with the patient, PSL Peer Support Specialist and/or the healthcare provider. The JFRD CORE Team member discusses the program and benefits.
5. The JFRD CORE Team member obtains the patient's written consent to enroll in the JFRD CORE Program and completes the CORE facesheet to aid in the continuity of care.
 - If the patient refuses buprenorphine induction services in the hospital, but still wants treatment, the JFRD CORE Team may transport a patient directly to Gateway Community Services (Detox).



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- If the patient agrees to take Buprenorphine, PSL Peer Support Specialist alerts the healthcare provider that the patient will participate in *CORE Induction Services* and Buprenorphine is initiated in the ED.
 - There may be occasional instances when the JFRD CORE Team, in consultation with the JFRD Medical Director, may begin Buprenorphine therapy outside the hospital setting.
 - For notifications and/or referrals made outside of operating hours, patients interested in joining the JFRD CORE Program, upon obtaining consent, may be transported to Gateway Community Services for *CORE Induction Services* Monday through Friday from 1000 to 1400.
 - Upon discharge from Gateway Community Services *CORE Induction Services*, the patient will receive a 2 week prescription of Buprenorphine and information on how to enroll in services via Treatment Today.
 - The JFRD CORE Team will continue to support the patient by providing transportation to scheduled outpatient MAT appointments and/or wraparound services, pharmacy runs, etc.
6. The JFRD CORE Team schedules the patient for continued Buprenorphine and/or comfort medications (Baclofen, Clonidine, Zofran) treatment at home until an outpatient MAT appointment is established at an approved treatment facility.
- No patient shall be medicated for longer than 7 days without approval from the JFRD Medical Director.
7. Patient completes an initial 90 minute outpatient MAT appointment at Sulzbacher Center.
- Patient will receive a 30 day prescription of Buprenorphine and will be scheduled for a follow up appointment the same day.
 - The JFRD CORE Team will continue to support the patient by providing transportation to scheduled outpatient MAT appointments and/or wraparound services, pharmacy runs, etc.



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DOSING IN FIELD

1. Perform patient assessment and obtain a set of vital signs.
2. Ensure the patient is appropriate for Buprenorphine
 - Confirm that last opioid use was greater than 48 hours ago.
 - Confirm that the patient has not recently used benzodiazepines or alcohol.
3. Administer Buprenorphine and/or comfort medications as needed.
 - Determine level of withdrawal by using the Clinical Opiate Withdrawal Scale (COWS- see Appendix 1). The patient should be experiencing some degree of withdrawal before administering the medication.
 - Ask when the patient's last dose of Buprenorphine was taken and ask whether or not the patient has used any other opioids (besides Buprenorphine). If the patient admits to other opioid use, DO NOT medicate. This is because Buprenorphine after recent opioid use WILL precipitate withdrawal.
 - When continuing the induction process, the dose of Buprenorphine should be equal or greater than the day before and based on COWS score (0-4: none; 5-12: 4mg; >12: 8mg). Maximum single dose is 8mg and maximum daily dose administered by JFRD is 16mg.
 - The goal of induction is to reach a therapeutic dose, then maintain that dosage. A low COWS score is expected once the patient is stabilized.
 - Place the tablets under the patient's tongue until they completely dissolve. If the desired dosage requires administering more than two tablets, limit administration to two tablets at a time. Repeating as necessary after prior tablets have fully dissolved.
 - While administering the medication, observe patient 1:1 until the medication has completely dissolved sublingually.
 - Monitor for worsening withdrawal (if recent opioid use) or sedation and respiratory compromise. Precipitation of mild withdrawal can be treated with comfort meds and an additional dose of 4mg Buprenorphine. Continued or



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worsening withdrawal requires patient to be transported via rescue to the most appropriate emergency department.

- Reassess the patient (and obtain another set of vital signs) after 30 minutes for adverse reaction. This must be documented in the patient care report.
- Document a new COWS score.

4. Administer Baclofen orally as needed

- Baclofen 5mg for bone or body aches

5. Administer Clonidine orally as needed

- Administer early and recheck blood pressure in 30 minutes
- 0.1mg for BP greater than 140/90
- 0.2mg for BP greater than 160/100
- Transport may be required for BP greater than 180/110

6. Administer Ondansetron (Zofran) 4mg Orally Disintegrating Tablet (ODT) for nausea as needed

DOCUMENTATION

All CORE interactions including medication administration, pharmacy pick-ups, transportation to appointments, etc., will require the completion of a patient care report (PCR). All PCR's should be completed as soon as possible and, per JFRD SOG 430 Section 1020, are always required to be completed by the end of the shift. Failure to comply with reporting requirements may result in disciplinary action and/or revocation of CORE Team privileges.



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APPENDIX 1 Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/____:_____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

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Appendices

Chapter 13

Appendices



Appendices

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Appendix A

Lucas Device

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Indication

- Cardiac Arrest
 - **Should be used in every cardiac arrest** except those contraindicated as listed below. Device should be applied as early as possible (e.g., while still inside a residence) and prior to moving the patient

Contraindications

- Patient is too large. Recognized when the Upper Part of the device will not lock to the Back Plate without compressing the patient's chest
- Patient is too small. Recognized when the Lucas device alerts with 3 fast signals when lowering the Suction Cup, and you cannot enter the PAUSE mode or ACTIVE mode.

Cautions

- If there is gel on the patient's chest, the Suction Cup position can change
- If the position of the Suction Cup changes during operation, immediately push the #1 button, and then adjust the position
- Pregnant patients greater than 20 weeks must have their uterine manually displaced to the left to offload aorta and vena cava compression
- Do not block the vent holes

Daily Inspection

- Ensure device is plugged in so that the inserted battery is fully charged
- Ensure Suction Cup is mounted
- Ensure that there is a spare Suction Cup and fully charged spare battery inside the case
- Inspect for physical damage to the unit/case

Batteries/Charging

- The device should remain plugged in inside the unit when not in use so that the inserted battery remains fully charged
- The inserted battery should be swapped with the spare battery once a week on Apparatus Day

Cleaning

- Clean all surfaces and straps with a mild cleaning agent or disinfectant
- Allow device to dry before placing into the carrying case
- Dispose of Suction Cup after each patient use

Procedure

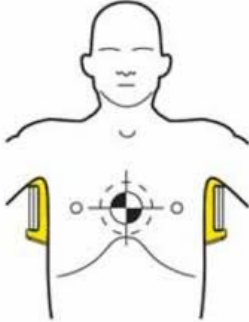
- Start manual CPR
- Unpack the device
- Push ON/OFF for 1 second to power up and start the self-test. The green LED adjacent to the key illuminates when the device is ready for use



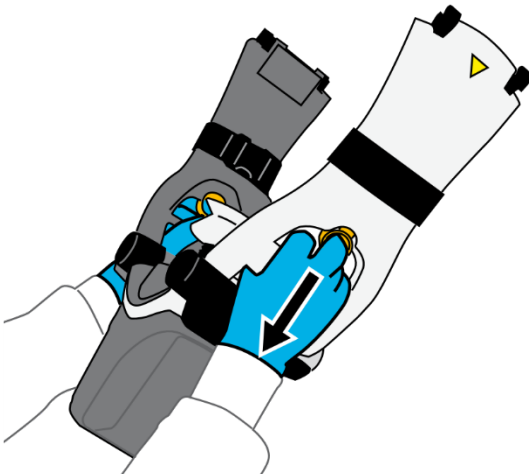
Appendix A

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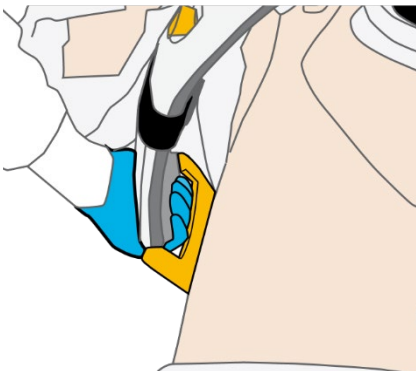
- Place the Lucas Back Plate under the patient, immediately below the arm pits



- Hold the handles on the support legs to remove the Lucas Upper Part from the carrying case
- Pull the release rings once to make sure that the claw locks are open



- Let go of the release rings
- Attach the support leg that is nearest to you to the Back Plate. Listen for a click



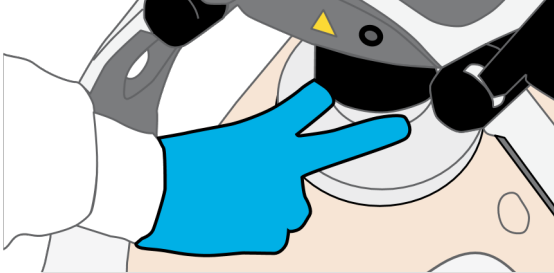
- Attach the other support leg to the Back Plate, so that the two support legs lock against the Back Plate. Listen for a click
- Ensure that the Lucas device is in the Adjust mode (#1)



Appendix A

Lucas Device Medical Director Review Date 08/2025

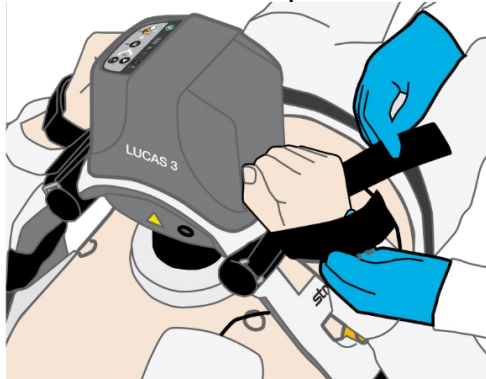
- Push the Suction Cup down until it touches the patient's chest without compressing the chest



- The lower edge of the Suction Cup should be immediately above the end of the sternum, which is the same spot for manual CPR
- Push the **#2** button on the control panel to lock the Start Position



- Push the **#3** button to start either **CONTINUOUS** or **30:2** chest compressions
 - **Continuous** mode if advanced airway in place
 - **30:2** mode if airway not secured (e.g., BVM only)
- If device needs to be paused, push **#2 (PAUSE)**
- If Suction Cup position needs adjustment, push **#1**, then pull up the Suction Cup to readjust
- You can secure the patient's arms with the straps attached to the Lucas device





Appendix A

Lucas Device

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- Defibrillation can be performed while the Lucas device is operating
- To remove the device from the patient, push **ON/OFF** for 1 second or press the **#2 (PAUSE)** button
- Pull the release rings to remove the Upper Part from the Back Plate
- If the situation and patient's condition permits, remove the Back Plate



Appendix B

External Pacer

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Transcutaneous pacing offers a noninvasive, rapid, and effective way to institute ventricular pacing, support the patient's hemodynamics and reestablish perfusion. The most common reason for using pacing is to maintain an optimal cardiac output when the patient has bradycardia with inadequate perfusion.

Indications

- Unstable bradycardia unresponsive to Atropine

Contraindications

- Asystole
- Severe hypothermia

Procedure

- **Prepare the Patient** - Remove all clothing covering the patient's chest. Dry chest if necessary. If the patient has excessive chest hair, shave it to ensure proper adhesion of the electrodes
- **Turn on unit** - Press the green power switch located on the top of the unit. The green, yellow, and red lights at the top of the unit flash on and off, and the unit displays the message SELF TEST PASSED
- **Apply ECG Electrodes and Fast Patches**
 - Poor adherence and/or air under the therapy electrodes can lead to the possibility of arcing and skin burns
- **Press the Lead quick access key and select I, II, or III** to provide the largest amplitude QRS complex
 - When the Pacer is on, the lead selection is restricted to Leads I, II, or III
- **Verify that R-waves are being properly detected** by confirming that a QRS tone occurs with each displayed R wave or by verifying that the X Series unit's heart rate display accurately reflects the patient's pulse rate
- **Press Pacer button** - Press the Pacer button on the front panel of the unit. The Pacer Settings window displays
- **Mode** - The monitor should default to Demand mode
- **Pacer Rate** - Use the arrow keys to navigate to Rate, which defaults to 70 ppm.
- **Turn On Pacer** - Use the arrow keys to navigate to Start Pacer and then press the Select button to select it. The Pacing window displays behind the Pacer Settings window
- **Set Pacer Output** - In the Pacer Settings window, use the arrow keys and the Select button to adjust the pacer output. The pacer output is adjustable in 10 mA increments when increasing the output, and in 5 mA increments when decreasing the output. Typical threshold currents range from 40 to 80 mA. Observe the ECG for evidence of electrical capture. Select the lowest output current that achieves both electrical and mechanical capture



Appendix B

External Pacer

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- Location of the fast patches affect the current required to obtain ventricular capture. Typically, the lowest threshold is obtained when the position of the electrodes provides the most direct current pathway through the heart while avoiding large chest muscles. Lower stimulation currents produce less skeletal muscle contraction and are better tolerated
- If the Pacer Settings window disappears before you have set the output current, press the **Pacer** button again to display the settings window
- **Determine Capture** - It is important to recognize when pacing stimulation has produced a ventricular response (capture). Determination of capture must be assessed both electrically and mechanically to ensure appropriate circulatory support of the patient. Electrical capture is determined by the presence of a widened QRS complex, the loss of any underlying intrinsic rhythm, and the appearance of an extended, and sometimes enlarged, T-wave. Ventricular response is normally characterized by suppression of the intrinsic QRS complex
- **Confirm mechanical capture by palpation of the peripheral pulse.** To avoid mistaking muscular response to pacing stimuli for arterial pulsations, use ONLY the following locations for palpating pulse during pacing:
 - Femoral artery
 - Right brachial or right radial artery



Appendix C

Traction Splint

Medical Director Review Date 08/2025

Indications

- Mid-thigh injury that is painful, swollen, and deformed

Contraindications

- Hip/pelvis injury
- Ankle/lower leg injury on affected side
- Fracture is close to the knee

Procedure

- Apply manual stabilization above and below the injury to reduce further injury
 - This JFRD member is solely dedicated to maintaining stabilization until mechanical traction takes over
- Remove clothing from the area
- Remove sock and shoe from the affected leg
- Position splint against uninjured leg
- Adjust splint to length, extending the splint so that the bend is even with the heel of the foot
- Tighten locking collars
- Open and position the Velcro straps along the splint
- Release the ratchet, extending the entire length of the traction splint
- Place the splint next to the injured leg
- Apply ankle hitch to the patient
- Firmly seat splint against the ischial
- Secure the pubic (high over the thigh) strap
- Attach ankle hitch to the traction strap
- Apply traction until pain and muscle spasms are relieved or the injured leg is the same length as the uninjured leg
- Secure the remaining Velcro straps
- When splint is properly applied, the patient's foot should be upright
- Transport patient on firm surface so the splint is supported
- Continue to reassess circulatory and neurological function distal to the injury site

Precaution

- If patient is unstable, do not waste time applying the traction splint. Concentrate on other life saving measures



Appendix C

Traction Splint

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Appendix D

King Tube

Medical Director Review Date 08/2025

Indications

- **Intended to be used as a rescue airway device after failed intubation attempts**
 - May be used as primary airway if intubation anticipated to be difficult and rapid airway control is necessary
- Designated advanced airway for EMTs

Contraindication

- Foreign body airway obstruction
- Intact gag reflex
- Caustic ingestion

Procedure for EMT and Paramedic

- Initiate BLS airway sequence
- Select proper size King Tube based on patient height/weight (includes pediatrics):
 - 4' to 5' tall = **#3**
 - 5'-6' tall = **#4**
 - Greater than 6' tall = **#5**
- Assemble equipment, inflate cuff to proper volume, test balloon for leaks and then deflate, lubricate posterior aspect distal tip with water-soluble lubricant
- Suction airway and pre-oxygenate with BVM ventilations, if possible
- If possible spinal injury, maintain cervical immobilization
- If no spinal injury, place head into sniffing position or with slight cervical hyperextension
- Hold King Tube in dominant hand at connector. With other hand, open mouth and lift chin
- Rotate King Tube so blue index line is facing corner of mouth
- Introduce tip into mouth and advance airway behind tongue into the hypopharynx
- As tube passes tongue, rotate King Tube so that blue index line is again facing the chin
- Without excessive force, advance King Tube so that base is aligned with teeth or gums
- Using supplied syringe, inflate cuff with correct volume of air (marked on King Tube), avoid overinflation, adjust as necessary to limit leaks
 - Size 3 = 40- 55 mL
 - Size 4 = 50- 70 mL
 - Size 5 = 60- 80 mL
- Attach bag to King Tube and begin ventilating patient. While ventilating, slowly and slightly withdraw King Tube until ventilations are easy and chest rise is adequate
- Confirm tube placement by auscultation, chest movement, and ETCO₂
- Secure tube with commercial tube holder (may use other means if necessary)
- Monitor patient for vomiting and aspiration
- Continuously **monitor ETCO₂** and SpO₂ values
- **Do not remove a properly functioning King Tube to attempt intubation**



Appendix D

King Tube

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Appendix E

Airtraq Video Laryngoscope

Medical Director Review Date 08/2025

Indications

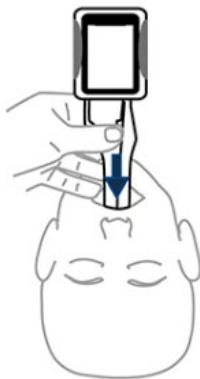
- Acceptable for use as the initial means of intubation in the routine airway
- To be used in place of standard laryngoscope in difficult or anticipated to be difficult adult intubations

Contraindications

- Small pediatrics when blade is too large

Procedure

- Select appropriate blade color based on ETT size:
 - Purple: 4.0 – 5.5
 - Green: 6.0 – 7.5
 - Blue: 7.0 – 8.5
- Connect blade and **press orange power button on underside of display to turn on the light**
- Lubricate guiding channel
- Preload guiding channel with the endotracheal tube
- Distal end of endotracheal tube should align with end of channel
- **Suction prior to inserting the blade to avoid secretions** which could cover the camera lens and cloud the image. May consider leaving suction catheter in mouth for continuous suction
- Use your left hand to facilitate insertion into patient's mouth. Hold it gently using your fingers rather than the full palm. Do not hold like a direct laryngoscope



- Insert blade midline around the tongue. Visualize airway structures while inserting blade
- Place blade tip in the vallecula and elevate the epiglottis
- The view of the vocal cords should be centered on the screen but **not** a close-up. A panoramic view is optimal and allows for plenty of room to pass the tube. The base of tongue and epiglottis should be visualized at upper portion of the camera view
- Twist device if needed to better center vocal cords
- Advance the endotracheal tube slowly and watch for the cuff to pass through the vocal cords

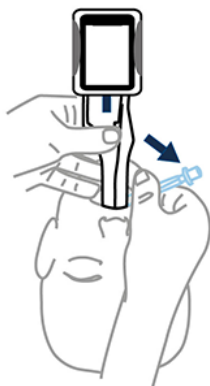


Appendix E

Airtraq Video Laryngoscope

Medical Director Review Date 08/2025

- Consider use of the bougie (Appendix I) when the vocal cords are visualized but the ETT can't be passed through the cords
- Grasp end of endotracheal tube and move to side of mouth while removing Airtraq midline. The endotracheal tube should easily separate from the channel



Precaution

- If the lens becomes obstructed with bodily fluids, remove the blade from the patient's mouth and clear the lens



Appendix F

Capnography

Medical Director Review Date 08/2025

Indications

- To confirm proper placement of **ALL** intubations and supraglottic airways (e.g., King Tube)
- To rule out esophageal intubation
- To identify endotracheal tube dislodgement
- To monitor patient's airway patency and respirations following chemical sedation
 - To provide an added level of monitoring beyond continuous cardiac and pulse oximetry for patients that have been administered sedatives that have not been intubated with an ETT or supraglottic device
 - **Capnography will be placed on patients that have received Etomidate, Ketamine, Fentanyl, and Versed**
 - The nasal capnography device will be placed on the patient as soon sedation is achieved
- Once capnography is initiated, it will be continued throughout transport, and into the hospital so that staff can confirm end tidal values and waveform
 - **Report documentation should note that hospital staff confirmed end tidal values and waveform**

Procedure for advanced airway (e.g., ETT, King Tube)

- Attach the sampling line to the unit's CO₂ inlet port
- In patient with ETT or advanced airway: place the ETCO₂ detector in-line between airway adaptor and BVM after airway positioned and secured
 - Place the airway adapter at the proximal end of the airway circuit between the elbow and the ventilator circuit wye. Do NOT place the airway adapter between the ET tube and the elbow as this may allow patient secretions to accumulate in the adapter
- Select the correct patient type - Adult, Pediatric, or Neonate
- Press the CO₂ quick access key to initiate CO₂ monitoring
- The numeric CO₂ display appears on the screen and displays the message, *INITIALIZING*. The CO₂ display gives the current EtCO₂ value, and after a delay of approximately 1 minute, the patient's Respiration Rate (in Breaths/Minute), identified as **BR**:
- Check that connections have been made correctly by verifying the display a proper capnogram (the waveform is inserted automatically on the waveform display window)

Procedure for nasal capnography following chemical sedation

- Place ETCO₂ sampling nasal cannula on patient
- Connect sampling cannula to oxygen source if needed
- Attach sampling tube to cardiac monitor CO₂ intake
- Select the correct patient type - Adult, Pediatric, or Neonate
- Press the CO₂ quick access key to initiate CO₂ monitoring
- The numeric CO₂ display appears on the screen and displays the message, *INITIALIZING*. The CO₂ display gives the current EtCO₂ value, and after a delay of



Appendix F

Capnography Medical Director Review Date 08/2025

approximately 1 minute, the patient's Respiration Rate (in Breaths/Minute), identified as **BR**:

- Check that connections have been made correctly by verifying the display and proper capnogram (the waveform is inserted automatically on the waveform display window)

Readings

- Normal readings are 35-45 mmHg in a healthy patient
- High ETCO₂ (>45)
 - Rising values indicate hypoventilation/CO₂ retention and suggest airway intervention is needed by BVM and/or an advanced airway; especially with unconsciousness, decreased LOC, or decreasing respiratory effort and rate
 - Increase ventilation rate to decrease high ETCO₂ values
- Low ETCO₂ (<35)
 - Values below 35 could indicate hyperventilation from a metabolic acidotic state (e.g. agitated delirium) and appropriate fluid resuscitation should be initiated
 - Low perfusion: shock, PE, sepsis
 - In the intubated patient, decrease ventilation rate to increase low ETCO₂ values
- Cardiac Arrest:
 - In low-pulmonary blood flow states, such as cardiac arrest, the primary determinant of ETCO₂ is blood flow, so ETCO₂ is a good indicator of quality of CPR
 - If ETCO₂ is dropping, change out person doing chest compression
 - In cardiac arrest, if ETCO₂ not >10 mmHg after 20 minutes of good CPR, this likely reflects very low CO₂ production and an extended down time
 - Typical cardiac arrest values with good CPR are 10-20 mmHg.
 - If there is a sudden rise in end tidal, check for a pulse

Precaution

- Sudden loss of ETCO₂:
 - Tube dislodged
 - Tube obstruction (e.g., secretions)
 - Circuit disconnected
 - Cardiac arrest



Appendix G

BVM/ET Tube with Inline Nebulizer

Medical Director Review Date 08/2025

Via BVM



Via ETT





Appendix G

BVM/ET Tube with Inline Nebulizer

Medical Director Review Date 08/2025

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CPAP & CPAP with Inline Nebulizer

Medical Director Review Date 08/2025

Appendix H

Pulmonary O2-Max is a high-pressure disposable CPAP that filters inspiratory and expiratory air.

Indication

- Symptomatic patients with moderate-to-severe respiratory distress (wheezes, rales, decreased breath sounds, etc.)

Contraindications

- Respiratory or cardiac arrest
- Systolic BP less than 90mmHg
- Lack of airway protective reflexes
- Decreased LOC or unable to follow verbal instructions
- Vomiting or active upper GI bleed
- Suspected pneumothorax
- Trauma
- Patient size or anatomy prevents adequate mask seal

Procedure

- Place patient in a seated position and explain the procedure to him or her
- Select appropriate size mask
- Connect O₂ tubing to the high-pressure oxygen source
- Hand mask to the patient and allow them to feel the air flow on their face
- Apply the CPAP mask and secure with provided straps, progressively tightening as tolerated to minimize air leak
- Adjust the PEEP valve so that the desired pressure is obtained. The valve comes preset at 5 cm H₂O, but can be adjusted to 7.5 or 10 cm H₂O
 - **<12 y/o** – maintain the 5 cm H₂O
 - **Adult and pediatric ≥12 y/o** – adjust valve to 10 cm H₂O
- Advanced airway indicated if signs of deterioration or failure of response to CPAP present:
 - Decrease in level of consciousness
 - Substantially increased heart rate or respiratory rate
 - Substantially decreased blood pressure
 - Visible signs of fatigue
 - Sustained low or decreasing SpO₂ readings
 - Diminished or no improvement in tidal volume



CPAP & CPAP with Inline Nebulizer

Medical Director Review Date 08/2025

Appendix H



Utilize Ohmeda style connector for high-pressure wall outlet



CPAP with inline nebulized medications

- Continue with normal CPAP
- Insert nebulizer into the designated integrated port
- Connect nebulizer to a standard low-pressure oxygen port





Appendix I

Bougie

Medical Director Review Date 08/2025

Indication

- To be used as an endotracheal tube inducer (ETI) when the tube cannot be passed despite a good view of the vocal cords or an incomplete view of the glottis opening
- Can be used with standard laryngoscope or Airtraq
- Can be used as a tube exchanger should the need arise for a replacement ET tube
- To be used when performing a cricothyrotomy (Appendix K)

Precaution

- Not to be used in a completely blind fashion
- Excessive force, passage beyond the carina, or blind introduction may result in damage to oropharynx or trachea/bronchi

Procedure

- Size 15 Fr appropriate for **≥ 6.0 mm** ET tubes (10 years and older)
- Place bougie (with curved tip) into the mouth and direct into glottis with the firm end of the ETI pointing anterior
- You should feel the tip of the bougie 'click' as it passes along the tracheal rings
- Advance the ETI to approximately 20 cm at the teeth (look for black mark)
- If possible, continue laryngoscopy to elevate the pharyngeal soft tissue **while an assistant** threads an endotracheal tube over the introducer into the trachea. If the endotracheal tube meets resistance at the laryngeal inlet and will not pass, stop advancement efforts, withdraw the endotracheal tube 1-2 cm with rotation of the tube 90° in either or both directions while reattempting to advance the tube may help negotiate passage of the tube
- While the assistant holds the ETI, advance the endotracheal tube to the desired depth and hold the tube firmly in place while the ETI is gently withdrawn
- Remove laryngoscope, secure the endotracheal tube, and confirm tube placement as usual



Appendix I

Bougie

Medical Director Review Date 08/2025





Appendix J

Needle Decompression

Medical Director Review Date 08/2025

Indications

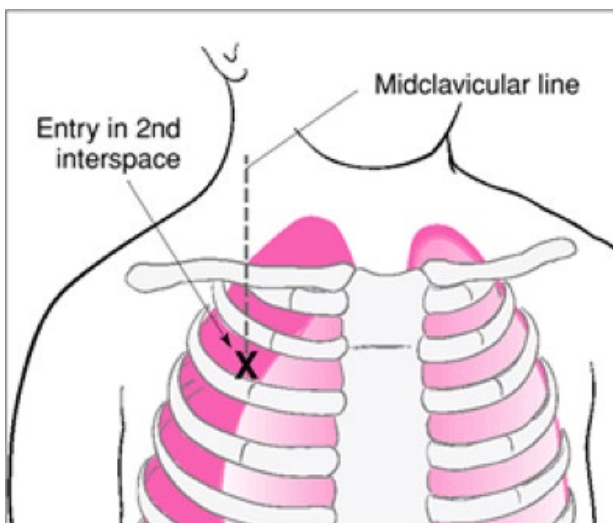
- Trauma Arrest from penetrating chest injury
- Unilateral absent or decreased breath sounds **with** severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, and hypoxia

Procedure for Paramedics

- Expose entire chest
- Clean skin overlying site with available skin prep
- Insert largest, longest available angiocath (typically 14g 3.25" for adults and 14g 1.25" for pediatrics) over top of inferior rib at the 2nd intercostal space at mid-clavicular line on the affected side(s)
- Remove needle while leaving catheter in place
- Consider placement of second angiocath if initial placement was successful but patient deteriorates. First angiocath may have become occluded with blood or soft tissue

Notify receiving hospital of needle decompression attempt.

A simple pneumothorax is **NOT** an indication for needle decompression.





Appendix J

Needle Decompression

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Appendix K

Cricothyrotomy

Medical Director Review Date 08/2025

Indications

- "Failed Airway" (unable to ventilate and/or intubate)
- Facial trauma that prohibits orotracheal intubation
- Unrelieved Foreign Body Airway Obstruction (FBAO)
- Upper airway obstruction not from a foreign body

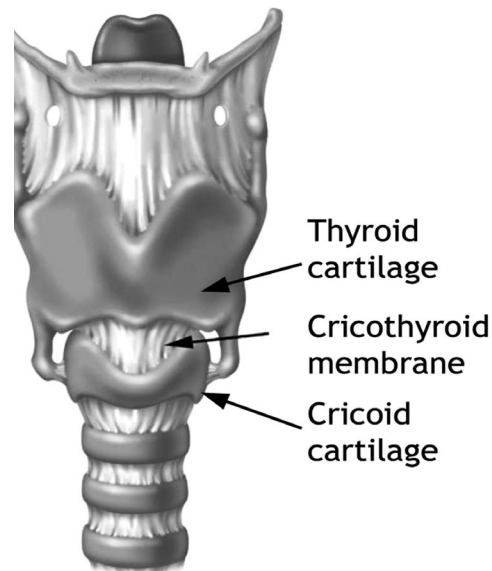
Contraindications

- Ability to secure the airway by other means
- Unable to locate anatomical landmarks
- Laryngeal injury

Procedure for Paramedic

Surgical (>8 years old):

- Assemble all equipment
- Place the head/neck in the neutral position
- Locate and stabilize the larynx with your non-dominant hand
- Locate the cricothyroid membrane
- Clean the area with alcohol prep
- Pull the skin taut over the cricothyroid membrane
- Make a vertical incision to the skin over the membrane
- Identify the cricothyroid membrane
- With the scalpel vertical to the cricothyroid membrane, puncture the membrane
- Insert the bougie (curved tip first) through the incision and angled towards the patient's feet
- You should feel the tip of the bougie 'click' as it passes along the tracheal rings
- Secure the scalpel
- Advance a 6.0 ET tube over the bougie and into the opening in the trachea
- Remove bougie while stabilizing ET tube
- Inflate the pilot balloon
- Ventilate with 100% O₂
- Confirm ET tube placement
 - Monitor adequacy of ventilations
 - Document ETCO₂ value (Appendix F)
- Secure the ET tube with tape





Cricothyrotomy

Medical Director Review Date 08/2025

Needle (≤ 8 years old):

- Assemble all equipment
- Place the head/neck in the neutral position
- Locate and stabilize the larynx with your non-dominant hand
- Locate the cricothyroid membrane
- Clean the area with alcohol prep
- Direct a 16g angiocath 45-60 degrees caudally
- Puncture the cricothyroid membrane with the needle
- Advance the catheter over the needle
- Attach a 10cc syringe and aspirate air to confirm placement in the trachea
- Once the catheter is in the trachea, attach a 3 mL syringe to the catheter and attach a 7.0 ETT adapter to the syringe
- Ventilate via BVM
- Secure with 4x4's and tape and dedicate one member to maintain control of the catheter throughout transport to prevent dislodgement or kinking
- Needle cricothyrotomy may provide adequate oxygenation for a limited time, rapid transport is necessary





Pediatric Restraint device

Medical Director Review Date 08/2025

Indications

- Transporting a non-immobilized pediatric patient
 - Use of this device should be the standard. Exceptions may be made based on the child's level of distress
 - A car seat is a viable option to the Pediatric Restraint Device. Both methods are better alternatives than a parent's lap

Procedure for EMT or Paramedic

- Place Pediatric Stretcher Restraint Device (PSRD) on the stretcher pad
- Release the buckles from the long strap and the 2 smaller straps
- Open it and lay it flat on the stretcher pad
- Wrap the large strap from the PSRD around the head portion of the stretcher, close the buckle and tighten the strap
- Wrap the short straps from the PSRD around the stretcher rail, close the buckle and tighten the strap
 - Pick a point closest to the strap
- Open the buckle on the "V" strap of the PSRD
- Open the buckle on the lateral chest strap
- Place the child on the stretcher and on top of the PSRD
- Secure the patient in the PSRD by bringing the "V" strap over the patient's head
- Connect the "V" strap to the groin strap, close the buckle and tighten the strap
- Pad around the child if there are any gaps between the patient and the PSRD
- Close the lateral chest strap buckle and tighten
- Always document every use of the PSRD in the PCR

Caution

- Do not cut any portion of the device



Appendix L

Pediatric Restraint device

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Tourniquet

Medical Director Review Date 08/2025

Indications

- To control potentially fatal extremity hemorrhage only after other means of hemorrhage control has failed. Examples may include an amputation, profuse pulsating bleeding, blood soaking through pressure bandage and signs of shock with continued bleeding

Procedure for EMT or Paramedic

- First attempt to control hemorrhage by using direct pressure over bleeding area
- If a bleeding vessel can be identified, point pressure over bleeding vessel is more effective than a large bandage applying diffuse pressure

If unable to control hemorrhage using direct pressure, apply **SOF® Tactical Tourniquet**:

1. Cut away any clothing so that the tourniquet will be clearly visible. NEVER obscure a tourniquet with clothing or bandages
2. Select location proximal to the wound and not across any joints
3. Place tourniquet 2-3" proximal to the wound
 - Slide tourniquet over extremity if possible. Otherwise, unbuckle tourniquet, go around the limb and then re-buckle
 - If a single tourniquet is not sufficient to stop the bleeding, apply a second tourniquet more proximal to the first
4. Pull tail tight
5. Twist handle until bleeding stops. Applying tourniquet too loosely will only increase blood loss by inhibiting venous return
6. Lock handle into triangle
7. Mark the time and date of application on the patient's skin next to the tourniquet
8. Keep tourniquet on throughout hospital transport – a correctly applied tourniquet should only be removed by the receiving hospital. This also applies to tourniquets placed prior to JFRD arrival (i.e., JSO)
9. Consider analgesic: Adult and pediatric, **Fentanyl 1 mcg/kg slow IVP only; maximum single dose 100 mcg**. Capnography is required after analgesic/sedative administration (Appendix F). Dose may be repeated every 5-10 minutes. **Total maximum dose 200 mcg**
10. A patient that requires a tourniquet from a traumatic injury should be transported to a hospital with trauma capabilities, with a Trauma Alert declared when appropriate



Tourniquet

Medical Director Review Date 08/2025

Precaution

- Injury due to a properly applied tourniquet is unlikely if the tourniquet is removed within 1-2 hours. In cases of life-threatening bleeding, benefit outweighs theoretical risk
- A commercially made tourniquet is the preferred tourniquet. If none is available, a blood pressure cuff inflated to a pressure sufficient to stop bleeding is an acceptable alternative. Other improvised tourniquets are not allowed

Prior to application and still buckled:



Properly applied with handle locked in triangle:





SAM Pelvic Splint

Medical Director Review Date 08/2025

Indications

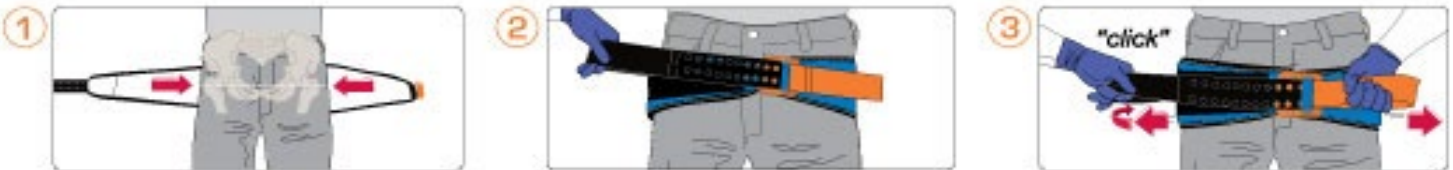
- Unstable pelvis

Procedure for EMT and Paramedic

- Remove all objects from the patient's pockets
- Lay the splint out next to the patient's pelvis (printed side down)
- Slide the splint under the pelvis at the level of the bottom of the buttock (figure 1)
- Wrap the black strap completely through the buckle (figure 2)
- Hold the orange strap and PULL the black strap in the opposite direction (figure 3)
- Pull until you hear the "Click"
- Maintain the tension and press the black strap onto the Velcro® portion of the splint

Cautions

- Do not use on pediatric patients
- Do not cut any portion of the splint





Appendix N

SAM Pelvic Splint

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Spinal Immobilization

Medical Director Review Date 08/2025

The goal of spinal immobilization is to prevent neurologic damage or limit the extent of a spinal cord injury.

Purpose

- To provide guidelines and recommendations for determining full or partial spinal immobilization

Indications for full spinal immobilization

- Numbness, tingling, or motor weakness in any extremity
- Point tenderness over the spinal process
- Neck pain that worsens with movement
- Head injury with GCS <15
- Significant mechanism of injury such as ejection, high falls, and abrupt deceleration crashes
 - An intoxicated patient who suffers a significant mechanism of injury must receive spinal immobilization regardless of whether they are alert and oriented
- Presence of significant distracting injuries

Indication for partial immobilization (cervical collar only)

- Isolated neck pain with none of the indications above
- Any patient <5 or >65 who has experienced a mechanism of injury which could result in spinal injury (e.g. falls with head injury)
- Patient who refuses or can't tolerate full spinal immobilization
 - Deviation must be documented in the PCR

Ambulatory back pain patients from an MVC without any of the above indications do not require spinal immobilization

Precaution

- If there is any doubt during the evaluation of the spine, it is better to immobilize
- Patients with spinal curvature or rounding of the back may require improvised (towels, blanket, pillow, etc.) immobilization

The Kendrick Extrication Device (KED) may be useful in immobilizing a patient found in a sitting position. It is most commonly used in automobile accidents where the patient needs to be transitioned from the vehicle to the long backboard. If the patient is unstable, the KED is not appropriate as it is too time consuming

In penetrating injury to the head, neck, or torso with no evidence of spinal injury, immobilization is not necessary

Infants and children less than 60 lbs, use Pedi-Immobilizer™ when appropriate.



Spinal Immobilization

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Intraosseous Access

Medical Director Review Date 08/2025

Intraosseous Access (IO)

- May be used in adult or pediatric patients
- IO may be considered earlier in the arrest setting
- **Proximal Humerus is preferred site for volume resuscitation (except newborn/infants)**
- **Proximal Tibia is preferred site in cardiac arrests and medication administration only**
- IO insertion site selection is not affected by paralysis

Criteria for IO access

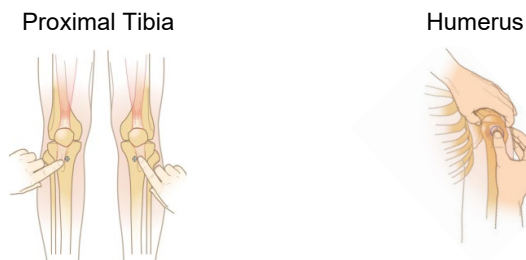
- Must meet all the following in the non-arrest patient:
 - Urgent need for fluid/medication administration
 - Two failed IV attempts or more than 90 seconds
 - Severe cardiovascular compromise or unconscious/unresponsive

Contraindications

- The humerus is contraindicated in newborns and infants
- The ability to readily obtain peripheral or external jugular IV access
- Fracture of the tibia, femur, or pelvis (consider humerus)
- Fracture of the humerus (consider proximal tibia)
- Excessive tissue at the selected insertion site (consider alternative site)
- Inability to identify appropriate anatomical landmarks
- Infection at the selected site
- Previous significant orthopedic procedures (e.g., IO within 24 hours, joint replacement)
- Compromising pre-existing medical condition (e.g., bone cancer, peripheral vascular disease)

Procedure

- Don appropriate PPE
- Identify appropriate indication(s) and absence of contraindications
- Select the site and identify the appropriate landmarks
 - Humerus
 - Proximal tibia (medial aspect)
- Cleanse insertion site with alcohol swab





Intraosseous Access

Medical Director Review Date 08/2025

- **Utilize EZ-IO® driver and appropriate needle set**
 - Needle selection will be based on the amount of soft tissue at the insertion site. Gauge the amount of soft tissue by pressing the site with your thumb and correlate the finding with the appropriate needle length. Better too long than too short
 - **Pink – 15mm long (3-39kg)**
 - **Blue – 25mm long (40kg and above)**
 - **Yellow – 45mm long (excessive tissue)**
 - Stabilize site and manually insert the needle set through the skin until it contacts the surface of the bone; DO NOT power (operate or squeeze trigger) the driver
 - Ensure black mark is visible on the needle. If not, remove needle, it is too short
 - Power the driver with firm and steady pressure until a sudden lack of resistance is felt indicating entrance into the bone marrow canal
 - Unnecessary excessive pressure will slow the drill (simulates a dying battery)
 - Remove the EZ-IO® driver from the needle set while stabilizing the catheter hub
 - Remove the stylet and secure it in a sharp's container
 - Confirm placement:
 - **IO catheter stands firmly seated** at a 90-degree angle to the insertion site
 - Able to aspirate blood
 - Fluids flow without evidence of extravasation
 - IO site should remain visible
 - IO should only be secured using commercial device, if available (no gauze)
 - Connect flushed EZ-Connect® or standard luer lock extension set
 - Conscious or semi-conscious patient administer **Lidocaine** for suppression of intramedullary pressure receptors; **allow 1 minute for anesthetic effect**
 - Flush the EZ-Connect® or extension set with Lidocaine
 - Adult patient: **20 - 40mg IO slow push**
 - Flush with 10mL intravenous fluid
 - Pediatric patient: **0.5mg/kg IO slow push; maximum dose 40mg**
 - Flush with 10mL intravenous fluid
 - Unconscious patient:
 - Flush site with 10mL intravenous fluid
 - Utilize a pressure infusion bag for intravenous fluid administration
 - Medication infusion - follow all medication infusions with 10mL intravenous fluid flush
 - Dress site and secure tubing
- **Manual Pediatric IO** (only for use when EZ-IO® is unavailable)
 - Restricted for use in the proximal tibia only
 - Procedures are the same as with the EZ-IO® as listed above with the following adjustments
 - Stabilize child's leg and begin insertion from a 90-degree angle to the plane of the tibial plateau
 - Gently advance the needle set into position—do not force. Stop when you feel the “pop” on smaller patients



Intraosseous Access

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Removal

- Monitor the EZ-IO site for evidence of leakage (extravasation) underneath the skin
 - If it is determined that the EZ-IO needle is not properly placed (extravasation noted), it will be removed prior to delivering the patient to the receiving facility
 - Attached a 10mL syringe to the catheter hub
 - Support the insertion site while rotating the syringe clockwise and gently pull the catheter out without rocking
 - If a catheter hub separation occurs grasp the catheter with a hemostat, rotate clockwise and gently pull the catheter out without rocking
 - Secure the catheter in an appropriate sharp's container
- A properly placed EZ-IO is NOT to be removed in the field; the patient MUST be transported to the appropriate receiving facility



Intraosseous Access

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Sports Helmet Removal

Medical Director Review Date 08/2025

In **all circumstances**, the **face mask should be removed first** for airway access. Also, cutting the ties of the shoulder pads can be performed (both anteriorly and under the arms) to allow for access to the chest if needed for cardiopulmonary resuscitation (CPR).

Equipment (helmet and shoulder pads) should be left in place until arrival to the ED, unless the circumstance dictates removal. When equipment removal is necessary, it needs to follow the “all or nothing” principle, meaning removed together. As the helmet and shoulder pads work together to help maintain a neutral spine when they are properly fitted, removing the helmet without the shoulder pads will lead to cervical spine hyperextension, potentially worsening an injury.

Team athletic trainers or health care professionals may be present and possess special training and knowledge related to the removal of sports equipment.

Procedure

- Stabilize helmet in a neutral in-line position
- Second individual removes the chin strap
- The individual that removes the chin strap will support the occipital and mandible of the patient
- The individual that stabilized the helmet then gently removes the helmet
- Once helmet is removed, apply C-collar and immobilize on a long back board, KED, or pediatric immobilization device
- If unable to remove helmet:
 - Assure the face shield/mask has been removed for airway access
 - Assure spinal immobilization with tape and towels





Sports Helmet Removal

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Appendix R

Advanced Trauma Care Bag

Medical Director Review Date 08/2025



Purpose

- With an assortment of advanced trauma care contents, these trauma kits are designed primarily for deployment at mass casualty incidents.

Contents

- **HALO VENT** - Adhesive, vented seal for treating penetrating chest injuries. Each package contains one vented and one non-vented seal. The vented seal should be applied anterior (with seal hole centered over wound) and the non-vented seal placed posterior. Prior to placement, ensure the skin is wiped of blood and sweat.



- **Z-PACK DRESSING** - Highly absorbent cotton gauze that is "Z-Folded" for ease in packing wounds.





Appendix R

Advanced Trauma Care Bag

Medical Director Review Date 08/2025

- **HEMORRHAGE CONTROL BANDAGE** - The Emergency Bandage (or Israeli bandage) is an elasticized bandage with a built-in pressure bar that can be twisted to apply more pressure to a wound. Designed to be applied on top of existing gauze/packing



- **CHITO GAUZE** - Hemostatic (promotes coagulation) dressing for the external, temporary control of severely bleeding wounds.



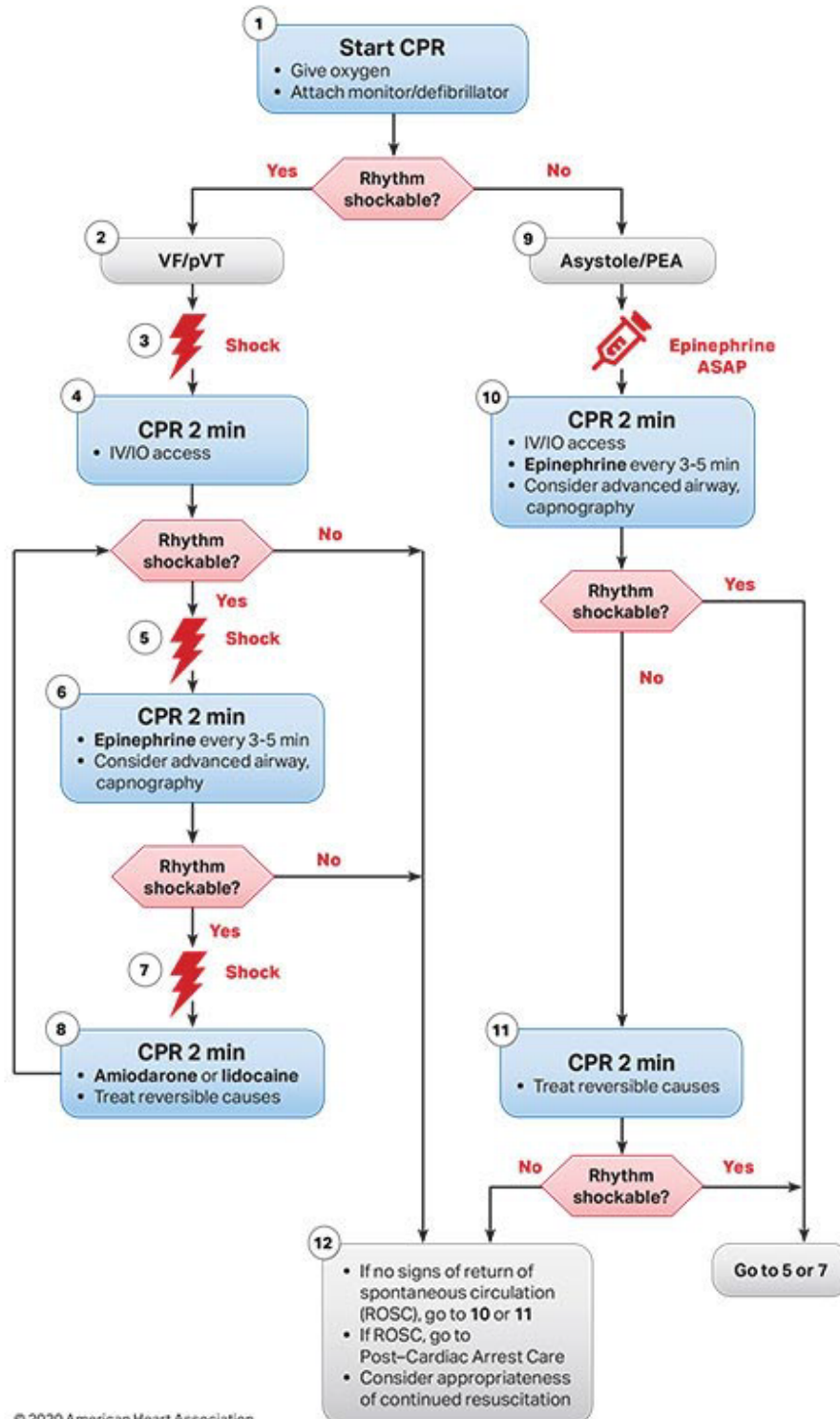
- **DRAG BLANKETS**
- **TOURNIQUETS**
- **DECOMPRESSIONS NEEDLES**
- **SHEARS**
- **ACE BANDAGES**
- **TRAUMA DRESSING**
- **4 X 4 GAUZE**



AHA Adult Cardiac Arrest Algorithm

Medical Director Review Date 08/2025

Adult Cardiac Arrest Algorithm (VF/pVT/Asystole/PEA)



CPR Quality

- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Change compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
 - If PETCO₂ is low or decreasing, reassess CPR quality.

Shock Energy for Defibrillation

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

Drug Therapy

- **Epinephrine IV/IO dose:** 1 mg every 3-5 minutes
- **Amiodarone IV/IO dose:** First dose: 300 mg bolus. Second dose: 150 mg, or
- **Lidocaine IV/IO dose:** First dose: 1-1.5 mg/kg. Second dose: 0.5-0.75 mg/kg.

Advanced Airway

- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions

Return of Spontaneous Circulation (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in PETCO₂ (typically >40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary



Appendix S

AHA Adult Cardiac Arrest Algorithm

Medical Director Review Date 08/2025

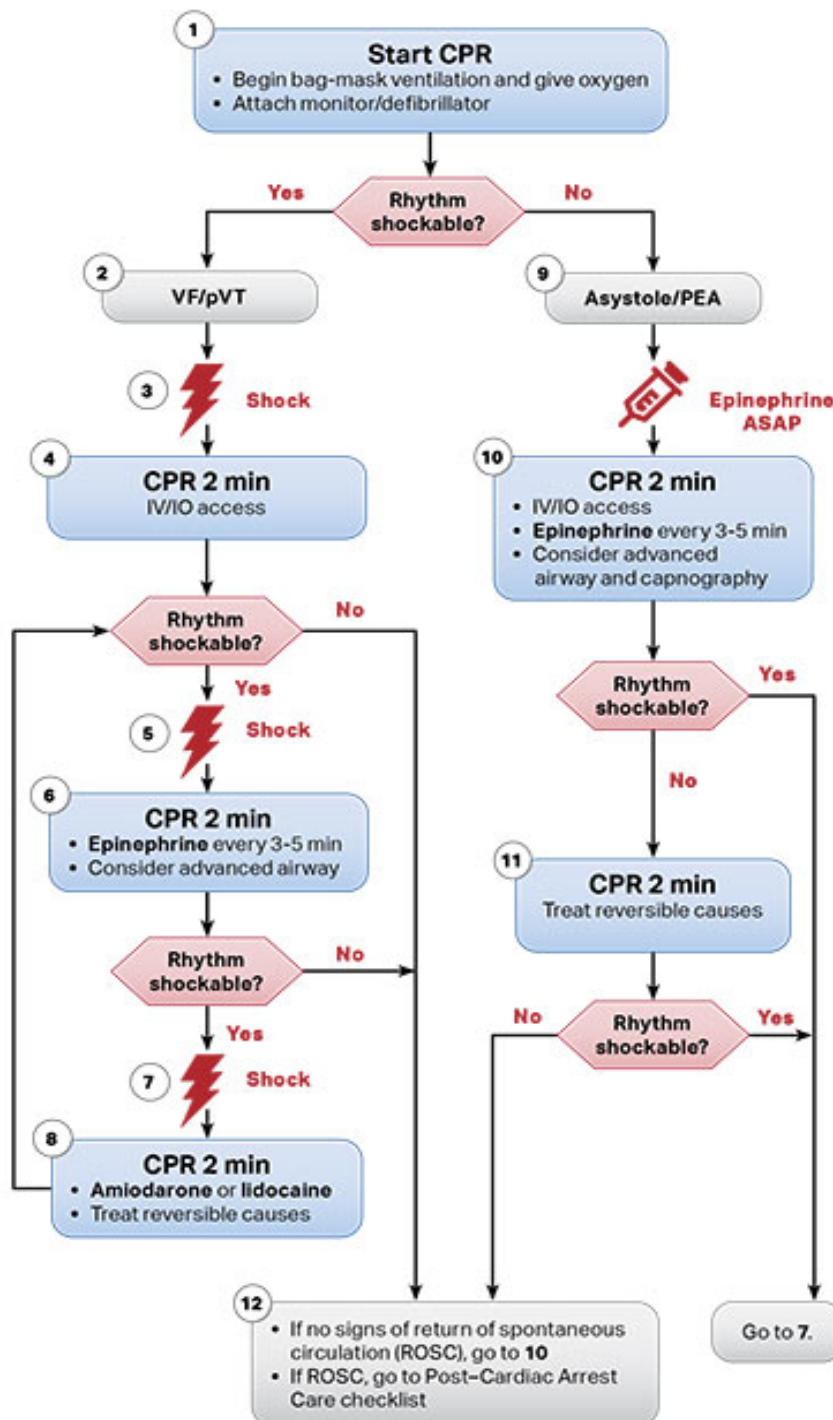
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AHA Pediatric Cardiac Arrest Algorithm

Medical Director Review Date 08/2025

Pediatric Cardiac Arrest Algorithm



CPR Quality

- Push hard ($\geq \frac{1}{2}$ of anteroposterior diameter of chest) and fast (100-120/min) and allow complete chest recoil
- Minimize interruptions in compressions
- Change compressor every 2 minutes, or sooner if fatigued
- If no advanced airway, 15:2 compression-ventilation ratio
- If advanced airway, provide continuous compressions and give a breath every 2-3 seconds

Shock Energy for Defibrillation

- First shock 2 J/kg
- Second shock 4 J/kg
- Subsequent shocks ≥ 4 J/kg, maximum 10 J/kg or adult dose

Drug Therapy

- **Epinephrine IV/IO dose:** 0.01 mg/kg (0.1 mL/kg of the 0.1 mg/mL concentration). Max dose 1 mg. Repeat every 3-5 minutes. If no IV/IO access, may give endotracheal dose: 0.1 mg/kg (0.1 mL/kg of the 1 mg/mL concentration).
- **Amiodarone IV/IO dose:** 5 mg/kg bolus during cardiac arrest. May repeat up to 3 total doses for refractory VF/pulseless VT
- **Lidocaine IV/IO dose:** Initial: 1 mg/kg loading dose

Advanced Airway

- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement

Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypoglycemia
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

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Appendix T

AHA Pediatric Cardiac Arrest Algorithm

Medical Director Review Date 08/2025

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Appendix U

Airway Clearance Device (LifeVac)

Medical Director Review Date 08/2025

The LifeVac kit contains one suction unit with a one-way valve and two face masks (adult and pediatric). The device is a non-powered, non-invasive, single use only airway clearance device for resuscitating a choking victim when other standard measures have been unsuccessful.

Indications

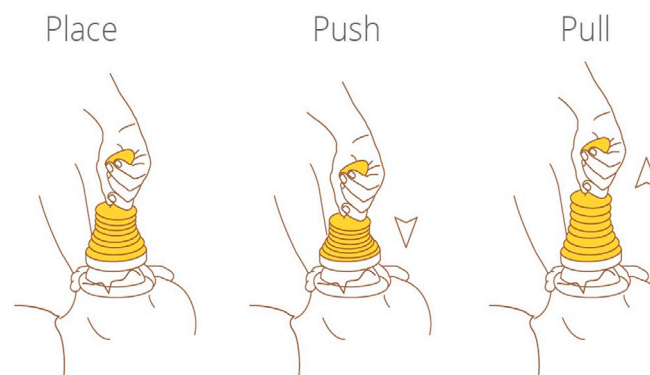
- Standard maneuvers to remove a foreign body airway obstruction have failed

Contraindication

- Pediatrics weighing <10kg

Procedure for EMT and Paramedic

1. Select appropriately sized mask.
2. Insert mask into the unit with a twisting motion while applying pressure.
3. Place mask over nose and mouth.
4. Holding mask in place with one hand and chin held upwards, push handle down with the other hand to compress unit.
5. Once handle is depressed, pull handle upward with a short, SWIFT tug while holding mask firmly in place.
6. Roll patient to side and sweep the mouth to clear any debris. Also check unit for debris.
7. Repeat steps as necessary.





Appendix U

Airway Clearance Device (LifeVac) Medical Director Review Date 08/2025

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Appendix V

Abbreviations

Medical Director Review Date 08/2025

Abbreviation	Meaning
ABCs	Airway, Breathing, Circulation
Abd	Abdomen
ABPD	Atlantic Beach Police Department
A/C	Antecubital fossa
ACLS	Advanced Cardiac Life Support
AED	Automated External Defibrillator
AICD	Automated Implantable Cardioverter Defibrillator
AIDS	Acquired Immune Deficiency Syndrome
ALOC	Altered Level of Consciousness
ALS	Advanced Life Support or Amyotrophic Lateral Sclerosis
AMA	Against Medical Advice
AMS	Altered Mental Status
AMI	Acute Myocardial Infarction
amt.	Amount
AOx3 / AOx4	Alert and oriented times 3 or times 4
A/P	Anteroposterior
ASA	Aspirin
ASAP	As soon as possible
ATU	Air Transport Unit
ATV	All-Terrain Vehicle
BBB	Bundle Branch Block
BBS	Bilateral Breath Sounds
BGL	Blood Glucose Level
B/F	Black Female
B/M	Black Male
BLS	Basic Life Support
BM	Bowel Movement
BP	Blood Pressure
BPM	Beats Per Minute
BS	Blood Sugar or Breath Sounds
BSA	Body Surface Area (Burns)
BSI	Body Substance Isolation
BVM	Bag/Valve/Mask
CA	Cancer
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
C/C	Chief Complaint
CHF	Congestive Heart Failure
CID	Cervical Immobilization Device
cm	centimeter
CMS	Circulatory, Motor and Sensory



Appendix V

Abbreviations

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CNS	Central Nervous System
c/o	Complains of
CO	Carbon Monoxide
CO₂	Carbon Dioxide
COPD	Chronic Obstructive Pulmonary Disease
CP	Chest pain
CPR	Cardiopulmonary Resuscitation
CSF	Cerebrospinal fluid
C-spine	Cervical Spine
CTAB	Clear to Auscultation Bilaterally
CVA	Cerebrovascular Accident
D₅W	5% Dextrose in Water
D₂₅W	Dextrose 25%
D₅₀W	Dextrose 50%
D/C	Discontinue or Discharge
D & C	Dilation and Curettage
DKA	Diabetic Ketoacidosis
DM	Diabetes mellitus
DNR	Do Not Resuscitate
DNRO	Do Not Resuscitate Order
DOA	Dead on arrival
DOS	Dead on scene
DOB	Date of birth
DUI	Driving Under the Influence
Dx.	Diagnosis
DVT	Deep Vein Thrombosis
ECG, EKG	Electrocardiogram
ED	Emergency Department
EDD	Estimated due date
EEG	Electroencephalogram
ETA	Estimated time of arrival
ETCO₂	End-tidal Carbon Dioxide
ENT	Ears, Nose and Throat
EOM	Extra-ocular Movement
epi	Epinephrine
est.	Estimate(d)
ET	Endotracheal
ETT	Endotracheal tube
ETOH	Ethyl Alcohol
FSED	Freestanding Emergency Department
g	gauge (diameter) or gram
GCS	Glasgow Coma Scale
GI	Gastrointestinal



Appendix V

Abbreviations

Medical Director Review Date 08/2025

GSW	Gunshot Wound
gtt(s)	Drop(s)
GYN	Gynecology
H₂O	Water
HEENT	Head, Ears, Eyes, Nose and Throat
H/F	Hispanic Female
H/M	Hispanic Male
HBV	Hepatitis B Virus
hgb	Hemoglobin
HIV	Human Immunodeficiency Virus
hosp.	Hospital
HPI	History of Present Illness
HTN	Hypertension
Hx	History
ICP	Intracranial Pressure
ICS	Intercostal Space
IDDM	Insulin Dependent Diabetes Mellitus
IM	Intramuscular
INT	Intermediate IV access; used when no fluids are being administered
IO	Intraosseous
IV	Intravenous
IVP	Intravenous Push
J	Joules
JVD	Jugular Venous Distension
kg.	Kilogram
KVO	Keep Vein Open
L & D	Labor and Delivery
L, l	Liter
lac	Laceration
LBB	Long Back Board
LBBB	Left Bundle Branch Block
lb(s)	Pound(s)
L/min	Liters Per Minute
LLQ	Left Lower Quadrant
LMP	Last Menstrual Period
LOC	Loss of Consciousness or Level of Consciousness
LPM/lpm	Liters Per Minute
LSB	Long Spinal Board
LUQ	Left Upper Quadrant
MAE	Moves All Extremities
mA	Milliampere
mcg	Microgram
MCI	Mass Casualty Incident



Appendix V

Abbreviations

Medical Director Review Date 08/2025

MD	Medical Doctor
meds	Medications
mEq	Milliequivalent
MI	Myocardial Infarction
mg.	Milligram
mL	Milliliter
mm	Millimeters
MOE	Movement of Extremities
MVA	Motor Vehicle Accident
NaCl	Sodium Chloride
NAD	No Acute Distress
NC	Nasal Cannula
NIDDM	Non-insulin dependent diabetes mellitus
NKA	No Known Allergies
NKDA	No known drug allergies
N/G	Nasogastric
NPO	Nothing by Mouth
NRB/NRBM	Non-Rebreather Mask
NS	Intravenous fluids
NSR	Normal Sinus Rhythm
NTG	Nitro/Nitroglycerin
N/V	Nausea and Vomiting
O₂	Oxygen
OB	Obstetrics
OB/Gyn	Obstetrics/Gynecology
OD	Right Eye or Overdose
OPQRST	Onset, Provocation, Quality, Radiation, Severity and Time
OR	Operating Room
P	Pulse
PAC	Premature Atrial Contraction
PCI	Percutaneous Coronary Intervention
PCP	Primary Care Physician
PE	Pulmonary Edema or Pulmonary Embolism
PEA	Pulseless Electrical Activity
PERL	Pupils Equal and Reactive to Light
PERLA	Pupils, Equal, Reactive to Light, and Accommodating
PERRLA	Pupils, Equal, Round, Reactive to Light, and Accommodating
PID	Pelvic Inflammatory Disease
PJC	Premature Junctional Contraction
PMH/PMHx	Past Medical History
PO	By Mouth
POV	Privately Owned/Operated Vehicle



Appendix V

Abbreviations

Medical Director Review Date 08/2025

PPE	Personal Protective Equipment
PRN	As Needed
PSVT	Paroxysmal Supraventricular Tachycardia
Pt	Patient
PTA	Prior to Arrival
PVC	Premature Ventricular Contraction
Px.	Physical History
RBBB	Right Bundle Branch Block
RBC	Red Blood Cell Count
RLQ	Right Lower Quadrant
R/O	Rule Out
ROM	Range of Motion
ROSC	Return of Spontaneous Circulation (Return of Pulses)
RR	Respiratory Rate
RUQ	Right Upper Quadrant
SAMPLE	Signs/Symptoms, Allergies, Medications, Past Hx, Last Oral Intake, Events Prior to Illness
SIDS	Sudden Infant Death Syndrome
SL	Sublingual
SOB	Short of Breath
SQ, SC, Sub Q	Subcutaneous Injection of Medication
SpO2	Saturation of Oxygen on the Red Blood Cells
SpCO	Saturation of Carbon Monoxide on the Red Blood Cells
STEMI	ST Elevated Myocardial Infarction
S/S	Signs and Symptoms
SVT	Supraventricular tachycardia
tab.	Tablet
TB	Tuberculosis
Temp.	Temperature
TIA	Transient Ischemic Attack
TKO	To Keep Open
TTP	Trauma Transport Protocol
Tx	Treatment
ULQ	Upper Left Quadrant
VFib (VF)	Ventricular Fibrillation
VTach (VT)	Ventricular Tachycardia
VS	Vital Signs
WBC	White Blood Cell Count
W/D	Warm and Dry
W/F	White Female
W/M	White Male
WNL	Within Normal Limits



Appendix V

Abbreviations

Medical Director Review Date 08/2025

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Medical Authorization

EMT VERSION

This excerpt of SOG 430 is limited to EMT-level content.

AUTHORIZATION

These treatment guidelines were developed under the authorization of the below-signed Medical Director in accordance with Florida Statute 401, Chapter 64J-1 and 64J-2 of the Florida Administrative Code. Changes to these guidelines can only be made with the authorization of the Jacksonville Fire and Rescue Department Medical Director, Division Chief of Rescue and Fire Chief.

Bradley J. Elias, M.D.
Medical Director

A handwritten signature in black ink that reads "Bradley J. Elias M.D." is positioned below the printed name. A large, yellow, diagonal watermark with the word "EMT" is overlaid on the signature area.

Created 04/16
Last Revision 02/23



Medical Authorization

A special *Thank You* to the following individuals for their contributions, talent, and time during this latest revision of the Jacksonville Fire/Rescue EMS SOG:

Medical Director Brad Elias, M.D.

Division Chief David Castleman

Deputy Division Chief Jake Blanton

Assistant Chief Brien Marx

District Chief Maurice Williams

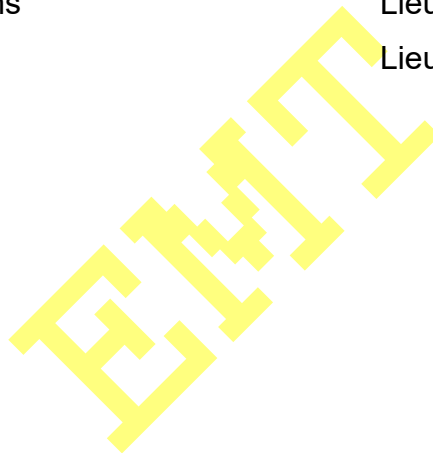
Captain Harry Hutchens, IV

Captain Lawrence Mack

Captain Michael Rady

Lieutenant Matt Avera

Lieutenant Derek Golden





Administrative Policy

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EMT



Administrative Policy

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EMT



Administrative Policy

Chapter 1

Administrative Policies



Administrative Policy

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EMT



Introduction

Medical Director Review Date 12-7-2022

Purpose

The guidelines and treatments contained within this document are intended to ensure uniform treatment for all patients who receive pre-hospital care by JFRD personnel and auxiliary affiliations.

Scope

These guidelines have been written to cover all medical emergencies; however, the Medical Director realizes that unforeseen scenarios or situations may arise. In these cases, JFRD personnel should attempt to follow the most appropriate intervention and contact online medical control (receiving physician) for treatment recommendations outside the scope of these guidelines.

Medical Direction

Providing Emergency Medical Services is the responsibility of all members of the JFRD. All EMTs and Paramedics must function under the direction of a Medical Director as mandated by F.S. 401.265 and F.A.C. 64J-1.004. The Medical Director functions autonomously as administrator of clinical care and medical ethics for the Fire and Rescue personnel who work under his medical license.

Standard of Care

It is the philosophy of the JFRD that the well-being of the patient is our primary concern. This is accomplished by practicing the highest standard of care as defined by current medical science and treatment guidelines, as well as federal, state, and local laws.

The standard of care is dynamic, changing and improving regularly. Every member of the JFRD is responsible for maintaining their EMT and Paramedic skills to meet the current standard of care.

Ocean Rescue (COJ Lifeguards)

Personnel will operate within these treatment guidelines and initiate treatment only within their scope of practice.

First Responders will perform those procedures they are credentialed and/or have been trained to perform such as blood pressure check, CPR, glucose check, spinal immobilization, tourniquet application, splinting, etc.

Mutual Aid/Deployment

JFRD treatment guidelines are permitted in mutual aid jurisdictions. Deployments using JFRD treatment guidelines will be approved on an as needed basis by the Medical Director and Division Chief of Rescue.



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Introduction

Medical Director Review Date 12-7-2022

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EMT



Scope of Practice

Medical Director Review Date 12-7-2022

All JFRD Field Personnel

EMTs and Paramedics are trained in basic and advanced emergency medical procedures and certified by the Florida Department of Health.

- Responsibilities (not inclusive):
 - Perform scene assessments for safety
 - Perform primary and secondary patient assessments as appropriate, including obtaining vital signs
 - A primary assessment consists of general appearance with initial emphasis on airway, breathing, and circulation. This is accomplished with a full head to toe assessment.
 - A secondary assessment consists of a focal exam of the affected body systems, with a detailed history
 - A complete set of vital signs includes the following: blood pressure, heart rate, pulse oximetry, respirations, blood sugar (when indicated), and temperature (when indicated)
 - Be familiar with all equipment and procedures as listed in this document
 - Be familiar with and provide appropriate treatment as listed in this document
 - Utilize appropriate infection control practices to reduce risk of exposure(s)
 - Be familiar with and comply with various reporting requirements as listed in this document
 - Be familiar with and follow the instructions found in F.A.C. 64J-(1)(2)
 - Always display professional conduct, which includes providing full name, rank, and assignment when requested
 - Comply with all EMS related laws, regulations, and policies
 - Comply with the patient care report (PCR) signature requirements as set forth by the Centers for Medicare & Medicaid Services (CMS)
 - **Complete all PCRs by the end of shift**



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Scope of Practice

Medical Director Review Date 12-7-2022

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DRAFT



Consent and Capacity

Medical Director Review Date 12-7-2022

Patients and Patient Encounters

A **patient** shall be defined as: a person who presents with subjective and/or objective signs and/or symptoms or a complaint which results in evaluation and/or treatment.

- Someone who arrives at a fire station requesting a blood pressure check and also verbalizes a medical complaint will be considered a patient and a full patient care report must be completed

A **patient encounter** does not require treatment, transport, or cooperation from the patient. If a technician perceives a medical problem that requires evaluation, a patient encounter has been made and a full patient care report must be completed.

If JFRD units arrive at a crash scene and those involved indicate they are "ok" and the technician sees no signs or symptoms that would warrant evaluation or treatment, **no** patient encounter has been made

Capacity versus Competency

Medical decision-making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment). Capacity is the basis of informed consent. Patients have medical decision-making capacity if they can demonstrate understanding of the situation, the consequences of their decision, reasoning in their thought process, and if they can communicate their wishes.

Competency is a global assessment and legal determination made by a judge in court.

Informed Consent

A patient with medical decision-making capacity is considered to give informed consent when any of the following occur:

- Patient gives verbal permission to treat
- Patient gives written permission to treat
- Patient does not object as you begin assessment

To give informed consent, a patient must be legally allowed to act as an adult. This means that the patient must be:

- At least 18 years of age
- **OR**
- Emancipated
 - Less than 18 and married or legally released from custody of parent or guardian
- **Exceptions**
 - An unmarried pregnant minor may consent to or refuse treatment for medical problems related to her pregnancy only
 - An unmarried minor mother may consent to or refuse treatment for her child



Consent and Capacity

Medical Director Review Date 12-7-2022

Withholding Consent for Treatment

An adult with medical decision-making capacity may withhold consent to treat. A parent with medical decision-making capacity may withhold consent to treat their child. This shall be documented in the patient care report. Personnel shall obtain the patient/parent signature on the refusal form. If the patient/parent refuses to sign, have a witness of the refusal sign the refusal form and select "Not Signed – Unwilling/Refused to Sign."

- Patients/parents are not considered to have medical decision-making capacity if any of the following are present:
 - Significant mental impairment (e.g., alcohol, drugs, head injury or significant illness)
 - Resident in a memory care facility
 - At risk for self-harm, suicide, or homicide

Treatment of Children

In the case of children under the care of a parent or legal guardian, consent must be obtained from the parent or legal guardian. If consent cannot be obtained, follow Florida Statute 743.064

If medical personnel are concerned for the safety of a minor and the parent or legal guardian refuses treatment and transport, contact the Rescue District/Battalion Chief and law enforcement for guidance.

Florida Statute 743.064

Emergency medical care or treatment to minors without parental consent

- (1) Emergency medical care or treatment may also be rendered in the pre-hospital setting by paramedics, emergency medical technicians, and other emergency medical services personnel, provided such care is rendered consistent with the provisions of chapter 401. These persons shall follow the general guidelines and notification provisions of this section.
- (2) This section shall apply only when parental consent cannot be immediately obtained for one of the following reasons:
 - (a) The minor's condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the minor to the hospital.
 - (b) The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.
- (3) Notification shall be accomplished as soon as possible after the emergency medical care or treatment is administered. The hospital records shall reflect the reason such consent was not obtained and shall contain a statement by the attending physician that immediate medical care or treatment was necessary for the patient's health or physical well-being. The hospital records shall be open for inspection by the person legally responsible for the minor.
- (4) No person as delineated in subsection (1), hospital, or college health service shall incur civil liability by reason of having rendered emergency medical care or treatment pursuant to this section, provided such treatment or care was rendered in accordance with acceptable standards of medical practice.



Consent and Capacity

Medical Director Review Date 12-7-2022

Approved Health Care Agents

A health care agent is an individual authorized to make medical decisions on behalf of an incapacitated patient. There are three types (as listed below) recognized by the State of Florida which may impact JFRD operations. **If any unusual circumstances arise, contact the Rescue District/Battalion Chief for guidance.**

Durable Power of Attorney (Florida Statute 709)

A Durable Power of Attorney form authorizes a designated individual to handle affairs and conduct business on a patient's behalf. This form is completed in advance of a patient becoming incapacitated. In Florida, the Durable Power of Attorney may include language that allows the designated decision-maker to also make medical decisions. However, because the Durable Power of Attorney is often a lengthy detailed document that includes financial considerations, the Health Care Surrogate form is more commonly utilized in these situations. Should a patient be alert and oriented, they maintain the right to override the form.

Health Care Surrogate (Florida Statute 765.202)

A Health Care Surrogate form authorizes a designated individual to make health care decisions on a patient's behalf. This form is completed in advance of a patient becoming incapacitated. Should a patient be alert and oriented, they maintain the right to override the form.

The Proxy (Florida Statute 765.401)

If an individual is incapacitated and did not previously complete an advance directive (as listed above), decisions regarding the patient's medical treatment are made by a designated Proxy. Because these type situations often occur unexpectedly, a completed Proxy Form may not be present. Regardless, any of the following individuals, in order of priority, may make health care decisions on the patient's behalf:

- The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment
- The patient's spouse
- An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation
- A parent of the patient
- The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation
- An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs
- A close friend of the patient
- A clinical social worker licensed pursuant to chapter 491



Consent and Capacity

Medical Director Review Date 12-7-2022

If there is any doubt as to the authenticity of any of the above documents, JFRD members should provide examination and treatment of the mentally incapacitated in accordance with this SOG and Florida Statute 401.445.

An approved health care agent may verbally revoke a Do Not Resuscitate Order (DNRO) if their signature is appropriately listed on the yellow DNRO form (see Guideline 1130, page 4). However, a healthcare agent **may not** verbally withhold consent for CPR in the absence of a DNRO. Resuscitation may only be withheld or withdrawn upon presentation of a valid DNRO as described in JFRD Resuscitation Guideline 1130.

Florida Patient's Bill of Rights – Information Request

In accordance with Florida Statute 381.026, a patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. JFRD members must provide such information when requested.

Baker Act

In accordance with Florida Statute 394.453, a Baker Act is an involuntary mental health commitment by law enforcement when the patient does not have the capacity to make a medical decision and is believed to be a danger to themselves and/or others.

- If JFRD members feel that a Baker Act is warranted, law enforcement must be contacted
- A Baker Act will not be used as a pretext to provide medical treatment/transportation to an individual who refuses treatment
- JFRD members are not legally authorized to execute a Baker Act



Cooperation with Law Enforcement

Medical Director Review Date 12-7-2022

Responsibilities

- JFRD personnel are to cooperate with law enforcement
- The JFRD is responsible for the welfare of the patient and all medical treatment at the scene of an emergency. Law enforcement is responsible for traffic control and general scene management

Patients in police custody (includes incarceration)

- Patients with mental capacity in police custody can still make decisions about their medical treatment and sign an AMA Refusal or Non-Emergency/Non-Transport Waiver if allowed by law enforcement. If Law enforcement refuses to remove the handcuffs to allow the patient to sign, document in the Narrative section of the PCR that the patient verbalized a refusal of treatment. Select "Not Signed – In Law Enforcement Custody" under the Signature Type tab when selecting Refusal of Assessment/Care/Transport. Have the law enforcement officer sign the Witness signature in the PCR. Also include the officer's ID number
- Transport Destination
 - If the patient is unstable (includes any Alert), transport to the closest most appropriate hospital
 - If the patient is stable, law enforcement will dictate the hospital destination



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Cooperation with Law Enforcement

Medical Director Review Date 12-7-2022

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EMT



Patient Restraints

Medical Director Review Date 12-7-2022

Patients who may be physically restrained

- Patient restraints are to be utilized only when necessary, and in those situations where the patient is exhibiting behavior deemed to present a danger to themselves or to others

Approved methods of restraint

- **Law enforcement**
 - Handcuffs
 - Plastic ties
 - "Hobble" restraints
 - If Law Enforcement restrains the patient, ensure they accompany in the back of the rescue or follow behind in case the restraints need to be removed
- **JFRD personnel**
 - Consider appropriate sedative, as necessary. See Guideline 6030
 - Soft limb restraints
 - Stretcher straps/harness
 - Wide cloth restraints

Care of restrained patients

- **No patient will be restrained in the prone or "hogtied" position**
- Restraints shall not prohibit evaluation of the patient's medical status or injure the patient in any way
- Frequently assess the patient to ensure that the airway is patent, distal limb circulation is adequate and that restraints can be released quickly should the patient's condition deteriorate
- When restraints are in use, circulation to the extremities shall be evaluated at least every 5 minutes
- JFRD personnel shall never leave the restrained patient unattended

Documentation of patient restraint

Documentation of the use of restraints on the EMS field copy report and PCR shall include:

- The patient's behavior necessitating placement of restraints
- The type of restraint used
- Status of circulation distal to restraints at least every 5 minutes



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Patient Restraints

Medical Director Review Date 12-7-2022

This page is for formatting only

EMT



Patient Care Report

Medical Director Review Date 12-7-2022

Patient Care Reports (PCR)

The primary purpose of a PCR (electronic or field copy) is to document the clinical care provided to a patient. The PCR is a legal medical record and must be treated with the same degree of confidentiality as other medical records. The PCR documentation must also satisfy billing processes required for reimbursement. Accurate and legible signatures are critically important in both transport and non-transport reports.

Properly documenting the patient assessment, treatment, interventions, reassessment after interventions and the patient's response to treatment will reduce your liability, and ultimately improve the overall patient care and outcome. Proper documentation also results in more accurate and timely billing.

General

- All patient care reports should be completed as soon as possible and are always required to be completed **by the end of the shift**
 - This is governed by F.A.C. 64J-1.014(14)
 - ANY EXCEPTIONS (e.g., CAD links, disposition code(s), etc.) shall be immediately relayed to QI and the appropriate District/Battalion chief
- All chief officers and captains must review E-Pro daily for outstanding reports to ensure that all reports have been completed on time
- The Suppression Officer will provide the completed EMS field copy to the Rescue Officer
 - This is governed by F.A.C. 64J-1.014(4)
- The Rescue Officer will ensure the EMS field copy is completed and provide the white copy to the hospital
 - This is governed by F.A.C. 64J-1.014(2)
- All EMS field copies must be shredded after completion of the electronic PCR
- The Emergency Pro report system is designed to recognize the report writer as the lead crew member. The proper procedure is for all report authors to ensure their name is listed in the first (top) position on the sign-in roster
- Anytime an ALS procedure is performed, the paramedic's name (unit number is not acceptable) that performed the procedure must be listed in the flow sheet
- Avoid phrases that do not add value
- Always document objectively
- Below is the ONLY approved JFRD format for your PCR Narrative
 - CC: (Chief Complaint)
 - The patient's main complaint (e.g., chest pain)
 - HPI: (History of Present Illness)
 - Exactly how the patient was presented to JFRD personnel (e.g., upon arrival at the patient's residence, the patient was found lying on the bedroom floor...)
 - Complete description of why the patient called 911 (e.g., onset of symptoms and activity related to the complaint)
 - Include a detailed description of the patient's complaints



Patient Care Report

Medical Director Review Date 12-7-2022

- PE: (Physical Exam)
 - Evaluate objective anatomic findings through observation, palpation, percussion, and auscultation
 - For any complaints of pain, document: Onset, Provocation, Quality, Radiation, Severity and Time (OPQRST)
 - Include any associated signs or symptoms that relate to the present illness
 - List any pertinent positive and negative findings
- TX: (Treatment)
 - Describe patient's condition and any changes that occurred during transport and transfer of care at the hospital
 - Document the interventions performed (paint the picture)
 - Document how the patient was moved to the JFRD stretcher (e.g., assisted, carried, sheeted, stair-chaired, etc.) and to the hospital bed, including that a hospital staff member was at the bedside upon patient transfer
 - Unsuccessful interventions must also be documented
- NOTE:
 - This section should be used for any unusual circumstances that occur during the entire duration of the incident. (e.g., patient contact delays, scene delays, patient/family issues, equipment issues, transfer of care issues, etc.)

NON-TRANSPORT DOCUMENTATION (AMA REFUSAL & NON-EMERGENCY)

- If permitted, perform a physical examination
- Assess and document the mental capacity of the patient, to ensure **all** of the following criteria are met:
 - Awake, alert, and fully oriented to person, place, time, and event
 - Is greater than or equal to 18 years of age or a court certified emancipated minor.
 - Is not intoxicated and under the influence of drugs, or otherwise incapable of providing informed consent
- Assess for any trauma or medical illness that may represent a threat to well-being of the patient or alter their ability to make decisions and document findings
- Assess for psychiatric illness (e.g., suicidal/homicidal behavior, hallucinations, delusions, etc.) and document findings
- Assess for the presence of a toxic ingestion or exposure (e.g., alcohol, drugs, narcotics, or CO) and document findings
- If the patient does **not** have the mental capacity to refuse transport:
 - Explain to the patient (or parent/legal guardian), the need for transport
 - Reassure the patient that no harm will result from transport but complications, up to and including death, may result from a delay in treatment
- If the patient continues to refuse care and satisfies Florida Statute 401.445 "Emergency examination and treatment of incapacitated persons":
 - Enlist the aid of law enforcement personnel for patient and crew safety
 - Proceed with transport of the patient



Patient Care Report

Medical Director Review Date 12-7-2022

- If the patient (or parent/legal guardian) has the mental capacity to refuse transport, emphasize:
 - The need for treatment/transportation
 - The risks of refusal of care (including death and disability)
 - The willingness of EMS to transport the patient
 - The patient or parent/legal guardian should call 911 again if there are any changes in their condition
- Document on a patient care report:
 - Details concerning the assessment of mental capacity
 - The following statement must be included in the narrative section:
 - “The patient/parent/guardian was advised multiple times that they needed treatment/transport to the emergency department for evaluation by a physician. The patient/guardian was also advised of the consequences, up to and including death if treatment/transport was refused. The patient/guardian verbalized understanding of the instructions and refused treatment/transport as indicated on the signed AMA refusal. The patient/guardian was advised to call us back if anything changes in their condition.”
 - A full assessment and at least one complete set of vital signs for each patient (If unobtainable, justify reason on report)
 - Any improvement from initial complaint
 - **Care may be refused for a minor (less than 18 years of age) only when all the following criteria are met:**
 - The patient exhibits no historical or physical findings of potentially life, limb, organ threatening injury or illness
 - The patient is not intoxicated and has no alterations in mental status, level of consciousness or vital signs
 - The responsible parent/legal guardian is present and has mental capacity
- **REFUSAL SIGNATURE REQUIREMENTS**
 - The JFRD member executing the refusal must read the statement below aloud to the patient. The individual serving as the witness must observe this statement being read aloud and then then sign acknowledging same in the appropriate section of the refusal form
 - **“You have a health condition that needs to be evaluated by a physician and you need to be transported to the hospital. If you are not transported to the hospital, you may die or be severely disabled.”**
 - Obtain signature of patient (or parent/legal guardian or medical power of attorney if applicable). The officer (regardless of apparatus type) that performed the assessment and obtained the verbal refusal is responsible for acquiring all signature(s) and completing the electronic PCR.
 - No one else can sign for an adult patient with mental capacity (e.g., spouses, relatives, and friends, etc.)
 - If patient refuses to sign, then document “Refused to Sign”



Patient Care Report

Medical Director Review Date 12-7-2022

- Printed name and signature of witness(es) with mental capacity
 - Appropriate witnesses (in order of preference)
 - Spouses, relatives, law enforcement, friends, other fire/rescue personnel
 - **Fellow fire/rescue personnel are an absolute last resort**
- The documented refusal is only valid with an appropriate witness signature
 - The JFRD member who is documenting and executing the legal refusal CANNOT sign as the witness
- Patients with medical decision-making capacity in police custody can still make decisions about their medical treatment and sign an AMA Refusal or Non-Emergency/Non-Transport Waiver if allowed by law enforcement. If Law enforcement refuses to remove the handcuffs to allow the patient to sign, document in the Narrative section of the PCR that the patient verbalized a refusal of treatment. Select "Not Signed – In Law Enforcement Custody" under the Signature Type tab when selecting Refusal of Assessment/Care/Transport. Have the law enforcement officer sign the Witness signature in the PCR. Also include the officer's ID number.
- All signatures shall be acquired on the laptop
 - Any circumstance in which the laptop is unavailable or not functioning, the Officer-in-Charge will select "Laptop Technical Issue" as the reason for not obtaining a signature. If a laptop technical issue occurs:
 - Every field on the **field copy report** must be completed
 - Ensure signature on back of form is in **appropriate** area (AMA refusal or non-emergency non-transport)
 - Include an explanation of the technical issue in the narrative
 - Witness name and signature
 - Signed refusals on the EMS field copy (laptop failure only) will be completed and filed at the station
 - Monthly, completed paper refusals will be forwarded to the Quality Improvement Office



Quality Improvement

Medical Director Review Date 12-7-2022

JFRD Quality Improvement Program

Purpose

The purpose of Quality Improvement is to promote practices that will provide the highest quality, pre-hospital emergency care by utilizing the most well-trained, courteous employees for the benefit of all residents and visitors of the Jacksonville area.

Intent

The Intention of Quality Improvement will be to train. The program will identify individual and system weaknesses and will develop plans to improve patient care.

Authority

The Authority for the continuous Quality Improvement program comes from the Director/Fire Chief in addition to the Medical Director as mandated by F.S. 401 and F.A.C. 64J-1

Annual Review

The program will review present standards of practice at least annually so that they reflect currently accepted medical practices that are of the highest quality.

Administration

Administration of the continuous Quality Improvement Program will be the responsibility of the:

- Medical Director
- Division Chief of Rescue
- Deputy Division Chief/ Rescue
- Quality Improvement Officer

The Director/Fire Chief will appoint the Quality Improvement Officer after receiving recommendations from the Division Chief of Rescue.

Quality Improvement Meetings

The Medical Director and Quality Improvement Officer will communicate on a weekly basis.



Quality Improvement

Medical Director Review Date 12-7-2022

The Quality Improvement process

The Quality Improvement program will be a dynamic process, changing with the identified needs of the department and consisting of the following three aspects:

- Proactive
- Concurrent
- Retrospective

Proactive Quality Improvement

Proactive Quality Improvement will consist of evaluation and training of practices that promote high quality patient care, **prior** to the delivery of patient care by JFRD personnel.

The Quality Improvement Officer, Division Chief of Rescue, and Medical Director will apply an Accepted Standard of Care (ASC) with benchmarks based upon JFRD Rules, this Emergency Medical Services SOG and national standards.

Concurrent Quality Improvement

Concurrent Quality Improvement will consist of supervision and evaluation of practices for quality **during** the delivery of patient care by JFRD personnel. This will be accomplished by the Rescue District/Battalion Chiefs and the Medical Director.

Retrospective Quality Improvement

Retrospective Quality Improvement will consist of the evaluation of practices for quality **after** the delivery of patient care by JFRD personnel.

The Division Chief of Rescue will appoint select individuals to the Quality Improvement Review Committee. The committee will meet as needed.

Practices, which deviate from the SOG or the ASC, will be identified by:

- PCR database queries
- Concerns regarding the delivery of patient care
- Patient outcome reports from the area hospitals
- Patient care complaints



Quality Improvement

Medical Director Review Date 12-7-2022

Emergency-Pro Review Process

The primary purpose of a patient care report (PCR) review is to verify that the clinical care provided to the patient meets the established standards set forth in this EMS SOG. In addition, the report review must also verify that the documentation itself satisfies both legal and billing processes required for reimbursement, up to and including, the presence of a legal and legible signature(s) captured and documented on the PCR prior to departing the medical facility (as noted by the time stamp).

Rescue Captains

- Must review the following reports monthly:
 - **20** PCRs per month to include a sampling from all report authors assigned to that unit during the month, either permanently or temporarily, with an emphasis on refusals and calls of a critical nature

Rescue District/Battalion Chiefs

- Must review all of the following reports monthly, if not already reviewed by a Captain:
 - All Cardiac/Trauma Arrest reports
 - All "Alerts" (Trauma, STEMI, Stroke, etc.)
 - All advanced airways
 - Minimum of **30** PCRs per month to include a sampling from all report authors assigned to their district. This number of reviews may have already been accomplished with criteria above
 - Specific reports identified by the Medical Director

Daily Emergency-Pro PCR Signature Audits

As part of ongoing and continuous improvement in EMS documentation, the Quality Improvement (QI) Office will conduct daily audits of Emergency-Pro patient care reports (PCR) to ensure that the documentation satisfies the legal and billing processes required, up to and including the presence of a legal and legible responsibility signature captured PRIOR to departing the medical facility (as noted by the time stamp in the PCR).

The QI Office receives automated daily queries of Emergency-Pro PCRs that have a responsibility signature timestamp notated **AFTER** the transport unit has gone available from the medical facility. The purpose of the query is not to suggest that the report author acquired a false or inappropriate signature. Rather, the daily query is a means by which the QI Office can determine the signature's appropriateness and validity by further review of the PCR including, but not limited to, the patient's condition and Glasgow Coma Score (GCS); justification provided for a patient not signing the PCR; review of the signature image; and review of the unit's geographical location at the time the signature time-stamp is notated utilizing AVL and GPS software.



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Quality Improvement

Medical Director Review Date 12-7-2022

The QI Office will subsequently forward any PCR populated in the automated daily query to the report author for notification that the report was audited by the QI office, with the District/Battalion Chief copied on the email. All PCRs populated in the automated daily query will also be forwarded to the JFRD EMS Billing Manager and will not be processed for billing/reimbursement until such time confirmation is received by the QI Office that the PCR contains explicit documentation in the narrative section that the following occurred: *The Rescue unit returned to the medical facility to legally obtain the patient or receiving facility representative signature **AND** the AVL data confirms the same*, if data is available.

If, after review of the PCR by the QI Office, there is no documentation or notation in the narrative by the report author that the Rescue unit returned to the medical facility to legally obtain an appropriate signature on the PCR **AND** the AVL data confirms that the Rescue unit was not at the medical facility when the responsibility signature time-stamp was captured on the PCR, a formal request for investigation will be immediately forwarded to the appropriate District/Battalion chief, with Rule Infraction Charges to follow when necessary. Copies of the PCR and supporting AVL data shall be forwarded to the appropriate District/Battalion chief to assist with their investigation.



Reporting Abuse/Neglect

Medical Director Review Date 12-7-2022

Policy

This policy requires reporting of all known or suspected cases of abuse or neglect to a child or vulnerable adult where such knowledge is the result of employment with the City of Jacksonville.

A vulnerable adult is defined as one who, due to their age or disability, may be unable to adequately provide for their own care or protection.

All employees are required to report known or suspected child or vulnerable adult abuse, abandonment, or neglect. Anyone who knowingly and willfully fails to do so, or who knowingly and willfully prevents another person from doing so, commits a felony of the third degree, punishable as provided in Florida Statutes.

Anyone who knowingly and willfully makes a false report of child or vulnerable adult abuse, abandonment, or neglect, or who advises another to make a false report, is guilty of a felony of the third degree, punishable as provided in Florida Statutes.

Anyone making a report who is acting in good faith is immune from any liability per FL Statute.

Suspected Abuse

- When JFRD personnel suspect that abuse or neglect to a child or vulnerable adult has taken place, they shall initiate the following:
 - Treat related injuries
 - Transport all suspected cases
 - If transport is refused:
 - Request law enforcement at scene
 - Stay with patient until law enforcement arrival
 - Notify the Rescue District/Battalion Chief

Reporting Abuse

- In addition to the above, JFRD personnel shall also report the abuse/neglect according to the following procedure:
 - **Immediately report the actual or suspected child abuse, neglect or abandonment to the central abuse hotline maintained by the Department of Children and Family Services (DCF)**
 - The officer-in-charge shall make the initial verbal report by calling the statewide toll-free number (1-800-962-2873 or 1-866-532-2873). Obtain name and ID Number from the contact person
 - Report suspicions to emergency department physician
 - Notify the Rescue District/Battalion Chief
 - Notify the Division Chief of Rescue via email within 24 hours indicating that you have reported the case to the FL Abuse/Neglect Registry, including **ONLY** the **first name**



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Reporting Abuse/Neglect

Medical Director Review Date 12-7-2022

(agency gives a first name only) and **ID number** of the contact person. **Do not** provide any patient information in the email (HIPAA concern)

- Document in the PCR narrative the circumstances and reporting of abuse

EMT



Resuscitation Guideline

Medical Director Review Date 12-7-2022

Application

This guideline is to assist JFRD personnel in making resuscitation decisions. All resuscitations will follow JFRD EMS guidelines.

Unquestionable Death Criteria

Patients meeting the criteria listed below shall be considered DOS (**criteria must be documented in the narrative**):

- Unresponsive
- Apneic
- Pulseless
- **In addition to the above**, the patient shall meet **at least one** of the following criteria:
 - The patient has lividity (discoloration of dependent parts of the body by gravitation of blood)
 - The patient has clear signs of body decay or visible decomposition
 - The patient has rigor mortis (rigidity)
 - The patient has an open cranium with exposed brain matter
 - The patient is decapitated or has a severed trunk
 - The patient has full thickness burns to the entire body

Trauma Death Criteria

Blunt chest trauma or multi-system trauma patients meeting the following criteria shall be considered DOS:

- Unresponsive
- Apneic
- Pulseless

Acutely hypothermic patients in cardiac arrest shall be treated and transported.

- Includes submersion victims < 60 minutes



Resuscitation Guideline

Medical Director Review Date 12-7-2022

Florida Statute 401.45

Denial of emergency treatment; civil liability—

- (1)(a) Except as provided in subsection (3), a person may not be denied needed pre-hospital treatment or transport from any licensee for an emergency medical condition.
- (b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.
- (2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.
- (3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 609. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.
- (b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.
- (c) The department, in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration, shall develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a patient for whom a physician has issued an order not to administer cardiopulmonary resuscitation. The department may charge a reasonable fee to cover the cost of producing and distributing such identification devices. Use of such devices shall be voluntary.
- (4) Any licensee or emergency medical technician or paramedic who in good faith provides emergency medical care or treatment within the scope of their employment and pursuant to oral or written instructions of a medical director shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2)(b).
- (5) The department shall adopt and enforce all rules necessary to implement this section.



Resuscitation Guideline

Medical Director Review Date 12-7-2022

Death Scene Procedure

Except for healthcare facilities, a JFRD unit shall remain on scene until law enforcement arrives. Control of death scenes is the responsibility of law enforcement. Generally, law enforcement officers voluntarily defer to the EMS provider for resuscitation decisions; however, ultimate responsibility for control of death scenes rests with law enforcement. If a law enforcement officer denies you access to the scene, they are assuming full responsibility and acting within the law to preserve evidence. You must obtain the law enforcement officer's name and ID number, explaining to them that you are required to document in the patient care report that they assumed the responsibility for the pronouncement of death and that they denied you access to the scene.

Do Not Resuscitate Orders

The State of Florida's "Do Not Resuscitate Order" (DNRO) form will be honored per the requirements of Florida Statute 401.45(3)(a) and Florida Administrative Code 64J-2.018. If there is any doubt of the authenticity of the form, resuscitation will be performed. Key points listed in the rule:

- According to the Florida Department of Health (DOH), the 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
- 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, which is defined by the state of Florida as the bottom detachable portion of the official DNRO form as notated on the following page, is voluntary and is intended to provide a convenient and portable DNRO which travels with the patient
- The DNRO form and patient identification device must be signed by the patient's physician
- There will be times when family/caregivers call 911 for a variety of reasons. In those cases, the EMS provider shall provide comforting, pain relief and any other medically indicated care, short of respiratory or cardiac resuscitation. **A DNRO only means that in the event of cardiac or pulmonary arrest, that CPR will not be initiated.**
- During each transport, the EMS provider shall ensure that a copy of the DNRO form or the patient identification device accompanies the live patient
- 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



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Resuscitation Guideline

Medical Director Review Date 12-7-2022


State of Florida
DO NOT RESUSCITATE ORDER
(please use ink)

Patient's Full Legal Name: _____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(Signature of Physician) (Date) Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

OH Form 1-89G, Revised December 2002

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(Signature of Physician) (Date) Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

OH Form 1-89G, Revised December 2002

 **State of Florida**
DO NOT RESUSCITATE ORDER

Patient's Full Legal Name (Print or Type) _____ (Date) _____

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. (If not signed by patient, check applicable box):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)



Transport/Destination

Medical Director Review Date 2-17-2023

General

Transportation to the appropriate facility of those patients requiring further medical care is the final step in assuring the continuity of patient care. Patient care and well-being must be the overriding consideration in every case.

All patients will be transported based on patient assessment in the most appropriate manner consistent with their condition. Deviations will be documented on the patient care report.

Transportation and destination must be determined from specific guidelines and free from the influence of ability to pay, social status, convenience of personnel or other discriminatory factors. In those situations where extraordinary circumstances exist, as in multiple patient incidents, the Incident Commander, or Transport Officer, may elect to deviate from existing guidelines in determining destination of patients.

Patients who will be transported by rescue (with proper consent)

The following situations require **transport**:

- Life-threatening emergencies and those situations which could become life-threatening
- Chest pain/cardiac signs and symptoms/epigastric discomfort
- Systolic B/P greater than 180 mmHg OR Diastolic B/P greater than 110 mmHg
- Systolic B/P less than 90 mmHg
- Abdominal pain
- Reported loss of consciousness
- Report of blood in stool or vomit
- Severe sudden onset headache, light intolerance and/or neck stiffness
- Difficulty breathing
- Pregnancy
- Diabetic emergencies
- Altered mental status
- Suspected or known overdoses
- Suicidal (attempted or suspected) patients unless transported by law enforcement
- All non-fatal drowning patients
- Patients who meet Trauma, STEMI, or Stroke Alert status
- Patients who require or have received Advanced Life Support treatment and/or medications
- Patient's injury or condition that might be exacerbated by improper handling or transport by privately owned vehicle (POV) or other means of transportation
- Pediatric patients **15 years of age or less** who are symptomatic
 - Exceptions are superficial injuries when a parent or legal guardian with mental capacity is on-scene or documented signed refusal of treatment/transportation



Transport/Destination

Medical Director Review Date 2-17-2023

- Elderly patients **65 years of age or greater**
 - Exceptions are non-symptomatic patients with mental capacity without a documented chief complaint or documented signed refusal of treatment/transportation

Transport after administration of medications

- Patients will not be given medications in the field and then released or allowed transport by private vehicle
- Prior to medication administration, patient condition permitting, the patient should be informed that if JFRD personnel administer medication, the patient must be transported by JFRD for physician evaluation
- Even if the patient's condition improves, the patient should still be transported by Rescue for evaluation

Non-transport situations

The following situations will not require transportation of the patient to the hospital by Rescue: (Complete signed AMA or non-emergency/non-transport refusal when appropriate).

- Situations where no emergency exists
- Injuries of a superficial or minor nature
- Situations where transport would endanger the safety of rescue crew members
- Patients, otherwise stable, who require transport to a mental health resource or Detox facility
- Situations where patient requests private provider or private vehicle transportation
- DOS victims will not be transported
- Patients who refuse transport

Transport of passengers

Various circumstances (e.g., elderly spouse, medical POA, etc.) warrant consideration for allowing passengers to accompany the patient during transport, utilizing common sense and a customer service approach. However, transport of passengers is at the sole discretion of the officer in charge of the rescue unit.

- Exceptions
 - Pediatric patients requiring a parent or guardian
 - School representative when a parent or guardian is not available
 - Geriatric patients requiring a guardian or caregiver
 - Patients with language barriers requiring a translator
 - Patients with speech disabilities requiring someone proficient in sign language

Transport of multiple patients

Many times, JFRD personnel are faced with the situation of transporting more than one patient to the hospital via one Rescue Company. In these situations, no patient shall be left unattended in the back of the rescue unit, under any circumstances.



Transport/Destination

Medical Director Review Date 2-17-2023

When transporting more than one patient to the hospital, the Officer-in-Charge of the Suppression Company will provide personnel to ride along to assist in patient care and monitor the patient until they can be taken into the emergency room.

The District/Battalion Chief may wave the maximum of two patients per Rescue Company in extenuating circumstances.

Transports of unstable patients should begin within 10 minutes when possible.

Adult destination determination policy

The officer-in-charge will determine the transport destination after considering the following:

- Refer to the most recent *Hospital Capabilities Chart for JFRD* as needed to assist with determining a hospital's capabilities
- Patients who are **unstable or in cardiac arrest** will be transported to the closest most appropriate emergency department
- Patients who are **stable** will generally be transported to their hospital of choice; however, patients who have recently been discharged from the hospital should be encouraged to return to that same hospital
- Special Transport Circumstances:
 - Patients who meet Stroke Alert status will be transported to the most appropriate State of Florida approved Comprehensive or Primary Stroke Center (See Stroke SOG)
 - Patients who meet Trauma Alert status will be transported in accordance with Trauma Transport Guidelines
 - Patients with pregnancy related complaints will be transported to a facility with obstetric (OB) capability

Pediatric destination determination policy

The officer-in-charge will determine the transport destination after considering the following:

- Refer to the most recent *Hospital Capabilities Chart for JFRD* as needed to assist with determining a hospital's capabilities
 - Adhere to the facility's specific pediatric coverage hours
- Pediatric patients who are **unstable or in cardiac arrest** should be transported to the closest approved Pediatric Emergency Department
 - Transport to an alternate hospital should only take place if that hospital is closer to the scene of the incident and the patient's immediate condition is such that the patient's life will be endangered if care is delayed by proceeding directly to an approved pediatric emergency department
- Patients who are **stable** should be transported to the hospital where the patient is usually seen and has the patient's medical records
 - Stable pediatric with a simple injury or complaint and no hospital affiliation: Transport to the closest approved Pediatric Emergency Department. If the parent/guardian insists on their child being transported to a hospital without pediatric capabilities, the details of your attempt to encourage transport to a pediatric facility must be documented in the PCR



Transport/Destination

Medical Director Review Date 2-17-2023

- Stable pediatric with a complex complaint and/or medical history: Transport to Baptist Medical Center- Downtown (Wolfson Children's Hospital) or UF Health Jacksonville

Pediatrics should be secured to the stretcher with the Pediatric Restraint Device (Appendix L) (if size appropriate) or their own car seat.

- Exceptions may be made for level of distress and/or treatment. However, use of the Pediatric Restraint Device (Appendix L) or car seat is optimal

Stand-alone emergency departments

Most patients can be transported to a Stand-alone ED. Exceptions include:

- **Those patients expected to be admitted or require specialized services** (e.g., OR, ICU, Cath Lab, GI suite)
- Cardiac Arrest with a shockable rhythm
- Cardiac Arrest with ROSC
- Chest pain
- All Alerts (Trauma, STEMI, Stroke, COVID)
- Pediatric (except during designated hours as defined on the *Hospital Capabilities Chart*)
- Pregnancy
- Baker Act
- Trauma Red
- Baker Act

Approved Adult Hospitals

- See most recent *Hospital Capabilities Chart for JFRD*

Approved Pediatric Hospitals - Hours may vary

- See most recent *Hospital Capabilities Chart for JFRD*

Air transport units

- Air Transport Units (ATU) should be considered for critically ill or injured patients any time ground transport time to the closest appropriate hospital exceeds 20 minutes
- An ATU for direct flight to UF Gainesville's Burn Center should also be considered for isolated burns without other significant trauma when:
 - 2nd and 3rd degree burns greater than 20% of the total body substance area (TBSA)
 - 3rd degree burns greater than 5% of the TBSA
 - 2nd and 3rd degree burns with the threat of functional or cosmetic impairment to the face, hands, feet, genitalia, perineum, or major joint
- Patients in cardiac or traumatic arrest are not appropriate for an ATU



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Transport/Destination

Medical Director Review Date 2-17-2023

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EMT



Transport of Patients With Service Animal

Medical Director Review Date 12-7-2022

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

A service animal, utilized by a patient for a disability, shall be permitted to accompany a patient or guardian of a minor patient in the rescue unless the presence of the service animal will disrupt patient care, the patient is unstable or there is some basis for the crew members to believe that the safety of the crew, the patient or others would be compromised by the presence of the service animal in the rescue.

- Growling may be considered threatening behavior in which case the service animal may be transported by other means. Barking may also be considered threatening; however, specific service animals are required to bark to get their owner's attention

When transporting a patient with a service animal, every effort should be made to do so in a safe manner for the patient, the animal, and the crew members. If possible, the animal should be secured in some manner to prevent injury to either the animal or the crew during transport. The patient should be loaded into the rescue first, and then the service animal. Whenever possible, the receiving hospital should be notified that you are in route with a service animal.

When the presence of a service animal in the rescue might interfere with patient care, jeopardize the safety of the crew, the patient or others, personnel should make other arrangements for simultaneous transport of the service animal to the receiving facility.

- Acceptable alternative methods of transporting a service animal to the receiving facility include, but are not limited to, family members, friends or neighbors of the patient, animal control, a District/Battalion Chief, or a law enforcement official



Transport of Patients With Service Animal

Medical Director Review Date 12-7-2022

Personnel should document on the Patient Care Report (PCR) instances where the patient or guardian accompanying a minor patient utilize a service animal and note whether the service animal was transported with the patient. If the service animal was not transported in the rescue with the patient, the PCR should contain the reason(s) and how the animal was transported.

When it is not obvious what service an animal provides, only limited inquiries are allowed.

Personnel may ask **only** two questions:

1. Is the dog a service animal because of a disability?
2. What work or task has the dog been trained to perform?

Personnel **cannot** ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals.

In addition to the provisions about service dogs, the Department's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 60 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether or not the miniature horse's presence will compromise legitimate safety requirements necessary for safe operation of the facility.



Transport of Injured Police Canines (K9)

Medical Director Review Date 2/17/2023

Introduction

As authorized by Florida Statute, Chapter 401.254, JFRD may provide treatment and transport of injured "police canines." F.S. 401.254 also states, "A paramedic or an emergency medical technician who acts in good faith to provide emergency medical care to an injured police canine (K9) is immune from criminal or civil liability."

Under **no circumstances** are JFRD personnel and/or units authorized to transport any other animal (domestic pet, animal, etc.) outside the scope of this specific statutory authority.

Police Canine Defined (per F.S. 401.254)

"Any canine that is owned, or the service of which is employed, by a federal, state or local law enforcement agency, a fire department, a special fire district, or the State Fire Marshal for the principal purpose of aiding in the detection of criminal activity, flammable materials, or missing person; the enforcement of laws; the investigation of fires; or the apprehension of offenders."

Treatment

Initial priority must be given to the examination, treatment, and transport of any injured persons on the scene.

JFRD personnel must operate within these guidelines and only initiate treatment within their scope of practice, which includes basic medical procedures such as oxygen administration, tourniquet application (must be high on the extremity), splinting, and bandaging.

The canine handler may possess additional specialized veterinary training. JFRD personnel shall allow such treatment and may assist when necessary.

Transport (approved veterinary clinics)

When possible, the canine should be secured to the stretcher with the handler sitting alongside on the bench. The handler will place a safety muzzle on the dog when necessary.

If the canine is with the Jacksonville Sheriff's office (JSO), the transport destination shall be selected from either of the two clinics listed below as they provide 24/7 emergency veterinary care and are also contracted by the JSO. As soon as feasible, on-scene personnel should notify the receiving clinic of the in-bound injured canine and approximate eta.

- BluePearl Pet Hospital (Orange Park location) - 275 Corporate Way, Ste. 100
 - (904) 278-0287
- BluePearl Pet Hospital (Southside location) - 3444 Southside Blvd, Ste. 103
 - (904) 646-1287



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Transport of Injured Police Canines (K9)

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The destination facility for non-JSO canines will be determined after consultation with the K9 handler. There may be agency specific existing contracts, or the handler may have a preference based upon the injuries present.

EMT



Trauma Transport

Medical Director Review Date 12-7-2022

Service Description

The Jacksonville Fire and Rescue Department (JFRD) is a state licensed Advanced Life Support (ALS) provider of pre-hospital emergency care. The JFRD is the primary provider of pre-hospital EMS in Duval County.

Communications Procedures

For each EMS call, Fire Rescue Communications Center (FRCC) shall obtain the following information:

- Address or location of the incident
- Nature of emergency
 - Number of patients
 - Type and severity of injury(s)
- Type of location (house, apartment, street, or highway, etc.)
- Complainant's name
- Complainant's phone number

Using the Computer Aided Dispatch (CAD) system, the Emergency Medical Dispatcher (EMD) shall ensure dispatch of the closest available ALS unit. The CAD system will display the appropriate apparatus that normally responds to the listed address in order of priority.

Outside Agency Assistance

While at the scene of an emergency, personnel may request assistance from other emergency response agencies (Air Transport Unit, law enforcement, etc.) by contacting FRCC via radio or telephone. FRCC will forward the request to the appropriate agency and advise on-scene personnel of the disposition of the request and ETA of the required agency.

Pre-hospital Procedures

Upon arrival at the location of the incident, the EMT or Paramedic shall assess the condition of each trauma patient using the Trauma Scorecard Methodology as outlined in F.A.C. 64J-2.004 for adults and F.A.C. 64J-2.005 for pediatrics to determine if the patient meets "Trauma Alert" criteria. Transport destination of trauma patients shall be determined by this assessment.



Trauma Transport

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Assessing **ADULT** Trauma Patients:

The EMT or Paramedic shall assess all adult trauma patients using the following Trauma Scorecard Methodology in the order presented. If any **ONE** of the following conditions is identified, the patient shall be considered a trauma alert patient:

- **Airway** – The patient receives active airway assistance beyond the administration of O₂
- **Circulation** –
 - The patient lacks a radial pulse with a sustained heart rate greater than 120 beats per minute
 - Has a systolic blood pressure of less than 90 mmHg
- **Best Motor Response (BMR)** – The patient exhibits a score of four or less on the motor assessment component of the Glasgow Coma Scale
- **Spinal** – There is the presence of paralysis; or loss of sensation; or there is the suspicion of a spinal cord injury
- **Cutaneous** –
 - The patient has 2nd or 3rd degree burns to 15% or more of total body surface area
 - Amputation proximal to the wrist or ankle
 - Any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined)
- **Long bone Fracture** – The patient reveals signs or symptoms of two or more long bone fracture sites (humerus, femur, radius/ulna, or tibia/fibula). The radius/ulna and tibia/fibula each count as only one fracture when isolated to the same extremity.

Should the trauma patient not be identified as a trauma alert using the previous criteria, they shall be further assessed using the following criteria and shall be considered a trauma alert patient when any **TWO** of the following conditions are identified:

- **Airway** – The patient has a respiratory rate of 30 or greater
- **Circulation** – The patient has a sustained heart rate of 120 beats per minute or greater
- **BMR** – The patient has a BMR of 5 on the motor component of the GCS
- **Cutaneous** –
 - The patient has a soft tissue loss from either a major degloving injury or a major flap avulsion greater than 5 inches
 - Sustained a gunshot wound to the extremities of the body
- **Long bone Fracture** –
 - The patient reveals signs or symptoms of a single long bone fracture resulting from a motor vehicle collision
 - Fall from an elevation of 10 feet or greater
- **Age** – The patient is 55 years of age or older
- **Mechanism of Injury** –
 - The patient has been ejected from a motor vehicle (excluding any motorcycle, moped, all-terrain vehicle, bicycle, or the open body of a pick-up truck)
 - The driver of the motor vehicle has impacted with the steering wheel causing steering wheel deformity



Trauma Transport

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If, after evaluating the patient using the previous criteria, the patient is not identified as a trauma alert patient, they will be evaluated using all elements of the Glasgow Coma Scale. If the patient's score is **12 or less**, the patient shall be considered a trauma alert patient (excluding patients whose normal Glasgow Coma Scale Score is 12 or less, as established by the patient's medical history or preexisting medical condition when known).

If the patient meets none of the aforementioned trauma alert criteria, the EMT or Paramedic can call a trauma alert if, in his or her judgment, the patient's condition warrants such action. Where EMT or Paramedic judgment is used as the basis for calling a trauma alert, it shall be documented as required in section F.A.C. 64J-2.002(5).

Assessing PEDIATRIC Trauma Patients:

Trauma patients with the anatomical and physical characteristics of a person **fifteen years of age or less** will be assessed as pediatric patients using the following Trauma Scorecard Methodology. If any **ONE** of the following conditions are identified, the patient shall be considered a pediatric trauma alert patient:

- **Airway** – In order to maintain optimal ventilation, the patient is intubated; or the patient's breathing is assisted through such measures as manual jaw thrust, continuous suctioning, or through the use of other adjuncts to assist ventilatory efforts
- **Circulation** –
 - The patient has a faint or non-palpable carotid or femoral pulse
 - The patient has a systolic blood pressure of less than 50 mmHg
- **Consciousness** – The patient exhibits an altered mental status that includes drowsiness, lethargy, the inability to follow commands, unresponsiveness to voice, totally unresponsive, or is in a coma
- **Spinal** – There is the presence of paralysis; or loss of sensation; or there is the suspicion of a spinal cord injury
- **Fracture** – There is evidence of an open long bone (humerus, radius, ulna, femur, tibia, or fibula) fracture; or there are multiple fracture sites or multiple dislocations (except for isolated wrist or ankle fractures or dislocations)
- **Cutaneous** –
 - The patient has a major soft tissue disruption including major degloving injury or major flap avulsion
 - 2nd or 3rd degree burns to 10% or more of the total body surface area
 - Amputation proximal to the wrist or ankle
 - Penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined)

Should the pediatric trauma patient not be identified as a trauma alert using the previous criteria, they shall be further assessed using the following criteria and shall be considered a pediatric trauma alert patient when any **TWO** of the following conditions are identified:



Trauma Transport

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- **Consciousness** – The patient exhibits symptoms of amnesia; or there is loss of consciousness
- **Circulation** –
 - The carotid or femoral pulse is palpable, but the radial or pedal pulses are not palpable
 - The systolic blood pressure is less than 90 mmHg
- **Fracture** – The patient reveals signs or symptoms of a single closed long bone fracture (does not include isolated wrist or ankle fractures)
- **Size** – Pediatric trauma patients weighing 11 kilograms or less, or the body length is equivalent to this weight on a pediatric length and weight emergency tape (the equivalent of 33 inches in measurement or less)

If the patient meets none of the aforementioned trauma alert criteria, the EMT or Paramedic can call a trauma alert if, in his or her judgment, the patient's condition warrants such action. Where EMT or Paramedic judgment is used as the basis for calling a trauma alert, it shall be documented as required in section F.A.C. 64J-2.002(5).

Issuing a Trauma Alert:

Upon determining that a trauma patient meets either Adult or Pediatric Trauma Scorecard Methodology, that patient will be classified as a "Trauma Alert" patient. JFRD personnel will issue a trauma alert using the words "Trauma Alert," state the criteria, and announce the destination.

The "Trauma Red" declaration is a JFRD term that represents a Trauma Alert patient who is in cardiac arrest. The patient shall still be considered a Trauma Alert and documented accordingly.

FRCC shall notify the State-Approved Trauma Center (SATC), State-Approved Pediatric Trauma Center (SAPTC), or receiving hospital that they will be receiving a "Trauma Alert" patient.

The **Medical Director** of the EMS provider issuing the trauma alert or the **physician** at the receiving trauma center or hospital, are the only people authorized to change the trauma alert status, as documented in F.A.C. 64J-2.002(5).

Documentation of Trauma Patients

JFRD personnel will provide required trauma information to the receiving facility in accordance with F.A.C. 64J-2.004 for adults and F.A.C. 64J-2.005 for pediatrics, and F.A.C. 64J-2.002(5).

A JFRD EMS patient care record will be completed as required in F.A.C. 64J-1.014 (3).



Trauma Transport

Medical Director Review Date 12-7-2022

Transporting to SATC or SAPTC

All patients meeting Adult or Pediatric Trauma Scorecard Methodology will be transported by JFRD ground transport to a SATC or SAPTC nearest to the location of the incident.

Other patients that don't meet Trauma Alert criteria but should still be considered for transport to a SATC or SAPTC include the following: high speed MVC, significant intrusion from an MVC (roll-over, T-bone, etc.), motorcycle accident, chest or abdominal injury, open fractures, and patients on anticoagulants.

When the officer-in-charge or Incident Commander deems that rapid transport is necessary (e.g., distance, severity of injury, traffic conditions, etc.), an air transport unit should be considered.

Receiving Facilities

A receiving facility is one which is identified in these guidelines, and which meets the requirements of F.A.C. 64J-2.002.

- **State-Approved Trauma Centers (SATC)**
 - UF Health Hospital Jacksonville
 - Memorial Hospital
 - Orange Park Medical Center
- **State-Approved Pediatric Trauma Centers (SAPTC)**
 - UF Health Hospital Jacksonville
 - Wolfson Children's Hospital

Transporting to Other Than SATC or SAPTC

A trauma alert patient may be transported to a receiving facility other than a SATC or SAPTC under the conditions listed below. Such variances must be documented in Emergency-Pro in the "Trauma section of the Incident Tab." Under "Trauma Protocol Exception," select "Yes."

- Transport to a SATC or SAPTC is impractical due to unforeseen events (MCI, natural disaster, or another catastrophic event, etc.)
- The patient's immediate condition is such that the patient's life may be endangered if care is delayed by proceeding directly to a SATC or SAPTC
- If, after informing patient of the state guidelines, the patient still insists on transport to another facility, transport will proceed according to patient's wishes.
 - In this rare circumstance, immediate consult with the appropriate District/Battalion Rescue Chief must occur
 - In the Narrative of the PCR, document that the JFRD Trauma Transport protocols were explained to the patient, the patient verbalized understanding of the protocols and refused transport to the trauma center



Protocol Approval

Medical Director Review Date 12-7-2022

MEDICAL DIRECTOR APPROVAL

I, **Bradley J. Elias, M.D.**, Medical Director for the Jacksonville Fire/Rescue Department certify that I have reviewed and approved the Trauma Transport Guidelines.

Bradley J. Elias, M.D.
Medical Director

Bradley J. Elias M.D.



Trauma

Chapter 2

Trauma

EMT



Trauma

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EMT



Trauma

Adult Glasgow Coma Score		
RESPONSE		VALUE
Eye Opening	Spontaneous	4
	To Speech	3
	To Pain	2
	None	1
Best Verbal Response	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	None	1
Best Motor Response	Obeys	6
	Localizes	5
	Withdraws	4
	Abnormal flexion	3
	Abnormal extension	2
	None	1
Total Score		3-15



Trauma

PEDIATRIC GLASCOW COMA SCORE				
RESPONSE	ADOLESCENT	CHILD	INFANT	VALUE
Eye Opening	Spontaneous	Spontaneous	Spontaneous	4
	To Speech	To speech	To speech	3
	To Pain	To pain	To pain	2
	None	None	None	1
Best Verbal Response	Oriented	Oriented, appropriate	Coos and babbles	5
	Confused	Confused	Irritable, cries	4
	Inappropriate words	Inappropriate words	Cries in response to pain	3
	Incomprehensible sounds	Incomprehensible words or nonspecific sounds	Moans in response to pain	2
	None	None	None	1
Best Motor Response	Obeys	Obeys commands	Moves spontaneously and purposely	6
	Localizes	Localizes painful stimulus	Withdraws in response to touch	5
	Withdraws	Withdraws in response to pain	Withdraws in response to pain	4
	Abnormal flexion	Flexion in response to pain	Abnormal flexion in response to pain	3
	Abnormal extension	Extension in response to pain	Abnormal extension in response to pain	2
	None	None	None	1
Total Score				3-15



2010

Trauma Arrest

Medical Director Review Date 12-7-2022

If patient does not meet unquestionable death criteria as listed in Guideline 1130, follow this guideline.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- The Lucas Device is permitted in trauma
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Refer to appropriate medical cardiac arrest and advanced airway guidelines
- Provide spinal immobilization if indicated



2010

Trauma Arrest

Medical Director Review Date 12-7-2022

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EMT



2020

Multi-System Trauma

Medical Director Review Date 12-7-2022

Patients with multi-system involvement may deteriorate rapidly, load and go is a priority.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
- Increase temperature in patient compartment
- Provide spinal immobilization
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain adequate oxygen saturation of 95% or greater
- Consider SAM pelvic splint (Appendix N) for pelvic fractures
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Bleeding from the nose and/or ears should not be stopped, but a sterile dressing should be placed over the nose and/or ears
- Determine Blood Glucose Level



2020

Multi-System Trauma

Medical Director Review Date 12-7-2022

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EMT



Head Trauma

Medical Director Review Date 12-7-2022

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- Provide spinal immobilization if indicated (Appendix O)
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - The head injured patient with a decreased LOC is more likely to suffer airway compromise than the standard trauma patient
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Bleeding from the nose and/or ears should not be stopped, but a sterile dressing should be placed over the nose and/or ears
- Determine Blood Glucose Level
- **Protective** (e.g., motorcycle, bicycle) **helmets** should be removed
- **Sporting helmet** removal indications:
 - The face mask should always be removed for airway access
 - Helmets and shoulder pads should be left in place except in the following situations:
 - Helmet in place and no shoulder pads
 - Head/facial trauma
 - Face mask cannot be removed
 - Cervical/spinal regions are unstable because the helmet fits poorly
 - Airway management cannot be achieved with just face mask removal
 - Patient is in cardiac arrest (requires removal of shoulder pads)
 - If the helmet is removed, the shoulder pads also need to be removed. It is an “all or nothing” principle
- Refer to Appendix Q for Helmet Removal Procedure



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Head Trauma

Medical Director Review Date 12-7-2022

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EMT



Spinal Trauma

Medical Director Review Date 12-7-2022

In cases of isolated spinal injuries, scene time is less critical, and care should be taken in performing proper spinal immobilization.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Provide spinal immobilization if indicated (Appendix O)
- Maintain body warmth
 - Increase temperature in patient compartment
- **Protective** (e.g., motorcycle, bicycle) **helmets** should be removed
- **Sporting helmet** removal indications:
 - The face mask should always be removed for airway access
 - Helmets and shoulder pads should be left in place except in the following situations:
 - Helmet in place and no shoulder pads
 - Head/facial trauma
 - Face mask cannot be removed
 - Cervical/spinal regions are unstable because the helmet fits poorly
 - Airway management cannot be achieved with just face mask removal
 - Patient is in cardiac arrest (requires removal of shoulder pads)
 - If the helmet is removed, the shoulder pads also need to be removed. It's an "all or nothing" principle
- Refer to Appendix Q for Helmet Removal Procedure
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - High cervical injury may cause apnea
- Consider SAM pelvic splint (Appendix N) for pelvic fractures
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway



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Spinal Trauma

Medical Director Review Date 12-7-2022

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EMT



Chest Trauma

Medical Director Review Date 12-7-2022

Chest Trauma patients may deteriorate rapidly. Load and go is a priority.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- **Transport to a Trauma Center when discoloration, severe tenderness, crepitus, respiratory distress, or decreased breath sounds are present. Elderly patients on anticoagulants should also be transported to a Trauma Center**
 - Consider Trauma Alert based on EMT/Paramedic judgement
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Treatments based on injuries:
 - Sucking Chest Wound
 - Apply vented Halo Chest Seal if available (**currently contained in the Advanced Trauma Care Bags carried in all field chief vehicles**)
 - Otherwise, apply Vaseline-type occlusive dressing(s) to cover the wound(s)
 - Cover the occlusive dressing with sterile 4X4s
 - Tape the dressing on three sides
 - Tension Pneumothorax
 - Unilateral absent breath sounds **with** severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, and hypoxia



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Chest Trauma

Medical Director Review Date 12-7-2022

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EMT



Abdominal Trauma

Medical Director Review Date 12-7-2022

Mechanism of injury is the most important indicator of abdominal trauma. The best treatment for the patient with severe abdominal trauma is rapid transport.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- **Transport to a Trauma Center when discoloration and/or severe tenderness are present**
 - Consider Trauma Alert based on EMT/Paramedic judgement
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Apply hemostatic gauze if available (currently contained in the Advanced Trauma Care Bags carried in all field chief vehicles) for life-threatening hemorrhage
- Abdominal Evisceration
 - Never replace abdominal viscera
 - Cover with sterile dressing and moisten with intravenous fluid (may need to periodically remoisten)
 - Secure the wet dressing in place if possible



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Abdominal Trauma

Medical Director Review Date 12-7-2022

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EMT



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Trauma Pregnancy

Medical Director Review Date 12-7-2022

Signs and symptoms of shock may be delayed due to increased maternal blood volume.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- Provide spinal immobilization if indicated (Appendix O)
 - Immobilizing a pregnant patient greater than **20 weeks** may impair ventilation as the fetus and the uterus press against the diaphragm
 - After immobilization is complete and patient is secure, elevate the patient's right side of the LSB approximately 6 inches. This will displace the uterus and fetus to the left side and off the inferior vena cava
 - If the long spine board (LSB) cannot be elevated, manually displace the uterus to the left as much as possible without causing spinal movement and maintain this displacement throughout the transport
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
 - Apply hemostatic gauze if available (currently contained in the Advanced Trauma Care Bags carried in all field chief vehicles) for life-threatening hemorrhage
- Determine Blood Glucose Level



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Trauma Pregnancy

Medical Director Review Date 12-7-2022

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EMT



Extremity Trauma

Medical Director Review Date 12-7-2022

This guideline does NOT apply to a multi-system trauma patient.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- **Transport to a Trauma Center when open fractures are present**
- Provide spinal immobilization if indicated (Appendix O)
 - Infants and children less than 60 lbs., use Pedi-Immobilizer™
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Consider SAM pelvic splint (Appendix N) for pelvic fractures
- Immobilize impaled objects in place
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Splint all areas of tenderness or deformity
 - May consider pain management prior to patient movement or splinting
 - Splint dislocations and joint injuries in the position found
 - Consider ice pack to reduce swelling and pain
 - Reduce fractures (open or closed) by axial traction if absence of distal pulses
 - Consider traction splint (Appendix C) for presumed femur fracture
 - Elevate the extremity when practical
 - Locate, mark, and monitor distal pulses before and after splinting. Record sensation and motor function before and after splinting
- Amputation
 - Place the amputated part in sterile gauze, moisten with intravenous fluids
 - Keep amputated part cool
 - Dress and splint partial amputations in alignment with the extremity, being careful to avoid torsion
 - Do not clamp vessels



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Extremity Trauma

Medical Director Review Date 12-7-2022

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2090

Crush Injury

Medical Director Review Date 12-7-2022

The patient's overall health status, total amount of entrapped body surface area, length of the entrapment and weight of the object dictate the extent of the symptoms. Crush injury is to be distinguished from a simple entrapment.

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage



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Crush Injury

Medical Director Review Date 12-7-2022

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Taser Trauma

Medical Director Review Date 12-7-2022

Only law enforcement officers are permitted to remove probe(s).

Patient Transport

- The patient should be transported to the hospital if any of the following underlying circumstances apply:
 - History of delirium, mania, or irrational bizarre behavior before being tased
 - Abnormal vital signs
 - History or physical findings consistent with amphetamine or hallucinogenic drug use
 - Cardiac history
 - Altered level of consciousness or aggressive, violent behavior including resistance to evaluation
 - Evidence of hyperthermia
 - JSO unable or unwilling to remove probe(s)
 - Any patient that meets the JFRD transport criteria

TREATMENT

- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Control bleeding
 - Refer to Hemorrhage Control Guideline 2140 if applicable for uncontrolled hemorrhage
- Determine Blood Glucose Level



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Taser Trauma

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Burns

Medical Director Review Date 12-7-2022

Burns are classified according to type (Thermal, Electrical, and Chemical) and thickness. Use the Rule of Nines or the "palm of hand method" (palm of the patient's hand including the fingers is 1% of body surface area) to estimate burn area.

ASSESSMENT

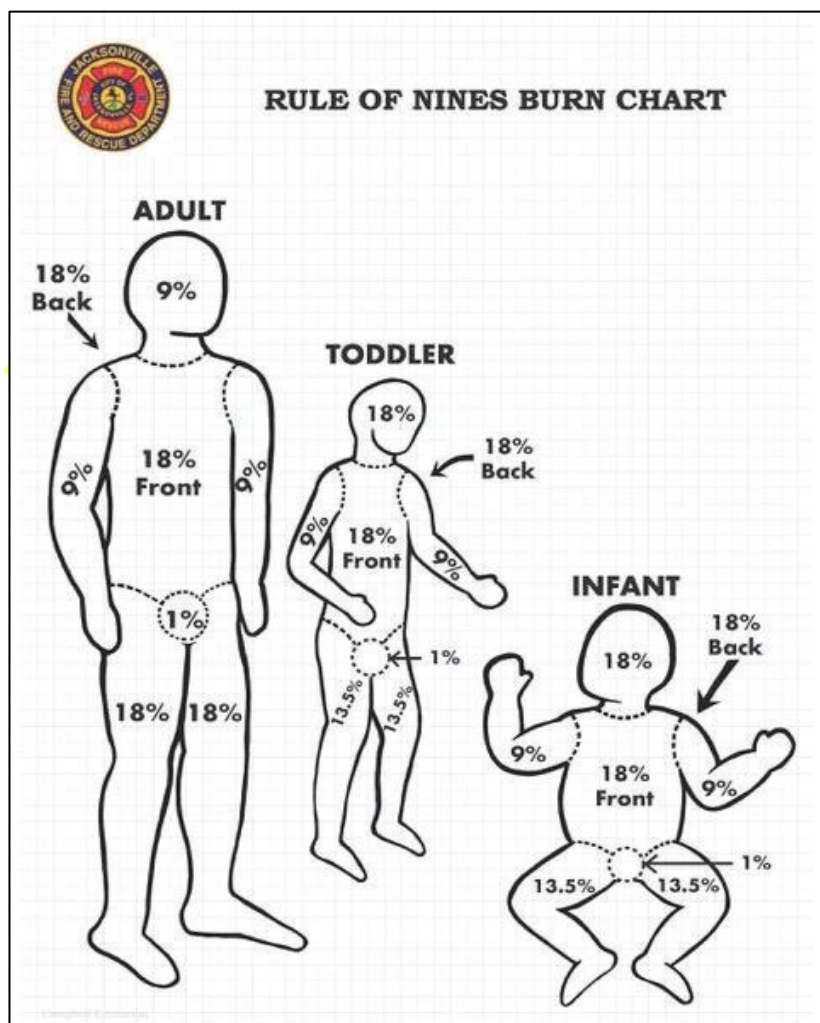
Burn Trauma Alert Criteria:

- Adult
 - Partial/full thickness (2nd/3rd degree) burns to 15% or more BSA
- Pediatric
 - Partial/full thickness (2nd/3rd degree) burns to 10% or more BSA

Entire Adult Head 9%
Entire Adult Arm 9%
Entire Adult Torso 36%
Entire Adult Leg 18%
Entire Adult Genitalia 1%

Entire Toddler Head 18%
Entire Toddler Arm 9%
Entire Toddler Torso 36%
Entire Toddler Leg 13.5%
Entire Toddler Genitalia 1%

Entire Infant Head 18%
Entire Infant Arm 9%
Entire Infant Torso 36%
Entire Infant Leg 13.5%
Entire Infant Genitalia 1%





Burns

Medical Director Review Date 12-7-2022

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- Airway/breathing management
 - Patients with known inhalation injury or with signs of potential airway burns who are in respiratory distress should be intubated early to prevent airway collapse
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Remove all clothing, jewelry or constricting items from the burned area unless adhered to the patient
- Request HAZMAT Team when appropriate
- Treatment
 - Chemical burns (not involving Lime, Carboic Acid, Sulfuric Acid, Solid Potassium or Sodium metals)
 - Irrigate with intravenous fluid for 20 minutes
 - Chemical burns involving Lime, Carboic Acid, Sulfuric Acid, Solid Potassium or Sodium metals
 - Do not flush wound(s) with water, intravenous fluids, sterile water, etc.
 - Contact receiving physician for treatment
 - Superficial burns
 - Apply burn gel dressing(s) if needed
 - Partial-Thickness/Full-Thickness burns
 - Apply dry, sterile dressing(s)
 - Leave blisters intact



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Electrical Trauma

Medical Director Review Date 12-7-2022

TREATMENT

- Expose and examine patient to perform a complete assessment
- Maintain body warmth
 - Increase temperature in patient compartment
- Provide spinal immobilization if indicated (Appendix O)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- In electrocutions that involve multiple patients, reverse triage shall be applied and patients in cardiac arrest shall be worked **first**

DRAFT



2120

Electrical Trauma

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Eye Trauma

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Immobilize impaled objects in place unless the object must be removed to stabilize the airway
- Transport to a Trauma Center when penetrating eye trauma is present
- Remove contact lenses when applicable
- Assess nature of eye emergency
 - Direct Trauma
 - Patch both eyes gently without pressure to the globes
 - Maintain patient in supine position to reduce leakage of fluids from the eye
 - If blood is noted in anterior chamber, place the patient in semi-Fowler's
 - Immobilize any impaled object and cover both eyes
 - Dim lights for patient comfort
 - Chemical/Irritant Exposure (e.g., pepper spray, tear gas)
 - Irrigate affected eye with intravenous fluids during transport
 - Apply dry sterile dressings to both eyes
 - Dim lights for patient comfort
 - Atraumatic
 - Patch both eyes gently without pressure to the globes
 - Dim lights for patient comfort



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Eye Trauma

Medical Director Review Date 12-7-2022

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Hemorrhage Control

Medical Director Review Date 12-7-2022

Bleeding to extremity

- Life-threatening (Signs/Symptoms include amputation, profuse pulsating bleeding, blood soaking through pressure bandage and signs of shock with continuous bleeding)
 - Immediately apply tourniquet (Appendix M)
- Non-life-threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing

Bleeding to Head, Neck, or Torso

- Life-threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply Hemostatic gauze if available. Otherwise, apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing
- Non-life threatening
 1. Control with direct pressure to bleeding area or vessel
 2. Apply trauma dressing
 3. Apply pressure bandage on top of any previously applied dressing

Advanced Trauma Care Bags (Appendix R) are carried on all field chief vehicles. These bags contain an assortment of hemorrhage control supplies for use at multi-casualty patient incidents.



2140

Hemorrhage Control

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Cardiovascular Emergencies

Chapter 3

Cardiovascular Emergencies

EMERGENCY



Cardiovascular Emergencies

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3010

Chest Pain

Medical Director Review Date 12-7-2022

TREATMENT

- Vitals should be obtained
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Treatment situations:
 - Patients presenting with chest pain should receive Aspirin unless contraindicated or previously taken within 2 hours
 - **Aspirin 324 mg PO**
 - Contraindications
 - Allergies to salicylates
 - Active GI bleeding
 - **Aspirin 81 mg PO**
 - Use caution in pregnant patients
 - History of GI bleeding
 - Use of anticoagulants

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Chest Pain

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Acute Stroke

Medical Director Review Date 12-7-2022

JFRD STROKE ALERT POLICY

1. Assess patient using the BE-FAST algorithm to **IDENTIFY** the presence of a stroke

- **B**alance – Sudden dizziness, loss of balance or coordination
- **E**yes – Sudden trouble seeing out of one or both eyes
- **F**ace – Facial Weakness, uneven smile
- **A**rm – Weakness, unable to raise both arms evenly
- **S**peech – Impaired, slurred, difficulty repeating simple phrases
- **T**ime - Last seen normal?

2. Perform the *Los Angeles Motor Scale* (LAMS) assessment to determine the **SEVERITY** of the stroke. LAMS of 3, 4, or 5 are indicative of a potential large vessel occlusion that requires mechanical thrombectomy.

Los Angeles Motor Scale (LAMS)		
Face	0	Both sides move normally
	1	One side is weak or flaccid
Arm	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Grip	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/doesn't move
Total	0 - 5	

3. If the patient's blood glucose is ≥ 60 mg/dL, proceed with assessment. If stroke symptoms persist despite treatment, continue with assessment.



Acute Stroke

Medical Director Review Date 12-7-2022

4. After identifying stroke alert criteria, determine closest, most appropriate Stroke Center per parameters below. If symptoms present greater than 24 hours, any hospital is appropriate, and a Stroke Alert is not indicated.

- **Comprehensive/Thrombectomy Capable Stroke Center**
 - **All LAMS score of 3, 4, or 5** with onset up to 24 hours
 - LAMS score of 0, 1, or 2 when that facility is the closest Stroke Center
 - All suspected strokes with onset greater than 3 hours and less than 24 hours
 - Patient wakes up with stroke symptoms
 - Suspicion of subarachnoid hemorrhage/intracranial hemorrhage, sudden severe headache ("Thunderclap Headache") or sudden decrease in LOC
 - Current or recent GI bleeding
 - Trauma, surgery, or invasive procedure within past 3 months
 - Currently on anticoagulants
 - Bleeding disorders (e.g., low platelets, cirrhosis)
- **Primary Stroke Center**
 - LAMS score of 0, 1, or 2 with onset up to 3 hours when that facility is the closest Stroke Center

Notify FRCC of Stroke Alert, destination, LAMS score, onset time, and ETA.

Obtain contact information from the family (name, phone number etc.) for hospital history verification and possible procedural consents. This information should be noted on the field copy and relayed to hospital staff.

Comprehensive/Thrombectomy Capable Stroke Centers

- See most recent *Hospital Capabilities Chart for JFRD*

Primary Stroke Centers

- See most recent *Hospital Capabilities Chart for JFRD*

TREATMENT

- Place patient on the stretcher in semi-Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater



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Acute Stroke

Medical Director Review Date 12-7-2022

- Consider alternate diagnosis based on clinical presentation (e.g., seizure, bilateral weakness or symptoms, fever with hypotension, prolonged mental status changes, etc.)
- Determine Blood Glucose Level
 - Treat if indicated (should be performed **BEFORE** issuing Stroke Alert)

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Acute Stroke

Medical Director Review Date 12-7-2022

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Acute Heart Failure Pulmonary Edema

Medical Director Review Date 12-7-2022

TREATMENT

- Place the patient in full Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - **Consider early use of the CPAP (Appendix H) to treat pulmonary edema**

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Acute Heart Failure Pulmonary Edema

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Hypertension

Medical Director Review Date 12-7-2022

Hypertensive Urgency (systolic BP greater than 220 mmHg and diastolic BP greater than 120 mmHg) can present with or without symptoms. If stroke, cardiovascular, or respiratory symptoms are present with an abnormally elevated BP, refer to the appropriate guideline.

TREATMENT

- Place patient in semi-Fowler's position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater

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Hypertension

Medical Director Review Date 12-7-2022

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Cardiac Arrest (Shockable)

Medical Director Review Date 12-7-2022

The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions and defibrillation as outlined in Appendix S.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (Should not take more than 10 seconds)
- Initiate CPR and apply defibrillator pads as soon as possible
 - If an unwitnessed arrest or no bystander CPR, perform 2 minutes of CPR prior to defibrillation
 - If witnessed arrest by JFRD or bystander CPR in progress, analyze and defibrillate immediately, if indicated
 - If shockable, give **1 shock**
 - Continue to provide defibrillation every two minutes if shockable rhythm is noted upon reassessment
 - The time from the last compression to defibrillation should be minimized
 - After each defibrillation, **IMMEDIATELY** continue CPR, starting with compressions for 2 minutes then reassess
 - If no shock advised, **IMMEDIATELY** continue CPR, starting with compressions, for 2 minutes then reassess
- Utilize Lucas CPR device (Appendix A) as early as possible
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Airway/breathing management
 - Insert supraglottic airway (Appendix D)
- Determine Blood Glucose Level
- Consider the following possible causes of cardiac arrest and their appropriate treatments:
 - Hypoxia
 - Provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Hyperthermia/Hypothermia
 - Cool or warm as needed



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Cardiac Arrest (Shockable)

Medical Director Review Date 12-7-2022

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Cardiac Arrest (Non-shockable)

Medical Director Review Date 12-7-2022

The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions as outlined in Appendix S.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
- Initiate CPR and apply defibrillator pads as soon as possible
- Utilize Lucas CPR device (Appendix A) as early as possible
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Airway/breathing management
 - Insert supraglottic airway (Appendix D)
- Determine Blood Glucose Level
- Consider the following possible causes of cardiac arrest and their appropriate treatments:
 - Hypoxia
 - Provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Hyperthermia/Hypothermia
 - Cool or warm as needed



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Cardiac Arrest (Non-shockable)

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Respiratory Emergencies

Chapter 4 Respiratory Emergencies



Respiratory Emergencies

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4010

Respiratory Distress

Medical Director Review Date 12-7-2022

In the patient with severe respiratory compromise, treatment should be aggressive to prevent respiratory arrest. Lung sounds and degree of distress should guide treatment.

TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
- Consider possible treatment situations and refer to appropriate guideline
 - Clear lung sounds with difficulty breathing
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Assess temperature
- Determine Blood Glucose Level



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Respiratory Distress

Medical Director Review Date 12-7-2022

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Respiratory Arrest

Medical Director Review Date 12-7-2022

TREATMENT

- Provide 100% oxygen via BVM with an airway adjunct(s) (oropharyngeal airway and/or nasopharyngeal airway)
- Provide suction as needed
- Airway/breathing management
 - Insert supraglottic airway (Appendix D)
- Assess Blood Glucose Level

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Respiratory Arrest

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Reactive Airway Disease (Asthma, COPD)

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - **Consider early use of the CPAP (Appendix H)**
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
- Assess temperature
- Determine Blood Glucose Level

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Reactive Airway Disease (Asthma, COPD)

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Foreign Body Airway Obstruction

Medical Director Review Date 12-7-2022

TREATMENT

- Foreign Body Airway Obstruction (FBAO) maneuvers as indicated below:
 - **Conscious**
 - Mild Obstruction (with good air exchange)
 - Encourage patient's own spontaneous coughing and breathing efforts
 - Severe Obstruction
 - Abdominal Thrusts (Heimlich maneuver)
 - If patient is pregnant or obese, perform chest thrusts instead of abdominal thrusts
 - **Unconscious**
 - Reposition airway and remove object with Magill forceps
 - Begin CPR as indicated
 - Suction as indicated
 - Assist ventilations with appropriate BVM with a nasopharyngeal airway
 - Consider Mechanical Airway Clearance Device (Appendix U)
 - If foreign body cannot be removed, supraglottic airway is **contraindicated**
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Auscultate lung sounds
 - Determine respiratory rate, depth, and quality



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Foreign Body Airway Obstruction

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Hyperventilation

Medical Director Review Date 12-7-2022

Many serious medical problems can cause hyperventilation. Consider possible underlying causes.

TREATMENT

- Airway/breathing management
 - Administer O₂ via NRB until hyperventilation has resolved, then administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Auscultate lung sounds
 - Determine respiratory rate, depth, and quality
 - Do not administer CO₂ re-breathing techniques
- Assess temperature
- Determine Blood Glucose Level

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Hyperventilation

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Medical Emergencies

Chapter 5

Medical Emergencies





Medical Emergencies

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5010

Abdominal/Flank Pain

Medical Director Review Date 12-7-2022

TREATMENT

- Place patient in position of comfort
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature

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Abdominal/Flank Pain

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Alcohol Related Illness

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation 95% or greater
- Assess temperature
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050

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Alcohol Related Illness

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Allergic Reaction/Anaphylaxis

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Anticipate rapid deterioration and the need for supraglottic airway (Appendix D)
- Assist with administration of patient's Auto-Injector Epinephrine if respiratory compromise present
- Determine Blood Glucose Level
- Assess temperature

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Allergic Reaction/Anaphylaxis

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Altered Consciousness

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing patient in the recovery position
- Determine Blood Glucose Level. If BGL less than 60 mg/dL, refer to Diabetic Guideline 5050
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - If GCS $\leq$ 8 or inability to protect airway, insert supraglottic airway (Appendix D)
- Assess temperature
- Treatment based on underlying cause:
 - Unknown etiology
 - Consider other treatable neurological or metabolic disorders and if identified follow the appropriate guideline
 - Assess for head trauma and consider use of a C-collar



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Altered Consciousness

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Diabetic

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation 95% or greater
- Determine Blood Glucose Level
- Assess temperature
- Look for underlying causes
- **Treatments based on blood glucose level and level of consciousness:**
 - Hypoglycemia
 - Conscious and alert patient (GCS ≥ 14) with BGL <60 mg/dL, administer oral **Glucose paste 15 grams** (1 tube)
 - May repeat once in 10 minutes if BGL still <60 mg/dL
 - Contraindications
 - Altered level of consciousness
 - Difficulty swallowing



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Diabetic

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Nosebleed

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Look for underlying causes
- If other injuries do not exist, prevent aspiration of blood by placing the patient in a sitting position with their head leaning forward
 - Suction the airway as required if unable to position the patient
 - Encourage patient not to swallow blood as it could precipitate vomiting
- Control hemorrhage by pinching the nostrils
 - To facilitate clotting instruct the patient to hold pressure for at least 20 minutes and not to sniff, blow or manipulate the nasal passages in any way



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Nosebleed

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Headache

Medical Director Review Date 12-7-2022

Headaches with an elevated temperature, nausea/vomiting, and/or altered mental status may indicate meningitis or a neurological event.

TREATMENT

- If sudden severe headache ("Thunderclap Headache") or sudden decrease in LOC, refer to Acute Stroke Guideline 3020
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature
 - Headaches with elevated temperature, nausea/vomiting and/or altered mental status may indicate meningitis or neurological event
- Look for underlying causes



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Headache

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Nausea/Vomiting

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
- Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature

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Nausea/Vomiting

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Seizures

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- If trauma suspected, immobilize patient using proper technique
- If the patient is actively seizing, protect the patient from further injury
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050
 - Assess temperature

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Seizures

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5100

Shock Medical

Medical Director Review Date 12-7-2022

Shock patients may deteriorate rapidly. Signs of poor perfusion include cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds), tachycardia AND systolic BP less than 90 mm/hg.

TREATMENT

- Place patient in supine position with legs elevated
- Maintain body warmth
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature
 - If patient is febrile, apply cooling measures
- Look for underlying causes



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Shock Medical

Medical Director Review Date 12-7-2022

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5110

Syncope/Near Syncope

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Look for underlying causes
 - Determine Blood Glucose Level. If BGL is abnormal, refer to Diabetic Guideline 5050
- Assess temperature

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Syncope/Near Syncope

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Special Emergencies

Chapter 6

Special Emergencies



Special Emergencies

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6010

Non-Fatal Drowning

Medical Director Review Date 12-7-2022

TREATMENT

- If trauma suspected, immobilize patient using proper technique
- Determine submersion time
- Airway/breathing management
 - Monitor SpO₂. However, SpO₂ is not a reliable indicator of the patient's level of distress
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Determine respiratory rate, depth, and quality
 - Auscultate lung sounds
 - Consider CPAP (Appendix H) for patients with pulmonary edema
 - Anticipate rapid deterioration and the need for supraglottic airway (Appendix D)
- Assess temperature
 - Maintain body warmth and correct as necessary
- Determine Blood Glucose Level



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Non-Fatal Drowning

Medical Director Review Date 12-7-2022

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Decompression Sickness

Medical Director Review Date 12-7-2022

TREATMENT

- Place patient in recovery position (left side)
- Airway/breathing management
 - Monitor SpO₂ and provide 100% O₂ via NRB
- Assess temperature
 - Maintain body warmth and correct as necessary
- Retrieve dive computer (if appropriate) and ensure transport with patient or try to obtain depth and length of dive from patient or bystanders
- Determine Blood Glucose Level
- Do not transport to a Stand-alone ED
- Transport to closest most appropriate emergency department
 - **There is currently no emergent hyperbaric treatment chamber in Duval County**



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Decompression Sickness

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Combative Patient

Medical Director Review Date 12-7-2022

Request law enforcement if they are not already on scene.

A wide variety of medical conditions can cause a patient to become combative.

Excited Delirium can mimic several medical conditions including hypoxia, hypoglycemia, stroke, or intracranial bleeding. All patients suspected of experiencing Excited Delirium must be transported.

- Physical signs of excited delirium include:
 - Unfounded fear and panic
 - Shouting/irrational speech
 - Bizarre behavior (hallucinations/paranoia)
 - Hyperactivity and thrashing about (especially after restraint)
 - Unexplained strength/endurance
 - Shedding clothes/nudity (due to increased body temperature)
 - Profuse diaphoresis
 - Decreased sensitivity to pain

A previously combative patient who suddenly becomes quiet should raise a red flag.

TREATMENT

- Attempt to calm patient
 - Move patient to a calm, quiet environment
 - Respond in a confident, supportive manner
 - Inquire about resolving the cause of anger
 - Express sympathy and concern
- Apply restraints if needed and not already in place by law enforcement (e.g., handcuffs, flex cuffs)
 - Approved JFRD physical restraints include:
 - Soft limb restraints
 - Stretcher straps/harness
 - Wide cloth restraints
 - **No patient will be restrained in the prone or "hogtied" position**
 - Restraints shall not prohibit evaluation of the patient's medical status or injure the patient in any way
 - Frequently assess the patient to ensure that the airway is patent, distal limb circulation is adequate and that restraints can be released quickly should the patient's condition deteriorate
 - When restraints are in use, circulation to the extremities shall be evaluated at least every 5 minutes
 - JFRD personnel shall never leave the restrained patient unattended



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Combative Patient

Medical Director Review Date 12-7-2022

- Document the following in the patient care report:
 - The patient's behavior necessitating placement of restraints
 - The type of restraint used
 - Status of circulation distal to restraints at least every 5 minutes
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature
- Look for underlying causes

EMT



6040

Hyperthermia

Medical Director Review Date 12-7-2022

TREATMENT

- Move patient to cooler environment and remove any clothing or gear
- Assess temperature
 - Oral and/or tympanic readings are typically less accurate and lower than actual body core temperature
 - Reduce temperature in patient compartment
- Treat heat stroke aggressively
 - Apply and practice cooling measures (application of ice packs/wet towels to neck, axillae, groin, etc. and fanning the skin) to reduce body temperature to less than 104 degrees as quickly as possible
 - **If ice water immersion cooling has been initiated by health care professionals or athletic trainers, consider allowing continued treatment for up to an additional 10 minutes after arrival**
 - When removing patient from ice bath, place some of the ice on the stretcher around the patient. A drag blanket or tarp may prove beneficial in this scenario
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level



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Hyperthermia

Medical Director Review Date 12-7-2022

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6050

Hypothermia

Medical Director Review Date 12-7-2022

TREATMENT

- Place patient in supine position
- Move patient to warmer environment
- Handle patient gently
 - The hypothermic heart is irritable
- Assess temperature
 - Rewarming is the priority
 - Remove any wet clothing
 - Increase core temperature with blankets
 - Increase temperature in patient compartment to at least 85°
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level



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Hypothermia

Medical Director Review Date 12-7-2022

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6060

Bites and Stings

Medical Director Review Date 12-7-2022

If signs of allergic reaction noted, follow Allergic Reaction/Anaphylaxis Guideline (Guideline 5030).

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Insects and Spiders
 - Remove stinger if present and cleanse with peroxide
- Marine Stings
 - Remove any clinging tentacles by saltwater rinse (if unavailable, intravenous fluids) or by using a gloved hand
 - Avoid rinsing with fresh water
- Stings involving the eye(s)
 - Irrigate affected eye with intravenous fluids
- Snake Bites
 - Remove any constricting bands
 - Immobilize extremity
 - Mark initial edematous area with pen and note time
 - Attempt to identify type of snake
 - If venomous, have FRCC contact potential receiving facilities to determine if they have anti-venom on hand
- Apply sterile dressing



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Bites and Stings

Medical Director Review Date 12-7-2022

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6070

Overdose/Poisoning

Medical Director Review Date 12-7-2022

TREATMENT

- If substance is known, contact Poison Control at **1-800-222-1222**. Provide all information requested by poison control representative
- Do not delay treatment or transport, but if possible, bring medication or substance ingested
- Wear appropriate personal protective equipment
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine blood glucose Level
- Seizures may develop in many overdose/poison/ingestion situations
 - **Airway assistance may be necessary based on LOC, respiratory effort, and airway patency**
- Narcotic use
 - If nasal Narcan administered prior to JFRD arrival, transport shall be encouraged
- Organophosphate exposure
 - For all suspected organophosphate exposures, notify Haz Mat Team
 - Signs and symptoms include Diarrhea, Urination, Miosis, Bradycardia, Bronchorrhea, Bronchospasm, Emesis, Lacrimation and Salivation
 - Duodote Kits are currently carried by Haz Mat Rescues and the Rescue Chiefs
- Acute Dystonic Reaction to anti-psychotics (e.g., Haldol)
 - Signs and symptoms include painful muscle spasms of the face, neck and back



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Overdose/Poisoning

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Carbon Monoxide/Cyanide Exposure

Medical Director Review Date 12-7-2022

TREATMENT

- Request the HAZMAT team when appropriate
- Wear appropriate personal protective barrier
- Remove the patient to an environment with fresh air
- Determine the carboxyhemoglobin saturation (SpCO) if possible
 - Abnormal values
 - Non-smoker
 - Greater than 5%
 - Smoker
 - Greater than 10%
- Airway/breathing management
 - Monitor SpO₂, readings may be falsely high in the presence of Carbon Monoxide
 - Administer 100% O₂ via NRB
- Suspected Cyanide poisoning
 - Smoke inhalation is most common source
 - Signs/symptoms include headache, confusion, dyspnea, chest tightness, nausea, ALOC, seizure, vomiting, hypertension (early), hypotension (late), tachypnea (early), apnea (late), dilated pupils
 - Cyanokits are currently carried by Haz Mat Rescues and the Rescue Chiefs
- Assess blood glucose level
- Do not transport to a Stand-alone ED
- **There is currently no emergent hyperbaric treatment chamber in Duval County**



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Carbon Monoxide/Cyanide Exposure

Medical Director Review Date 12-7-2022

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Left Ventricular Assist Device (LVAD)

Medical Director Review Date 12-7-2022

An LVAD is a mechanical pump that is used to support heart function and blood flow in people who have weakened hearts. The device takes blood from the lower chamber of the heart and helps pump it to the body and vital organs just as a healthy heart would. A properly functioning device produces a continuous whirling sound, which can be heard with auscultation of the chest.

This protocol applies to the management of all patients who have an LVAD implanted. Please remember that these patients, along with their families, have been well trained in the care of themselves and their devices. **LISTEN TO THEM!** Patients always carry a "backup bag" which contains 2 extra fully charged batteries, a second controller, and an emergency guide. Make sure to always bring this emergency backup equipment with them to the hospital.

Call the number listed on the device for the on-call LVAD coordinator and you must transport to Mayo Clinic.

TREATMENT

- Auscultate for heart sounds to determine if LVAD is operating
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Obtain vital signs:
 - In most of these patients, a **pulse** will not be palpable. This is because the LVAD unloads the ventricle in a continuous fashion and therefore the aortic valve may not open with each contraction
 - A manual **blood pressure** may not be obtainable. An automated cuff should be used and is likely to measure a narrow pulse pressure
 - Your treatment of the patient will be based on the mean arterial pressure. In these patients, the normal range for the MAP is greater than 60 and less than 90
 - **Pulse oximetry** may not be accurate due to the continuous flow nature of the LVAD Monitoring
- Cautions
 - The most common complications associated with an LVAD patient are the increased risks for stroke, bleeding disorders, arrhythmias, dehydration, and right sided heart failure
 - Ensure modular cable connections are tight as shown below. If the yellow line is showing, turn the connector to the locked position



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Left Ventricular Assist Device (LVAD)

Medical Director Review Date 12-7-2022



- If the patient is unconscious, unresponsive to stimuli, and pulseless:
 - **If LVAD is operating** (able to auscultate whirling sound), **DO NOT PERFORM CPR**
 - The LVAD device has been surgically placed into the left ventricle and CPR could dislodge this device, causing death
 - **If LVAD is NOT operating, perform CPR** per cardiac arrest protocol
- **All patients with an LVAD implanted must be TRANSPORTED TO MAYO CLINIC regardless of specific complaint.** Alert hospital early in the transport

EMT



Obstetrical/Gynecological

Chapter 7

Obstetrical/Gynecological

EMT



Obstetrical/Gynecological

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7010

Vaginal Bleeding

Medical Director Review Date 12-7-2022

TREATMENT

- Determine last menstrual period (LMP)
- Place patient in position of comfort
 - If pregnant and greater than 20 weeks, place patient in recovery position (left side)
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Apply trauma pads to vaginal area for significant bleeding

EMT



7010

Vaginal Bleeding

Medical Director Review Date 12-7-2022

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Pre-Eclampsia/Eclampsia

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature
- Place patient in recovery position (left side)
- **Pre-eclampsia**
 - Disorder of pregnancy **after 20 weeks** characterized by the onset of fluid retention and high blood pressure
 - Physical exam may reveal blood pressure greater than 140/90 mmHg, tachycardia, tachypnea, pulmonary edema, confusion, and generalized edema
- **Eclampsia/Severe Pre-eclampsia**
 - Further complication of the pre-eclampsia patient
 - Defined by altered LOC and a blood pressure greater than 160/110 mmHg
 - Can occur postpartum (up to six weeks after delivery)
 - This condition is life-threatening to the mother and baby if not treated promptly



7020

Pre-Eclampsia/Eclampsia

Medical Director Review Date 12-7-2022

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7030

Imminent Delivery

Medical Director Review Date 12-7-2022

TREATMENT

- Provide rapid transport
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- **Delivery – without complications**
 - Apply gentle perineal pressure to allow a slow, controlled delivery of the head
 - Observe for meconium staining, suctioning is imperative
 - Gently guide the head downward to allow delivery of the upper shoulder. Do not pull on the newborn to facilitate delivery
 - Gently guide the head upward and allow delivery of the lower shoulder
 - Once the shoulders are delivered, the newborn's trunk and legs will follow rapidly. Be prepared to grasp and support the newborn as it emerges
 - Once the newborn is delivered, maintain body position at the same level as the vagina to prevent blood drainage from the umbilical cord
 - Wipe any blood or mucus from the newborn's nose and mouth with a sterile gauze
 - Use a bulb syringe to suction the mouth and nostrils **only** when the newborn is having difficulty clearing the airway, if secretions are obstructing the airway, or if BVM ventilation is necessary
 - Dry the newborn and wrap in dry blanket
 - Record the time of birth
 - Apply 2 clamps (2 to 3 inches apart), 7 to 10 inches from abdomen of the neonate
 - Cut cord between clamps
 - Closely monitor the cut umbilical cord for bleeding
- Maintain body temperature of neonate post delivery
- Assess and record APGAR at one minute and five minutes post delivery
- Placenta must be brought to the hospital for evaluation
- Postpartum
 - Assess for postpartum hemorrhage
 - Gently massage uterus until firm
- Transport to the hospital where patient has received their prenatal care if possible
 - **An additional PCR must be completed for the newborn**



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Imminent Delivery

Medical Director Review Date 12-7-2022

- For the complications listed below, transport to the nearest Emergency Department with L&D capabilities (see *Hospital Capabilities Chart for JFRD*)
 - **Nuchal Cord**
 - Feel for the cord around the neck as soon as the head is delivered
 - Gently remove the cord from around the neck
 - If unable to remove, clamp and cut the cord
 - Use extreme caution when cutting the cord
 - **Breech Delivery**
 - If delivery is not immediate:
 - Place the mother in the knee-chest position
 - If delivery is immediate:
 - Allow the buttocks or feet to deliver on their own and support the trunk
 - Check for the umbilical cord around the neonate's neck and allow the head to deliver
 - If the head does not deliver within 3 minutes, use a gloved hand to make an airway for the neonate, using the fingers to make airspace
 - **Limb or Brow Presentation**
 - Place the mother in the knee-chest position
 - **Prolapsed Cord**
 - Assessment should focus on the presence of pulses in the umbilical cord and relief of the pressure obstructing the blood flow within the cord
 - Place the mother in the knee-chest position or supine with hips elevated
 - Relieve pressure from the prolapsed cord if no pulses are detected in the cord
 - Use gloved hand to gently but firmly push the neonate's head back into the vagina; avoid pushing on the fontanel
 - Stop pushing upon the return of pulses in the cord
 - Do not push the cord back into the vagina, but keep moist with soaked towels
 - **Abruptio Placenta or Placenta Previa**
 - Treat for shock if indicated (Guideline 5100)

**7040**

Newborn Stabilization/Resuscitation

Medical Director Review Date 12-7-2022

The majority of newborns require no stabilization beyond drying, warming, positioning, suctioning, and tactile stimulation. More invasive procedures may be required for multiple births, pre-mature birth, or there is meconium staining.

ASSESSMENT

APGAR Score	0	1	2
Appearance	Blue all over	Acrocyanosis	Pink all over
Pulse	Absent	<100	≥100
Grimace/Irritability	No response or none	Grimace Weak cry	Sneeze Cough Vigorous cry
Activity/Muscle Tone	Limp/flaccid	Some motion / flexion of extremities	Active motion
Respirations	None	Slow/irregular	Vigorous cry or Normal respirations



Newborn Stabilization/Resuscitation

Medical Director Review Date 12-7-2022

TREATMENT

- If complications are present with mother or child, request a second rescue if necessary
- Wipe any blood or mucus from the newborn's nose and mouth with a sterile gauze
- Use a bulb syringe to suction the mouth and nostrils **only** when the newborn is having difficulty clearing the airway, if secretions are obstructing the airway, or if BVM ventilation is necessary
- Thoroughly dry the newborn with towels or blankets. Wrap newborn in a dry blanket
- Administer tactile stimulation, if required, by tapping soles of feet
- Assess and record APGAR at one minute and five minutes post delivery
- Position the infant in the supine position with the neck in a neutral position. A 1" blanket roll under the shoulders will help maintain head position, if aggressive airway management is needed
- Re-assess newborn every 30 seconds
- Determine BGL by heel stick
- Airway/breathing management
 - Assess respiratory rate and effort
- Consider specific treatment situations:
 - Pre-viable delivery is defined as 24 weeks or less
 - Resuscitation should not be initiated
 - Any treatment should be comfort only
 - Cyanosis isolated to the extremities (acrocyanosis)
 - Saturation may remain less than normal for up to 10 minutes after birth
 - Administer blow-by O₂
 - Heart rate less than 100 with labored breathing, apnea, persistent central cyanosis, and/or no muscle tone
 - Provide 100% O₂ at 40 to 60 ventilations/minute via infant BVM



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Newborn Stabilization/Resuscitation

Medical Director Review Date 12-7-2022

- Heart rate less than 60
 - Administer chest compressions/ventilations
 - A **3:1 ratio of compressions to ventilation**, with 90 compressions and 30 breaths to achieve approximately **120 events per minute** to maximize ventilation at an achievable rate is recommended. Compressions and ventilations should be coordinated to avoid simultaneous delivery. The chest should be allowed to re-expand fully during relaxation (after each compression), but the rescuer's thumbs should not leave the chest.

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Newborn Stabilization/Resuscitation

Medical Director Review Date 12-7-2022

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Pediatric

Chapter 8 Pediatric Emergencies



Pediatric

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Pediatric Assessment

Medical Director Review Date 12-7-2022

A pediatric patient is 17 years of age or less. The only exception is the pediatric trauma alert patient, which is 15 years of age or less (as defined by the Florida Administrative Code).

Pediatric assessment

- Identify parent, care giver or legal guardian
- Identify signs of abuse/neglect (observe patient's surroundings)
- Ensure medications or accurate medication list is available for receiving facility
- Assessment of pediatric patient requires observation, auscultation and palpation

Abnormal findings:

- Appearance
 - Decreased response to parents or environmental stimuli
 - Rigid or poor muscle tone or not moving
- Breathing
 - Abnormal or no cry or speech
 - Increased/excessive nasal flaring
 - Retractions or abdominal muscle use
 - Decreased or no respiratory effort
 - Noisy breathing (wheezing, grunting, gasping, or gurgling)
 - Respiratory rate outside normal range
- Circulation
 - Abnormal skin color (cyanosis, mottling, or paleness)
 - Obvious significant bleeding
 - Capillary refill >2 seconds with other abnormal findings

Normal vital signs:

<u>Normal Respiratory Rate</u>		<u>Normal Pulse Rate</u>		<u>Lower Limit of Normal Systolic BP</u>	
Infant (<1yr):	30- 53	Infant:	100-180	Infant:	>72 (or strong pulses)
Toddler (1-3yr):	22 -37	Toddler:	98-140	Toddler:	>86 (or strong pulses)
Preschooler(4-5yr):	20-28	Preschooler:	80-120	Preschooler:	>89
School-age(6-12yr):	18-25	School-age:	75-118	School-age:	>97
Adolescent(13-17yr):	12 -20	Adolescent:	60-100	Adolescent:	>110
		Pulses slower in sleeping child/athlete			



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Pediatric Assessment

Medical Director Review Date 12-7-2022

PEDIATRIC GLASCOW COMA SCORE				
RESPONSE	ADOLESCENT	CHILD	INFANT	VALUE
Eye Opening	Spontaneous	Spontaneous	Spontaneous	4
	To Speech	To speech	To speech	3
	To Pain	To pain	To pain	2
	None	None	None	1
Best Verbal Response	Oriented	Oriented, appropriate	Coos and babbles	5
	Confused	Confused	Irritable, cries	4
	Inappropriate words	Inappropriate words	Cries in response to pain	3
	Incomprehensible sounds	Incomprehensible words or nonspecific sounds	Moans in response to pain	2
	None	None	None	1
Best Motor Response	Obeys	Obeys commands	Moves spontaneously and purposely	6
	Localizes	Localizes painful stimulus	Withdraws in response to touch	5
	Withdraws	Withdraws in response to pain	Withdraws in response to pain	4
	Abnormal flexion	Flexion in response to pain	Abnormal flexion in response to pain	3
	Abnormal extension	Extension in response to pain	Abnormal extension in response to pain	2
	None	None	None	1
Total Score				3-15



8010

Pediatric Bradycardia

Medical Director Review Date 12-7-2022

Symptomatic pediatric bradycardia: cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds). Pediatric bradycardia is frequently caused by a respiratory disorder (hypoxia).

TREATMENT

- Airway/breathing management
 - Monitor SpO₂ and administer 100% O₂ via NRB
- If signs of severe cardiopulmonary compromise are present
 - Ventilate with BVM
- If patient 8 years old or less and has signs of poor perfusion (as described above) with a heart rate <60 despite 100% O₂ and ventilation for 2 minutes, initiate chest compressions
- Look for signs of airway obstruction:
 - No breath sounds
 - Tachypnea
 - Intercostal and suprasternal retractions
 - Stridor
 - Choking
 - Cyanosis
- Determine Blood Glucose Level
- Assess temperature
 - Hypothermia – Rewarm patient, ensure patient compartment is warm



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Pediatric Bradycardia

Medical Director Review Date 12-7-2022

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8020

Pediatric Tachycardia

Medical Director Review Date 12-7-2022

Symptomatic pediatric tachycardia: cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds).

Symptomatic Tachycardia = Infant ≥ 220 or Child (1-17 years) ≥ 180 with signs of poor perfusion

TREATMENT

- **If the patient is asymptomatic look for underlying causes** (fever, dehydration, pain etc.)
- Airway/breathing management
 - Monitor SpO₂ and administer 100% O₂ via NRB
- Determine Blood Glucose Level
- Assess temperature

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Pediatric Tachycardia

Medical Director Review Date 12-7-2022

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8030

Pediatric Shock

Medical Director Review Date 12-7-2022

Shock patients may deteriorate rapidly. Signs of shock include hypotension, cool mottled skin, diminished pulses, altered mental status, increased capillary refill time (>2 seconds) and tachycardia.

TREATMENT

- Place patient in supine position
- Maintain body warmth
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Assess temperature
- Determine Blood Glucose Level

EMT



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Pediatric Shock

Medical Director Review Date 12-7-2022

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Pediatric Foreign Body Airway Obstruction

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Foreign Body **AIRWAY OBSTRUCTION MANEUVERS** as indicated below:
 - **Infant (less than 1 year)**
 - **Conscious**
 - Mild Obstruction with good air exchange
 - Do not interfere with patient's own attempts to expel the obstruction
 - Monitor closely for signs of worsening
 - Attempt to keep patient calm
 - Severe Obstruction
 - If possible, bare the infant's chest
 - Support the infant in prone position, deliver up to 5 back blows in the middle of the upper back
 - Continuing to support the infant, rotate to a supine position with the head lower than the trunk
 - Deliver up to 5 quick downward chest thrusts in the same location as chest compressions
 - Repeat sequence until obstruction is cleared, or the infant becomes unconscious
 - **Unconscious**
 - Reposition airway and attempt to remove object with Magill forceps
 - Begin CPR as indicated
 - Suction as indicated
 - **Child (1-17 years)**
 - **Conscious**
 - Mild Obstruction with good air exchange
 - Encourage patient's own spontaneous coughing and breathing efforts
 - Attempt to keep patient calm
 - Severe Obstruction:
 - Abdominal thrusts (Heimlich maneuver)
 - **Unconscious**
 - Reposition airway and attempt to remove object with Magill forceps
 - Begin CPR as indicated
 - Suction as indicated
 - Consider Mechanical Airway Clearance Device (Appendix U)
- Airway/breathing management
 - Once obstruction is removed, administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater



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Pediatric Foreign Body Airway Obstruction

Medical Director Review Date 12-7-2022

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Pediatric Respiratory Distress

Medical Director Review Date 12-7-2022

The following signs and symptoms will be treated as Respiratory Distress: increased respiratory rate, increased work of breathing, retractions, nasal flaring, SpO₂ <95%.

- Normal Respiratory Rates
 - Infant (<1yr): 30- 53
 - Toddler (1-3yr): 22 -37
 - Preschooler (4-5yr): 20-28
 - School-age (6-12yr): 18 -25
 - Adolescent (13-17yr): 12 -20

TREATMENT

- Airway/breathing management
 - Assess breath sounds
 - Administer O₂ via NRB
 - If unable to maintain an oxygen saturation of $\geq 92\%$ with NRB, provide 100% O₂ with BVM and positive pressure ventilations
- Assess temperature
- Determine Blood Glucose Level



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Pediatric Respiratory Distress

Medical Director Review Date 12-7-2022

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Pediatric Asthma

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Assess breath sounds
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Assess temperature
- Determine Blood Glucose Level

EMT



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Pediatric Asthma

Medical Director Review Date 12-7-2022

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Pediatric Cardiac Arrest (Shockable)

Medical Director Review Date 12-7-2022

Children usually experience cardiopulmonary failure secondary to respiratory failure or shock and rarely due to primary cardiac disease or primary cardiac arrest. The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions and defibrillation as outlined in Appendix T.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
 - Start cycles of 15 compressions to 2 breaths for 2 person CPR (with 100% O₂ and BVM)
 - Start cycles of 30 compressions to 2 breaths for single rescuer CPR (with 100% O₂ and BVM)
- Continue CPR and apply defibrillator pads as soon as possible (Pediatric pads should be used for patients <8 years of age)
 - If an unwitnessed arrest or no bystander CPR, perform 2 minutes of CPR prior to defibrillation
 - If witnessed arrest by JFRD or bystander CPR in progress, analyze and defibrillate immediately, if indicated
 - If shockable, give **1 shock**
 - Continue to provide defibrillation every two minutes if shockable rhythm is noted upon reassessment
 - The time from the last compression to defibrillation should be minimized
 - After each defibrillation, **IMMEDIATELY** continue CPR, starting with compressions for 2 minutes then reassess
- If no shock advised, **IMMEDIATELY** continue CPR, starting with compressions, for 2 minutes then reassess
- Utilize Lucas CPR device (Appendix A) as early as possible
 - If the patient is too small, the Lucas device will alert with 3 fast signals when lowering the Suction Cup and will not enter the PAUSE mode or ACTIVE mode
- Airway/breathing management
 - Utilize BVM and/or King Tube #1
 - Once an airway is placed, provide continuous chest compressions and provide 1 breath every 6 seconds
 - Continue this compression to ventilation ratio until placement of a supraglottic airway
 - Use of basic airway adjuncts (OPA and/or NPAs) should be utilized when ventilating the patient without a supraglottic airway in place



8070

Pediatric Cardiac Arrest (Shockable)

Medical Director Review Date 12-7-2022

- Determine Blood Glucose Level
- Consider the following less common causes of cardiac arrest and their appropriate treatments:
 - Hypoxia – provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Hyperthermia/Hypothermia – cool or warm as needed

EMT



8080

Pediatric Cardiac Arrest (Non-shockable) or Symptomatic Bradycardia (≤ 8 y/o)

Medical Director Review Date 2-17-2023

Children usually experience cardiopulmonary failure secondary to respiratory failure or shock and rarely due to primary cardiac disease or primary cardiac arrest. The emphasis should be placed on early identification of cardiac arrest with continuous well-performed compressions as outlined in Appendix T.

TREATMENT

- Check responsiveness, check for breathing (no breathing or only gasping), check for carotid pulse (should not take more than 10 seconds)
- If **NO** pulse present, OR patient is 8 years or less and has a heart rate less than 60 with signs of poor perfusion (e.g., cool mottled skin, altered mental status) despite oxygenation and ventilation, initiate CPR.
 - Start cycles of 15 compressions to 2 breaths for 2 person CPR (with 100% O₂ and BVM)
 - Start cycles of 30 compressions to 2 breaths for single rescuer CPR (with 100% O₂ and BVM)
- Apply defibrillator pads as soon as possible
- Utilize Lucas CPR device (Appendix A) as early as possible
 - If the patient is too small, the Lucas device will alert with 3 fast signals when lowering the Suction Cup and will not enter the PAUSE mode or ACTIVE mode
- If the provider is alone, the use of a BVM in single rescuer CPR is no longer recommended. Continuous, uninterrupted chest compressions with pauses for AED application/use only until assisting units arrive
- Airway/breathing management
 - Utilize BVM and/or King Tube #1
 - Once a supraglottic airway is placed, provide continuous chest compressions and provide 1 breath every 6 seconds
 - Continue this compression to ventilation ratio until placement of a supraglottic airway
 - Use of basic airway adjuncts (OPA and/or NPAs) should be utilized when ventilating the patient without a supraglottic airway in place
- Determine Blood Glucose Level
- Consider the following less common causes of cardiac arrest and their appropriate treatments:
 - Hypoxia – provide 100% O₂ with use of BVM and appropriate airway adjunct
 - Hyperthermia/Hypothermia – cool or warm as needed



8080

Pediatric Cardiac Arrest (Non-shockable) or Symptomatic Bradycardia (≤ 8 y/o)

Medical Director Review Date 2-17-2023

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8090

Pediatric Allergic Reaction/Anaphylaxis

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - Anticipate rapid deterioration and the need for supraglottic airway (Appendix D)
- Assist with administration of patient's Auto-Injector Epinephrine if present
- Determine Blood Glucose Level
- Assess temperature

EMT



8090

Pediatric Allergic Reaction/Anaphylaxis

Medical Director Review Date 12-7-2022

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8100

Pediatric Altered Consciousness

Medical Director Review Date 12-7-2022

TREATMENT

- Prevent aspiration by placing the patient in the recovery position
- Determine blood glucose level. If BGL is abnormal, refer to Pediatric Diabetic Guideline 8110
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
 - If GCS $\leq$ 8 or inability to protect airway, insert supraglottic airway (Appendix D)
- Assess temperature
- Treatment based on underlying cause:
 - Narcotic use/exposure
 - Refer to Pediatric Overdose/Poisoning Guideline 8120
 - Unknown etiology
 - Consider other treatable neurological or metabolic disorders and, if identified, follow the appropriate guideline



8100

Pediatric Altered Consciousness

Medical Director Review Date 12-7-2022

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8110

Pediatric Diabetic

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Assess temperature
- Look for underlying causes
- Treatments based on blood glucose level and level of consciousness:
 - Hypoglycemia (BGL <60 mg/dL or altered mental status) **WITHOUT** vascular access
 - Conscious and alert patient (GCS $\geq$ 14) with BGL <60 mg/dL, administer oral **Glucose paste 15 grams** (1 tube)
 - May repeat once in 10 minutes if BGL still <60 mg/dL
 - Contraindications
 - Patient less than 2 years old
 - Altered level of consciousness
 - Difficulty swallowing



8110

Pediatric Diabetic

Medical Director Review Date 12-7-2022

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8120

Pediatric Overdose/Poisoning

Medical Director Review Date 12-7-2022

TREATMENT

- If substance is known, contact Poison Control at **1-800-222-1222**. Provide all information requested by poison control representative
- Do not delay treatment or transport, but if possible, bring medication or substance ingested
- Wear appropriate personal protective equipment
- Airway/breathing management
 - Prevent aspiration by placing the patient in the recovery position
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Determine Blood Glucose Level
- Consider specific treatment situations:
 - Organophosphate exposure
 - For all suspected organophosphate exposures, notify HAZMAT Team
 - Signs and symptoms include Diarrhea, Urination, Miosis, Bradycardia, Bronchorrhea, Bronchospasm, Emesis, Lacrimation and Salivation



8120

**Pediatric
Overdose/Poisoning**
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8130

Pediatric Seizures

Medical Director Review Date 12-7-2022

TREATMENT

- Maintain aspiration precaution by placing the patient in the recovery position
- If trauma suspected, immobilize patient using proper technique
- If the patient is actively seizing, protect the patient from further injury
- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Look for underlying causes
 - Determine blood glucose level. If BGL is abnormal, refer to Pediatric Diabetic Guideline 8110
 - Assess temperature
 - Apply cooling measures (ice packs or wet towels to neck, axillae, groin, etc.) when the patient has a temperature ≥ 102 degrees



8130

Pediatric Seizures

Medical Director Review Date 12-7-2022

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8140

Pediatric Fever

Medical Director Review Date 12-7-2022

TREATMENT

- Airway/breathing management
 - Administer O₂ via proper adjunct to maintain oxygen saturation of 95% or greater
- Assess temperature
 - Apply cooling measures (ice packs or wet towels to neck, axillae, groin, etc.) when the patient has a temperature ≥ 102 degrees
- Determine Blood Glucose Level
- If the pediatric patient has a temperature ≥ 102 degrees and the parent has Ibuprofen or Acetaminophen:
 - Administer **Ibuprofen 10 mg/kg** (not for children under 6 months) PO or **Acetaminophen 15 mg/kg** PO

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8140

Pediatric Fever

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Advanced Airway

Chapter 9

Advanced Airway





Advanced Airway

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Airway – Adult

Medical Director Review Date 12-7-2022

- Continuous Positive Airway Pressure (CPAP) (Appendix H) should be considered prior to intubation for those without a decreased LOC
 - Give 10 cm/H₂O and titrate to the patient's work of breathing
- If airway obstruction present and unable to oxygenate/ventilate
- Assess for tension pneumothorax (unilateral absent or decreased breath sounds **with** severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, JVD, and hypoxia)
 - In the non-trauma setting, only spontaneous pneumothorax is normally present. However, positive pressure ventilation can lead to tension pneumothorax
- Insert supraglottic airway (Appendix D).
 - If supraglottic airway unsuccessful, use a BVM with airway adjunct(s)

AFTER INSERTION OF SUPRAGLOTTIC AIRWAY:

- Confirm tube placement and constantly monitor adequacy of ventilations:
 - Absence of gastric sounds with auscultation
 - Auscultating for the presence of bilateral breath sounds
 - Look for equal chest rise
- If vomit is forcefully coming from the King Tube, remove it and utilize a BVM
- Secure tube with commercial tube holder (may use other means if necessary)
- DO NOT HYPERVENTILATE patients with suspected Ischemic Brain Injury



9010

Airway – Adult

Medical Director Review Date 12-7-2022

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9030

Airway – Pediatric

Medical Director Review Date 12-7-2022

- Continuous Positive Airway Pressure (CPAP) (Appendix H) should be considered for those without a decreased LOC
 - If patient less than 12 years old, give **5 cm/H₂O** and titrate to the patient's work of breathing
 - If 12 years or older, give **10 cm/H₂O** and titrate to the patient's work of breathing
- Assess for tension pneumothorax (unilateral absent or decreased breath sounds with severe respiratory distress or signs/symptoms of tension pneumothorax such as hypotension, tachycardia, and hypoxia
 - In the non-trauma setting, only spontaneous pneumothorax is normally present. However, positive pressure ventilation can lead to tension pneumothorax
- Pre-oxygenate with adjunct(s) for 1 minute with NRBM for spontaneous breathing or BVM for apnea/agonal respirations
 - BVM ventilation rates
 - Premature Neonate and Neonate: 40 to 60 per minute
 - Infants and Children: 12 to 20 per minute
- Suction as necessary
- Supraglottic airway (King Tube) may be used for patients 2 - 5 years old
 - If supraglottic airway unsuccessful, use a BVM with airway adjunct(s)

AFTER INSERTION OF SUPRAGLOTTIC AIRWAY:

- Confirm tube placement and constantly monitor adequacy of ventilations:
 - Absence of gastric sounds with auscultation
 - Auscultating for the presence of bilateral breath sounds
 - Look for equal chest rise
- If vomit is forcefully coming from the King Tube, remove it and utilize a BVM
- Secure tube with commercial tube holder (may use other means if necessary)
- DO NOT HYPERVENTILATE patients with suspected Ischemic Brain Injury



9030

Airway – Pediatric

Medical Director Review Date 12-7-2022

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Appendices

Chapter 10

Appendices



Appendices

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Appendix A

Lucas Device

Medical Director Review Date 12-7-2022

Indication

- Cardiac Arrest
 - Should be used in every cardiac arrest except those contraindicated as listed below. Device should be applied as early as possible (e.g., while still inside a residence) and prior to moving the patient

Contraindications

- Patient is too large. Recognized when the Upper Part of the device will not lock to the Back Plate without compressing the patient's chest
- Patient is too small. Recognized when the Lucas device alerts with 3 fast signals when lowering the Suction Cup, and you cannot enter the PAUSE mode or ACTIVE mode.

Cautions

- If there is gel on the patient's chest, the Suction Cup position can change
- If the position of the Suction Cup changes during operation, immediately push the #1 button, and then adjust the position
- Pregnant patients greater than 20 weeks must have their uterine manually displaced to the left to offload aorta and vena cava compression
- Do not block the vent holes

Daily Inspection

- Ensure device is plugged in so that the inserted battery is fully charged
- Ensure Suction Cup is mounted
- Ensure that there is a spare Suction Cup and fully charged spare battery inside the case
- Inspect for physical damage to the unit/case

Batteries/Charging

- The device should remain plugged in inside the unit when not in use so that the inserted battery remains fully charged
- The inserted battery should be swapped with the spare battery once a week on Apparatus Day

Cleaning

- Clean all surfaces and straps with a mild cleaning agent or disinfectant
- Allow device to dry before placing into the carrying case
- Dispose of Suction Cup after each patient use

Procedure

- Start manual CPR
- Unpack the device
- Push ON/OFF for 1 second to power up and start the self-test. The green LED adjacent to the key illuminates when the device is ready for use

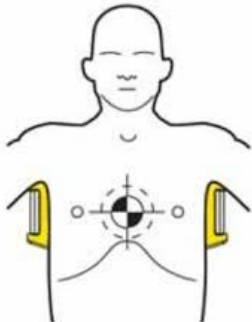


Appendix A

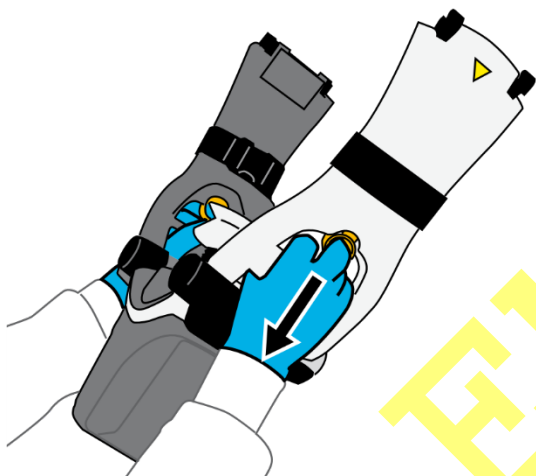
Lucas Device

Medical Director Review Date 12-7-2022

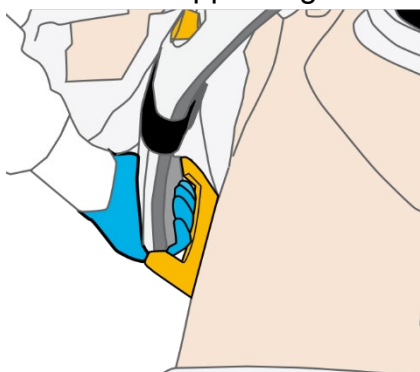
- Place the Lucas Back Plate under the patient, immediately below the arm pits



- Hold the handles on the support legs to remove the Lucas Upper Part from the carrying case
- Pull the release rings once to make sure that the claw locks are open



- Let go of the release rings
- Attach the support leg that is nearest to you to the Back Plate. Listen for a click



- Attach the other support leg to the Back Plate, so that the two support legs lock against the Back Plate. Listen for a click
- Ensure that the Lucas device is in the Adjust mode (#1)



Appendix A

Lucas Device

Medical Director Review Date 12-7-2022

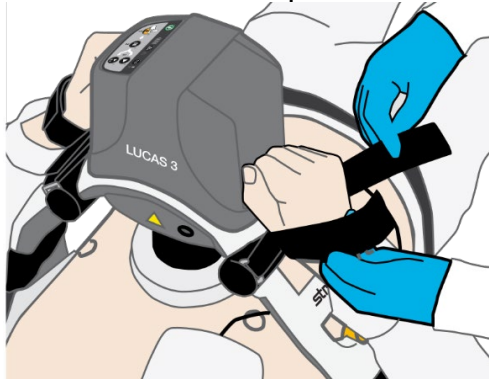
- Push the Suction Cup down until it touches the patient's chest without compressing the chest



- The lower edge of the Suction Cup should be immediately above the end of the sternum, which is the same spot for manual CPR
- Push the **#2** button on the control panel to lock the Start Position



- Push the **#3** button to start either **CONTINUOUS** or **30:2** chest compressions
 - **Continuous** mode if advanced airway in place
 - **30:2** mode if airway not secured (e.g., BVM only)
- If device needs to be paused, push **#2 (PAUSE)**
- If Suction Cup position needs adjustment, push **#1**, then pull up the Suction Cup to readjust
- You can secure the patient's arms with the straps attached to the Lucas device





Appendix A

Lucas Device

Medical Director Review Date 12-7-2022

- Defibrillation can be performed while the Lucas device is operating
- To remove the device from the patient, push **ON/OFF** for 1 second or press the **#2 (PAUSE)** button
- Pull the release rings to remove the Upper Part from the Back Plate
- If the situation and patient's condition permits, remove the Back Plate

EMT



Appendix C

Traction Splint

Medical Director Review Date 12-7-2022

Indications

- Mid-thigh injury that is painful, swollen, and deformed

Contraindications

- Hip/pelvis injury
- Ankle/lower leg injury on affected side
- Fracture is close to the knee

Procedure

- Apply manual stabilization above and below the injury to reduce further injury
 - This JFRD member is solely dedicated to maintaining stabilization until mechanical traction takes over
- Remove clothing from the area
- Remove sock and shoe from the affected leg
- Position splint against uninjured leg
- Adjust splint to length, extending the splint so that the bend is even with the heel of the foot
- Tighten locking collars
- Open and position the Velcro straps along the splint
- Release the ratchet, extending the entire length of the traction splint
- Place the splint next to the injured leg
- Apply ankle hitch to the patient
- Firmly seat splint against the ischial
- Secure the pubic (high over the thigh) strap
- Attach ankle hitch to the traction strap
- Apply traction until pain and muscle spasms are relieved or the injured leg is the same length as the uninjured leg
- Secure the remaining Velcro straps
- When splint is properly applied, the patient's foot should be upright
- Transport patient on firm surface so the splint is supported
- Continue to reassess circulatory and neurological function distal to the injury site

Precaution

- If patient is unstable, do not waste time applying the traction splint. Concentrate on other life saving measures



Appendix C

Traction Splint

Medical Director Review Date 12-7-2022

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Appendix D

King Tube

Medical Director Review Date 12-7-2022

Indications

- **Intended to be used as a rescue airway device after failed intubation attempts**
 - May be used as primary airway if intubation anticipated to be difficult and rapid airway control is necessary
- Designated advanced airway for EMTs

Contraindication

- Foreign body airway obstruction
- Intact gag reflex
- Caustic ingestion

Procedure for EMT and Paramedic

- Initiate BLS airway sequence
- Select proper size King Tube based on patient height/weight (includes pediatrics):
 - 5-12 kg = **#1**
 - 12- 25 kg= **#2**
 - 4' to 5' tall = **#3**
 - 5'-6' tall = **#4**
 - Greater than 6' tall = **#5**
- Assemble equipment, inflate cuff to proper volume, test balloon for leaks and then deflate, lubricate posterior aspect distal tip with water-soluble lubricant
- Suction airway and pre-oxygenate with BVM ventilations, if possible
- If possible spinal injury, maintain cervical immobilization
- If no spinal injury, place head into sniffing position or with slight cervical hyperextension
- Hold King Tube in dominant hand at connector. With other hand, open mouth and lift chin
- Rotate King Tube so blue index line is facing corner of mouth
- Introduce tip into mouth and advance airway behind tongue into the hypopharynx
- As tube passes tongue, rotate King Tube so that blue index line is again facing the chin
- Without excessive force, advance King Tube so that base is aligned with teeth or gums
- Using supplied syringe, inflate cuff with correct volume of air (marked on King Tube)
 - Size 1 = 20 mL
 - Size 2 = 35 mL
 - Size 3 = 50 mL
 - Size 4 = 70 mL
 - Size 5 = 80 mL
- Attach bag to King Tube and begin ventilating patient. While ventilating, slowly and slightly withdraw King Tube until ventilations are easy and chest rise is adequate
- Confirm tube placement by auscultation, chest movement, and ETCO₂
- Secure tube with commercial tube holder (may use other means if necessary)
- Insert properly sized NG/OG tube into gastric lumen for suctioning and/or passive venting. This can decrease gastric pressure and reduce the risk of aspiration
- Monitor patient for vomiting and aspiration
- Continuously monitor ETCO₂ and SpO₂ values
- Do not remove a properly functioning King Tube to attempt intubation



Appendix D

King Tube

Medical Director Review Date 12-7-2022

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Appendix H

CPAP

Medical Director Review Date 09/01/2022

Pulmonary O2-Max is a high-pressure disposable CPAP that filters inspiratory and expiratory air.

Indication

- Symptomatic patients with moderate-to-severe respiratory distress (wheezes, rales, decreased breath sounds, etc.)

Contraindications

- Respiratory or cardiac arrest
- Systolic BP less than 90mmHg
- Lack of airway protective reflexes
- Decreased LOC or unable to follow verbal instructions
- Vomiting or active upper GI bleed
- Suspected pneumothorax
- Trauma
- Patient size or anatomy prevents adequate mask seal

Procedure

- Place patient in a seated position and explain the procedure to him or her
- Select appropriate size mask
- Connect O₂ tubing to the high-pressure oxygen source
- Hand mask to the patient and allow them to feel the air flow on their face
- Apply the CPAP mask and secure with provided straps, progressively tightening as tolerated to minimize air leak
- Adjust the PEEP valve so that the desired pressure is obtained. The valve comes preset at 5 cm H₂O, but can be adjusted to 7.5 or 10 cm H₂O
 - **<12 y/o** – maintain the 5 cm H₂O
 - **Adult and pediatric ≥12 y/o** – adjust valve to 10 cm H₂O
- Advanced airway indicated if signs of deterioration or failure of response to CPAP present:
 - Decrease in level of consciousness
 - Substantially increased heart rate or respiratory rate
 - Substantially decreased blood pressure
 - Visible signs of fatigue
 - Sustained low or decreasing SpO₂ readings
 - Diminished or no improvement in tidal volume



Appendix H

CPAP

Medical Director Review Date 09/01/2022



Utilize Ohmeda style connector for high-pressure wall outlet





Appendix L

Pediatric Restraint device

Medical Director Review Date 12-7-2022

Indications

- Transporting a non-immobilized pediatric patient
 - Use of this device should be the standard. Exceptions may be made based on the child's level of distress
 - A car seat is a viable option to the Pediatric Restraint Device. Both methods are better alternatives than a parent's lap

Procedure for EMT or Paramedic

- Place Pediatric Stretcher Restraint Device (PSRD) on the stretcher pad
- Release the buckles from the long strap and the 2 smaller straps
- Open it and lay it flat on the stretcher pad
- Wrap the large strap from the PSRD around the head portion of the stretcher, close the buckle and tighten the strap
- Wrap the short straps from the PSRD around the stretcher rail, close the buckle and tighten the strap
 - Pick a point closest to the strap
- Open the buckle on the "V" strap of the PSRD
- Open the buckle on the lateral chest strap
- Place the child on the stretcher and on top of the PSRD
- Secure the patient in the PSRD by bringing the "V" strap over the patient's head
- Connect the "V" strap to the groin strap, close the buckle and tighten the strap
- Pad around the child if there are any gaps between the patient and the PSRD
- Close the lateral chest strap buckle and tighten
- Always document every use of the PSRD in the PCR

Caution

- Do not cut any portion of the device



Appendix L

Pediatric Restraint device

Medical Director Review Date 12-7-2022

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EMT



Tourniquet

Medical Director Review Date 12-7-2022

Indications

- To control potentially fatal extremity hemorrhage only after other means of hemorrhage control has failed. Examples may include an amputation, profuse pulsating bleeding, blood soaking through pressure bandage and signs of shock with continued bleeding

Procedure for EMT or Paramedic

- First attempt to control hemorrhage by using direct pressure over bleeding area
- If a bleeding vessel can be identified, point pressure over bleeding vessel is more effective than a large bandage applying diffuse pressure

If unable to control hemorrhage using direct pressure, apply **SOF© Tactical Tourniquet**:

1. Cut away any clothing so that the tourniquet will be clearly visible. NEVER obscure a tourniquet with clothing or bandages
2. Select location proximal to the wound and not across any joints
3. Place tourniquet 2-3" proximal to the wound
 - Slide tourniquet over extremity if possible. Otherwise, unbuckle tourniquet, go around the limb and then re-buckle
 - If a single tourniquet is not sufficient to stop the bleeding, apply a second tourniquet more proximal to the first
4. Pull tail tight
5. Twist handle until bleeding stops. Applying tourniquet too loosely will only increase blood loss by inhibiting venous return
6. Lock handle into triangle
7. Mark the time and date of application on the patient's skin next to the tourniquet
8. Keep tourniquet on throughout hospital transport – a correctly applied tourniquet should only be removed by the receiving hospital. This also applies to tourniquets placed prior to JFRD arrival (i.e., JSO)
9. A patient that requires a tourniquet from a traumatic injury should be transported to a hospital with trauma capabilities, with a Trauma Alert declared when appropriate



Tourniquet

Medical Director Review Date 12-7-2022

Precaution

- Injury due to a properly applied tourniquet is unlikely if the tourniquet is removed within 1-2 hours. In cases of life-threatening bleeding, benefit outweighs theoretical risk
- A commercially made tourniquet is the preferred tourniquet. If none is available, a blood pressure cuff inflated to a pressure sufficient to stop bleeding is an acceptable alternative. Other improvised tourniquets are not allowed

Prior to application and still buckled:



Properly applied with handle locked in triangle:





SAM Pelvic Splint

Medical Director Review Date 12-7-2022

Indications

- Unstable pelvis

Procedure for EMT and Paramedic

- Remove all objects from the patient's pockets
- Lay the splint out next to the patient's pelvis (printed side down)
- Slide the splint under the pelvis at the level of the bottom of the buttock (figure 1)
- Wrap the black strap completely through the buckle (figure 2)
- Hold the orange strap and PULL the black strap in the opposite direction (figure 3)
- Pull until you hear the "Click"
- Maintain the tension and press the black strap onto the Velcro® portion of the splint

Cautions

- Do not use on pediatric patients
- Do not cut any portion of the splint





SAM Pelvic Splint

Medical Director Review Date 12-7-2022

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Spinal Immobilization

Medical Director Review Date 12-7-2022

The goal of spinal immobilization is to prevent neurologic damage or limit the extent of a spinal cord injury.

Purpose

- To provide guidelines and recommendations for determining full or partial spinal immobilization

Indications for full spinal immobilization

- Numbness, tingling, or motor weakness in any extremity
- Point tenderness over the spinal process
- Neck pain during movement
- Head injury with GCS <15
- Significant mechanism of injury such as ejection, high falls, and abrupt deceleration crashes
 - An intoxicated patient who suffers a significant mechanism of injury must receive spinal immobilization regardless of whether they are alert and oriented
- Presence of significant distracting injuries

Indication for partial immobilization (cervical collar only)

- Isolated neck pain with none of the indications above
- Any patient <5 or >65 who has experienced a mechanism of injury which could result in spinal injury
- Patient who refuses or can't tolerate full spinal immobilization
 - Deviation must be documented in the PCR

Precaution

- Range of motion should NOT be assessed if patient has midline spinal tenderness
- Range of motion should not be assisted
- Consider spinal immobilization in any patient with arthritis, cancer, or other underlying spinal or bone disease
- If there is any doubt during the evaluation of the spine, it is better to immobilize
- Patients with spinal curvature or rounding of the back may require improvised (towels, blanket, pillow, etc.) immobilization

The Kendrick Extrication Device (KED) may be useful in immobilizing a patient found in a sitting position. It is most commonly used in automobile accidents where the patient needs to be transitioned from the vehicle to the long backboard. If the patient is unstable, the KED is not appropriate as it is too time consuming

In penetrating injury to the head, neck, or torso with no evidence of spinal injury, immobilization is not necessary

Infants and children less than 60 lbs, use Pedi-Immobilizer™ when appropriate.



Spinal Immobilization

Medical Director Review Date 12-7-2022

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Sports Helmet Removal

Medical Director Review Date 12-7-2022

In **all circumstances, the face mask should be removed first** for airway access. Also, cutting of the ties of the shoulder pads can be performed (both anteriorly and under the arms) to allow for access to the chest if needed for cardiopulmonary resuscitation (CPR).

Equipment (helmet and shoulder pads) should be left in place until arrival to the ED, unless the circumstance dictates removal. When equipment removal is necessary, it needs to follow the "all or nothing" principle, meaning removed together. As the helmet and shoulder pads work together to help maintain a neutral spine when they are properly fitted, removing the helmet without the shoulder pads will lead to cervical spine hyperextension, potentially worsening an injury.

Team athletic trainers or health care professionals may be present and able to provide assistance.

Procedure

- Stabilize helmet in a neutral in-line position
- Second individual removes the chin strap
- The individual that removes the chin strap will support the occipital and mandible of the patient
- The individual that stabilized the helmet then gently removes the helmet
- Once helmet is removed, apply C-collar and immobilize on a long back board, KED, or pediatric immobilization device
- If unable to remove helmet:
 - Assure the face shield/mask has been removed for airway access
 - Assure spinal immobilization with tape and towels





Sports Helmet Removal

Medical Director Review Date 12-7-2022

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Appendix R

Advanced Trauma Care Bag

Medical Director Review Date 12-7-2022

Every field chief vehicle contains an Advanced Trauma Care Bag as pictured below.



Purpose

- With an assortment of advanced trauma care contents, these trauma kits are designed primarily for deployment at mass casualty incidents.

Contents

- **HALO VENT** - Adhesive, vented seal for treating penetrating chest injuries. Each package contains one vented and one non-vented seal. The vented seal should be applied anterior (with seal hole centered over wound) and the non-vented seal placed posterior. Prior to placement, ensure the skin is wiped of blood and sweat.



- **Z-PACK DRESSING** - Highly absorbent cotton gauze that is "Z-Folded" for ease in packing wounds.





Advanced Trauma Care Bag

Medical Director Review Date 12-7-2022

- **HEMORRHAGE CONTROL BANDAGE** - The Emergency Bandage (or Israeli bandage) is an elasticized bandage with a built-in pressure bar that can be twisted to apply more pressure to a wound. Designed to be applied on top of existing gauze/packing



- **CHITO GAUZE** - Hemostatic (promotes coagulation) dressing for the external, temporary control of severely bleeding wounds.



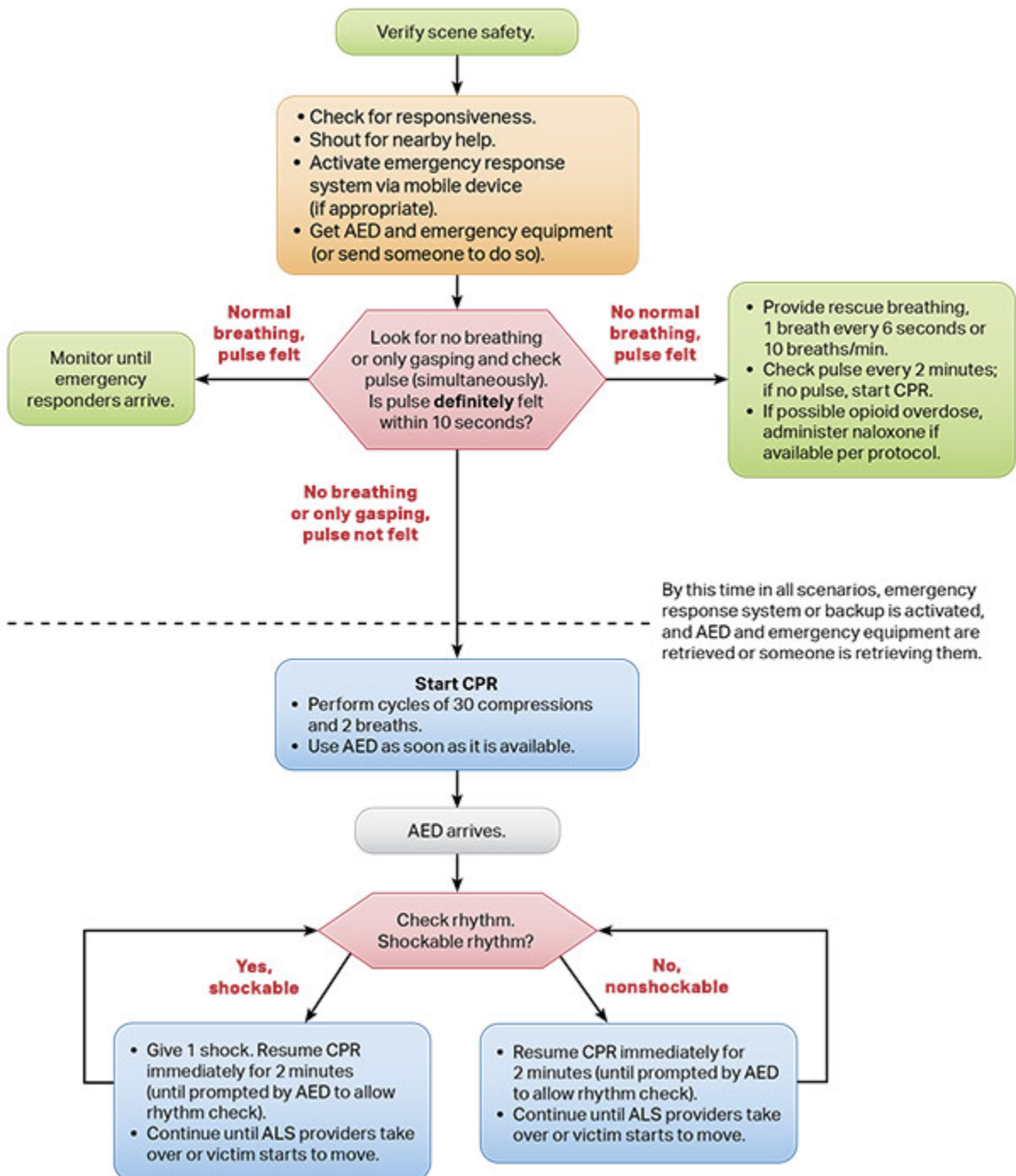
- **DRAG BLANKETS**
- **TOURNIQUETS**
- **DECOMPRESSIONS NEEDLES**
- **SHEARS**
- **ACE BANDAGES**
- **TRAUMA DRESSING**
- **4 X 4 GAUZE**



AHA Adult Cardiac Arrest Algorithm

Medical Director Review Date 09/01/2022

Adult Basic Life Support Algorithm for Healthcare Providers





AHA Adult Cardiac Arrest Algorithm

Medical Director Review Date 09/01/2022

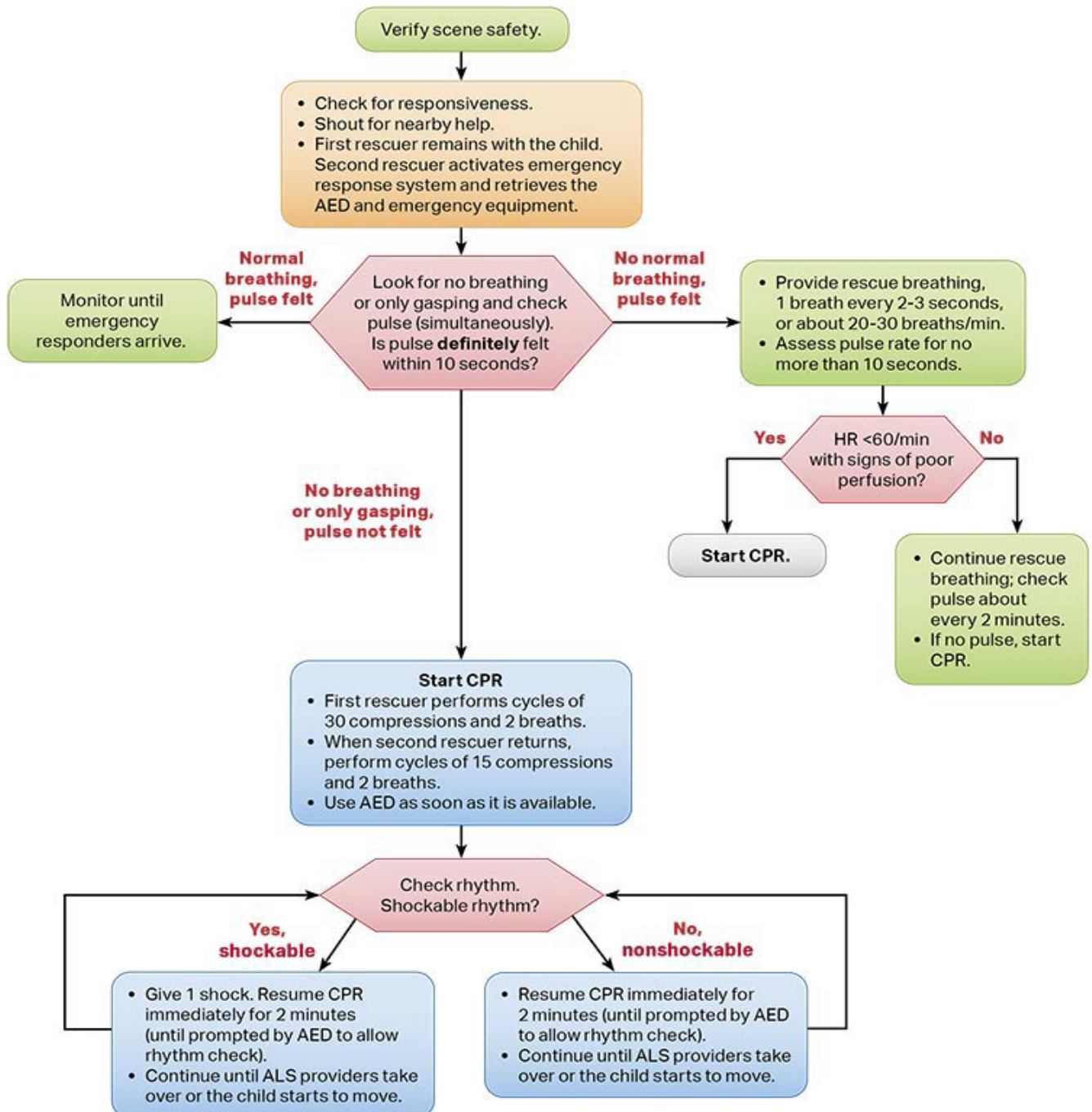
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AHA Pediatric Cardiac Arrest Algorithm Medical Director Review Date 09/01/2022

Pediatric Basic Life Support Algorithm for Healthcare Providers—2 or More Rescuers





Appendix T

AHA Pediatric Cardiac Arrest Algorithm

Medical Director Review Date 09/01/2022

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Airway Clearance Device (LifeVac)

Medical Director Review Date 09/01/2022

The LifeVac kit contains one suction unit with a one-way valve and two face masks (adult and pediatric). The device is a non-powered, non-invasive, single use only airway clearance device for resuscitating a choking victim when other standard measures have been unsuccessful.

Indications

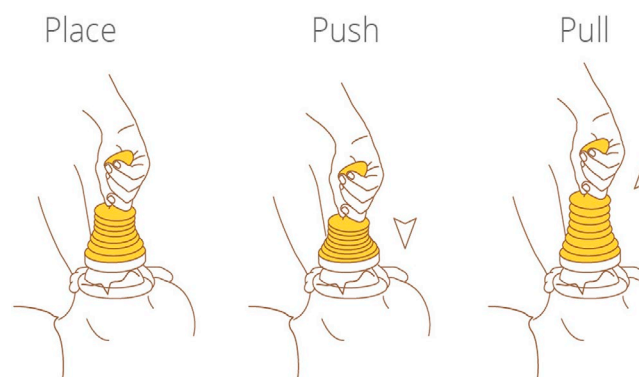
- Standard maneuvers to remove a foreign body airway obstruction have failed

Contraindication

- Pediatrics weighing <10kg

Procedure for EMT and Paramedic

1. Select appropriately sized mask.
2. Insert mask into the unit with a twisting motion while applying pressure.
3. Place mask over nose and mouth.
4. Holding mask in place with one hand and chin held upwards, push handle down with the other hand to compress unit.
5. Once handle is depressed, pull handle upward with a short, SWIFT tug while holding mask firmly in place.
6. Roll patient to side and sweep the mouth to clear any debris. Also check unit for debris.
7. Repeat steps as necessary.





Appendix U

Airway Clearance Device (LifeVac) Medical Director Review Date 09/01/2022

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Appendix V

Abbreviations

Medical Director Review Date 12-7-2022

Abbreviation	Meaning
ABCs	Airway, Breathing, Circulation
Abd	Abdomen
ABPD	Atlantic Beach Police Department
A/C	Antecubital fossa
ACLS	Advanced Cardiac Life Support
AED	Automated External Defibrillator
AICD	Automated Implantable Cardioverter Defibrillator
AIDS	Acquired Immune Deficiency Syndrome
ALOC	Altered Level of Consciousness
ALS	Advanced Life Support or Amyotrophic Lateral Sclerosis
AMA	Against Medical Advice
AMS	Altered Mental Status
AMI	Acute Myocardial Infarction
amt.	Amount
AOx3 / AOx4	Alert and oriented times 3 or times 4
A/P	Anteroposterior
ASA	Aspirin
ASAP	As soon as possible
ATU	Air Transport Unit
ATV	All-Terrain Vehicle
BBB	Bundle Branch Block
BBS	Bilateral Breath Sounds
BGL	Blood Glucose Level
B/F	Black Female
B/M	Black Male
BLS	Basic Life Support
BM	Bowel Movement
BP	Blood Pressure
BPM	Beats Per Minute
BS	Blood Sugar or Breath Sounds
BSA	Body Surface Area (Burns)
BSI	Body Substance Isolation
BVM	Bag/Valve/Mask
CA	Cancer
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
C/C	Chief Complaint
CHF	Congestive Heart Failure
CID	Cervical Immobilization Device
cm	centimeter
CMS	Circulatory, Motor and Sensory



Abbreviations

Medical Director Review Date 12-7-2022

CNS	Central Nervous System
c/o	Complains of
CO	Carbon Monoxide
CO₂	Carbon Dioxide
COPD	Chronic Obstructive Pulmonary Disease
CP	Chest pain
CPR	Cardiopulmonary Resuscitation
CSF	Cerebrospinal fluid
C-spine	Cervical Spine
CTAB	Clear to Auscultation Bilaterally
CVA	Cerebrovascular Accident
D₅W	5% Dextrose in Water
D₂₅W	Dextrose 25%
D₅₀W	Dextrose 50%
D/C	Discontinue or Discharge
D & C	Dilation and Curettage
DKA	Diabetic Ketoacidosis
DM	Diabetes mellitus
DNR	Do Not Resuscitate
DNRO	Do Not Resuscitate Order
DOA	Dead on arrival
DOS	Dead on scene
DOB	Date of birth
DUI	Driving Under the Influence
Dx.	Diagnosis
DVT	Deep Vein Thrombosis
ECG, EKG	Electrocardiogram
ED	Emergency Department
EDD	Estimated due date
EEG	Electroencephalogram
ETA	Estimated time of arrival
ETCO₂	End-tidal Carbon Dioxide
ENT	Ears, Nose and Throat
EOM	Extra-ocular Movement
epi	Epinephrine
est.	Estimate(d)
ET	Endotracheal
ETT	Endotracheal tube
ETOH	Ethyl Alcohol
FSED	Freestanding Emergency Department
g	gauge (diameter) or gram
GCS	Glasgow Coma Scale
GI	Gastrointestinal



Appendix V

Abbreviations

Medical Director Review Date 12-7-2022

GSW	Gunshot Wound
gtt(s)	Drop(s)
GYN	Gynecology
H₂O	Water
HEENT	Head, Ears, Eyes, Nose and Throat
H/F	Hispanic Female
H/M	Hispanic Male
HBV	Hepatitis B Virus
hgb	Hemoglobin
HIV	Human Immunodeficiency Virus
hosp.	Hospital
HPI	History of Present Illness
HTN	Hypertension
Hx	History
ICP	Intracranial Pressure
ICS	Intercostal Space
IDDM	Insulin Dependent Diabetes Mellitus
IM	Intramuscular
INT	Intermediate IV access; used when no fluids are being administered
IO	Intraosseous
IV	Intravenous
IVP	Intravenous Push
J	Joules
JVD	Jugular Venous Distension
kg.	Kilogram
KVO	Keep Vein Open
L & D	Labor and Delivery
L, l	Liter
lac	Laceration
LBB	Long Back Board
LBBB	Left Bundle Branch Block
lb(s)	Pound(s)
L/min	Liters Per Minute
LLQ	Left Lower Quadrant
LMP	Last Menstrual Period
LOC	Loss of Consciousness or Level of Consciousness
LPM/lpm	Liters Per Minute
LSB	Long Spinal Board
LUQ	Left Upper Quadrant
MAE	Moves All Extremities
mA	Milliampere
mcg	Microgram
MCI	Mass Casualty Incident



Appendix V

Abbreviations

Medical Director Review Date 12-7-2022

MD	Medical Doctor
meds	Medications
mEq	Milliequivalent
MI	Myocardial Infarction
mg.	Milligram
mL	Milliliter
mm	Millimeters
MOE	Movement of Extremities
MVA	Motor Vehicle Accident
NaCl	Sodium Chloride
NAD	No Acute Distress
NC	Nasal Cannula
NIDDM	Non-insulin dependent diabetes mellitus
NKA	No Known Allergies
NKDA	No known drug allergies
N/G	Nasogastric
NPO	Nothing by Mouth
NRB/NRBM	Non-Rebreather Mask
NS	Intravenous fluids
NSR	Normal Sinus Rhythm
NTG	Nitro/Nitroglycerin
N/V	Nausea and Vomiting
O₂	Oxygen
OB	Obstetrics
OB/Gyn	Obstetrics/Gynecology
OD	Right Eye or Overdose
OPQRST	Onset, Provocation, Quality, Radiation, Severity and Time
OR	Operating Room
P	Pulse
PAC	Premature Atrial Contraction
PCI	Percutaneous Coronary Intervention
PCP	Primary Care Physician
PE	Pulmonary Edema or Pulmonary Embolism
PEA	Pulseless Electrical Activity
PERL	Pupils Equal and Reactive to Light
PERLA	Pupils, Equal, Reactive to Light, and Accommodating
PERRLA	Pupils, Equal, Round, Reactive to Light, and Accommodating
PID	Pelvic Inflammatory Disease
PJC	Premature Junctional Contraction
PMH/PMHx	Past Medical History
PO	By Mouth
POV	Privately Owned/Operated Vehicle
PPE	Personal Protective Equipment



Abbreviations

Medical Director Review Date 12-7-2022

PRN	As Needed
PSVT	Paroxysmal Supraventricular Tachycardia
Pt	Patient
PTA	Prior to Arrival
PVC	Premature Ventricular Contraction
Px.	Physical History
RBBB	Right Bundle Branch Block
RBC	Red Blood Cell Count
RLQ	Right Lower Quadrant
R/O	Rule Out
ROM	Range of Motion
ROSC	Return of Spontaneous Circulation (Return of Pulses)
RR	Respiratory Rate
RUQ	Right Upper Quadrant
SAMPLE	Signs/Symptoms, Allergies, Medications, Past Hx, Last Oral Intake, Events Prior to Illness
SIDS	Sudden Infant Death Syndrome
SL	Sublingual
SOB	Short of Breath
SQ, SC, Sub Q	Subcutaneous Injection of Medication
SpO2	Saturation of Oxygen on the Red Blood Cells
SpCO	Saturation of Carbon Monoxide on the Red Blood Cells
STEMI	ST Elevated Myocardial Infarction
S/S	Signs and Symptoms
SVT	Supraventricular tachycardia
tab.	Tablet
TB	Tuberculosis
Temp.	Temperature
TIA	Transient Ischemic Attack
TKO	To Keep Open
TTP	Trauma Transport Protocol
Tx	Treatment
ULQ	Upper Left Quadrant
VFib (VF)	Ventricular Fibrillation
VTach (VT)	Ventricular Tachycardia
VS	Vital Signs
WBC	White Blood Cell Count
W/D	Warm and Dry
W/F	White Female
W/M	White Male
WNL	Within Normal Limits



Abbreviations

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EMT



STANDARD OPERATING GUIDELINES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT

TITLE: Mass Casualty
Incidents

CREATED: 03/86

REVISED: 7/18

SOG: 413

413.00 PURPOSE

To provide an organizational plan to effectively triage, treat, and transport victims of *Mass Casualty Incidents* (MCIs).

413.01 GENERAL

An MCI is an incident, resulting from manmade or natural causes, in which personnel and equipment at the scene are overwhelmed by the number and severity of the casualties.

Due to the wide-ranging nature of MCIs, the command structure and required resources will vary with each incident. An MCI Level 1 may not require any designated officers other than Command, whereas an MCI Level 3 may require every officer be designated. Utilize the Field Operations Guide (**FOG**) for management of this event.

Apparatus assignments and automatic hospital notifications are found in **SOG 401**.

If an **Active Assailant Incident**, refer to **SOG 445** for specific additional guidance.

413.02 MCI LEVELS

- **MCI Level 1** – 5 – 10 victims
- **MCI Level 2** – 11–20 victims
- **MCI Level 3** – 21 – 100 victims
- **MCI Level 4** – 101–1000 victims
- **MCI Level 5** – Over 1000 victims, or when regional resources are exhausted or overwhelmed

413.03 FIRST ARRIVING UNIT

- Will perform duties as outline in **FOG #1**
- Establish Command (**FOG #2**)
- Estimate the number of victims and declare the MCI Level 1, 2, 3, 4, or 5
 - The initial MCI Level will be based on the estimated number of victims prior to triage. The MCI Level may change when a more accurate number of victims are identified
- Request additional resources (MCI trailers, Rehab/MCI unit, extrication



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assignment, private ambulances, ATU, hazmat, other agencies)

- Identify a Staging Area
- Begin initial triage
 - Utilize personnel to begin triage. Mark victims with appropriate colored ribbons
- Locate the walking wounded
 - Move to a location away from the incident and assign someone to keep them together
 - Assess when feasible

413.04 **ADDITIONAL ARRIVING UNITS**

All units will respond to the Staging Area unless otherwise directed by Command.

413.05 **COMMAND**

First arriving chief will assume command after a transfer of command from first arriving unit.

Will perform duties as outlined in **FOG #2**.

Consider designating the following officers as the situation dictates:

- Medical Branch (large scale or complex MCI's)
 - Triage (already begun)
 - Treatment
 - Transport
- Staging
- Safety
- Rehab

413.06 **OPERATIONAL PERSONNEL**

Medical Branch Officer

- Will perform duties as outlined in **FOG #3**
- Oversees medical operations (Triage, Treatment, and Transportation Sectors) at the scene

Triage Officer

- Will perform duties as outlined in **FOG #4**
- Directs triage of all victims



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Treatment Officer

- Will perform duties as outlined in **FOG # 5**
- Ensure you have sufficient personnel available to move victims to the treatment area
- Coordinates the re-triage of all victims
- Coordinates on-site medical care

Transportation Officer

- Will perform duties as outlined in **FOG #6**
- Communicates with FRCC to determine hospital availabilities and capabilities
- Coordinates, tracks and ensures transport of victims to appropriate medical facilities
- Records the triage tag number and destination hospital for each victim on the hospital transport log

Staging Officer

- Will perform duties as outlined in **FOG #7**
- Coordinates activities in the Staging Area
- Ensures that personnel stay with their apparatus/vehicle unless otherwise directed

413.07

MCI BAGS/KITS

Each JFRD apparatus will carry an MCI bag. This bag contains equipment (ribbons, triage tags, etc.) to assist with the initial triage.

Each field chief's vehicle will carry a Trauma Kit bag. This bag contains equipment (tourniquets, bandaging, etc.) to assist with the treatment of trauma victims.

413.08

MCI TRAILERS

The JFRD has three MCI Trailers that contain equipment for handling large MCIs. These units will be dispatched by FRCC based on the MCI Level or by request from field personnel.

- MCI-9 is an attached truck and trailer that is housed at Station 9. It carries an assortment of equipment and supplies for **IMMEDIATE** needs throughout the region
- MCI-16 is a trailer that is housed at Station 16. It carries an assortment of equipment and supplies for IMMEDIATE needs on JIA property.
- MCI-32 is a trailer that is housed at Station 32. It carries equipment for **LONG-TERM** needs throughout the region



413.09

TRIAGE

The goal of triage is to quickly identify those victims who are in the most need of rapid treatment and transport. During the triage phase, only life-threatening conditions (opening the airway, controlling severe hemorrhage, etc.) are to be addressed. Each victim should be triaged where they are found (unless a hazard exists) in less than 60 seconds.

A colored ribbon is to be attached to each patient to denote their priority:

- **Red** = Immediate. Highest priority. Rapid transport needed
 - Examples include Trauma Alerts, airway obstructions, altered mental status, severe bleeding, and hypoxia
- **Yellow** = Delayed. Second-highest Priority
 - Examples include stable head/torso injuries, eye injuries, tachycardia without hypotension, long bone fractures
- **Green** = Ambulatory (Minor). Allow for transport of higher priority patients
 - Examples include walking wounded, minor fractures, lacerations without severe bleeding, minor burns, sprains, abrasions
- **Black** = Deceased (expectant, non-salvageable)
 - In most cases, these patients are to be left where they are found

413.10

START TRIAGE

Simple triage and rapid treatment (START) is a triage method that may be used to quickly classify victims based on their severity. The colored ribbons are attached to each patient based on assessment findings. Ambulatory patients with only minor injuries are assigned a Green ribbon. The remaining patients are assessed in the following order: **RPM** (Respirations, Perfusion, and Mental Status).

- **Respirations**
 - If respiratory rate is 30 per minute or less, move on to Perfusion
 - If respiratory rate is 31 per minute or more, tag Red
 - If victim is not breathing, open the airway. If after opening the airway, breathing is:
 - Spontaneous - tag Red
 - Absent - tag Black
- **Perfusion**
 - If radial pulse present or capillary refill is 2 seconds or less, move on to Mental Status
 - If radial pulse is absent or capillary refill is greater than 2 seconds, tag Red
 - In addition, any major bleeding should be controlled at this time



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- **Mental Status**
 - Assess the patient's ability to follow simple commands and their orientation to person, place, time, and event
 - If the victim follows commands and is alert and oriented x 4, *tag Yellow*
 - If the victim exhibits any signs of altered level of consciousness, *tag Red*



Appendix

FIRST ARRIVING UNIT - FOG #1

Establish COMMAND and prepare to direct incoming units

Perform initial size-up

Approximate the number of victims and announce the level of MCI:

- Level 1 (5-10 victims)
- Level 2 (11-20 victims)
- Level 3 (21-100 victims)
- Level 4 (101-1000 victims)
- Level 5 (over 1000 victims) or when regional resources are exhausted or overwhelmed

Determine any specific resource needs including:

- MCI Trailer(s) and/or Rehab/MCI Unit
- Extrication assignment
- Private ambulances
- ATU's
- Hazardous materials response
- Other assisting agencies

Remain in a visible location or with your unit

Direct remaining personnel to begin START Triage

Locate and remove the walking wounded away from the incident site for later triage

Establish a staging area for incoming resources

Assign positions per Command FOG-2 as units arrive



COMMAND - FOG #2

Don the appropriate vest

Utilize radio designation COMMAND

Establish an Incident Command Post in a visible location and remain there

Request additional resources early as needed

Confirm the location of the staging area as soon as possible and notify FRCC

Assign positions to perform the following functions as necessary:

- Triage (already begun)
- Treatment
- Transport
- Medical Branch (large scale or complex MCI's)
- Staging
- Safety
- Rehab

Advise Fire Communications of the number of victims and their categories once reported from the TRIAGE OFFICER

When applicable, have a liaison of each involved party at the command post. Examples include:

- Law Enforcement
- Private Ambulance Supervisors
- Occupancy Owner

In large scale or complex MCI's designate a MEDICAL BRANCH DIRECTOR, notify TRIAGE, TREATMENT, AND TRANSPORT OFFICER'S. They will now report to the MEDICAL BRANCH DIRECTOR.



MEDICAL BRANCH – FOG #3

Don the appropriate vest

Utilize radio designation MEDICAL BRANCH

Establish operations in a visible location and remain there or join the Incident Command Post that has already been established

Assign positions to perform the following functions, if not already established by COMMAND:

- TRIAGE
- TREATMENT
- TRANSPORT
- STAGING

Advise Fire Communications of the exact number of victims and their categories once reported from the TRIAGE OFFICER



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TRIAGE – FOG #4

Don the appropriate vest

Utilize radio designation TRIAGE

Direct personnel to triage victims where they lie and identify them utilizing the applicable colored ribbons

Contact Command for additional resources

Ensure that all areas of the incident have been checked for victims and that all victims have been triaged

Assign personnel to triage the “walking wounded”

Report to COMMAND (or MEDICAL BRANCH if established) the number and category of victims

Coordinate with TREATMENT and TRANSPORT for the movement of all victims. The triage team will normally assist in moving patients to the treatment area

Once triage is completed, contact COMMAND (or MEDICAL BRANCH if established) for further assignment of personnel



TREATMENT – FOG #5

Don the appropriate vest

Utilize radio designation TREATMENT

Direct personnel to either begin treatment of victims where they lie or establish a centralized treatment area. Consider use of colored tarps or other identifying areas

Ensure you have sufficient personnel available to move victims

Direct personnel to perform secondary triage with the TRIAGE TAG and provide lifesaving interventions. Treatment Officer will keep a corner of the TRIAGE TAG for future documentation

If the incident size warrants it, designate a TREATMENT TEAM OFFICER for each triage color category

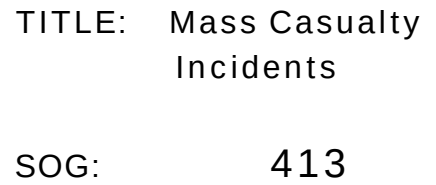
Advise TRANSPORT of victims requiring immediate transportation

Consider having a documentation aide

Account for all victims triaged and treated on the TREATMENT OFFICER's LOG

Advise Command (or MEDICAL BRANCH if established) of any changes in the victim count or category

Coordinate with TRANSPORT the movement of victims to the transportation area



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TRANSPORT - FOG #6

Don the appropriate vest

Utilize radio designation TRANSPORT

Establish early communications with Fire Communications to coordinate hospital availability

Establish a transportation area accessible to the treatment area and preferably having clear ingress and egress

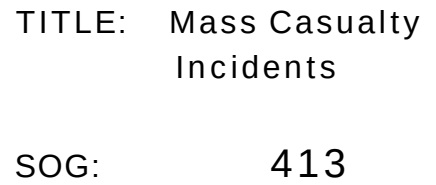
Coordinate the loading of patients by priority

Record the TRIAGE TAG number and destination hospital for each victim on the HOSPITAL TRANSPORTATION LOG

After each unit is loaded advise Fire Communications as to the number of patients and their priorities with an ETA to the assigned facility

Request additional transport units from STAGING

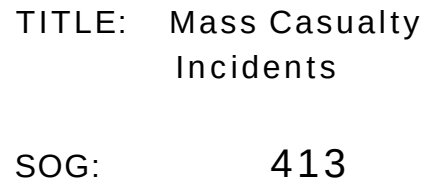
Utilize the HOSPITAL CAPABILITIES LOG and VICTIM TALLY LOG



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(This information is normally gathered from Fire Communications)

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TRANSPORT - LOG #6C

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VICTIM TALLY LOG

INCIDENT / LOCATION ADDRESS:

CCR #:

NOTE: Keep continuous track of the number of victims from each triage category being sent to individual hospitals by placing hash marks in appropriate blanks. Refer to the HOSPITAL CAPABILITY LOG (LOG-6B) to avoid overloading any facilities. Do not tally the totals until the end of the incident.

HOSPITAL	VICTIM TALLY BY TRIAGE CATEGORY							
1.	RED		YELLOW		GREEN		TOTAL	
2.	RED		YELLOW		GREEN		TOTAL	
3.	RED		YELLOW		GREEN		TOTAL	
4.	RED		YELLOW		GREEN		TOTAL	
5.	RED		YELLOW		GREEN		TOTAL	
6.	RED		YELLOW		GREEN		TOTAL	
7.	RED		YELLOW		GREEN		TOTAL	
8.	RED		YELLOW		GREEN		TOTAL	
9.	RED		YELLOW		GREEN		TOTAL	
10.	RED		YELLOW		GREEN		TOTAL	



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STAGING – FOG #7

Don the appropriate vest

Utilize radio designation STAGING

Establish staging location and advise COMMAND (MEDICAL BRANCH if established) and Fire Communications to direct all incoming resources

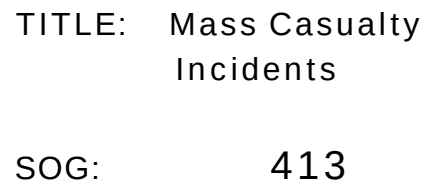
Maintain a UNIT STAGING LOG

Ensure that personnel stay with their apparatus / vehicles unless otherwise directed

If personnel leave keep the keys with each apparatus / vehicle

Coordinate with TRANSPORT the needs for units

Maintain a reserve of transport units as needed. Should this number diminish, advise COMMAND (MEDICAL BRANCH if established) to request additional units if warranted



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CCR #:

BLS / ALS



Telehealth Services

Medical Director Review Date 6-1-2024

Chapter 14

Telehealth Services



Telehealth Services

Medical Director Review Date 6-1-2024

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Telehealth Services

Medical Director Review Date 6-1-2024

PURPOSE

This policy is intended to create a process that allows JFRD members to refer non-emergent patients to a telehealth service when Emergency Department transport has been deemed unnecessary.

OVERVIEW

RightSite is a telehealth provider partnering with JFRD to help satisfy the medical needs of non-emergent patients. While on scene, and when appropriate, JFRD members will connect virtually to this telehealth service for consultation with an Emergency Department (ED) doctor and services navigator. RightSite will work alongside JFRD personnel to assess and redirect non-emergent patients to alternative services, thereby avoiding unnecessary transports to Emergency Departments. In the setting of a non-emergent complaint (as detailed below), RightSite navigators will work with JFRD and an online physician to determine if a patient is suitable for telehealth services, which may include private transport to an urgent care, prescription call in or refill, or a scheduled evaluation/treatment at an urgent care or physician's office.

RightSite may also be of value when social or economic issues are believed to be the cause of a frequent non-emergent caller. The RightSite navigators may be able to connect the patient with a variety of medical and non-medical wrap-around services.

Lastly, the online emergency physician may determine the patient is not suitable for telehealth and instead encourage JFRD to proceed with transport to an ED.

The program hours are currently restricted to Monday-Friday, 0700-2300, including holidays. These hours may expand.

SCOPE

All Rescue and Suppression paramedics who have received the JFRD/RightSite training may utilize this service when appropriate. Eligible patients for referral should be offered this service. A patient or parent may accept or decline the offer.

A patient with a minor complaint (as listed in under the *Appropriate for Referral* list) that has had a complete assessment with a full set of vital signs may be appropriate for a telehealth referral.

JFRD maintains authority over the scene. If JFRD personnel believe the advice being given may not be in the best interest of the patient and/or places JFRD in a position of potential liability, JFRD personnel shall resume patient engagement and manage the scene per current JFRD practice.



Telehealth Services

Medical Director Review Date 6-1-2024

APPROPRIATE FOR REFERRAL

Eligible candidates include those of a non-emergent nature which can be handled with a prescription or will not require diagnostic imaging such as a CT, MRI, or ultrasound. Examples of illnesses/issues appropriate for referral include:

- Med Refill
- Dental pain/fracture
- Stable illness (sinusitis, pharyngitis, bronchitis, earaches, conjunctivitis, etc.)
- Simple UTI, not pyelonephritis (no fever or flank pain)
- Extremity injuries without deformity
- Asymptomatic mild hypertension (systolic ≤ 180 , diastolic ≤ 110)
- Mild hyperglycemia < 200
- Abrasions
- Isolated rashes without fever and stable vitals
- Patients returning to completely normal mental status after being treated for hypoglycemia or unintentional opioid overdose

NOT APPROPRIATE FOR REFERRAL:

Patients that have complaints which will require hospital level interventions, assessments or diagnostic procedures or patients with conditions that require timely evaluations or treatments. Examples include:

- 2 years of age or less
- All of the mandatory transport criteria as listed in Section 1140 of the EMS SOG
- Abnormal vital signs: Temp ≥ 101 , Heart Rate ≥ 110 , O2 Sat $< 95\%$
- Open fractures
- Dislocations
- Vision loss or Eye pain
- Severe pain
- Heat illness
- Urinary retention
- Traumatic neck and/or back pain
- Intoxication
- Drug or alcohol withdrawal
- Pregnant patients (regardless of complaint)
- Non-ambulatory (regardless of complaint)
- Patients in police custody (regardless of complaint)
- Residents of nursing homes



Telehealth Services

Medical Director Review Date 6-1-2024

PROCEDURE

Should the patient/parent agree to engage with RightSite, proceed as follows:

1. Log into the RightSite link and connect patient with the on-demand navigator. You can utilize the RightSite QR code or access their weblink at ems.rightsitehealth.com.
2. Remain with the patient until the telehealth assessment is complete.
3. If the RightSite physician has agreed that non-emergent care is appropriate, ask the patient if they are agreeable to the arranged care.
4. If the patient agrees to non-emergent care arranged by RightSite, complete a full patient care report (PCR) utilizing a patient disposition of "Patient Evaluated, No Care Required."
5. Have patient sign the "Non-Emergency/Non-Transport" option within the signature section.
6. JFRD can leave the scene.

Should the patient not wish to engage with RightSite or should RightSite determine the patient is not appropriate for a RightSite referral, JFRD will manage the scene/documentation according to current JFRD practice.

DOCUMENTATION

When RightSite is utilized, the documentation in the PCR should include a complete set of vital signs, chief complaint and a brief description of the situation, communication with RightSite and the disposition of the patient.



Telehealth Services

Medical Director Review Date 6-1-2024

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**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

CREATED: 08/25

REVISED:

**TITLE: Coordinated Opioid
Recovery Program
(CORE)**

SOP: 260

260.00 **PURPOSE**

This policy is intended to define and outline JFRD's role as a partner in the Coordinated Opioid Recovery (CORE) Network.

260.01 **OVERVIEW**

CORE began as an initiative by the Florida Department of Health (FDOH) focused on reducing opioid-related deaths. Following the success of the CORE Pilot Programs implemented in select counties, Governor Ron DeSantis chose to expand this initiative ensuring that every county in Florida has access to a CORE Program.

Although CORE Programs vary in their partnerships and/or specific operational strategies, they all share the same mission – to eliminate the stigma surrounding addiction, treat opioid use disorder (OUD) as a disease, and provide a high level of continuous care.

The JFRD CORE Program is dedicated to supporting individuals struggling with OUD by facilitating access to care, providing medication-assisted therapy (MAT), emotional support, and referrals to wraparound services.

The JFRD CORE Team will consist of JFRD paramedics scheduled to work overtime while off shift.

260.02 **SCOPE**

The JFRD CORE Team will interact with OUD patients in various settings including hospitals, Gateway Community Services, the Sulzbacher Center, and other off-site locations that are prearranged by the JFRD CORE Team.

The roles and responsibilities of JFRD CORE Team members will evolve as the JFRD CORE Program develops. Therefore, the JFRD CORE Team members must stay flexible, recognizing that the CORE Network was created because standard treatment models were ineffective in achieving stable, long-term recoveries.

260.03 **PERSONAL CONDUCT**

All members of the JFRD CORE Team shall conduct themselves in an orderly and acceptable manner. JFRD CORE Team members shall adhere to the JFRD Rules and Regulations.



**STANDARD OPERATING PROCEDURES
CITY OF JACKSONVILLE
FIRE AND RESCUE DEPARTMENT**

CREATED: 08/25

REVISED:

**TITLE: Coordinated Opioid
Recovery Program
(CORE)**

SOP: 260

260.04 MEDICAL DIRECTOR AUTHORITY

The JFRD Medical Director, under authority of F.S. 401.265 and F.A.C. 64J-1, will have clinical oversight of the JFRD CORE Program. The Medical Director will collaborate with physicians at hospitals, Gateway Community Services, and the Sulzbacher Center to ensure the overall treatment plans are safe and effective.

260.05 CORE PROGRAM MANAGER

The JFRD CORE Program Manager is an administrative part-time position. Job responsibilities include acting as the primary liaison between the JFRD CORE Team and other CORE partnering organizations. Internal job responsibilities include ensuring all team members are adequately trained, scheduling work assignments, recruitment of personnel, quality improvement, review of best practices literature, and retrospective evaluation of the program's effectiveness.

260.06 CORE UNIFORM OF THE DAY

The issued black polo shirt and khaki pants with solid black sneakers or issued or approved black boots shall be the uniform of the day for the ranks of Firefighter through Captain. All personnel shall present a neat appearance and be properly groomed per SOP 218 (Personal Grooming) at all times.

260.07 ATTENDANCE POLICY

JFRD personnel scheduled to work a CORE shift shall report for duty no later than the start of their shift, either 0800 to 1700 or 1000 to 1900 and remain available until the end of shift.

260.07.01 Unable to Report

Prior to an assigned CORE shift, if a JFRD CORE Team member finds that they are unable to work, the employee is responsible for obtaining a replacement. The assigned employee and the replacement employee must then both notify the CORE Program Manager.

If a JFRD CORE Team member assigned to work a CORE shift is unable to report on time, they must notify the CORE Program Manager at least one hour prior to the start of their assigned CORE shift.



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If the JFRD CORE Team member does not report to an assigned CORE shift, does not find a replacement, or does not notify the CORE Program Manager prior to the start of the shift, then section 100.04.03 of the JFRD Rules and Regulations will apply. Personnel who are absent or late without proper notification and permission shall be considered absent without leave (AWOL) and shall be disciplined accordingly.

260.08

DAILY ROUTINE

Obtain the keys for CORE 11 and/or CORE 13 from the designated lockbox outside of R108's quarters at Station 5.

Contact the JFRD CORE Program Manager for the daily schedule.

Inspect and verify the vehicle and equipment are in a state of readiness.

The required equipment in the CORE vehicle(s) includes:

- Jump bag
- Airway bag
- AED
- Nasal Narcan
- Portable radio
- MDT

Daily inspection of controlled substances and documenting on the JFRD Controlled Substance Daily Checklist per SOG 430 (EMS).

Check the CORE 11 and/or CORE 13 phone for missed calls, voicemails, and text messages related to after-hours notifications.

Respond promptly to all calls and notifications. The CORE 11 phone must be answered between the hours of 1000 and 1900, seven days a week, without exception, as this is the primary method for receiving notification of patients.

Notify the JFRD CORE Program Manager when buprenorphine tablets reach the minimum inventory of 120mg.

Restock supplies and paperwork as needed, including consent forms, CORE facesheets, Clinical Opiate Withdrawal Scale (COWS) forms, flyers, and other essential documents.



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Keep the vehicles fueled and clean at all times.

Record a daily logbook entry detailing completed tasks and any outstanding items that need follow up.

Submit consent forms and CORE facesheets weekly to the JFRD CORE Program Manager every Friday.

All PCR's should be completed as soon as possible and are always required to be completed by the end of the shift per SOG 430 (EMS).

When workload permits, visit hospitals to discuss the JFRD CORE Program and encourage referrals.

260.09

CORE WORKFLOW

A patient arrives at the emergency department (ED) or is discharged from the hospital and is identified by a healthcare provider as having OUD.

A healthcare provider notifies Project Save Lives (PSL). When PSL is not present, the healthcare provider will notify the JFRD CORE Team directly at (904) 575-0503.

An OUD patient meets a PSL Peer Support Specialist and is offered Hospital Bridge Program – PSL services.

- If the patient declines entry into the PSL program, the patient is offered JFRD CORE Program services.
- If the patient accepts entry into the JFRD CORE Program, the PSL Peer Support Specialist contacts the JFRD CORE Team at (904) 575-0503 for a warm handoff of the patient.

JFRD CORE Team members respond to the ED to meet with the patient, the PSL Peer Support Specialist, and/or the healthcare provider to discuss the program and benefits.



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JFRD CORE Team members obtain the patient's written consent to enroll in the JFRD CORE Program and complete the CORE facesheet to aid in the continuity of care.

- If the patient refuses buprenorphine induction services in the hospital, but still wants treatment, the JFRD CORE Team may transport a patient directly to Gateway Community Services (Detox).
- If the patient agrees to take buprenorphine, the PSL Peer Support Specialist alerts the healthcare provider that the patient will participate in *CORE Induction Services* and buprenorphine is initiated in the ED.
- There may be occasional instances when the JFRD CORE Team, in consultation with the JFRD Medical Director, may begin buprenorphine therapy outside the hospital setting.
- For notifications and/or referrals made outside of normal operating hours, patients interested in joining the JFRD CORE Program, upon obtaining consent, may be transported to Gateway Community Services for *CORE Induction Services* Monday through Friday from 1000 to 1400.
 - Upon discharge from Gateway Community Services *CORE Induction Services*, the patient will receive a 2 week prescription of buprenorphine and information on how to enroll in services via Treatment Today.
 - The JFRD CORE Team will continue to support the patient by providing transportation to scheduled outpatient MAT appointments and/or wraparound services, pharmacy runs, etc.

The JFRD CORE Team schedules the patient for continued buprenorphine and/or comfort medication (Baclofen, Clonidine, Zofran) treatment at home until an outpatient MAT appointment is established at an approved treatment facility.

- No patient shall be medicated for longer than 7 days without approval from the JFRD Medical Director.



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Patients complete an initial 90 minute outpatient MAT appointment at the Sulzbacher Center.

- The patient will receive a 30 day prescription of buprenorphine and will be scheduled for a follow up appointment the same day.
- The JFRD CORE Team will continue to support the patient by providing transportation to scheduled outpatient MAT appointments and/or wraparound services, pharmacy runs, etc.

260.10 DOSING IN FIELD

See CORE Supplement, Chapter 12 in SOG 430 (EMS).

260.11 DOCUMENTATION

All CORE interactions including medication administration, pharmacy pick ups, transportation to appointments, etc., will require the completion of a patient care report (PCR). All PCRs should be completed as soon as possible and, per SOG 430 (EMS), are always required to be completed by the end of the shift. Failure to comply with reporting requirements may result in disciplinary action and/or revocation of CORE Team privileges. To ensure the accuracy of data, JFRD CORE Team members are to utilize the *Guide to CORE Documentation* for all CORE related calls.

260.12 SELECTION PROCESS FOR THE JFRD CORE TEAM

JFRD members interested in becoming a part of the team should contact the CORE Program Manager expressing their interest.

The job responsibilities of JFRD CORE Team members will primarily involve interactions with OUD patients and the staff of partnering CORE organizations. Team members must, therefore, demonstrate the ability to collaborate well with fellow team members and partnering organizations, while also demonstrating sincere compassion and patience towards those patients suffering from OUD.



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REVISED: 06/24

TITLE: Safe Haven
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223.00 **SCOPE**

This policy applies to all JFRD firefighters.

223.01 **PURPOSE**

Identify the actions to be taken should an infant be left by a parent with a JFRD firefighter, either at a JFRD station or on a call.

223.02 **AUTHORITY**

Authority for this program is derived from:

- Florida State Statute Chapter 2023 383.50

223.03 **POLICY**

The JFRD will comply with Florida State law which identifies hospitals and fire stations as "Safe Places" in which a parent may leave an infant with anonymity, confidentiality, and limited freedom of prosecution. Any employee who receives such an infant will assure the safety and health of the infant. Parents may also call 911 to have JFRD meet them at a specified location to surrender an infant to a JFRD firefighter.

223.04 **DEFINITIONS**

An infant shall be defined as a child believed to be 30 days old or younger.

For the purposes of this SOP, firefighter shall mean any full-time, paid firefighter EMT or firefighter paramedic employed by the JFRD.

223.05 **PROCEDURES**

Any firefighter who receives an infant at a fire station or while a call shall:

- Ask if the parents have any significant medical history which may impact on the immediate health of the infant, and
- Attempt to obtain as much information about the infant as possible to include known medical conditions, birth date and weight, any problems during pregnancy or delivery, and



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- Provide emergency medical services to the newborn infant to the extent they are trained, and
- Notify FRCC, obtain CCR #, and provide immediate transportation of the newborn infant to the nearest hospital with pediatric emergency services. FRCC will notify JSO and give the station location and hospital to which the newborn is being transported. FRCC will notify the Duty Division Chief and the PIO. The PIO shall notify the *Gloria M. Silverio Foundation* at 1-877-767-BABY (2229).
- JFRD may provide the mother with the *Safe Haven Medical Questionnaire* and retain any information the mother may provide.
- Complete an EMS incident report, including patient assessment, treatment rendered, and any orders issued by the hospital emergency room. If the child's name is not given when the baby is dropped off or the baby is not named, they are to be referred to as "Safe Haven Baby".
- If abuse is suspected, JFRD personnel shall notify the Abuse Registry Hotline upon completion of the call and provide them with the incident information.
- The hospital shall admit and provide all necessary emergency services and care to the newborn infant.

The act of leaving an infant with a firefighter, EMT, or paramedic, does not constitute abandonment for purposes of reporting child abuse, neglect or abandonment under *Section 39.201, Florida Statutes*.

Should a parent attempt to reclaim the infant after expressing intent to leave the infant and leaving the premises, JFRD personnel should continue to proceed as stated above and should refer the parental claim to the Department of Children and Family Services or the Department of Health.



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223.06 ABUSED NEWBORN

223.06.01 Definition

Abuse means any willful act or threatened act that results in a physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Such injuries include, but are not limited to, the following:

- Sprains, dislocations or cartilage damage
- Bone or skull fractures
- Brain or spinal cord damage
- Asphyxiation, suffocation, or drowning
- Injury resulting from a deadly weapon
- Burns or scalding
- Cuts, lacerations, punctures, or bites
- Purposely giving a child poison, drugs, or alcohol

Abuse may also be considered when the child has been deprived of necessary food, clothing, shelter, or medical care to the point that the child's physical, mental or emotional health are significantly impaired.

223.06.02 Procedures

If JFRD personnel find actual or suspected child abuse, they shall:

- Provide emergency medical services to the newborn infant to the extent they are trained, and
- Notify FRCC, obtain a CCR #, and provide immediate transportation of the newborn infant to the nearest hospital with pediatric emergency services, and
- Immediately report the actual or suspected child abuse, neglect or abandonment to the central abuse hotline maintained by the Department of Children and Family Services and to JSO. Both JSO and DCF may investigate the suspected abuse.

**Department of Children and Families
Abuse Registry Hotline
1-800-96ABUSE (1-800-962-2873)
Fax: 1-800-914-0004**



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- Document in the incident report, a physical description of the abuse, a description of the parent or individual leaving the child and any other information which would help identify the responsible party (vehicle type, license number, etc.).
- Preserve all clothing and any other items left with the child, for transfer to the appropriate investigating agency.

Should a parent attempt to reclaim the infant after expressing the intent to leave the infant and leaving the premises, JFRD personnel should continue to proceed as stated above and should refer the parental claim to the Department of Children and Family Services or the Department of Health.

If a child is left at the fire station, but is not left with a firefighter, EMT or paramedic, or if a child left with a firefighter, EMT, or paramedic appears to be more than 30 days old, this should be treated as an abandonment and must be reported to the central abuse hotline maintained by the Department of Children and Family Services.

223.07 **LEGAL**

There is a presumption that a parent who leaves an infant at a fire station or with a JFRD firefighter on a call has done so with intent to leave the newborn infant and consented to termination of their parental rights.

Any firefighter, EMT, or paramedic accepting or providing emergency medical services to an infant left with them on a call or at a fire station is immune from criminal or civil liability for having performed the act. Nothing in this policy, or state law, limits liability for negligence.

An infant left at a fire station or with a firefighter, EMT or paramedic on a call shall not be deemed abandoned subject to reporting and investigative requirements under Section 39.201, Florida Statutes, unless there is actual or suspected child abuse or until the Department of Children and Family Services takes physical custody of the child.



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223.08 **CONFIDENTIALITY OF PARENT**

Except where there is actual or suspected child abuse or neglect, any parent who leaves an infant with a firefighter, EMT, or paramedic at a fire station or on a call and expresses intent to leave the newborn infant and not return has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant.

The identity of a parent who leaves an infant at a fire station is confidential and exempt from public records. The identity of a parent leaving a child shall only be disclosed to a person claiming to be a parent of the newborn infant, or in cases of suspected or confirmed abuse.



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Appendix A

SAFE HAVEN MEDICAL QUESTIONNAIRE



YOU MAY ASK THE MOTHER OR FATHER IF SHE OR HE IS WILLING TO PROVIDE ANY HEALTH INFORMATION THAT MAY BE IMPORTANT FOR THE CHILD TO KNOW IN HIS OR HER FUTURE. IT IS NOT REQUIRED BY LAW FOR HER OR HIM TO DO SO.

Dear Birth Mother (You are not required to provide any information, but please read on):

You have taken the first step in assuring that your child will be safe and well taken care of. We know this has been a very difficult decision for you, and we want to assure you that we will give your child the best possible care.

We are asking for your help by providing some health information that may be important for your child to know in his or her future. This information is important for your child's care, and will be most helpful for the adoptive family. The information will be used only for this purpose. It will not be used to identify you or find you. You may not know all of the answers - Please provide as much information as you do know.

What is the baby's birth date? _____ Was the baby premature? _____ If yes, when was the approximate date you became pregnant? _____

Were there any problems with the pregnancy or delivery? If yes, please describe: _____

Did you smoke, use alcohol, drugs or any medication during the pregnancy? If yes, please list them: _____

Do you have any medical conditions such as:	Does the baby's Father have any medical conditions such as:
☐ Diabetes	☐ Diabetes
☐ Asthma	☐ Arthritis
☐ Allergies	☐ Eye problems
☐ Seizures	☐ Hearing Impairment
☐ Cancer	☐ Other (explain)
☐ Heart Disease	☐ Other (explain)
☐ High Blood Pressure	☐ Other (explain)
☐ Mental illness	☐ Other (explain)

What is your:	What is the baby's father's
Age: _____ Race: _____	Age: _____ Race: _____
Height: _____ Weight: _____	Height: _____ Weight: _____

To your knowledge are there any hereditary conditions that run in your family, or the father's family? _____

Please feel free to include a note to your baby, or to the people who will adopt your child. You can use the back of this form. You can provide this information before you leave, or email it to: safehaven@safehavenfornewborns.com.

You have given your baby a special gift by providing this medical information. You have taken good care of your baby; now please take care of yourself. It is now important that you personally get a medical check-up - you will remain anonymous, just as the law allows. We can assist you. 24/7 Confidential Helpline: 1-877-767-2229



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CUESTIONARIO MÉDICO DE SAFE HAVEN



YOU MAY ASK THE MOTHER OR FATHER IF SHE OR HE IS WILLING TO PROVIDE ANY HEALTH INFORMATION THAT MAY BE IMPORTANT FOR THE CHILD TO KNOW IN HIS OR HER FUTURE. IT IS NOT REQUIRED BY LAW FOR HER OR HIM TO DO SO.

Estimada madre biológica (no es necesario que proporciones ninguna información, pero por favor sigue leyendo):

Has dado el primer paso para asegurarte de que tu hijo esté seguro y bien cuidado. Sabemos que esta ha sido una decisión muy difícil para ti, y queremos asegurarte que le brindaremos a tu hijo la mejor atención posible.

Te estamos pidiendo que nos ayudes y proporciones cierta información de salud que puede ser importante que tu hijo sepa en el futuro. Esta información es importante para el cuidado de tu hijo y será de gran ayuda para la familia adoptiva. La información se usará solo para este fin. No se utilizará para identificarte ni para buscarte. Es posible que no tengas respuesta para todas las preguntas. Danos toda la información que sí sepas.

¿Cuál es la fecha de nacimiento del bebé? ¿El bebé nació prematuro? _____ En caso afirmativo, ¿cuál es la fecha aproximada en la que quedaste embarazada? _____

¿Hubo algún problema con el embarazo o el parto? En caso afirmativo, describe: _____

¿Fumaste, consumiste alcohol, drogas o algún medicamento durante el embarazo? En caso afirmativo, enuméralos: _____

¿Tienes alguna de estas condiciones?

☐ Diabetes	☐ Artritis
☐ Asma	☐ Problemas de la vista
☐ Alergias	☐ Discapacidad auditiva
☐ Convulsiones	☐ Otro (explicar)
☐ Cáncer	
☐ Enfermedad cardíaca	
☐ Presión alta	
☐ Enfermedad mental	

Tus datos personales:

Edad: _____ Raza: _____

Estatura: _____ Peso: _____

¿El padre del bebé tiene alguna de estas condiciones?

☐ Diabetes	☐ Artritis
☐ Asma	☐ Problemas de la vista
☐ Alergias	☐ Discapacidad auditiva
☐ Convulsiones	☐ Otro (explicar)
☐ Cáncer	
☐ Enfermedad cardíaca	
☐ Presión alta	
☐ Enfermedad mental	

Datos personales del padre:

Edad: _____ Raza: _____

Estatura: _____ Peso: _____

Que tú sepas, ¿hay alguna condición hereditaria en tu familia o en la familia del padre? _____

No dudes en incluir una nota para tu bebé o para las personas que lo adoptarán. Puedes usar el reverso de este formulario.

Puedes proporcionar esta información antes de irte o enviarla por correo electrónico a:

safehaven@safehavenfornewborns.com.

Le has dado un regalo especial a tu bebé al brindarle esta información médica. Cuidaste bien a tu bebé; ahora cuídate tú. Ahora es importante que tú te hagas un chequeo médico; permanecerás en el anonimato, tal como lo permite la ley. Podemos ayudarte. Línea de ayuda confidencial disponible 24/7: 1-877-767-2229



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KESYONÈ MEDIKAL SAFE HAVEN



YOU MAY ASK THE MOTHER OR FATHER IF SHE OR HE IS WILLING TO PROVIDE ANY HEALTH INFORMATION THAT MAY BE IMPORTANT FOR THE CHILD TO KNOW IN HIS OR HER FUTURE. IT IS NOT REQUIRED BY LAW FOR HER OR HIM TO DO SO

Chè Manman Natirèl (Ou pa oblije bay okenn enfòmasyon, men tanpri kontinye li):

Ou te pran premye pa pou garanti pitit ou pral an sekirite epi li pral gen yon moun pou pran swen li byen. Nou konnen desizyon sa a te difisil anpil pou ou, epi nou vle asire w nou pral bay pitit ou pi bon swen posib.

N ap mande èd ou pou nou ka jwenn enfòmasyon sante ki ka enpòtan pou pitit ou konnen pi devan. Enfòmasyon sa yo enpòtan pou swen pitit ou, epi yo pral pi itil toujou pou fanmi adoptif la. Se sèlman pou rezon sa a nou pral itilize enfòmasyon yo. Nou pa pral itilize yo pou idantifye ou oswa pou jwenn ou. Ou gendwa pa konnen tout repons yo -Tanpri bay mezi enfòmasyon ou konnen.

Ki dat ti bebe a te fèt? _____ Èske ti bebe a te fèt prematire? Si repons la se wi, vè ki dat ou te anse? _____

Èske te gen okenn pwoblèm ak gwosès la oswa akouchman an? Si se wi, tanpri deklare: _____

Èske ou te fimen, bwè alkòl, pran dwòg oswa nenpòt medikaman pandan gwosès la? Si se wi, tanpri ekri yo la: _____

Èske ou gen okenn pwoblèm medikal tankou:

☐ Dyabèt	☐ Rematis
☐ Opresyon	☐ Pwoblèm je
☐ Alèji	☐ Pwoblèm pou tande
☐ Kriz	☐ Lòt (eksplike)
☐ Kansè	
☐ Maladi kè	
☐ Tansyon wo	
☐ Maladi mantal	

Èske Papa tibebe a gen nenpòt pwoblèm medikal tankou:

☐ Dyabèt	☐ Rematis
☐ Opresyon	☐ Pwoblèm je
☐ Alèji	☐ Pwoblèm pou tande
☐ Kriz	☐ Lòt (eksplike)
☐ Kansè	
☐ Maladi kè	
☐ Tansyon wo	
☐ Maladi mantal	

Nou bezwen enfòmasyon sa yo sou oumenm?

Laj: _____ Ras: _____

Wotè: _____ Pwa: _____

Nou bezwen enfòmasyon sa yo sou papa a:

Laj: _____ Ras: _____

Wotè: _____ Pwa: _____

Selon sa ou konnen, èske fanmi oumenm oswa fanmi papa a gen okenn maladi ereditè nan fanmi nou?

Ou mèt kite yon nòt pou bebe ou a, oswa moun yo ki pral adopte pitit ou a. Ou ka itilize do fòm sa a.

Ou ka bay enfòmasyon sa yo avan ou pati, oswa imèl yo bay: safehaven@asafehavenfornewborns.com

Ou bay tibebe w la yon bèl kado lè w bay enfòmasyon medikal sa yo. Ou te pran bon swen bebe w la; kounye a tanpri pran swen tèt ou. Kounye a la li enpòtan pou w fè yon egzamen medikal pou tèt ou - non ou ap rete anonim, nan mezi lalwa pèmèt sa. Nou ka ede ou. Liy Èd Konfidansyèl 24 sou 24, 7 jou sou 7: 1-877-767-2229