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*Revision No. 2 – January 2017*
# EMS CONTACT LIST

**EMS CONTACT LIST**

**BOYNTON BEACH FIRE RESCUE**

**CONTROLLED MEDICATION ADMINISTRATION LOG**

<table>
<thead>
<tr>
<th>Station unit No.</th>
<th>Dates covered by log: ____________________________</th>
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<tbody>
<tr>
<td>Administering Medic</td>
<td>Witness</td>
</tr>
<tr>
<td>Date</td>
<td>Run No.</td>
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*Revision No. 2 – January 2017*
The following Emergency Medical Services Standard Operating Guidelines are the official guidelines for Boynton Beach Fire Rescue and are approved for such use by Paramedics and EMTs of the department to care for the sick and injured.

Kenneth A. Scheppke, MD FAAEM
Statement of Purpose

The intention of this document is to supplement the Advanced Life Support Protocols in a pre-hospital health care delivery system is to facilitate the rapid dispersal of adequate and acceptable measures aimed at stabilizing the sick and injured. These procedures are written to better define the responsibilities of Boynton Beach Fire Rescue Paramedics, to decrease the chance of confusion at any emergency scene and to ensure a coordinated and efficient procedure for treatment and transport to a designated medical facility.

These guidelines are to be followed as closely as possible on each and every patient encountered by all Paramedics when hospital medical direction is not readily available, or impractical based on patient condition. They are to be used only when the Paramedic is on duty as a representative of the Boynton Beach Fire Rescue Services. If a BBFR Paramedic encounters a medical, or trauma situation not specifically covered by these protocols, the Paramedic should follow the standard of care as outlined in the 2010 United States Department of Transportation National Standard Curriculum.

Authorization

These EMS SOG’s and Advanced Life Support Protocols have been developed and circulated for use by Boynton Beach Fire Rescue Paramedics in the pre-hospital emergency care of the sick and injured, under authority granted in Chapter 401 Florida Statutes, and 64J Florida Administrative Code.

Changes to these protocols can only be made and promulgated by the Boynton Beach Fire Rescue Medical Director. Certified Boynton Beach Fire Rescue Paramedics approved by the Medical Director, are the only personnel authorized to perform ALS procedures called for in these protocols, except as authorized by the Boynton Beach Fire Rescue Medical Director.
GUIDELINES FOR TREATMENT

Guidelines for Treatment

A) The following general measures shall be applied to help promote speed and efficiency when rendering emergency medical care to the sick and injured. These protocols constitute guidelines for treatment and may be altered at the discretion of the supervising hospital physician, providing those revisions are within the standard practice of emergency care.

B) When applicable, verbal informed consent should be obtained prior to treatment. Respect the patient’s right to privacy and dignity. Courtesy, concern, and common sense will assure the patient the best possible care. Remember;

- Implied Consent: used for minors and those persons deemed incapacitated
- Informed Consent: All other patients
- Duty to Act:

C) In accordance with (FAC 401.45) paramedics shall offer transport to the hospital via ambulance to all patients who have a complaint of or present with s/s of illness, injury or have mechanism for injury. At no time should a patient be encouraged to drive or be taken POV to the hospital. Patients who elect to go POV must sign a refusal of service form. Paramedics should attempt to transport all patients treated with ALS measures to the hospital. In most cases, competent adult patients have the right to refuse all, or any portion of treatment or transport.

Rationale

Paramedics are required by law to provide medical treatment and transport for patients who have emergency medical needs. Multiple studies show that paramedics cannot accurately determine which patients need definitive care, which is only available in a hospital. Medical care providers and equipment are not available in the average citizen’s personal vehicle. If the patient wishes to self-transport to a medical facility, it can be assumed that they acknowledge medical need and are refusing further care and transport. Any refusal of care must be documented (FAC 381.026).

D) Appropriate therapy must be continued during transport if indicated. Vital signs should be monitored and recorded frequently on all Priority One and Two patients during transport. All transported patients shall have at least two sets of vital signs taken and documented. BBFR Paramedics should bring medication bottles with the patient and or accurately document the medications and dosages for the receiving facility.

E) All Priority One Medical patients must be transported to the nearest licensed emergency room facility.
Guidelines for Treatment

F) Under no circumstances should a Priority 1 medical patient be transported to a hospital that is not the closest qualified facility on the basis of telephone orders from the patient's private physician. Should the patient’s physician object to the treatment and or transport arrangements made by the Paramedic on scene, simply explain that you are following the protocol and refer the Physician to the Boynton Beach Fire Rescue Services Medical Director. For the patient's physician to give orders regarding treatment and or transport; The physician must be on-scene and **must accompany the patient to the hospital.**

G) If the family has contacted the private physician, then extreme tact and courtesy must be used. Your primary concern is the patient’s health. Treatment and or transportation should not be delayed or hindered in order to speak with a private physician. If time is critical, have the family inform the physician to contact the destination hospital. No telephone orders may be taken from any physician other than the Boynton Beach Fire Rescue Services Medical Director or the receiving hospital’s ER Physician, unless, so authorized by the Boynton Beach Fire Rescue Services Medical Director.

H) Should a physician present at an emergency scene and assumes direct medical to alter the protocols or supervise the care of a patient, he/she must provide a valid Florida Physician's License and a current ACLS certification card. The physician must be informed that he/she is taking full responsibility of the patient; must sign all medical reports; and **must accompany the patient to the hospital**. The receiving hospital should be notified prior to relinquishing control to the physician on scene.

I) Physicians who activate the 911 system for treatment of patients in their office, need NOT provide proof of licensure nor an ACLS card. These physicians may give orders on their patients, providing those orders DO-NOT conflict with these protocols or are otherwise not outside the standard of practice for emergency care. Should an ER Physician give additional orders, the physician's name should be documented on the Patient Care Report.

J) Medical communications are to be established via telemetry radio or telephone with the appropriate facility ASAP into the call. Contact can be made during or after the appropriate protocol has been initiated. Orders can only be given by a physician. Should an ER Physician give additional orders, the physician’s name should be documented on the Patient Care Report.
Blood Drawing Procedure

Florida Statute, Section 316.1933(1)(a) & Florida Statute, Section 327.353

K) Blood Drawing Procedure: Blood specimens will be drawn by certified Paramedics for blood alcohol analysis upon request of an authorized Law Enforcement Officer. The blood should only be drawn with a sealed kit provided by the Officer. The following information must be documented on a Patient Care Report;

- Officer’s name
- Officer’s ID number
- Kit opened by the Paramedic, or in the presence of the Paramedic
- Type of skin prep used
- Number of tubes drawn
- All tubes placed back in kit
- Kit resealed by Paramedic or in the presence of the Paramedic
- Note any problems with the incident

- BBPD Blood Drawing Kit (Lynn Peavey Company – 1-800-255-6499)

Steps for assembly
1) Remove bottom (white cap) from catheter
2) Attach catheter to protective shield
3) Slide blood tube inside the protective shield. Do not “seat” the tube until skin penetration has been established. Doing so, could inactivate the vacuum.
4) Remove top (yellow cap) from catheter
5) Gain venous access
6) Slide (seat) blood tube firmly in position

Note: Florida Highway Patrol (FHP) may utilize a different brand of kit however, the components are essentially identical.

The patient shall be treated for injury or illness prior to any blood draw procedure.

The Boynton Beach Fire Rescue Medical Director shall be notified if the blood drawing procedure conflicts with patient care. Blood draws may also be performed at the hospital – treat the patient first!
Guidelines for Treatment

L) Properly executed DO NOT RESUSCITATE ORDERS will be honored. If CPR has been initiated and a valid DNRO is discovered, resuscitation efforts should be ceased. If necessary, contact Medical Control for assistance.

Chapter 401.45, Florida Statutes

The EMT or Paramedic shall withhold, or withdraw cardiopulmonary resuscitation upon presentation of the following;

1) Original or completed certified copy of DOH Form 1896, The form must be signed by the patient’s physician, the patient, and/or the patient’s health care surrogate, proxy, court appointed guardian, or person with durable power of attorney.

2) Patient Identification Device (PID) which is simply a miniature copy of the DNRO. It is attached to the form and designed for portability. It is acceptable, provided it is signed and complete as aforementioned above.

3) Upon verifying the identity of the patient who is the subject of the DNRO form or P.I.D. Verification shall be obtained from the patient’s driver license, other photograph identification, or from a witness in the presence of the patient.

4) During each transport, the Paramedic shall ensure that a copy of the DNRO form or the P.I.D. accompanies the live patient. EMS personnel shall provide comforting, pain-relieving and any other medically indicated care, short of respiratory or cardiac resuscitation.

5) A DNRO may be revoked at any time by the patient, if signed by the patient, or the patient’s health care surrogate, proxy, or court appointed guardian, or the person acting pursuant to a durable power of attorney. The aforementioned guardians would need to present documentation of proof.

M) In accordance with (FAC 381.026), all patients should be informed of planned course of treatment, alternatives, risks, and benefit of treatment and/or transport for evaluation at an emergency department.
System Overview

Given the many different agencies involved in the delivery of EMS, it becomes imperative that the responsibilities and authorities be clearly defined and known to all agencies within the system. Patient care must remain the most important priority. Teamwork, cooperation and communication are desired and considered essential to our goals.

The Boynton Beach Fire Rescue Services shall be responsible for primary response of BLS and/or ALS units. Fire Rescue personnel shall assume immediate control and initiate an incident command system as deemed appropriate and as specified in the Standard Operating Procedures.

If hazardous conditions exist, the Incident Commander shall take immediate steps to control the hazard and protect the patient(s), Fire Department, and non-Fire Department personnel as deemed appropriate.

Transport agencies are responsible for providing the timely response and efficient care and transport of patients to a designated medical facility as set forth in their COPCN, Certificate Of Public Convenience and Necessity with Palm Beach County. Also, in mass casualty or mutual aid situations, Boynton Beach Fire Rescue Services Paramedics may elect to turn patients over to other agencies. The Paramedic shall provide the transporting agency with all necessary and available information in a timely manner regarding the patient’s condition and treatment rendered.

Upon completion of this interaction, the Paramedic crews will give any assistance necessary to the transport agency to assure continuity of care, quick, safe, proper loading and transport to the designated medical facility. The Paramedic may elect to accompany any patient during transport.

If the receiving hospital requests that the BLS patient have ALS procedures initiated, i.e., IV, medication administration etc. that does not appear to be indicated, every attempt should be made to resolve the problem quickly and congenially.

At times it may be more prudent to resolve these types of issues after the call has been completed. If necessary, the Medical Director can be notified to assist with the conflict.
Transport Destinations

**STEMI Alert** patients presenting with acute ST segment elevation MI, shall be transported to the closest Interventional Cardiac Catheterization Hospital, (JFK, Delray Medical Center and/or BMH).

**Stroke Alert** patients meeting the Stroke Alert criteria as determined by the Cincinnati stroke scale and supplemented by the Risk Assessment Cardiovascular Events (RACE) score shall be transported to the nearest comprehensive stroke center. **All pediatric stroke patients must be transported to St. Mary’s Medical Center (SMMC) by ground and/or air.**

**Trauma Alert** patients meeting Trauma Alert status as per the PBCHCD Scorecard methodology shall be transported to Delray Medical Center.

Note: Trauma patients injured south of Southern Blvd shall be transported to Delray Medical Center. Patients injured north of Southern Blvd. are transported to St. Mary’s. If crews decide to “work” a severely injured trauma patient – that patient should be transported to a Trauma Center. In the unlikely event that DMC and St. Mary’s Trauma Center are both on BY-PASS Status, then the patient shall be transported to the closest medical facility.

**Sepsis Alert** patients meeting sepsis alert criteria should be transported to the nearest appropriate facility as a Priority 2.

**Dive Accident/Decompression Injury** St. Mary’s Hospital is the only hospital in Palm Beach County that has a Hyperbaric Chamber capable of handling this condition. Crews may elect to call Trauma Hawk to provide transport. If the St. Mary’s Hyperbaric Chamber is out-of-service, then the patient shall be transported to the closest facility. Special circumstances such as drive time vs. flight time, traffic patterns and time of day should be considered.

**Sexual Assault/Rape** patients consider Wellington Regional Hospital.

**OB** patients with an estimated gestational age greater than or equal to 20-weeks. All such patients regardless of complaint, should go to an OB hospital, unless they meet trauma or cardiac transport criteria. Note: Minor falls can lead to an abruption in 6% of all cases. These patients will need monitoring in Labor and Delivery. All medical concerns will have OB concerns as well.

Primarily, OB patients are transported to BMH. St. Mary’s and/or Good Samaritan are alternative choices. And, as of 2016, JFK Medical.
Bethesda Memorial Hospital West is located at the NE corner of State Road 441 (aka State Road 7) and Boynton Beach Blvd. BBFRD can transport patients to this facility, upon patient request, provided their condition warrants. The channel designated to contact the new ER is Zone B, channel 8.

JFK South (Free-Standing ER)

JFK Medical opened a free-standing ER in Western Boynton Beach in March of 2013. The ER is located at the corner of Jog Road and Woolbright Road. BBFRD may utilize. The address and contact information is as follows; 10921 S. Jog Road Suite 156, Boynton Beach 33437 -- land line phone: 561-548-8250.

Note: The radio frequency and channel will remain the same, zone B, channel 4. However, we will need to specify when contacting this ER as JFK South. JFK Main is the primary hospital call sign and JFK North is the call sign for the free-standing ER in Palm Beach Gardens. JFK Medical Main is also capable of handling psychiatric patients.

Transport Directive

As of October 3, 2016, Boynton Beach Fire Department Rescue began to transport all level of care patients (BLS, ALS and CLS) in which the Rescue has arrived on the scene. Rescue Companies will no longer request for AMR to transport for patients after they arrived on the scene. Engine and Ladder Companies that are dispatched for BLS may request AMR if transport is needed. If an Engine or Ladder Company arrives before a Rescue Company, and determines the Patient to be BLS, the OIC may elect to cancel the Rescue and request AMR. It is our goal to provide all BLS & ALS transports beginning in April of 2017.

Rescue Companies are to utilize the following hospitals as the primary destinations:

- Bethesda Hospital
- Delray Medical Center
- JFK Hospital
- St. Mary’s for back up Trauma Center and Decompression Chamber
- VA Hospital for Veterans who require transport to the Center
- Wellington Regional for Sexual Assault Patients
- Bethesda West Hospital

All other patient request for transport to hospitals that do not meet the criteria listed above, will require the approval of the on duty Battalion Chief for transport.
Baker Act & Related Laws

The Baker Act (Chapter 394, Part I, F.S.) is actually The Florida Mental Health Act. It does not authorize the provision of medical treatment. It may be initiated by a Certified Law Enforcement Officer. A Law Enforcement Officer may give EMS Personnel verbal permission to treat a patient under the auspices of the Baker Act. The Law Enforcement Officer must accompany the patient to the receiving facility and complete all related Baker Act Forms. Ensure the Officer’s name and ID number are clearly documented on the patient care report. It is important to remember; the Baker Act relates to mental illness only.

Marchman’s Act

The Marchman Act (Chapter 397, F.S.) This Act states that; A person may be taken into custody by a Law Enforcement Officer and court ordered into treatment for “substance abuse impairment”. This means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance to such a manner as to induce mental, emotional, or physical problems, and cause socially dysfunctional behavior.

The Emergency Examination and Treatment of Incapacitated Persons Act

The Emergency Examination and Treatment of Incapacitated Persons Act (Chapter 401.445, F.S.) This Act gives EMS Personnel the power to treat without informed consent if the person at the time of exam or treatment is intoxicated, under the influence of drugs, a Emergency Medical Condition, or otherwise incapable of providing informed consent without fear of having to respond to civil suits. This Act is specifically tailored for pre-hospital use.

Reference the 2014 Baker Act Handbook

Quick link

Controlled Medications Procedures

In accordance with United States Department of Justice, Drug Enforcement Administration Title 21 and 64J-1.021 of the Florida Administrative Code, a log shall be maintained for Fentanyl, Versed, Ketamine and Etomidate (Controlled Medications). All medications used, removed or missing, must be logged in the appropriate places.

The controlled medication log shall contain

1) The vehicle unit ID number (Example R101)
2) The legible name of the Paramedic conducting the inventory.
3) The Paramedic’s FD identification number.
4) The date and time of the inventory.
5) The drug’s name, volume, quantity, Lot No. and expiration date.
   Note: Medications dated for example, Fentanyl July 17, would expire at the end of July 2017, unless otherwise indicated.
6) The alarm number and the amount for each medication administered.
7) The printed name and signature of the administering Paramedic.
8) The printed name and signature of the person witnessing the disposal of the unused portion.
9) No lines in the log should be skipped or left blank.
10) The medication shall be recorded on a station medication usage form.

Non-controlled medications must be logged

1) On the Patient Care Report.
2) In the vehicle log book.

Each ALS Lock Box will have a dedicated key that will be kept in the possession of the Paramedic assigned to that vehicle. The only other key that can open this box will be a master key held by the Battalion Chief. During shift change each morning, the off-going Paramedic will turn the key over to the on-coming Paramedic AFTER he/she visually verifies that the medications are present. Each Paramedic who is assigned to the vehicle as the Paramedic in charge is responsible for medications within the ALS Box.

Keys are to be carried by the Paramedic at all times and not left in the vehicle

This procedure shall be followed each time the drug key is turned over to the other shift personnel, or anytime there is a change of paramedic during the shift.
Controlled Medications Procedures

Expired Medications

Expired medications will be removed and submitted to the on duty Captain on the first day of each new month. Expired medications will be logged on the same medication usage form used to record medications administered. Expired medications will be turned over to the on-duty Battalion (after normal business hours) or the EMS Coordinator as soon as possible for proper disposal in accordance with state and federal guidelines.

Missing or Broken Medications

Medications found missing or broken will be logged on the “Broken or Missing Drug Information” sheet. Details concerning the circumstances involved with those medications will be listed under the comments section. Company Officers will make attempts to determine if the medications were improperly logged. Missing controlled medications will require a police report, if there is a determination made that a paperwork error was not the cause for the missing medication(s). These guidelines are based upon Federal DEA and State of Florida regulations for handling controlled substances. Medications with broken or missing caps must be turned into the EMS office as soon as possible. Using tape to secure a broken cap on narcotics, or any other medication packaged in a vial is strictly prohibited!

Disposal of Unused Controlled Medication

Disposal of unused portions of “Lock & Key” medications/narcotics carried by the BBFRD (fentanyl, versed, ketamine, etomidate) shall be documented in the vehicle’s medication log and signed by the paramedic along with FD ID, and by the person witnessing the disposal, either a hospital representative, and/or BBFRD company officer, or other BBFRD paramedic.

Controlled Substance Forms

The DEA 222 form for purchases of controlled substances

The DEA 41 form for disposal of controlled substances
CONTROLLED MEDICATIONS PROCEDURE

"S" Drive > fire admin > shift ops > forms

BOYNTON BEACH FIRE RESCUE
CONTROLLED MEDICATION ADMINISTRATION LOG

Station unit No. ___________ Dates covered by log: ____________________________

<table>
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<th>Date</th>
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<th>Amount Given</th>
<th>Amount Wasted</th>
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Administering Medic  Witness
BOYNTON BEACH FIRE RESCUE
- BROKEN/MISSING -
EQUIPMENT/MEDICATION REPORT

BBFD Incident # (if applicable) ___________________ DATE: _______________ SHIFT: __________

Medic/Company Officer: ____________________________ Rescue/Engine # _____________________

Reporting Action on: ______________________________________________ (medication and/or equipment)

Reported medication was: Found Broken Found Missing Broken on Call

Reported Equipment was: Found Broken Found Missing Broken on Call

Comments:________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Disposition of Equipment: Turned in for Repairs by: ___________ Initials ___________ Date: ____________

Equipment turned over to:_________________________________________________________________

Replacement obtained? Yes No Date: ____________

Obtained From?_________________________________________________________________________

Company Officer Initials: ___________ 

This form is to be used by all personnel to log any missing or broken equipment or medications. All relevant information should be completed. Details should include the how, what, where and when why of the missing or broken item and the how, what, where and why of it’s replacement.
General Purpose

The following procedures shall be followed in the event an employee is exposed to a communicable and/or infectious disease while on duty.

Important Definitions

A **contact** is defined as blood, blood products or body fluids coming in contact with intact skin.

An **exposure** is defined as blood, blood products or body fluids coming in contact with non-intact skin. Examples include; lacerations, abrasions, puncture wounds and needle-stick injuries. Exposures may also occur through mucous membranes such as; mouth, eyes, nose and respiratory tract. Any question regarding whether an exposure has occurred will be determined by the Shift Battalion Chief and/or the Designated Infectious Disease Officer.

The Procedure for an exposure is as follows;

Any necessary first aid treatment will be rendered by available, appropriate personnel. The employee shall, as soon as practical, wash the affected area(s) thoroughly with soap and water or with any available alcohol-based cleanser. The employee shall, as soon as possible, notify his/her Company Officer (immediate supervisor) of the incident. Based on the nature and type of exposure, a determination will be made if the incident was either a contact or an exposure.

The Company Officer shall notify the on-duty Battalion Chief.

Exposures will be treated as any other work related injury. The employee shall, as soon as possible, and at the direction of his/her Company Officer, report the incident to Risk Management @ 742-OOPS (6677).

The employee shall request that the examining physician order both a Hepatitis profile and a baseline HIV blood test. Follow-up HIV testing on the employee will be done at 6-weeks, 3-months, 6-months, and 1-year after the initial baseline test (or a schedule established by treating infectious disease physician). Risk Management will monitor the scheduling of the follow-up tests.
If the exposure involves a known or suspected source patient (i.e. the patient whose blood or fluids contacted the employee) the company officer will request the receiving facility’s physician to test the source patient per Florida State Statute. The results will be sent to the respective infectious disease physician responsible for the employee treatment.

A Supervisor’s Incident Report Form (Revised May 2015) shall be completed for all Exposures. In the event of Exposure to a communicable disease that may be transmitted by other means (example – via contact with respiratory products – droplet infection); the employee shall, as soon as possible, contact the company officer with the information concerning the incident to determine if an actual exposure may have occurred.

If it is determined that an exposure has or may have occurred, the employee will follow the Exposure control plan as outlined above.

As with other job-related incidents, the employee shall report the incident to Risk Management @ 742-OOPS (6677) as soon as possible.

Note: Airborne contact does not always mean an exposure has occurred, as in certain cases of TB. The Supervisor’s Incident Report form does not need to be completed in the event of a contact.

Supervisor’s Incident Report Form (Revised Feb -- May 2015)

Quick link

Cross-contamination

The purpose of this document is to establish a written policy that will assist in preventing cross-contamination between patients and departmental personnel. This document shall serve as the Department’s Exposure Control Plan as required by the Occupational Safety and Health Standards for General Industry, CFR Part 1910.1030.

Definitions:

Bio-hazard Waste is any solid or liquid waste which may present a threat of infection to humans.

Bio-hazard Container is any 30-gallon cardboard containers placed in the station’s biohazard containment area for use of disposal of biohazard bags and sharps containers.

Bio-hazard Containment Area at each station shall have an area designated specifically for the storage of accumulated biohazard waste which shall include Bio-hazard Containers and Sharps Disposal Boxes. All biohazard containers shall be stored in this area away from general traffic flow patterns and be accessible only to authorized personnel. Bio-hazard waste shall not be stored for a period greater than 30-days and shall remain secured in the containment area until removed by the biohazard disposal company.

Body Fluids are those fluids which have the potential to harbor pathogens, such as HIV, Hepatitis B and C to include: lymph, semen, vaginal secretions, CSF, synovial, pleural, peritoneal, pericardial and amniotic fluids. Body secretions such as feces, nasal discharges, saliva, sputum, sweat, tears, urine and vomitus shall not be treated as bio-hazardous waste unless contaminated with blood.

Contamination is the presence or the reasonable anticipated presence of blood or other potentially infectious materials on an item or surface.

Decontamination is the use of physical or chemical means to remove, inactivate or destroy blood-borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.
**Occupational Exposure** is reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.

**Sharps** are devices with physical characteristics capable of puncturing, lacerating and/or otherwise penetrating the skin.

**Uniform Contamination** is defined as any article of departmental clothing or personal protective equipment (PPE) that is soiled by body fluids.

**Infection Control**

Each employee has the responsibility to take the appropriate measures to ensure that cross-contamination does not occur. Frequent hand washing shall be performed. Medicated soaps and solutions are made available and shall be used ASAP after each call. All disinfecting of equipment shall take place in the designated decontamination locations installed at each fire station. GLOVES SHALL BE WORN FOR ALL PATIENT CONTACT.

All equipment and apparatus shall be maintained in a sanitary state. Contaminated surfaces shall be cleaned with a solution of industrial strength detergent to remove visible soil and then disinfected by a chemical germicidal, tuberculocidal agent registered by the EPA as a hospital disinfectant. Airing the Rescue Unit out will dilute the number of pathogens.

**Masks, Eyewear & Gowns**

Masks, eyewear and gowns are provided on all Engines and Transport Units. These protective barriers should be used in accordance with the level of exposure encountered. Minor lacerations or small amounts of blood do not merit the same extent of barrier use as required for massive arterial bleeding. Management of a patient who is not bleeding and who has no bloody body fluids present, should not routinely require use of these barrier precautions. Masks and eyewear should be worn together in any situation where airborne pathogens are suspected or splashes of blood or other body fluids are likely to occur. Gowns should be worn to protect clothing from splashes of blood or other body fluids or when a contagious situation exist. An extra change of work clothing shall be kept at the station during the employee’s tour of duty. Gross contamination of Bunker gear will require professional cleaning.
INFECTIONIOUS DISEASE POLICY

Replacement gear will be made available during the cleaning process. Minor contamination of bunker gear can be handled at the Station with the heavy-duty commercial washer & dryer.

Disposable Items

Sharps – All needles, catheters, scalpels and other sharps shall be handled carefully. The recapping of contaminated sharps is strictly prohibited. All sharps shall be placed in an approved needle/sharp container only!

Infectious Waste Disposal – Every effort shall be made to separate bio-hazardous waste from normal trash prior to containment. The proper disposal of bio-hazardous waste is addressed thoroughly in Chapter 64J-16 of The Florida Administrative Code. The following is reflective of those rules;

Biohazard Waste – All bio-hazardous waste generated on the scene, with the exception of sharp objects (needles, scalpels, razors, etc.) shall be secured in an approved biohazard plastic bag and sealed. All bio-hazard bags shall be labeled with “BBFRD”, the date generated and the station address. The bag will be brought back to the station and placed in an approved biohazard container inside the Bio-hazard Containment Area. Whenever bio-hazard waste is generated, it shall be noted on the Patient Care Report.

Sharps – All sharps shall be secured in approved sharps disposal boxes ONLY. Care should be taken not to overload the containers/boxes. All sharps disposal boxes shall be labeled with the unit number. Whenever procedures using sharp objects are performed, a sharps container should be within reach of the Paramedic performing the procedure. Used sharps disposal boxes shall be removed from the units when they become approximately ¾ full and placed in the Biohazard Containment Area. **DO NOT FORCE SHARPS INTO A CONTAINER.**

Resuscitation Equipment – When disposable resuscitation equipment and devices are used they should be used once and then disposed of as bio-hazard waste.

Bio-hazard Waste Removal – A private disposal company is contracted to remove sharps disposal boxes and biohazard waste containers. The company will make periodic stops at each station picking up biohazard waste containers. The private provider will leave a receipt for each container taken. Receipts will be forwarded to Fire Administration for record maintenance.

Blood-borne Pathogen Exposure – Any City employee that sustains an on-the-job exposure to blood or body fluid shall abide by the Infectious Disease Policy of this document.
High Risk Infectious Disease Policy

Post Exposure Management

1) Provide First Aid
a) Secure area to prevent further contamination, i.e. sharps into approved container, limit personnel into the area of contamination (ambulance compartment), properly dispose or confinement of body fluid soaked articles, etc.
b) Remove contaminated clothing if indicated.
c) Wash the injured area with soap and water, or waterless hand cleaner, and apply antiseptic if available.
d) If the eyes, nose, or mouth are involved, flush them well with large amounts of water.
e) If a high risk exposure should occur to a non-Fire Department employee, 9-1-1 may be called to assist in both the treatment and proper follow-up procedures in obtaining source patient blood samples and/or Emergency Room treatment.

2) Assess the Exposure/Blood or Body Fluid. A significant (High Risk) blood borne exposure is considered a combination of one or more of the types of body fluids and one or more of the injuries listed below.

a) Body Fluids:
i) Blood, serum, plasma, and all fluids visibly contaminated with blood
ii) Pleural, amniotic, pericardial, peritoneal, synovial, and cerebrospinal fluid
iii) Uterine/vaginal secretions or semen
iv) Saliva

b) Injuries:
i) Percutaneous (contaminated needle-stick, laceration, abrasion, bites, etc.)
ii) Mucous membrane (i.e. eyes, nose, mouth)
iii) Skin (i.e. cut, chapped or abraded skin). The larger the area of skin exposed and the longer the time of contact, the more important. It is to verify that all the relevant skin area is intact.
3) Assess the Exposure/Air or Droplet. A significant airborne exposure is considered a combination of a subject (source) exhibiting signs/symptoms of suspected airborne illness and an activity that would place the worker at risk of droplet or airborne exposure:

a) Source: An aerosolized exhalations, sputum, or saliva, either by source patient coughing, spitting, breathing; any pulmonary secretions either brought forth by patient (source) or by manual suctioning or ventilating and exposed individual has not worn appropriate barrier protection.

b) Activity: Suctioning of naso-pharyngeal airway; active gag/cough reflex upon suctioning or insertion of nasogastric tube and/or intubation.

4) Report the exposure. The employee or immediate supervisor must promptly contact the City’s Risk Management Department OOPS @ 742-6677 as soon as possible. This notification should not delay the immediate treatment of the employee or the testing of the source patient. The department safety officer (Division Chief of Training) must also be contacted as soon as practical.

**Medical Counseling, Consent & Testing**

**Source Patient Available**

1) Transport. A High Risk exposed worker should be transported to a designated facility (Bethesda Memorial, JFK, or Delray Medical Center) for medical evaluation, counseling and testing within 2 hours after the exposure, the sooner the better. The worker and source patient should be transported to the same medical facility. The three hospitals listed above all provide rapid HIV testing programs. These rapid tests will provide source patient HIV status within 2 hours of testing.

2) The hospital’s infectious disease or employee health nurse will arrange for the source patient testing and the post-exposure prophylaxis (PEP) medications. Based on the nature of the contact and the medical history of the source patient, an employee may elect to begin the HIV prophylactic medications prior to the results of the rapid test being known. The nurse in charge at the hospital will notify the employee of the results of the rapid test as soon as possible after those results are known. The employee may then elect to discontinue treatment. All employees experiencing a High Risk exposure will be seen by the City’s infectious disease physician for follow-up and counseling.
All source patient and employee blood work drawn after the exposure will be requested by the City’s infectious disease physician for his/her review and record keeping.

Non-source patient exposures: Employees may receive high-risk exposures without involving a source patient, i.e. receiving a needle-stick from a syringe found in a garbage bag. These employees can be seen at the worker’s comp clinic or local emergency room. Since the HIV virus cannot live outside of the body for more than an hour, HIV is generally not a concern, however, Hepatitis B is. These patients may be given post exposure medications so excessive delays in treatment should be avoided (> 24 hours).

Additional High Risk exposures include, Tuberculosis(TB), Chicken Pox and Bacterial Meningitis. Depending on the exposure and the history of the employee exposed, each of these diseases may require post exposure medications. In both cases getting medications on board is a time sensitive element. These High Risk exposures require consultation with a physician ASAP.

NOTE: In all High Risk exposure situations Risk Management must be notified, however; under no circumstances should that notification delay treatment

County-Wide Infectious Disease Protocol to be followed by all hospitals in Palm Beach Co.

Quick link

WWW.PBCEMS.ORG
Our agency has a duty to act, as stated in our Certificate Of Public Convenience and Necessity (COPCN). Patients can have hidden injuries due to a fall, MVC or other reasons and then be released without a medical record. This results in significant exposure to liability from a patient who claims that they were not assessed by a paramedic.

**Patient Care Reports, whether electronic or paper, shall be initiated on all patients with a medical complaint or mechanism for injury (without exception).**

2) If you assess or take vital signs of a patient and find no obvious medical problem, a Patient Care Report shall be generated. The only exception is for routine blood pressure checks performed at the station, provided the patient has no medical complaint and their vital signs do not suggest a need for further evaluation.

**BLS Documentation:** Basic Life Support Patient Care Reports are just as important as ALS documentation. The report should include one set of patient vital signs (two is best). When applicable, refusals shall be signed by the patient. If the patient is unwilling or unable to sign the refusal form, circumstances for the failure to obtain a refusal shall be documented. A witness’s signature to the refusal is required. Family members or Police Officers are good sources. Crew members should sign if an uninvolved witness is not available. Witnesses must sign the form, print their names legibly, and should provide contact information. If the witness is a Police Officer, their agency and ID number is sufficient and shall be documented in place of contact information.

**Rationale:** All patients should be offered treatment and transport for further evaluation by a licensed physician (FAC 401.45). If a patient refuses, the patient’s signature may be used toward proof of patient-initiated refusal. Documentation of circumstances in which a patient refuses and cannot or will not sign the refusal may be the only evidence that the patient exercised his legal right to refuse and, in fact, is required by law (FAC 381.026). It also may prove that the paramedic did not refuse care to the patient in violation of (FAC 401.45). A person not involved in patient care who has no liability for the care provided will be the most credible witness in court.
ALS Documentation: Advanced Life Support Patient Care Reports shall be completed as accurately as possible. The report shall include two sets of patient vital signs (three is best). Any conscious, alert, and orientated patient with the mental capacity to understand the risks and benefits of medical evaluation and treatment who is without s/s of head injury or intoxication who that refuses medical treatment for a medical emergency shall sign a “informed refusal”. The paramedic should include as much detail as possible in his/her narrative for the refusal – including the paramedic’s recommendation, patient rationale for refusal etc. Statements such as; “no medical need” and “transport not needed” are unacceptable and shall not be used. Every effort should be made to use only standard medical terminology. Unapproved acronyms such as (P.U.T.S.) are unacceptable.

Rationale: A patient cannot refuse if they are not competent to understand the benefits and risks associated with treatment (FAC 401.445). Ref: to “no medical need” and other such statements which could be considered a final diagnosis. Paramedics have limited assessment tools. Only a licensed physician can offer definitive diagnoses of patient’s medical condition. Paramedics may not medically clear a patient. Any patient who is checked out and is not transported must sign a refusal of service.

Patient’s accepting medical treatment and transport shall sign the Patient Authorization Form (PAF) on the report. If the patient is not capable of signing, simply state the reason in one sentence and initial the appropriate space. If the patient is a minor a parent’s information should be included whenever possible.

Rationale: We cannot bill a minor for services rendered. We need the parent’s information as the guarantor. Attach all applicable documents to the original report – ECG Strip and hospital face-sheet.

Trauma Alert: Document at least two sets of vital signs and the patient’s Glasgow Coma Score. Reasons for prolonged on-scene times > 10-minutes must be documented on the Patient Care Report.

Rationale: Documentation of extended on-scene time is required by the PBCHCD and is examined by TQIC. Attach all applicable documents to the original report including a copy of the PBCHCD Trauma Scorecard, ECG, etc. As with all Patient Care Reports, the Trauma Alert Report should be clear, concise and complete.
Medical Evaluation of Firefighters and other Emergency Responders on Emergency Incidents and Training Exercises

**Purpose**

To examine and evaluate the physical and mental status of firefighters and other emergency responders working at an emergency incident or a training exercise and determine what treatment, if any, is necessary.

**Implementation:**

A Rehab Area will be set up at the discretion of the Incident Commander.

The Rehab Unit Leader will be responsible for the management and coordination of the Rehab Area.

**Location:**

Establish a Rehab Area away from environmental hazards (i.e. shady, cool place, upwind away from smoke and traffic) that is readily accessible to Rescue personnel for transport and supplies.

**Manning**

Assign a minimum of two Rescue personnel to monitor and assist firefighters and other emergency responders in the Rehab Area.
Medical Evaluations

Firefighters and other emergency responders shall be evaluated following:

- Use of two SCBAs bottles and/or 45 minutes of strenuous activity (i.e. use of chemical PPE, advancing hose lines, forcible entry, ventilation, etc.)
- An SCBA failure in an IDLH atmosphere
- A complaint of weakness, dizziness, chest pain, muscle cramps, nausea, altered mental status, difficulty breathing, etc.
- At the discretion of the Incident Commander, Rehab Officer, Safety Officer, or Company Officer.

Note: Crews who respond to the emergency scene and “stage” are not subject to rehab.

* Note: a firefighter cannot be refused evaluation for a medical complaint at any time if he/she feels emergency evaluation or treatment is necessary.

* Basic medical evaluation shall be documented on the Rehab Report #1584) for all personnel entering the Rehab Area.

* A Patient Care Report and a Supervisor’s Incident Report Form (Revised Feb -- May 2015) shall be completed on each firefighter or other emergency responder when he or she is not returned to normal duties.

Examination

Shall occur at 15 minute intervals and will involve a minimum of:

- Vital Signs including (BP, P, R, SAO2 and if smoke is present, CO level)
- Temperature
- Skin condition
- Lung sounds (if applicable)
- ECG (if applicable)

After 15 minutes of rest, any person whose vital signs exceed the limits stated below will be considered a patient who needs medical treatment that may require transport to the hospital for evaluation by a physician.

- Pulse greater than 100 AND temp greater than 101
- Pulse Greater than 100 AND systolic greater than 180
- Pulse Greater than 100 AND diastolic greater than 100
- Blood Pressure with a systolic less than 100
Guidelines for Rehab

Normal Presentations

The firefighter or other emergency responder will rehydrate and rest before returning to duty.

Abnormal Presentations

- Firefighter or other emergency responder will rehydrate and rest.

- Firefighter or other emergency responder will receive treatment and transport if presentations are abnormal for more than 15 minutes.

- Firefighter or other emergency responder with chest pain, difficulty breathing and/or altered mental status will receive immediate ALS treatment and transport.

- Any other abnormal presentation, not specified herein, where the examining paramedic's judgment determines a need for treatment and transport, will result in treatment and transport.

Firefighter or other emergency responder will report to their officer when released from Rehab. Presentations should return to normal within fifteen minutes.

- Treatment will consist of one or more of the following:
  - Prior to taking anything orally, the firefighter or other emergency responder will clean hands and face. On scene Rescue will provide water and cleaning agent.
  - Rest
  - Oral rehydration and nutrition, minimum of 1-2 quarts of fluids over a 15 minute time period. Water should be provided. Avoid administration of any substance containing caffeine. Sports drinks should be used with caution as some contain caffeine.
  - Oxygen
  - Cool environment (i.e. shade, electric fan, air conditioning, removal of bunker gear, showers, etc.)
  - ALS Protocols
BBFRD Rehabilitation Report

<table>
<thead>
<tr>
<th>Agency / Unit</th>
<th>Last Name/L.D.</th>
<th>Time-In</th>
<th>Number of SCBA Bottles</th>
<th>Blood Pressures</th>
<th>P a/o</th>
<th>R 12.24</th>
<th>T 94</th>
<th>SaO2</th>
<th>CO</th>
<th>Complaints/Observations</th>
<th>Treatment</th>
<th>Disposition</th>
<th>Time-out</th>
<th>Care Provider's L.D. Number</th>
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After 15 minutes of rest, any person whose vital signs exceed the limits stated below will be considered a patient who needs medical treatment that may require transport to the hospital for evaluation by a physician.

- Pulse greater than 100 AND temp greater than 101
- Pulse Greater than 100 AND systolic greater than 180
- Pulse Greater than 100 AND diastolic greater than 100
- Blood Pressure with a systolic less than 90
Heat Stress Index

- The USFA (United States Fire Administration) recommends that rehab operations be initiated whenever the heat stress index exceeds 90°F (32°C).

### Heat Stress Index

<table>
<thead>
<tr>
<th>Humidity</th>
<th>Temp °F</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
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* Note: Add 10° when protective clothing is worn and add 10° when in direct sunlight.

### Heat Stress

**Injuries Associated with Heat Stress**

<table>
<thead>
<tr>
<th>Heat Index, °F</th>
<th>Danger Category</th>
<th>Injury Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 60°</td>
<td>None</td>
<td>Little to no danger under normal circumstances</td>
</tr>
<tr>
<td>80° to 90°</td>
<td>Caution</td>
<td>Fatigue possible if exposure is prolonged, and there is prolonged physical activity</td>
</tr>
<tr>
<td>90° to 105°</td>
<td>Extreme Caution</td>
<td>Heat cramps and heat exhaustion possible if exposure is prolonged</td>
</tr>
<tr>
<td>105° to 130°</td>
<td>Danger</td>
<td>Heat cramps and heat exhaustion likely, and heat stroke possible</td>
</tr>
<tr>
<td>Above 130°</td>
<td>Extreme Danger</td>
<td>Heat stroke is imminent</td>
</tr>
</tbody>
</table>

### Heat Stress Example

- Firefighters are working in full PPE and in direct sunlight:
  - Temperature is 83°F
  - Relative Humidity is 50%
  - Heat index = 93°F
  - Thermal impact = 93°F + 10°F + 10°F = 113°F

Return to emergency duties & report to Rehab Unit Leader

- Vital signs are within normal limits
- Absence of abnormal signs and symptoms
- Minimum period of 15 minutes for rest and rehydration
Purpose

Personal property removed from, or given to Boynton Beach Fire Rescue employees by patients during emergency medical responses shall be secured. The property shall remain secured until the patient is transported and transferred to the receiving facility. The patient may elect to hold the secured items, if able. If not, the secured items shall be turned over to the ER staff at the receiving facility.

When the property is removed, it shall be placed into a “Smart Possessions and Tracking System” bag or similar system. The property shall be placed into the bag and sealed. The tracking tag shall be removed and attached to the patient’s wrist, foot or field medical report (yellow or hospital copy).

The paramedic shall then document the securing of the property on the field medical report (supplemental). Examples of some commonly seen items are as follows, but not limited to; Medications – Medical papers/cards – dentures – eyeglasses – Jewelry removed for treatment) – wallets
M-26 TAZER DART REMOVAL

Purpose

M-26 Taser Facts

The darts are attached to two bare wires approximately 21-feet in length and travel at speeds of 160 feet per second. The darts are ¼” to ½” in length which feature a barb on the tip similar to a straight fishhook. When deployed, the gun sends 50,000 volts of energy into the victim’s body for approximately 5-seconds.

Dart Removal

All darts should be removed by an ER Physician in the hospital setting and not in the field. Although the dart(s) only penetrate the body approximately ½” to 5/8”, in a thin person the dart(s) could cause problems with vital underlying structures, especially if they penetrate the neck.

If Fire Rescue arrives on scene and determines the patient needs BLS and/or ALS treatment, then the dart(s) should be treated as any other impaled object and the appropriate care given. If medical treatment is not warranted, then Boynton Beach Police should transport the patient to the hospital for removal of the dart(s).

Patient’s who have been hit in the head, neck or torso could in theory, be designated “Trauma Alerts” (penetrating injury, as per the PBC Scorecard Methodology) however, it is of the opinion of the Medical Director, that these cases be treated on a case-by-case basis, especially in dealing w/ a patient who is slight of build. In most cases, the closest facility will be appropriate for dart(s) removal. Fire Rescue crews should consider C-Spine injury and other injuries secondary to falls after deployment of the dart(s).
Determination of Death

Purpose

The purpose of this standard operating guideline is to provide guidelines to assist field personnel with determining when a patient is dead/non-salvageable and when to withhold resuscitative efforts.

These guidelines provide a basic framework for most incidents where cardiopulmonary resuscitation (CPR) should be withheld for patients found dead/non-salvageable in the field. The Paramedic may determine that the patient is dead/non-salvageable and decide not to resuscitate if:

At least one of the following conditions is present:

- Lividity
- Rigor mortis
- Tissue decomposition
- A valid DNRO is presented/discovered

And/or if all of the following are present:

- Known down time greater than thirty (30) minutes
- Asystole
- Pupils fixed and dilated
- Apneic
- Without hypothermic mechanism for arrest

Trauma Patient

Resuscitation should not be attempted for trauma patients that have ALL 3(three) of the following presumptive signs of death present:

- Apneic
- Pulseless
- Fixed and Dilated Pupils

Patients with injuries incompatible with life (e.g., decapitation, massive crush injury, incineration, etc.) shall not be resuscitated.
Resuscitation should not be attempted for trauma patients found in cardiac arrest, unless the arrest occurred in the presence of Fire Rescue personnel, has regained pulses after needle decompression (see below) or is in arrest as a result of electrocution or lightning injury.

Patients being resuscitated should be transported to the closest appropriate Trauma Center. If bystander CPR was administered prior to Fire Rescue’s arrival and Fire Rescue personnel find the patient to be pulseless, then further resuscitation should not be attempted.

Patients with suspected hypothermia, overdose, or electrocution require full ALS resuscitation unless there are injuries incompatible with life or tissue decomposition or other obvious signs of death are present.

Trauma Arrest should be treated the same as medical cardiac arrest in regards to medication administration with the exception of ICE post resuscitation.

**If there is any concern regarding determination of death, begin resuscitation and transport.**
Medical Direction

Kenneth A. Scheppke, MD (561) 436-2291

Peter Antevy, MD (954) 707-2692

Palm Beach County Division of Emergency Management

Sally Waite, EM Program Coordinator (561) 712-6484, Cell: (561) 281-5298

Lynette Schurter, EMS Specialist (561) 712-6696, Cell: (561) 707-7835

Poison Control

1-800-222-1222

Florida Department of Health (West Palm Beach)

Main, (561) 840-4500

Report a disease, (561) 671-4184

Palm Beach County Health Care District

(561) 659-1270

Palm Beach County Medical Examiner

(561) 688-4575