**Legend**

<table>
<thead>
<tr>
<th>A</th>
<th>EMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Paramedic</td>
</tr>
<tr>
<td>P</td>
<td>Medical Control</td>
</tr>
</tbody>
</table>

**Pertinent Positives and Negatives**
- Age, VS, GCS
- Time of Injury, Mechanism of Injury
- DCAP-BTLS
- SAMPLE History

<table>
<thead>
<tr>
<th>Differential</th>
</tr>
</thead>
</table>
| Stroke
| STEMI
| Overdose
| Elder Abuse
| Domestic Violence
| Non-Accidental Trauma |

**General Approach – Adult, Trauma**

**Assessment**

- Scene
- Safety
  - Safe
  - Unsafe
- PPE
  - Sufficient
  - Insufficient
- Hazmat
  - Yes
  - No
- Stage, Call for Law Enforcement and/or Additional Resources
- Presentation OR Traumatic Mechanism
  - Yes
  - No
- Primary Survey
  - Pulseless, Apneic
- Minimize Scene Time, Notify Receiving Facility of Trauma Patient Early
- Hemorrhage Control Protocol p92
- Evaluate and Treat Per Appropriate Trauma Protocol

**Airway Management Protocol p34**
- Obstructed Airway, Ventilations Inadequate
- A, B, C’s
- Exsanguinating Hemorrhage
- Ventilations Adequate, BP and HR Adequate
- Support Airway, Support Oxygenation, Support Circulation
- Long Board Selective Spinal Immobilization Protocol p95

**Trauma Protocols – Adult**

**Pearls**

**REQUIRED EXAM: Vital Signs, GCS, Loss of Consciousness, Location of Pain (then targeted per Appropriate Trauma Protocol)**

- Assess for major trauma criteria immediately upon patient contact
  - RR <10 or >29; SBP <90; Pulse <50 or >140; GCS <13; SpO2<93%
  - Transport to Trauma Center, minimize scene time to goal of <10 minutes
- Disability – assess for neuro deficits including paralysis, weakness, abnormal sensation
- Suspect Tension Pneumothorax when:
  - Mechanism consistent with Chest Trauma; Resp Distress; Decreased Breath Sounds; JVD; Low BP; Tachycardia; Tracheal Deviation
  - Signs and Symptoms of Tension Pneumothorax may be present with or without positive pressure ventilations
  - Needle Decompression should be performed with a 3” 14ga needle at the 2nd intercostal space, midclavicular line
  - If repeat decompression necessary, continue to move laterally along the superior aspect of the 3rd rib
Step One: Measure Vital Signs and Level of Consciousness

- Glasgow Coma Scale ≤13
- Systolic blood pressure (mmHg) <100 mmHg
- Respiratory rate <10 or >29 bpm
- OR need for ventilation support

Step Two: Assess Anatomy of Injury

- Penetrating injury to head, neck, torso, extremities proximal to knee
- Chest wall instability or deformity
- ≥2 proximal long bone fractures
- Crushed, degloved, or mangled extremity
- Amputation proximal to wrist or ankle
- Pelvic fracture
- Open or depressed skull fracture
- Paralysis


- Falls > 20 ft
- High Risk Auto Crash
- Auto vs. Pedestrian/Bicyclist thrown, run over or significant (>20 mph) impact
- Motorcycle crash >20 mph

Step Four: Assess Special Patient or System Considerations

- Age ≥55 years
- Anticoagulation and bleeding disorders
- Burns - without other trauma, transport to burn facility - with traumatic mechanism, transport to trauma center
- End Stage Renal Disease requiring Hemodialysis
- Pregnancy ≥20 weeks
- EMS provider judgment

Step Five: Transport according to Appropriate Trauma Protocol
Bites and Envenomations – Adult, Trauma

General Approach – Adult, Trauma

Offending Organism(s) Neutralized

No

Call For Resources, Stage Until Scene Safe

Contact Dane Co. Animal Control 1-608-255-2345

Yes

Active Hemorrhage

Yes

Hemorrhage Control Protocol p92

No

Allergic Reaction

Yes

Allergic Reaction Protocol p50

No

Evaluate Pain

Moderate OR Severe

Consider Pain Management – Adult, Protocol p69

None or Mild

Identify of Offending Organism

Situation

Identify of Offending Organism

Spider, Bee, Wasp, Hornet

Immobilize Injury, Remove jewelry distal to bite

Muscle Spasms

No

Yes

Consider Midazolam 5mg IM/IN OR Midazolam 2mg IV/IO

Snakebite

Immobilize Injury, Remove jewelry distal to bite

Mark Edges of Erythema with Marking Pen

Mammalian Bite (including Human)

Immobilize Injury, Remove jewelry distal to bite

Wound Care Procedure p197

Notify Receiving Facility, Contact Medical Control As Necessary

Pertinent Positives and Negatives

- Age, VS, Pulses distal to wound
- SAMPLE History
- OPQRST History
- Description or photo of offending creature
- Tetanus status
- Immunization History of Creature (if known)
- Domestic vs. Wild Animal
- Allergic Reaction
- Hypotension, Shock, Fever
- Non-Accidental Trauma
- Penetrating Trauma
- Dry Bite (Snake)
- Abscess/Cellulitis
- Projectile Injury

Legend

EMT
A A-EMT
P Paramedic
M Medical Control

REQUIRED EXAM: VS, GCS, Evidence of Intoxication, Affected Extremity Neurovascular Exam

- Cat bites may not initially appear serious, but can progress rapidly to severe infection
- Human bites have higher rates of infection than animal bites and necessitate evaluation in the Emergency Department for antibiotics
- It is not necessary to bring the offending insects, animals or reptiles to the ED for identification; this may result in added danger to others
- Bites on the hands and lacerations over knuckles should be assumed to be “Fight Bites” until proven otherwise, and need evaluation
- Brown recluse spider bites are usually painless at the time of bite. Pain and tissue necrosis develops over hours to days
- Immunocompromised patients have higher risk of infection – Think: Diabetes, Chemotherapy, Organ Transplant

Trauma Protocols - Adult
REQUIRED EXAM: VS, GCS, Lung Sounds, HEENT, Posterior Pharynx

- Burns to face and eyes, remove contact lenses prior to irrigation
- Chemical burns require removal of contaminated clothing, brush away dry powder before irrigation. Flush with copious warm water on scene and continue irrigation en route. Be sure to brush excess away and remove contaminated clothing BEFORE beginning irrigation. Early intubation is strongly recommended if suspicion of inhalation injury. Suspicion is high in patients involved in an enclosed space fire, who have facial burns or show signs of airway involvement; carbonaceous sputum, facial burns or edema, hoarseness, singed nasal hairs, agitation, hypoxia or cyanosis
- Indications of possible Cyanide Poisoning - Exposure to fumes from burning Nitrile (polyurethane, vinyl) Seizures, coma, cardiac arrest, headache, vertigo and/or cherry red skin color from increased venous O2 concentration
General Approach – Adult, Trauma

Injuries Incompatible With Life? (Incineration, Decapitation, Hemicopectomy)

Yes

Criteria for Death/Withholding Resuscitation Policy p15

No

Rigor Mortis, Dependent Lividity or Decomposition of Body Tissue?

Yes

Criteria for Death/Withholding Resuscitation Policy p15

No

Apply Continuous Cardiac Monitor

Blunt Trauma

Yes

Asystole OR PEA <40bpm

Yes

Pregnant >22 weeks

No

Begin Resuscitation

Continue HPCPR Procedure p173

Throughout Transport to Closest Leveled Trauma Center

(Preference to Level 1 Center, if possible)

No

Consider Airway Management Protocol p34

Full Spinal Immobilization with C-collar and Long Spine Board MANDATORY

A

IV Access Protocol p55

A

NS Bolus 500mL IV/IO

Return of Pulse

No

P

Consider Chest Decompression Procedure p181

Yes

Go To Appropriate Trauma Protocol

M

Notify Receiving Facility, Contact Medical Control As Necessary

Pertinent Positives and Negatives

• Age, if known
• Mechanism of Injury
• Events leading up to arrest

Differential

• Hypovolemic Shock
  - External Hemorrhage
  - Internal Hemorrhage
  - Unstable Pelvic Fracture
• Tension Pneumothorax
• Medical Condition Causing Trauma (i.e. Cardiac Arrest)

Criteria for Death/Withholding Resuscitation Policy p15

Contact Law Enforcement and/or Medical Examiner

Do Not Attempt Resuscitation

Pregnancy EDC can be estimated by palpating the gravid uterus; above the level of the umbilicus is generally >22 weeks

Legend

EMT
A EMT
P Paramedic
M Medical Control

Required Exam: Pupillary Light Reflex, Palpation of Pulses, Heart and Lung Auscultation

• Injuries incompatible with life include: decapitation, incineration, massively deforming head or chest injury, dependent lividity, rigor mortis
• As with all trauma patients, DO NOT delay transport
• Consider using medical cardiac arrest protocols if uncertainty exists regarding etiology of arrest
• Use of a long spine board will make chest compressions more effective; however, if spinal immobilization interferes with CPR use reasonable effort to limit patient and spine movement
• Be aware that these may be crime scenes: do your best to avoid disturbing forensic evidence
• If provider safety becomes a concern, transport of deceased patients to the hospital is acceptable

Pearls

Trauma Protocols - Adult

81
General Approach – Adult, Trauma

Consider need for Airway Management EARLY

Consider Responder and Citizen Safety, Follow Downed Power Lines Safety

Hazmat, General Protocol p90

Yes

Hazmat / Downed Power Lines Scene

No

Estimate TBSA Burned / Severity

Minor Burn

<5% TBSA, 1st – 2nd Degree Burn
No inhalation Injury
Normal BP, SpO2

Serious Burn

5-15% TBSA, 2nd – 3rd Degree Burn
Suspected Inhalation Injury
Hypotension, Altered Mental Status
Preferred Transfer to Burn Center

Critical Burn

>15% TBSA, 2nd – 3rd Degree Burn
Burn with Trauma
Burn with Airway Compromise
Preferred Transfer to Burn Center

Continuous Cardiac Monitor for ALL Electrical Burns

Irrigate Involved Eye(s) with 2L NS or Sterile Water x 15 minutes Repeat as needed

Eye Involvement

Yes

No

Consider Burn, Trauma Protocol p80

Flush Burned Areas with Normal Saline x 15 minutes Repeat as needed

Consider Pain Management, Adult p69

Chemical / Electrical Burn Patient Management

Consider provider safety, number of patients and early notification of receiving facility

Pearls

REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro

- Provider Safety is paramount! Ensure Chemical Source is not a hazard to responders and Electrical Sources are not contacting patient prior to assessment. Don’t allow yourself or your crew to become victims.
- Safety First! Assure a Chemical source of burn is NOT a hazard to responders. Assure an Electrical source of burn is OFF or no longer contacting pt.
- High Voltage Electrical Burns (>600 volts) require spinal immobilization, continuous cardiac monitor and IV access regardless of external appearance of injury
- Chemical burns require removal of contaminated clothing, brush dry powder before irrigation. Flush with copious warm water on scene and continue irrigation en route. Be sure to brush excess away and remove contaminated clothing BEFORE beginning irrigation
- Superficial appearance of Electrical Burns does NOT indicate severity of underlying tissue damage
- Attempt to locate contact points in Electrical Burns, generally contact point with source and where patient is grounded. Do not refer to them as entry or exit wounds. Surface appearance may belie the damage below
- Electrical Burns cause ventricular and atrial irritability and dysrhythmias; anticipate cardiac problems and treat accordingly
Chest Injury – Adult, Trauma

General Approach – Adult, Trauma

- Long Board Selective Spinal Immobilization Protocol p95
- IV Access Protocol p55
- Consider Pain Management, Trauma Protocol p69

Mechanism

Blunt

- Assess Breath Sounds, SpO2
- Clear and Equal Bilaterally
- Decreased Unilateral Breath Sounds
- Sign of Tension Pneumothorax
- Support Ventilations, Monitor VS, watch for JVD, tracheal deviation
- Notify Receiving Facility, Contact Medical Control As Necessary
- Continuous Cardiac Monitor
- Consider Airway Management Protocol p34

Penetrating

- Assess Breath Sounds, SpO2
- Decreased Unilateral Breath Sounds
- Open OR Sucking Chest Wound
- Decreased Unilateral Breath Sounds
- Clear and Equal Bilaterally
- Support Ventilations, Monitor VS, watch for JVD, tracheal deviation
- Notify Receiving Facility, Contact Medical Control As Necessary
- Continuous Cardiac Monitor
- Consider Airway Management Protocol p34

Pearls

- REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro
- Consider tension pneumothorax in any patient with penetrating chest trauma, OR blunt chest trauma with decreased unilateral breath sounds, hypotension, tachycardia, hypoxia, tracheal deviation (late) or JVD (late)
- Aortic root injuries, bronchial disruption and tracheal disruptions are common with major deceleration injuries (i.e. MVC)
- Cardiac contusions are common with blunt chest trauma, and may present with ectopy, PVCs or even STEMI appearance on cardiac monitor
- Pericardial Tamponade is a surgical emergency and needs rapid transport. Look for muffled heart tones, hypotension, tachycardia
Prolonged Crush Injury – Adult, Trauma

### Pertinent Positives and Negatives
- Age, VS, GCS
- SAMPLE History
- OPQRST History
- Crushed under heavy load ≥30 min

### Differential
- Compartment Syndrome
- Entrapment without Crush
- Fracture, Sprain, Strain

### General Approach – Adult, Trauma
- IV Access Protocol p55
- NS Bolus, 500mL
- Continuous Cardiac Monitor

### Management of Crush Injury Patient
Crush Injury should be suspected in prolonged pinnings >1 hour, AND proximal to the knee or elbow.

This protocol is **NOT** intended for hands or feet trapped in machinery or farm equipment.

### Legend
- EMT
- A - EMT
- P - Paramedic
- M - Medical Control

---

**Pearls**

**REQUIRED EXAM:** Vital Signs, GCS, Lung Sounds, Neuro Exam, Musculoskeletal Exam

- Structural Collapse, Crush Scenes are often full of hazards, provider safety is the most important consideration
- Patients may become hypothermic, even in warm environments
  - Hypothermia can lead to coagulopathy, which will increase bleeding times and have worse outcomes for the patient
- Crush injuries can result in hyperkalemia from shift of Potassium out of injured cells. Cardiac monitoring is required and 12-lead ECG preferred whenever possible (as dictated by the situation)
- Monitor extremities for signs of compartment syndrome after crush injury; **Pain, Pallor, Paresthesias, Paralysis, Pulselessness and Poikilothermia** (inability to regulate core body temperature)
- *Utilize different IV lines or flush between bicarb and calcium to prevent precipitation in the line

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**Trauma Protocols - Adult**

84
Near Drowning / Submersion Injury – Adult, Trauma

**Legend**
- EMT
- A-EMT
- Paramedic
- M Medical Control

**Pertinent Positives and Negatives**
- Submersion in water regardless of depth
- SAMPLE History
- OPQRST History
- Temperature of water
- Mental Status Changes

**Differential**
- Spinal Trauma
- Pre-Existing Medical Condition
- Hypothermia
- Aspiration
- The Bends
- Pressure Injury
  - Barotrauma
  - Decompression Sickness
- Post-Immersion Syndrome

**General Approach – Adult, Trauma**

**Long Board Selective Spinal Immobilization Protocol p95**

**Mental Status**

**Awake and Alert**
- Remove Wet Clothing
- Dry and Warm Patient
- Monitor and Reassess
- Encourage Transport and Evaluation even if asymptomatic

**Awake but Altered**
- Consider Airway Management Protocol p34
- Consider Altered Mental Status Protocol p51
- Remove Wet Clothing
- Dry and Warm Patient
- Monitor and Reassess

**Unresponsive**
- Go To Appropriate Adult MEDICAL Cardiac Arrest Protocol

**Pearls**
**REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro**
- Have a HIGH index of suspicion for possible spinal injuries. Any diving injury or submersion with unclear details should be fully immobilized
- Hypothermia is often associated with near-drowning and submersion injuries. **Consider the Hypothermia Protocol** as appropriate
- All patients with Near-Drowning / Submersion Injury should be transported for evaluation due to delayed presentation of respiratory failure
- With diving injuries (decompression / barotrauma) consider availability of a hyperbaric chamber; contact Medical Control early.
- Near-drowning patients who are awake and cooperative but with respiratory distress may benefit from CPAP / Positive Pressure Ventilation

**Trauma Protocols - Adult**
**Environmental, Hyperthermia – Adult, Trauma**

**Pertinent Positives and Negatives**
- Age, VS, Mental Status
- SAMPLE History
- OPQRST History
- Time and length of exposure to hot environment

**Differential**
- Alcohol Withdrawal (DTs)
- Hyperthyroidism (Thyroid Storm)
- Dehydration
- Cocaine or Sympathomimetic OD
- Sepsis

**CNS Lesion or Head Injury**
- Abuse or Neglect (Elderly or disabled)
- Medication (Serotonin Syndrome, Malignant Hyperthermia)

**If Evidence of Sympathomimetic OD**
Consider Overdose, Sympathomimetic Protocol p55

**Heat Cramps**
- Painful Spasms of Extremities and/or Abdominal Muscles
- Normal Mental Status
- Normal Vital Signs

**Heat Exhaustion**
- Dizziness, Lightheadedness, Headache, Irritability, Nausea
- Normal or Mildly Depressed Mental Status
- Mild Tachycardia (<150)
- Normal or Mildly Elevated Temp

**Heat Stroke**
- Marked Alteration in Level of Consciousness
- May Be Sweating OR Hot, Dry, Red Skin
- Extremely High Temp, >104°F

**General Approach – Adult, Trauma**

1. **Remove Patient from Hot Environment**
   (if applicable)

2. **Estimate Severity of Symptoms**

   - **Heat Cramps**
     - Oral Fluids
     - Sponge with Cool Water and Fan

   - **Heat Exhaustion**
     - Keep Patient Supine
     - Apply 100% Oxygen
     - Sponge with Cool Water and Fan

   - **Heat Stroke**
     - Semi-Reclining Position with Head Elevated
     - Apply 100% Oxygen
     - Rapid Cooling with Cold Packs, Sponge with Cool Water and Fan

3. **Tolerating Oral Fluids**
   - Yes
   - No

4. **Reassess and Document Mental Status, VS and ability to take PO**
   - Any Abnormal
   - Normal

5. **Consider Hypotension Shock / Trauma p97**
   - P
   - Ondansetron 4mg IV/IO
   - If Shivering, Consider Midazolam 2mg IV/IO

6. **Execute and Document Patient Refusal Protocol p70**

7. **Consider Hypotension / Shock (Trauma) p97**

8. **Notify Receiving Facility, Contact Medical Control As Necessary**

**Pertinent Positives and Negatives**
- Age, VS, Mental Status
- SAMPLE History
- OPQRST History
- Time and length of exposure to hot environment

**Differential**
- Alcohol Withdrawal (DTs)
- Hyperthyroidism (Thyroid Storm)
- Dehydration
- Cocaine or Sympathomimetic OD
- Sepsis

**CNS Lesion or Head Injury**
- Abuse or Neglect (Elderly or disabled)
- Medication (Serotonin Syndrome, Malignant Hyperthermia)

**Environmental, Hyperthermia – Adult, Trauma**

**Legend**
- EMT
- A-EMT
- A
- P
- Paramedic
- M
- Medical Control

**Pears**

**REQUIRED EXAM: VS, GCS, Skin, HEENT, Neuro, Evidence of Intoxication, Mental Status**

- Extremes of Age are more prone to heat emergencies due to inability to easily self-extricate from hot environments
- Patients on Tricyclic Antidepressants, Anticholinergics, Diuretics (i.e. Lasix) are more susceptible to heat emergencies due to medication effects
- Cocaine, amphetamines and salicylates all may elevate body temperature or interfere with the ability to auto-regulate
- Sweating generally disappears as body temperature rises above 104°F
- If Heat Cramps resolved without IV Access or Medications, patients may refuse transport, IF tolerating oral fluids and VS normal

**Trauma Protocols - Adult**
General Approach – Adult, Trauma

Remove Patient from Cold Environment (if applicable)
Remove Wet Clothing
Dry and Warm the Patient

Estimate Severity of Symptoms

Mild Hypothermia
90-95°F (32-35°C)

Sympathetic Nervous System Excitation – Shivering, Hypertension, Tachycardia, Tachypnea
Awake But May Be Confused

Moderate Hypothermia
82-90°F (28-32°C)

Shivering more violent, ataxia and incoordination apparent.
Stumbling pace and Moderate Confusion Appears pale as surface vessels constrict to retain heat.

Severe Hypothermia
<82°F (<28°C)

Heart rate, blood pressure and respiratory rate decrease.
Disoriented, confused and combative
Paradoxically may discard clothing

External Rewarming Measures

12-Lead ECG Procedure p142

Consider Altered Mental Status Protocol p51

Consider Pain Management – Adult p69

Localized Cold Injury Only (Frostbite)

Blood Glucose Procedure p169

>70

Diabetic Emergencies Protocol p53

<70

Consider Airway Management Protocol p34

Consider Pain Management – Adult p69

Critical Pearls

- Hypoglycemia is found in many hypothermic patients, because hypothermia may be a result of hypoglycemia
- Severe hypothermia may cause myocardial irritability and rough handling can theoretically cause V-fib. Please handle carefully.
- Do not withhold intubation or CPR for this concern, but only the most experienced provider available should gently attempt intubation
- Below 86°F (30°C), antiarrhythmics may not be effective. If given, they should be given at reduced intervals. Do NOT attempt to pace below 86°F. If antiarrhythmics necessary for severely hypothermic patient, Contact Medical Control
- Extremes of age, malnutrition, EtOH and drug abuse and outdoor hobbies / employment all predispose to hypothermia

REQUIRED EXAM: VS, GCS, Skin, HEENT, Neuro, Evidence of Intoxication, Mental Status

- Hypoglycemia is found in many hypothermic patients, because hypothermia may be a result of hypoglycemia
- Severe hypothermia may cause myocardial irritability and rough handling can theoretically cause V-fib. Please handle carefully.
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- Extremes of age, malnutrition, EtOH and drug abuse and outdoor hobbies / employment all predispose to hypothermia

Trauma Protocols - Adult
Extremity Injury – Adult, Trauma

Legend

| Legend   |  |
|----------|  |
| EMT      |  |
| A        | A-EMT |
| P        | Paramedic |
| M        | Medical Control |

Pertinent Positives and Negatives

- Type of injury
- Mechanism (blunt vs. penetrating)
- Central and Peripheral Pulses
- Neuro Function Distal to Injury

SAMPLE History
- OPQRST History
- Evidence of Intoxication
- Evidence of Multi-System Trauma

Differential
- Vascular Disruption
- Amputation
- Fracture, Dislocation
- Sprain, Strain
- Abrasion
- Contusion
- Laceration
- Compartment Syndrome

Required Exam
- Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro

- Immobilization of bony injuries should include the joint above and below. Joint injuries require immobilization of bone above and below.
- Palpate and document Circulation, Movement and Sensation both before and after splint application.
- Tourniquets should remain in place once hemorrhage control is adequate. The tourniquet is tight enough when the bleeding stops!
- If active hemorrhage and bony/soft tissue deformity, priority should be put on hemorrhage control first, then splinting — remember A,B,C’s
- If amputated extremities available, seal in a plastic bag and place in cool water and bring to the hospital with the patient.

Trauma Protocols - Adult
**Eye Pain – Adult, Trauma**

### General Approach – Adult, Trauma

1. **Nature of Complaint**
   - **Non-Traumatic**
   - **Traumatic**

2. **Injury**
   - Isolated to Eye(s)
   - Globally Rupture

3. **Mechanism**
   - Blunt / Trauma
   - Chemical

4. **Go To Appropriate Trauma Protocol**

5. **Irrigate with 2L NS or Sterile Water**

6. **Cover and Protect Both Eyes**

7. **Shield and Protect Both Eyes**

8. **Notify Receiving Facility, Contact Medical Control As Necessary**

#### Pearls
- **REQUIRED EXAM:** VS, GCS, Visual Acuity, Neuro Exam, Extraocular Movements
- Stabilize any penetrating objects. DO NOT remove any embedded / impaled objects
- If Long Spine Board not indicated, transport with head of stretcher elevated to 60 degrees to help reduce intraocular pressure
- Remove contact lenses when possible
- Always cover both eyes to prevent further injury
- Orbital fractures increase concern for globe or optic nerve injury; follow visual acuity and extraocular movements for changes
- Normal visual acuity can be present, even with severe injury

#### Differential Diagnosis
- Globe Rupture
- Acute Closed Angle Glaucoma
- Stroke
- Retinal Artery Occlusion
- Chemical Burn
- Retinal Venous Thrombus

#### Pertinent Positives and Negatives
- Age, VS, Visual Acuity
- SAMPLE History
- OPQRST History
- Time of Injury
- Involved Chemical MSDS
- Contact/Corrective Lens Use
- “Shooting” or “Streaking” Lights
- Rust Ring
- “Lowering Shade” in Vision

#### Legend
- EMT
- A - EMT
- P - Paramedic
- M - Medical Control

**Trauma Protocols - Adult**
Hazmat, General – Adult, Trauma

**Scene Assessment**

1. **Step 1 – Site Control**
   - Respond to suspected Hazmat release from uphill and upwind.
   - Utilize binoculars for scene size-up.
   - Wear all appropriate PPE.
   - Control the scene by preventing entry into the area.

2. **Step 2 – Identification of Products**
   - As soon as safely possible, ID product(s) involved.
   - If moderately or extremely hazardous, notify HIT.
   - Utilize ERG for ID of placards, containers or product(s).

3. **Step 3 – Hazard and Risk Assessment**
   - Utilize the ERG to make risk assessment.

4. **Step 4 – Personal Protective Equipment**
   - Use the ERG to determine PPE requirement.
   - Structural Firefighting Protective Clothing (SFPC) is not recommended for many Hazardous Materials.

5. **Step 5 – Information and Resource Coordination**
   - Communicate with additional units as appropriate.
   - Update HIT Leader on their arrival.

6. **Step 6 – Control Measures**
   - Confine and Contain product release as appropriate.
   - Consider additional resources as needed.

7. **Step 7 – Decontamination**
   - Consider appropriate decon after Hazmat incident.
   - Confer with HIT Leader as necessary.

8. **Step 8 – Termination Activities**
   - Before leaving the scene document all actions and equipment used.
   - Document possible parties names, addresses and phone numbers.
   - Turn the scene over to responsible party.

**Pertinent Positives and Negatives**
- Age, V5, Mental Status
- SAMPLE History
- OPOQST History
- Time and length of exposure to toxic environment

**Differential**
- Alcohol Intoxication
- Hyperthyroidism
- Drug Abuse, Intoxication
- Sepsis
- CNS Lesion or Head Injury
- Abuse or Neglect (Elderly or disabled)
- Medication (beta blocker overdose, opiate overdose)

**Additional Helpful Numbers**
- Chemtrec: 1-800-424-9300
- Chemtell: 1-888-255-3924
- Infotract: 1-800-535-5053
- 3E: 1-800-451-8346

**Pearls**
- REQUIRED EXAM: V5, GCS, Skin, HEENT, Neuro, Evidence of Intoxication, Mental Status
  - The most important factor in Hazmat response is provider safety – you can’t help anyone else if you’re a victim as well.
  - In any Hazmat situation, consider that the exposure may not be accidental; consider intentional releases, secondary devices and terrorism.
  - Always park upwind and uphill of any potential exposures, and be conscious of any symptoms you may begin to develop.
  - Communication is key; contact the appropriate Hazmat authority early and notify the Hazmat leader as well as the Comm Center of findings.
  - In a large-scale event, have the Comm Center activate Dane County Mass Casualty Plan and notify the Base Hospital to get prepared.

**Overdose and Poisoning**
Specific Protocol p60-68

**Consider Burns – Adult, Trauma Protocol p80**

Do NOT Use Water To Flush:
- Elemental metals (sodium, potassium, lithium)
- Phenols

If available, dilute these burns with (in order of effectiveness)
- Polyethylene Glycol
- Glycerol
- Vegetable Oil

**Inhalation Injury**
- Yes
- No

**Albuterol 2.5mg/3mL Neb AND Ipratropium Bromide 0.5mg/2.5mL Neb**

**Chlorine Gas OR Chloramine Gas**
- Yes
- No

**Notify Receiving Facility, Contact Medical Control As Necessary**

**Trauma Protocols - Adult**
Head Injury – Adult, Trauma

### Pertinent Positives and Negatives
- Type of injury
- Mechanism (blunt vs. penetrating)
- Loss of consciousness
- Vomiting, altered mental status

### SAMPLE History
- OPQRST History
- Evidence of intoxication
- Evidence of multi-system trauma

### Differential
- Skull fracture
- Epidural hematoma
- Concussion, contusion, laceration, hematoma
- Non-accidental trauma
- Spinal cord injury
- Subdural hematoma
- Subarachnoid hemorrhage

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**General Approach – Adult, Trauma**

- Elevate head of stretcher 15-30 degrees while maintaining spinal precautions
- Long board selective spinal immobilization protocol p95
- IV access protocol p53
- Diabetic emergencies protocol p53
- Blood glucose

**Document Response to Meds, Contact Medical Control as Necessary**

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**Nasal Airways are CONTRAINDICATED**

in patients with significant Maxillofacial trauma – the cribiform plate may be broken and result in the NPA going into the patient’s brain

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**Pertinent Positives and Negatives**

**REQUIRED EXAM:** Mental status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro

- If GCS ≤13 consider Air transport or Rapid Transport
- Airway interventions can be detrimental to patients with head injury by raising intracranial pressure, worsening hypoxia (and secondary brain injury) and increasing risk of aspiration. Whenever possible these patients should be managed in the least invasive manner to safely maintain O2 saturation >90% (i.e. NRB, BVM with 100% O2)
- Acute herniation should be suspected when the following signs are present: acute unilateral dilated and non-reactive pupil, abrupt deterioration in mental status, abrupt onset of motor posturing, abrupt increase in blood pressure, abrupt decrease in heart rate.
- Only in suspected acute herniation – increase ventilatory rate (rate 20/minute) and target EtCO2 30-35mmHg
- Increased intracranial pressure (ICP) may cause hypertension and bradycardia (Cushings response)
- Hypotension usually indicates injury or shock unrelated to the head injury and should be treated aggressively
- Most important vital sign to monitor and document is level of consciousness (GCS)
- Concussions are periods of confusion or loss of consciousness (LOC) associated with trauma which may have resolved by the time EMS arrives. Any confusion or mental status abnormality which does not return to normal within 15 minutes or any documented loss of consciousness should be transported to an Emergency Department. Any questions or clarifications, contact Medical Control.

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**Trauma Protocols - Adult**
Hemorrhage Control – Adult, Trauma

General Approach – Adult, Trauma

- Wound Severity / Hemorrhage Control
  - No
  - Mild-Moderate, Simple Wound
  - Direct Pressure
  - Yes
  - Bleeding Controlled
    - Yes
    - Consider Hypotension / Shock (Trauma) Protocol p97
    - SBP <100
    - Reassess BP
    - SBP >100
    - A Consider IV Access Protocol p55
    - P Consider TXA 1gm IV/IO over 10min As Appropriate
  - No
    - Extremity
      - Yes
      - Tourniquet Procedure p191
      - Hemostatic Dressing for Severe Hemorrhage, if available
      - Consider Wound Packing Procedure, As Appropriate p197
      - No

Legend

| Legend | EMT | A - EMT | Paramedic | Medical Control |

Pertinent Positives and Negatives
- Type of injury
- Mechanism (blunt vs. penetrating)
- Central and Peripheral Pulses
- Neuro Function Distal to Injury
- Time of Injury
- Deformity
- Diminished pulse / capillary refill

Differential
- Vascular Disruption
- Amputation
- Fracture, Dislocation
- Sprain, Strain
- Abrasion
- Contusion
- Laceration
- Compartment Syndrome

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- Contusion
- Laceration
- Compartment Syndrome

Pearls
- Hypotension in trauma needs blood products early, so minimize scene time. Goal for scene time in major trauma cases should be <10 min
- Multiple casualty incident or obvious life threatening hemorrhage, consider Tourniquet Procedure and/or Hemostatic Dressing FIRST
- Hemostatic Dressings are appropriate for hemorrhage that can’t be controlled with a tourniquet, such as junctional wounds in the groin or axilla.
- Remember - hemostatic agents are contraindicated in wounds that violate the thoracic or abdominal cavity; if unsure, use sterile roll gauze.
- Signs/Symptoms of Shock include: altered mental status, pallor, hypotension (SBP <100), cap refill >3 sec, faint/absent peripheral pulses

Trauma Protocols - Adult
**Lightning Strike – Adult, Trauma**

**General Approach – Adult, Trauma**

- **Stage, Call for Law Enforcement and/or Additional Resources**
  - No: Scene Safe
  - Yes: Go to Appropriate Medical Protocol

**Scene Safe**

- Yes: Normal Mental Status
  - No: Estimate Symptom Severity

**Estimate Symptom Severity**

- **Cardiorespiratory Arrest**
  - Cardiac Arrest – Adult Protocol p40-41
  - Full Spinal Immobilization Procedure p187

- **Altered Level of Consciousness**
  - Blood Glucose, SpO2, 12-Lead ECG, Full Spinal Immobilization Procedures
  - Cardiac Arrhythmia – Adult Protocol, As Appropriate

- **Inadequate Respirations**
  - Airway Management – Adult Protocol p34
  - Full Spinal Immobilization Procedure p187

**Seizure**

- Yes: Seizure, Adult Medical Protocol p72
- No: Notify Receiving Facility, Contact Medical Control As Necessary

**Lightning Strike Patient Management**

- Typically, victims of lightning strikes who do not suffer cardiac or respiratory arrest survive; typical triage protocols do not apply under these circumstances, and resuscitation should be provided to those who are PNB first.

ECG evidence of direct myocardial damage from lightning strike includes ST segment elevation, T-wave inversion and prolongation of the QT interval.

- Most injuries occur outdoors, but contact with plumbing, phone lines, etc. that are struck can injure people indoors.

**Pertinent Positives and Negatives**

- Type of Strike (Direct, Splash, Contact)
- Central and Peripheral Pulses
- Nausea, Vomiting, Diarrhea
- Amnesia, Confusion, Neuro Deficits
- Duration of Unresponsiveness (if applicable)
- Time of Strike
- Wounds to Hands, Feet or Areas of Contact

**Differential**

- Thermal Injury
- Electrical Injury
- Blast Injury
- Acute Myocardial Infarction

**Legend**

- EMT
- A - EMT
- P - Paramedic
- M - Medical Control

**Pearls**

- REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro
  - National lightning safety guidelines state that risk continues for 30 minutes after the last lightning is seen or thunder heard
  - Lightning not striking twice is a myth; if there is continued risk to EMS providers, remove the patient to a safe place before treatment
  - Full spinal immobilization should be performed in any patient with altered level of consciousness, as spinal injuries are common from the concussive force of the strike and/or involuntary muscle spasms
  - There are reports of patients surviving prolonged periods of arrest after lightning strike. Treatment for cardiopulmonary arrest is per ACLS protocols, but decision to terminate resuscitation should be made in coordination with Medical Control.
General Approach – Adult, Trauma

Stage, Call for Law Enforcement AND/OR Additional Resources

Scene Safe

Evidence of Exposure / Toxidrome

Begin Triage and Decontamination, As Appropriate

Location of Electrodes

Evidence of Exposure / Toxidrome

Removal by Law Enforcement prior to EMS Evaluation

ANY Electrodes Present In The Eye, Face, Neck, Groin, Spinal Column or Axilla

DO NOT REMOVE ELECTRODES Stabilize in Place and Transport

Examine Site for Bleeding, Expanding Hematoma or Distal Neuro Deficit

The Thomas A. Swift Electric Rifle (TASER)

The TASER fires two small dart-like electrodes, which stay connected to the main unit by conductive wire as they are propelled by small compressed nitrogen charges

Superficial Soft Tissues EXCLUDING Eye, Face, Neck, Groin, Spinal Column or Axilla

Place one hand flat on the patient around the probe and stabilize the skin surrounding the puncture site. Place your other hand/pliers firmly around the base of the probe

In one fluid motion pull the probe straight out from the puncture site. Repeat procedure with second probe

Examine Site for Bleeding, Expanding Hematoma or Distal Neuro Deficit

Consider Behavioral Emergencies – Adult, Medical Protocol p52

RR

Pertinent Positives and Negatives

- Age, V5, SpO2, EtCO2, RR
- SAMPLE History
- OPQRST History
- Situational Crisis
- Psychiatric Illness / Medication History
- Medic Alert Bracelet, DM history
- Anxiety, Agitation or Confusion
- Suicidal / Homicidal Thoughts or History
- Evidence of Substance Use / Overdose
- Illicit Drug Intoxication
- Drug/ETOH Withdrawal
- Primary Psychosis
- Hypoglycemia
- Hypoxia
- Head Injury
- Occult Trauma
- Cerebral Hypoperfusion
- Toxic Ingestion

Differential

REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro

- Safety first – for Providers, Police and Patients. Never restrain any patients in the prone (face down) position.
- Document the site of electrode penetration as well as whether the barb was completely intact or broken on removal
- Patients who require repeated deployments of the Electronic Control Device are at a significantly higher risk of cardiac dysrhythmias as well as in-custody death. Have a high index of suspicion and a low threshold to treat per the Behavioral Emergencies Protocol
- Patients who are actively restrained by Law Enforcement require an officer be present in the ambulance patient compartment during transport. It is a patient safety issue as well as a medicolegal liability for the EMS Provider.

Trauma Protocols – Adult
Long Board Selective Spinal Immobilization – Adult, Trauma

Selective Spinal Immobilization

The large majority of patients with traumatic injury SHOULD still be immobilized with a rigid C-collar until radiographically evaluated.

Assess Mechanism of Injury (MOI)

Blunt Trauma (With OR Without Penetrating Trauma)

- Altered level of consciousness OR
- (GCS < 15) OR
- Clinical Intoxication* OR
- Midline Neck Pain OR
- Midline Tenderness to Palpation of C-Spine OR
- Paraspinal Muscle Tenderness to Palpation OR
- Neurologic Deficits OR
- Abnormal Sensation OR
- ANY Anatomic Deformity OR
- Distracting Injury** OR
- Inability to Communicate OR
- Significant Mechanism of Injury OR

ALL ‘No’

- Spinal Immobilization not indicated

Evaluate and Treat per Appropriate Adult Trauma Protocol

Immobilization with Rigid Cervical Collar AND Long Spine Board Indicated

Notify Receiving Facility, Contact Medical Control As Necessary

Pears

REQUIRED EXAM: Motor Function both upper and lower extremities, Sensation of upper and lower extremities, subjective abnormal sensation, Tenderness to palpation of bony prominences OR paraspinal muscles

- *Clinical Intoxication – A transient condition resulting in disturbances in level of consciousness, cognition, perception, affect or behavior, or other psychophysiological functions and responses. Common examples include: ataxia, emotional instability, flight of ideas, tangential thought or motor incoordination.
- **Distracting Injury – Examples include, but are not limited to; long bone fracture, dislocations, large lacerations, deforming injuries, burns OR any condition preventing patient cooperation with history.
- ALL shallow water near drownings, diving injuries and high-voltage electrical injuries (lightning, ±1000V AC or ±1500V DC) MUST be fully immobilized
- If immobilization indicated but refused; advise the patient of risk of death, permanent disability or long term impairment. Clearly document the refusal and the conversation (re: risk); Apply a cervical collar, if allowed and transport in neutral alignment.
- Long spine boards have risks and benefits for patients. Spinal immobilization should always be applied when any doubt exists about the possibility of spinal trauma.
- It is always safer and better patient care to assume that a Cervical Spine injury has occurred and provide protection, and should be the standard of care in trauma patient management.
- Long spine boards can be very useful for extricating patients, transferring locations, and providing a firm surface for chest compressions.
- Very thoughtful consideration should go into any decision to NOT use the rigid cervical collar OR long spine board.
**General Approach – Adult, Trauma**

- **Long Board Selective Spinal Immobilization Protocol p93**
  - Consider Pain Management, Adult p69

### Differential
- **Hypovolemic Shock**
  - External Hemorrhage
  - Internal Hemorrhage
  - Unstable Pelvic Fracture

- **Abrasion**
- **Contusion**
- **Laceration**
- **Compartment Syndrome**

**Major Trauma Criteria**

- **SAMPLE History**
- **OPQRST History**
- **Evidence of Intoxication**
- **Evidence of Multi-System Trauma**

**Steps 1 and 2 in Destination Determination Protocol**

- **No**

### Pertinent Positives and Negatives

- **Age, VS, GCS**
- **Mechanism of Injury**
- **Events leading up to 9-1-1 Activation**
- **Relationship to and Location of Offender**
- **Strangling or Neck Injury**
- **Sexual Assault**

### Dane County Rape Crisis Center
- Rape Crisis Center: 608-251-5126
- Crisis Line: 608-251-7273

### Domestic Abuse Intervention Services
- DAIS Help Line: 608-251-4445

### Pearls

**REQUIRED EXAM: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro**

- Major Trauma Criteria – Step 1 and Step 2 in Destination Determination Protocol. GCS ≤13, SBP <90mmHg, Respiratory Rate <10 or >29 or need for ventilatory support
- Intimate Partner Violence is very difficult to disclose, and *many victims call 9-1-1 with vague complaints*; Have a HIGH index of suspicion
- Never judge a victim of intimate partner violence or sexual assault on the way they dress, act or present themselves
- Do not be afraid to involve Law Enforcement for assistance as needed, and have a low threshold to transport to a SANE Capable Emergency Department where Social Work, SANE Nurses, and Advocates can provide support and resources for these patients

**Transit to ED with SANE Nurse Capability**

**Notify Receiving Facility, Contact Medical Control As Necessary**
Hypotension / Shock (Trauma) – Adult, Trauma

**General Approach – Adult, Trauma**

- **A** IV Access Protocol p55
- External Bleeding Controlled
  - **A** Normal Saline Bolus 500mL IV/IO Repeat every 5 min, max 1L
  - No
  - Yes
    - No
    - Yes
      - SBP ≥100
        - No
        - Yes
          - Consider TXA 1gm IV/IO over 10min As Appropriate
    - Go To Appropriate Trauma Protocol
    - M Norepinephrine 8-12mcg/min IV/IO Titrated to SBP >100 OR
      - Notify Receiving Facility, Contact Medical Control As Necessary

**Legend**

- EMT
- A-EMT
- P Paramedic
- M Medical Control

**Pertinent Positives and Negatives**
- Type of injury
- Mechanism (blunt vs. penetrating)
- Central and Peripheral Pulses
- Neuro Function Distal to Injury
- Time of Injury
- Deformity
- Diminished pulse / capillary refill

**Differential**
- Vascular Disruption
- Amputation
- Fracture, Dislocation
- Sprain, Strain
- Abrasion
- Contusion
- Laceration
- Compartment Syndrome

**Hypotension in Trauma needs blood products early**, so minimize scene time. Goal for scene time in major trauma cases should be <10 min. Remember the Triad of Death in Trauma – Hypotension, Hypothermia and Coagulopathy; IVF are important during resuscitation, but it is important to remember how fluids impact these three elements. Multiple casualty incident or obvious life threatening hemorrhage, consider Tourniquet Procedure and/or Hemostatic Dressing FIRST. Hemostatic Dressings are appropriate for hemorrhage that can’t be controlled with a tourniquet, such as abdominal and pelvic wounds. Signs/Symptoms of Shock include: altered mental status, pallor, hypotension (SBP <100), cap refill >3 sec, faint/absent peripheral pulses.
WMD / Nerve Agent Exposure – Adult, Trauma

**Pertinent Positives and Negatives**
- Type of exposure (heat, gas, chemical)
- Central and Peripheral Pulses
- Nausea, Vomiting, Diarrhea
- Chemical Name (if known)

**Differential**
- Exposure to Chemical, Biologic, Nuclear or Radiologic Hazard
- Time of Exposure (duration)
- Pesticide Exposure

**WMD / Nerve Agent Exposure Patient Management**

Consider provider safety, number of patients and early notification of receiving facility

Toxicity to the crew may occur from inhalation or topical exposure to the offending agent

DuoDote AND/OR Mark-I Kit may be used for civilians if cache released from the State of Wisconsin

**Legend**
- EMT
- A-EMT
- P
- Paramedic
- M
- Medical Control

**General Approach – Adult, Trauma**

1. **Stage, Call for Law Enforcement and/or Additional Resources**
2. **Scene Safe**
   - Yes
   - No
3. **Evidence of Exposure / Toxidrome**
   - Yes
   - No

**Asymptomatic**
- A
- Consider IV Access Protocol p55

**Minor Symptoms**
- Respiratory Distress + SLUDGEM
- A
- IV Access Protocol p55

**Major Symptoms**
- Altered Mental Status, Seizure, Respiratory Distress/Failure
- A
- IV Access Protocol p55

**Estimate Symptom Severity**

**DuoDote x 1 dose IM**
- IF AVAILABLE
- EMS Provider Use only
- May repeat x1 if symptoms return at 10 minutes

**Atropine 2mg IV/IO/IM**
- Repeat Q5 min until symptoms resolve

**Atropine 6mg IV/IO/IM**
- Repeat Q5 min until symptoms resolve

**Pearls**

**REQUIRED EXAM:** Mental Status, HEENT, Heart, Lungs, Abdomen, Extremity, Back, Neuro

- *Each DuoDote Kit contains 600mg 2-PAM and 2.1mg of Atropine. The kits in the ambulance are intended for responder use only. If/When the emergency cache has been released by the State of Wisconsin, those kits may be used for the general public.
- SLUDGEM – Salivation, Lacrimation, Urination (Incontinence), Defecation (Incontinence), GI Upset, Emesis, Miosis
- For patients with major symptoms, there is no max dosing for Atropine; continue administering until salivation/secretions improved
- Follow all Hazmat procedures, strictly adhere to personal protective equipment for exposure prevention and begin decontamination early
- Patients who have been exposed to organophosphates are highly likely to off-gas; be sure to use all responder PPE and to avoid exposure to clothing or exhalations of victims. Helicopter EMS is generally NOT appropriate for these patients.

**Notify Receiving Facility, Contact Medical Control As Necessary**
Public Safety Personnel Rehab – Special Operations

General Approach – Adult, Medical
- Log Member into Rehab Sector
- Assist in removal of all PPE

Baseline Assessment
- Chest Pain OR
- Shortness of Breath not Improving with O2 OR
- Irregular HR and/or HR >160 OR
- STEMI OR
- Syncpe, Disorientation OR Confusion OR
- Member Requesting Transport For Any Reason

Criteria for Entering Rehab
- Use of a 2nd 30-minute OR 45-minute self-contained breathing apparatus (SCBA) cylinder OR
- A single 60-minute SCBA cylinder OR
- 40 minutes of intense work without SCBA

Infection Control
Members with direct involvement with patient care or exposure to bodily fluids must be decontaminated fully prior to entry into the Rehab Sector and accessing rehab supplies.

Go To Appropriate Adult Medical Protocol

Notify Incident Command, Begin ePCR and Initiate Transport to Hospital

Notify Receiving Facility, Contact Medical Control As Necessary

Consider Transport to Medical Facility
- Hydrate orally
- Begin temperature controls based on member temperature and environment
- Rest for at least 10 minutes
- Reassess Vital Signs at 10 minutes

Abnormal VS (as Previous)

Consider Transport to Medical Facility
- Continue temperature controls
- Orally hydrate, consider IV Fluids
- Rest for 10 minutes
- Reassess Vital Signs every 5 minutes

Release Member From Rehab Division

Evaluate and Treat per Appropriate Adult Medical Protocol

的要求
REQUIRED EXAM: Mental Status, Skin Condition, Temperature, Heart Rate, Respiratory Rate, Blood Pressure, SpO2, SpCO
- This Protocol was named “Public Safety Rehab”, and should be applied to any situation during which Firefighters, Law Enforcement Officers, Emergency Medical Services or ANY Emergency Response Personnel are exerting themselves for > 40 minutes.
  - This INCLUDES training operations, special events and non-emergency operations lasting longer than 40 minutes.
- Per NFPA 1584 Requirements, the Rehab Site should be set up in a location that provides shelter for the members, is far enough away from the active scene that the turnout gear, SCBA and protective equipment may be safety doffed, and provide protection from the environmental conditions.
  - Ideally, members should be shielded from view of the active scene, to reduce anxiety and to prevent members from trying to exit rehab inappropriately.
- The purpose of this Protocol is to protect the physical and mental condition of members operating at the scene of an emergent or a training exercise and to prevent decompensation of the individual. By keeping the individuals safe, it improves the safety and integrity of the team as well as the operation.
- At a minimum, turnout coat and nomex hood should be removed and turnout pants pushed down to the knees while seated in Rehab.