



EMS in the Fire Service

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**This chapter provides required knowledge items for the following
NFPA Standard 1001 Job Performance Requirements:**

FFI 4.3

This chapter contains Skill Drills. When you see this icon, refer to your Skill Drill book for step-by-step instructions.



OBJECTIVES

Upon completion of this chapter, you should be able to do the following:

- Describe the role of the emergency medical system in the fire service
- Describe the role of the emergency medical service as it relates to firefighter safety
- Define the term “Standard of Care” as it relates to emergency medical care
- Identify the training requirements for emergency medical care in the United States
- Describe the basic rules of initial patient assessment
- List and describe the common types of medical emergencies encountered by firefighters
- Describe the proper procedures for the transfer of patient care

INTRODUCTION

The public has come to expect many things of their firefighters. When they don't know who to call, the fire department is often called to assist. From bringing a cat down from a tree to having a ring stuck on a finger, it is common for the fire service to respond to all types of emergencies.

Whether or not the fire department where you work or volunteer is fully integrated with an emergency medical service (EMS) system, it surely interacts as first responders work side by side with emergency medical technicians and paramedics. Whether called to vehicle crashes with injured people or an unconscious or unresponsive person at a local mall, firefighters are often the first to arrive and are expected to begin basic medical treatment until the arrival of personnel with appropriate training and expertise. Most fire department statistics show that 70%–80% of what they do is EMS related. Those are some staggering numbers; and as the baby boomer generation grows older, those numbers are more likely to increase. This chapter provides some introduction into the EMS service and covers some basic skills firefighters need to protect themselves from injury and disease as well as begin appropriate care of sick and injured patients. Just like in any emergency, the goal is to prevent further damage or injury and to stabilize the situation.

This chapter covers the basic steps needed to begin appropriate care after identifying some symptoms. Further training should be sought for more advanced care. Firefighters should *never* attempt to do more than their training has covered.

THE EMERGENCY MEDICAL SERVICES SYSTEM

EMS is part of a system generally initiated immediately after someone recognizes their need for service, regardless of whether it's after a motor vehicle crash, following a fall down a flight of stairs, or if they are having trouble breathing and feeling faint. When they call 9-1-1, or if a police officer calls in a request, the system goes to work. Through the work of fire chiefs, medical directors, and communications specialists working in a dispatch center, each jurisdiction determines what resources are sent for every type of call. The role of the new firefighters on an emergency medical incident is to learn from the more experienced firefighters and officers, but be careful to avoid causing more harm. Prepare a patient for the arrival of EMS crews and assist crews on the scene. The rewards of being a firefighter most often come from using your skills and training as well as seeing people's lives and property saved. Not everyone's belongings can be salvaged and not every life will be saved, but many are given the chance to survive through the efforts of the fire and EMS. As part of that EMS system, firefighters have the opportunity to positively affect lives.

FIREFIGHTER SAFETY

As in all aspects of firefighting, safety should remain among the highest priorities of every crew member. A firefighter would never enter a burning building without proper protective clothing and self-contained breathing apparatus (SCBA). Likewise, there are basic precautions and personal protective equipment (PPE) needed when providing emergency medical care. Issues related to infectious control include proper disinfection procedures to clean equipment prior to its use or just after it is used. Preventing contact and exposure to body fluids also is an important aspect of safety; and the use of PPE including gloves, eye protection or face shields, and respirators can help ensure exposures are limited or eliminated. Standard precautions mandate that gloves be worn during care and contact with all patients, regardless of their infection status. Additional measures should be employed for potentially infectious patients according to department and local protocols. Prior to and after wearing gloves and immediately after coming in contact with a patient's body fluids, firefighters should wash their hands and any other body parts that comes in contact

with body fluid, using a bacteria cleaning soap or other appropriate agent.

FFI 4.3 Every department should have policies in place to provide guidance on infection control. Firefighters should be thoroughly familiar with methods of isolating body substances. It should always be presumed that all body substances are infectious, and therefore appropriate PPE should be worn. Appropriate PPE may include gloves, protective eyewear, gowns, and masks. Always remember that handwashing is the first and best line of defense against infection.

Scene safety

An appropriate scene size-up should not be limited to building fires. One way firefighters can become proficient at completing a scene size-up is by doing so on every incident to which they respond, including an EMS incident. An EMS-related size-up includes determining where the exits are, establishing the best means for other providers to approach the building, and ensuring a safe working area.

You may need to call for apparatus to provide barrier protection or for law enforcement to move hostile citizens away from an injured patient. Assailants who attack their victims may still be on the scene. Be aware of your surroundings and be cautious, because it is likely that the assailant does not want their victim to be treated.

TRAINING AND STANDARD OF CARE

A single chapter on the role of a basic firefighter in EMS cannot provide enough training to cover the needed aspects of EMS care. However, because training is expanded and skills are developed, there is a duty to act as a trained firefighter or first responder. Determine the local fire department policies regarding a duty to act, and ensure an adherence to the policies. Failure to follow them may be cause for legal action against the provider and/or the department.

The U.S. Department of Transportation develops a national curriculum for EMS care. Each state and local jurisdiction adopts a set of patient care standards and treatment protocols and is required to operate under the license of a medical director. Regardless of your training, or whether you are paid or volunteer, treat every patient with respect. It is important to understand

what is expected of you as well as your role in the local EMS system.

HEALTH INSURANCE PORTABILITY AND PRIVACY ACT

The **Health Insurance Portability and Privacy Act (HIPPA)** established a national standard for privacy of an individual's health information. Enacted into law in 1996, it defines and limits the circumstances in which an individual's health information may be released. Generally, there are three circumstances under which the law allows health care to be disclosed:

1. To the patient or persons the patient requests information be given to (e.g., a patient asks you to call his or her spouse)
2. For the purposes of health care operations, including providing pertinent information to other EMS providers and medical personnel rendering care to the patient or any individuals assessing care to improve quality
3. For the purposes of obtaining billing information, which is not generally done by firefighters

Essentially, firefighters only pass on a patient's health care information to another health care provider. A patient's health care information should never be shared with the public or media or discussed afterwards in a location where people not involved in patient care might overhear you. As a firefighter who treats injured and ill patients, it is important to understand the law and thoroughly know the policies and guidelines within the jurisdiction.

CRIME SCENES

Invariably, firefighters and EMS providers are called to the scene of a crime. The role of firefighters on any emergency scene is always life safety: the victim's and their own. Caring for a sick or injured patient is only secondary to your safety. If the scene is deemed unsafe, immediately call for law enforcement.

If the scene is safe, patient care is the first priority. Do not disturb anything more than is required to care for the patient. If you must move equipment or materials,

remember its initial location. Remember, local law enforcement must account for where everything is and how it got there; and you may be expected to describe what you saw, what you moved, and its location before you moved it. Restrict entry into the area to those required to be there. When you have finished taking care of the patient, check with the local law enforcement to see if there is anything they require from you before leaving the scene. You should write a narrative including the what, where, when, and how of the events to help you recall everything that occurred. Sometimes providers are called to testify in court up to months or years after the actual incident, and the narrative may be the only way to accurately remember the incident.

REPORTING TO LAW ENFORCEMENT

Federal and local laws require that certain cases be reported to local law enforcement, such as possible child abuse, elder abuse, domestic violence, and sexual abuse. Reporting should not be done in front of the patient, caregiver, or parent. Check with the local policies to ensure that you adhere to any existing regulations. Failing to report certain incidents may make you and your department liable.

INITIAL PATIENT ASSESSMENT



One of the basic rules of EMS is called the ABCs of patient care:

- A = Airway
- B = Breathing
- C = Circulation

When evaluating a patient, one of the first things to do is determine the patient's level of consciousness. This is done by checking to see if the patient is alert, able to respond to verbal commands, or unresponsive. If the patient is unresponsive, the provider must ensure the patient has an open airway. The airway of an unconscious patient can be obstructed if the head is tilted downward, blocking the airway passages. There are two different ways to open the airway: one is for a nontraumatic injury and the other is for a potential trauma patient. For

a patient with a nontraumatic injury, the provider places his or her hand on the patient's forehead and the fingers of the other hand underneath the chin. Placing slight pressure on the hand and the fingers, the provider pushes the patient's head back to open the airway (fig. 26–1a).

If the patient may be suffering from a neck injury, the provider uses the jaw-thrust method of opening the airway. This time, the provider places his or her hands on each side of the patient's head, places the fingers along the jaw bone, and pushes the jaw open, which in turn opens the airway (see fig. 26–1b). If unsuccessful, revert to the head-tilt, chin-lift method previously described. Opening the airway is more important than the potential risk of a spinal injury.

Once an airway is established, it is necessary to ensure that the patient is breathing. One way to check for breathing is for the provider to place his or her ear near the patient's mouth and look, listen, and feel. The provider looks for chest rise and fall, listens for the breaths coming from the patient's mouth, and feels for the breath on their ear. If the patient is not breathing, the provider should be prepared to conduct rescue breathing.

Once the airway and breathing are completed, the provider should check for circulation. For an unconscious patient, the provider can check for a pulse by placing his or her index and middle finger on the patient's carotid artery in the neck. This can be done while looking, listening, and feeling for a breath (fig. 26–2).

For conscious adult patients, the radial pulse in the wrist is most often used to determine circulation. The brachial artery in the upper arm is used for infants younger than one year old. In addition to checking for breaths and circulation, knowledge of the rate of breathing and pulse rates can help the first responder determine treatment options. The Maryland Medical Protocol lists some average heart and respirations rates (table 26–1).

Once the patient's ABCs have been established, the provider should conduct a rapid primary patient assessment. This includes checking the patient beginning with the head and neck, moving all the way down to the bottoms of the feet and toes, and checking the patient for any major bleeding and/or deformities; generally only stop the assessment to deal with any major bleeding, which is covered in depth later in the chapter.



Fig. 26–1a. The provider places his or her hand on the patient's forehead and the fingers of the other hand underneath the chin.



Fig. 26–1b. The provider places his or her hands on each side of the patient's head, places the fingers along the jaw bone, and pushes the jaw open.



Fig. 26–2. The provider is looking, listening, and feeling for a breath.

Table 26–1. Average heart and respiration rates

Age	Estimated Weight	Heart Rate	Respiratory Rate	Systolic B/P
Premature	< 3 kg	160	< 40	60
Newborn	3.5 kg	130	40	70
3 mo	6 kg	130	30	90
6 mo	8 kg	130	30	90
1 yr	10 kg	120	26	90
2 yrs	12 kg	115	26	90
3 yrs	15 kg	110	24	90
4 yrs	17 kg	100	24	90
6 yrs	20 kg	100	20	95
8 yrs	25 kg	90	20	95
10 yrs	35 kg	85	20	100
12 yrs	40 kg	85	20	100
14 yrs	50 kg	80	18	110
Adult	> 50 kg	80	18	120

TRAUMA PATIENTS

Firefighters most commonly see trauma patients who have been involved in motor vehicle crashes. A motor vehicle crash can include multiple injuries, including head and spinal injuries as well as injuries to the extremities and eyes.

For possible multiple injuries on a trauma patient that may occur as a result of a vehicle crash or long fall, injuries to the head, neck, and spine should always be suspected. To prevent further injury, immobilization of the head, neck, and spine is of the utmost importance. Improperly treating a patient with a neck or spinal injury can lead to more severe injuries and possible permanent paralysis.

Cervical collars are generally used to limit a patient from moving his or her head after an injury. Prior to the placement of the cervical collar, the head is kept from moving by holding the head with both hands, using only enough pressure to keep the head still. If the patient is lying down on his or her back, position yourself above the head or in the backseat of a vehicle if the patient is being extricated from the front seat of a vehicle. Hold the head still, as shown in figure 26–3, until the appropriate immobilization device is completely applied. Continue manual stabilization of the head after the cervical collar is in place, while other providers assist in further immobiliza-

tion by placing the patient on a backboard to immobilize the spine. ABC should be assessed and reassessed periodically. Talking to the patient and providing reassurance can help to keep the patient calm.



Fig. 26–3. Hold the head still until the appropriate immobilization device is completely applied.

Burns are also classified as trauma injuries. The first goal of treatment for burn injuries is to stop the burning. This is often done with copious amounts of water. The second goal is to protect the burned area from further injury and reduce pain by covering the area with a sterile dressing. According to the 2008 Maryland Medical Protocols for EMS Providers, moist dressings using a sterile solution are allowable for burns covering less than 9% of the body surface area. Do not place ice or ice packs on any patient with burns covering more than 5% of the total body surface area. Providers should become familiar with estimating the percentage of burned area and know their local protocols for treatment, which are usually based on the total body surface area burned (see fig. 26–4, a diagram for a body surface area rule of nines).

When treating a patient with multiple injuries, it is important to consider the injuries that are most life threatening and treat those first. The ABCs of patient care should be among the first considerations, followed by spinal immobilization and then the splinting of arms and legs that may show signs of a fracture.

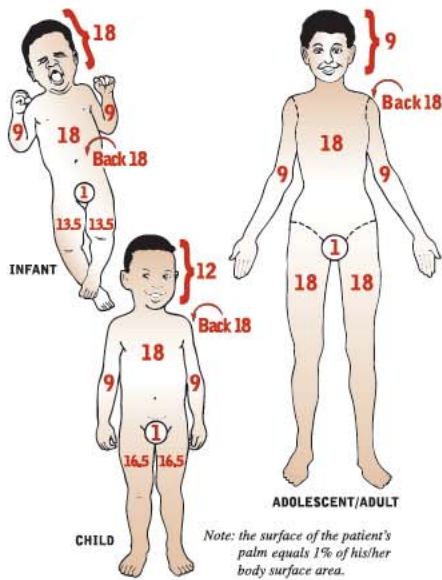


Fig. 26-4. The rule of nines

Fractures, dislocations, and sprains



It can be difficult for a field provider to distinguish the difference between a fracture, sprain, or dislocation. Without the benefit of an X-ray, even physicians may not be able to distinguish them. Regardless of the type of injury, the treatment is generally the same: They require splinting and immobilization. When examining an injured area, the provider should look for deformity, swelling, and bruising. It is possible to find a wound that suggests an **open fracture**, which is when a bone is broken and there is a wound through the skin in the same area as the break. The bone may be visible through the open surface of the skin. In this case take care to prevent contamination. In addition to splinting, the open area must be bandaged.

If the patient complains of pain when moving a possible fracture sight, do not attempt motion, unless it is necessary to prevent further injury to the patient. Prior to putting on a splint, check the extremity for a pulse to ensure that the fracture has not stopped the blood flow to the rest of the limb. Lack of blood flow between the injury site and the end of the limb may cause or be an indication of possible nerve damage. The patient should be transported to an appropriate medical facility without delay. Blood flow can be checked, as mentioned, by checking the pulse or by checking for capillary refill. It may be necessary to remove shoes, socks, and gloves to check appropriate blood flow. Capillary refill can be checked by gently pressing down on the fingernail or toe of the injured limb until the skin turns white. After

releasing the pressure, the nail bed should turn pink within 2 seconds, indicating that there is normal circulation. If it takes longer than 2 seconds, it may indicate a problem with circulation. Capillary refill should be checked before and after splinting. It should be noted that capillary refill is generally delayed in cold weather. In extremely cold weather, capillary refill may be an unreliable means of checking blood flow.

In addition to checking for a pulse or capillary refill, the provider should check the end of the limb for sensation and movement. Using the dull part of a pen or the eraser end of a pencil, gently rub the bottom of the foot or palm of the patient's hand, checking to see if the patient can feel it. Movement in the fingers and toes is a good indication that he or she has proper blood flow. As mentioned, if movement of the fingers and toes causes pain, it should be minimized.

Splinting can be done in a variety of ways, generally using commercially available splints secured with gauze. Splinting of long bones like arms and legs that don't involve joints can be a relatively simple task. Splinting shoulders, elbows, knees, and ankles can be complex and require more finesse, whereas pelvic and hip fractures as well as femur fractures (the long bone in the thigh) can be life-threatening injuries. A femur fracture, for example, can cause the large muscles (quadriceps and hamstring) to constrict, causing the two bone ends to draw inward. This type of fracture requires providers to put traction on the injury site and use specialized traction splinting to prevent further injury. Improper splinting, either too tight or too loose, can cause more damage. Therefore, providers should receive appropriate training in splinting before trying it. Unless you have been properly trained in splinting, simply make the patient as comfortable as possible and wait for the appropriate level of care to arrive.

MEDICAL EMERGENCIES

Medical emergencies can be caused by a variety of sicknesses and medical conditions. Providers are not trained to determine causes or diagnose medical conditions. That is why the main focus is to treat the symptoms displayed by the patient. After checking the ABCs of a patient and conducting an initial assessment, firefighters should attempt to determine the medical history of the patient. The SAMPLE format is the most common method of obtaining pertinent history from a patient, family member, or friend. **Signs and symptoms** reported

by the patient are the first piece of information needed. Next, ask about any **allergies** to medications or foods. Obtain a complete list of medications the patient is presently taking. Gathering pill bottles or a current written list from the patient or family can expedite obtaining this information. Past medical history should be acquired. Important questions to ask include whether the patient has previously been hospitalized and, if so, for what conditions. Determine if the patient has a history of diabetes, seizures, high blood pressure, stroke, heart problems, or breathing difficulties like asthma or lung disease. Ask when the **last meal** the patient ate was and how much food he or she consumed. Finally, inquire about the *events* leading up to the current problem. Any information found during the assessment should be recorded and communicated to the incoming EMS units.

Seizures are among the more common medical emergencies to which the fire service responds. In addition to attempting to obtain as much information as possible about the patient, check the ABCs and wait for EMS personnel. For patients who are actively seizing, prevent them from further injury; do not attempt to restrain seizing patients, and never put anything in their mouths. Protect their heads from hitting hard surfaces, and move them to a safer location if possible. Often, when patients stop seizing, they are sleepy, confused, and may be hostile. Continue to monitor the ABCs until the transport unit arrives. If patients are unconscious or unable to stay awake, they should be placed in a side lying or **recovery position**.

Another common medical emergency is for a patient who is suffering from chest pains. A variety of things can cause chest pains, such as heart attack, heart failure, and angina pectoris. Regardless of the specific condition, the pains are generally caused by a lack of oxygen to the heart. If personnel have been trained in oxygen therapy, oxygen can be applied as soon as practical. Until more advanced care arrives, place the patient in a position he or she finds most comfortable, reassuring him or her as much as possible by talking to and learning more about the patient's medical condition, medications he or she takes, and any other medical history that can be obtained. Never give a patient anything by mouth. If the patient asks for assistance with taking medication, the provider is usually permitted to assist but is not allowed to administer medications. This means that the provider may be able to provide a drink of water, but putting a pill in a patient's mouth is beyond the scope of a provider's training.

Generally, the same steps can be taken for most medical emergencies. Always check the ABCs, obtain as much

medical history as possible, check for any medical alerts (fig. 26–5), and make the patient as comfortable as possible until EMS personnel arrive on the scene.



Fig. 26–5. A medical alert bracelet

Heat exhaustion and heat stroke

Heat exhaustion can result when the body loses water as a result of heavy sweating. After a prolonged condition of heat exhaustion, heat stroke sets in. **Heat stroke** is caused when the body's ability to release heat is overcome. Even when properly treated, heat stroke is often fatal. Patients who are suffering from heat exhaustion feel light-headed, dizzy, and/or nauseated. A heat stroke patient has flushed dry skin (because they have lost the ability to sweat), may be semiconscious or unconscious, and have a high temperature. These patients should be moved to a cool location. Encourage the patient to drink fluids unless they are vomiting. Heat stroke patients should be cooled immediately. This can best be accomplished by stripping them down to their underclothes and soaking them with water. There should be no delay in transporting a heat stroke patient to an appropriate medical facility.

Frostbite

Frostbite occurs when uncovered parts of the body are exposed to extremely cold temperatures. Frostbitten skin can look white or waxy and may be firm or frozen. Swollen and blistered skin may be possible as well. Never rub or massage a frostbitten area. Patients should be removed from the cold and protected from further injury. Rewarming is best done in a medical facility where there are controlled conditions and should not be attempted in the field unless transport is excessively delayed. Avoid using heating devices or stoves. Patients cannot feel the frostbitten area, and it may cause more damage by burning the area. Initially, frostbite can be treated by using body heat (i.e., putting frostbitten fingers under the arm). Jewelry should be removed; and if the patient is wearing wet clothes, they should be removed if possible.

BLEEDING

**SKILL
DRILL**

After determining the ABCs of a patient and conducting an initial assessment, it is important to stop and address any major blood loss of a patient. There are three main methods of controlling the loss of blood: direct pressure, elevation, and pressure points.

Direct pressure consists of placing a dry and sterile dressing on the injury site and applying pressure. To maintain the direct pressure, wrap the wound with gauze; it should be tight enough to ensure that pressure is maintained but not so tight it cuts off the circulation to the area beyond the injury. Elevation involves raising a wounded leg or arm above the level of the heart while maintaining direct pressure. Elevation is done in addition to direct pressure, if that alone fails to stop the bleeding. If bleeding persists and the bandaging becomes blood soaked, additional bandaging should be applied.

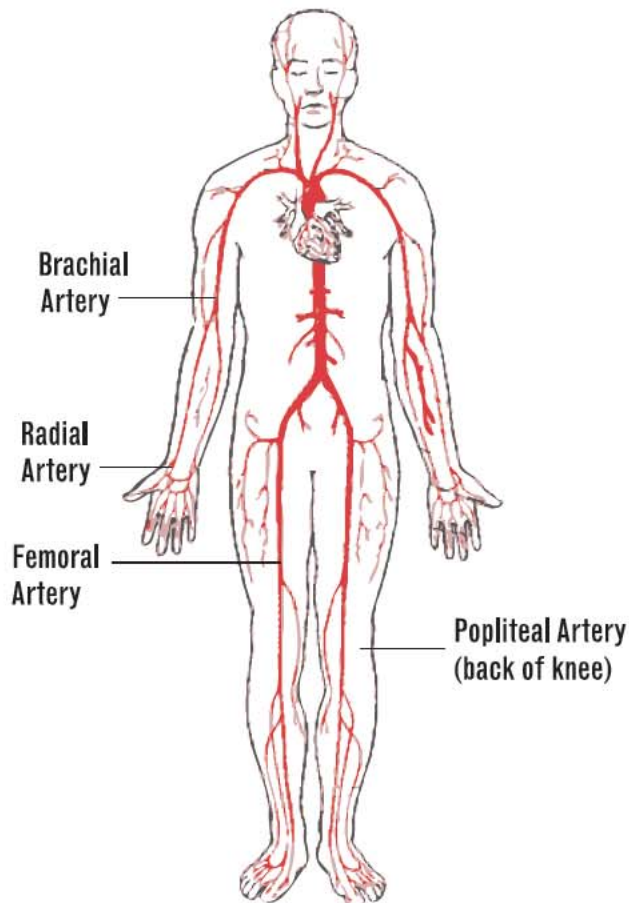


Fig. 26–6. The two main pressure point areas affecting the arm and the leg

If the direct pressure and elevation fail to control the bleeding, the provider may need to apply pressure directly to the appropriate artery to restrict the blood flow, like a hose clamp restricts water flow on a fire hose. Figure 26–6 shows the two main pressure point areas affecting the arm and the leg. Bleeding that continues despite these attempts may require application of a tourniquet, so follow local protocols. Whenever there are open wounds to a patient—whether they are caused by an **open fracture**, an abrasion, puncture, laceration, or avulsion—it is always the goal to control the bleeding; prevent further contamination by wearing appropriate PPE; use sterile dressings; immobilize the affected area; and when dealing with an impaled object, stabilize the object to prevent further injury and discomfort (fig. 26–7).

Presume that all body fluids and substances are infectious. Therefore, standard precautions should be taken when encountering body fluids and substances.



Fig. 26–7. When dealing with an impaled object, stabilize the object to prevent further injury and discomfort.

CHILDBIRTH

Commonly, the fire department is among the first to assist a mother in labor. Most events are not emergencies, but they may require some initial assistance to prevent a mother or child from becoming injured during labor. Actions should be taken until the arrival of personnel with greater training; transport of the mother should not be delayed.

The area where a baby develops in a mother's womb is called the uterus. The baby in the womb receives nutrients from the mother through the umbilical cord attached to the placenta. Attached to the wall of the mother's uterus and the baby inside the womb, the placenta is enveloped in a sac called the amniotic sac and is filled with amniotic fluid. There are three main stages of labor. Stage one is when the mother begins to sense initial contractions, indicated by typical labor pains. The provider should note the time and duration of the labor pain. When contractions begin to come approximately 1–2 minutes apart, and last for more than 1 minute each, the provider and mother should prepare for the baby's birth.

Sometimes the mother may announce that her “water has broken” meaning that the amniotic sac has released the amniotic fluid. This is nothing to cause alarm. The provider should check the mother's vaginal area and determine if the baby is **crowning**, which is when a part of the baby emerges from the vaginal opening (fig. 26–8). It should be noted that the average time of a mother having a first baby is more than 15 hours. Therefore, the provider should determine how long the mother has been having contractions, if this is her first baby, or if she has had multiple births. Labor and delivery times can be significantly shorter for a mother who has had multiple births.



Fig. 26–8. A crowning baby

The provider should use a sterile sheet to drape the mother and prepare to wrap the baby on arrival. Keep the area clear of unnecessary bystanders and unneeded providers. Allow the mother to get comfortable, laying on her back; raise the buttocks, if possible, with her knees drawn up and spread apart. Make sure the mother is as comfortable as possible and ensure the vaginal area is clear of any obstructions, including clothing. Baby delivery is a natural process that can often be done with little assistance. The main role of a provider is to prevent injury and assist in the case of a complicated delivery, which would require immediate transport to an appropriate facility.

As the baby begins to emerge, place one gloved hand below the baby's head to provide support; avoid placing pressure on the baby's head and spread the fingers to avoid pressing down on the soft spots (known as fontanelles). If the amniotic sac has not broken, the provider can puncture the membrane around the baby's head and pull it away from the mouth and nose. Allow the baby to continue to come out naturally, never pulling the baby. When the head emerges, ensure that the umbilical cord is not wrapped around the baby's neck; if it is, gently unwrap the cord from the neck using two fingers to bring the cord forward and over the baby's upper body. After the shoulders and feet emerge, continue to support the baby and check the baby's airway.

Once the baby is completely delivered, place the baby on his or her side with its head slightly lower than its body. Check on the exact time of birth. Once the infant begins to breathe, tie the umbilical cord halfway between the baby and mother to stop blood flow through the cord. Although it is preferable to use a sterile umbilical tie or commercial clamp, a shoelace will suffice in an emergency. Assure that the tie is sufficiently tight to stop blood flow through the cord. Initially, only one tie is needed. Cutting the cord can await the arrival of providers with additional training.

Shortly after the baby is delivered, the placenta emerges from the mother's vaginal area; the placenta should be kept intact and wrapped in a plastic bag if possible. Keep the baby warm and dry and the mother as comfortable as possible.

If any complications arise during childbirth, the mother and baby should be transported to the closest appropriate medical facility. Complications could include significant bleeding, unusual presentations such as a foot or arm instead of the head, or appearance of the umbilical cord in the vaginal opening prior to seeing the baby's head.

TRANSFER OF PATIENT CARE

As a firefighter on an EMS call, one of your main jobs is to stabilize the patient until the arrival of personnel with a higher level of EMS training. A proper assessment is started when the call is dispatched, and evaluation of the scene and the patient begin on arrival. When the emergency medical technician and/or paramedics arrive on the scene, it may be your responsibility to advise them of pertinent information. Sometimes this is relayed via radio prior to their arrival.

Information about the current condition of the patient can help incoming EMS providers prepare their action plan to assist the patient. It prompts them to consider what equipment they need upon their arrival, particularly if it's different from what the initial dispatch information provided. When they arrive be prepared to give them a brief report of what you saw when you arrived, what actions you took, and any history of the patient you obtained (e.g., the patient advised that he took a nitro tablet, a common medication for heart patients, 5 minutes before you arrived).

Sometimes, the EMS providers request assistance in getting a patient loaded onto the transport unit. Every firefighter should become familiar with their local EMS providers and their equipment, how to take the stretcher out of the ambulance, and how to put it back in with a patient on it. Often a wheeled chair device (i.e., stair chair) is used to bring patients down stairs where a stretcher cannot fit. There are also several devices used to immobilize patients after a motor vehicle crash. The Kendrick Extrication Device (KED®) is commonly used. Providers should be familiar with the type(s) of devices used in their local jurisdictions. If used improperly the specialized equipment used by EMS providers can cause injuries; therefore, it is vital to become familiar with them (fig. 26–9).



Fig. 26–9. A wheeled chair device, or stair chair

Remember, it is not one person's job or one individual crew's responsibility to provide care. As a firefighter on an EMS call, you are part of a system designed to bring the best possible outcome to a person in need. The transition of care is a vital link in the EMS system. Your work is not necessarily over when the EMS crew arrives. Ask them if they have any questions or if they need anything before you leave the scene.

QUESTIONS

1. You are a member of an engine crew that arrives first to a bicyclist who has been hit by an automobile. The rider is lying in the road with an obvious open fracture to his left lower leg. What personal protective equipment will you wear to help your patient, and what universal precautions will you need to consider after the patient has been transported away from the scene?
2. The Health Insurance Portability and Accountability Act (HIPAA) was enacted into law in 1996. Under what three circumstances can you as a firefighter disclose information about your patient to others?
3. Discuss why the ABCs of medical care are three of the most important patient concerns you will have while treating your patient.
4. Discuss the procedures for checking a pulse in a patient. Include the differences for an unconscious versus conscious patient and adult versus small children patients.
5. You are on the first arriving engine to a bleeding call. Upon arrival you find a 29-year-old male sitting on the house porch with a deep bleeding gash in his left arm just above the elbow. Describe your actions in treating this patient.
6. Your engine crew is the first arriving units to an automobile that has run into a telephone pole. The only occupant is the 17-year-old male driver who is still seated in the car. He is conscious and speaking. He has an open fracture below the right knee. Explain how you will direct other crewmembers to provide neck stabilization and how you will splint the open fracture.
7. You are assigned to an engine company fighting a house fire on a hot July day. Upon exiting the house and going to the rehab area your partner states he does not feel well. How would you determine if he is suffering from heat exhaustion or heat stroke?
8. You are conducting your morning truck checks in the station when a car screeches to a stop at the station door the woman driver gets out of the car asking for help. She explains to you that she is nine months pregnant, her water has broken, and her contractions are less than a minute apart. She was trying to make it to the hospital but the pain was too great. Discuss your actions to help this patient including actions to help birth the baby.
9. Upon arriving at the scene of a supposedly unconscious victim you realize the patient has in fact been shot. He is still alive. Describe your concerns from a safety standpoint and from an evidence preservation standpoint.
10. You are the first arriving unit to an altered level of consciousness call. Upon arrival you find a 50-year-old woman talking nonsense and is weak. She is surrounded by several family members who state this is not her normal behavior. What are some of the questions you will ask the family, and what are some of the things you are looking for to determine the patients needed treatment?