

# Introduction

*Our training program is designed to acquaint you with Forest View Volunteer Rescue Squad. The training manual is intended to be a guide, and to answer frequently asked questions. Of course, it cannot cover every possible question that may arise. This responsibility falls to the Lieutenant in charge of your crew.*

*Welcome to the Forest View Family*

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Name: \_\_\_\_\_  
 Crew: \_\_\_\_\_ Lieutenant \_\_\_\_\_

### FVRS New Thirds Checklist

Check boxes are for each time the skill is completed, ALL of the boxes DO NOT need to be checked if the third has mastered the skill BEFORE all of the boxes have been checked. The Lieutenant decides and will sign off on the skill when he/she believes the third has mastered their technique. There is no time limit to this checklist, but the list must be completed before the third is allowed to ride on other crews.

Check boxes should be checked as followed:  = Skill mastered (also initial)    I = Needs Improvement     = Not competent

<b>Safety: Practices safety/proper BSI precautions</b>	<b>Lieutenant's signature when skill mastered</b>						
BSI – Wears gloves							
Exits truck safely on MVA							
Wears a vest on MVA's							
Stays with crew on calls							
Demonstrate Backing Techniques							

<b>Equipment: Demonstrates knowledge of ALL equipment on truck</b>							
Arrives early for check out							
Locates items on truck							
Locates equipment on calls							

<b>Cleaning:</b>							
Cleans stretcher after calls							
Cleans truck after calls							
Helps keep station clean							
Restocks supplies after calls							
Knows where hampers and stockrooms are at hospitals							

<b>Vitals:</b>							
Blood Pressure							
Pulse							
Respirations							
Blood Glucose							

<b>O<sub>2</sub> Supplies:</b>							
Nasal Cannula							
Non-Rebreather							
nebulizer assembly							
Switch out small O <sub>2</sub> tank							

Name: \_\_\_\_\_ Crew \_\_\_\_\_

Lieutenant: \_\_\_\_\_

### Advanced Thirds Checklist

This sheet is a *guide* to assist you in *preparation* to precept AIC. Everything on this list must be completed in order to be considered for preception. Your Lieutenant must also feel you have demonstrated you are ready to precept. She/he will sign the bottom of the sheet when it is completed and she/he feels you are ready. The sheet must then be turned into the training team in order for you to be considered for the AIC preception process.

Check boxes are for each time the skill is completed, all of the boxes do not need to be checked if the third has mastered the skill before all of the boxes have been checked. The Lieutenant decides and will sign off on the skill off when she/he believes the third has mastered their technique. There is no time limit to this checklist, but the list must be completed before the sheet is turned in to the training team.

Check boxes should be checked as followed: = Skill mastered I = Needs Improvement =Not competent

Skills	Lieutenant's signature when skill mastered						
King Airway							
Combitube	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Standing backboard							
Palpated BP							
Automatic AED use -Zoll							
AED use on Lifepack							
C-Pap assembly							
Radio Traffic							
Knowledge of TAC use							
Map Reading							
PPCR – Visual Fire							
MIVT – fill out							
Autopulse – band change							

Classes to be taken:

Certificates (if applicable) must be turned into the training officer, and signed by that officer.

Class Name	Date Taken	Training Officer's Signature
CPR Certification – up to date		
EMT – Basic		
HAZMAT		
NIMS (IS 700) (internet)		
IS 100 (internet)		
IS 200 (internet)		
AIC class at FVRS		

\_\_\_\_\_ has all items on this list.

\_\_\_\_\_ Date \_\_\_\_\_  
Lieutenant's signature

\_\_\_\_\_ Date \_\_\_\_\_  
Training officer's signature

# Brief History of Forest View

The Forest View Volunteer Rescue Squad was formally organized on July 14, 1955 after nine men met to discuss how to make their neighborhood a safer place to live. The original members purchased and converted an old Buick hearse into an ambulance. It was parked next to the squad's new donated building, formally a "chicken house". The first president was Mr. R. L. Cavan.

In 1956 the new squad answered its first call, a woman having seizures at the Sunset Drive-In Theater. That year, the squad answered a total of 85 calls for help. By December, the squad had 41 members, 2 ambulances and a bank balance of \$1,295.35.

On May 20, 1963 a new squad building was dedicated at 5327 Forest Hill Avenue. A new addition was added to the building in 1966 consisting of 4 additional bays, a meeting room, kitchen, and sleeping facilities.

In 1969, due to growth in northern Chesterfield, the squad began running calls from a converted horse stable on Grove Road in Midlothian. In June 1981, a new building for Station 2 was dedicated. As the calls continued to increase, the need was felt for a third station. On December 10, 1993, Station 3 was dedicated. Located at 8008 Midlothian Turnpike, Forest View Station 3 is the largest building and serves as the headquarters for the organization.

Over the years the squad has grown from a "Chicken House" and a "Horse Stable" to three operating stations, from 9 members to 231 Senior Squad, Auxiliary and Junior members and from 1 converted hearse to 7 ambulances, a quick response vehicle and a chief's car. The calls have increased from 85 calls in 1956 to 6,847 calls in 1984 and over 11,000 calls a year today. Our training started with first aid and our level of service has increased to Advanced Life Support.

We, the members of Forest View Volunteer Rescue Squad are very proud of our accomplishments over the past 55 years and look forward to continuing our volunteer service to the citizens of our community.



# AUXILIARY HISTORY

The Forest View Auxiliary held its first meeting on January 30, 1957 to support the senior squad. During the early years fund raising projects included selling fruit cakes, having bake sales, and yard sales. Many of these projects were held during the year and at that time we thought our profits of \$500 to \$1,000 were outstanding. Today, we have one fund raising project, better known as the Picture Project, which gives us \$100,000 annually. These funds have purchased ambulances, a first responder vehicle, and paid for items at all three stations. Over the years we have helped with dispatching calls, being hostesses at dinners and meetings, Brunswick stew sales, and riding calls. We are proud to be a part of the Forest View team.



# JUNIOR SQUAD HISTORY

The Forest View Junior Squad was organized in June 1963 with a membership of 12. For many years Juniors were only allowed to assist in keeping the building, grounds and equipment clean and running. In the summer of 1965, Juniors were allowed to run their first emergency calls on an ambulance. Their training began with basic First Aid. Our Juniors continue to participate in Senior Squad and Auxiliary fundraisers. They have always competed on a statewide level, winning many trophies and awards. The Junior Squad is a vital part of our organization.



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# FOREST VIEW STATION LOCATIONS

## Station 1

5327 Forest Hill Ave  
Richmond, VA 23225  
804-232-8971

## Station 2

901 Grove Rd  
Midlothian, VA 23114  
804-794-8258

## Station 3 and Headquarters

8008 Midlothian Tnpk.  
Richmond, VA 23235  
804-330-2574

## Mailing Address

PO Box 36153  
Richmond, VA 23235  
FAX: 804-272-1969

## Website

[www.fvrs.org](http://www.fvrs.org)

## **GENERAL MEMBERSHIP MEETINGS**

**WHEN:** Held quarterly (March, June, September, and December) on the third Thursday of each month, except December when it will be on the second Thursday

**WHERE:** Forest View – Station 3

**WHAT:** Meeting begins promptly at 1930. Dinner (provided by the Auxiliary) and CEU training begins at 1830

**WHO:** Mandatory for ALL members of Forest View Rescue Squad, including senior and junior squads, auxiliary, active and associate members.

## **JUNIOR SQUAD MEMBERSHIP MEETINGS**

**WHEN:** Held monthly on the third Sunday of the month

**WHERE:** Forest View Station 3

**WHO:** Open to Junior Members

## **BOARD OF DIRECTORS MEETINGS**

**WHEN:** Held the 2<sup>nd</sup> Thursday of every month, unless otherwise indicated on the website. Check website for current schedule

**WHERE:** Forest View – Station 3

**WHO:** Mandatory for Executive BOD Members and Operations Leadership. Open to all members.

## UNIFORMS

### Primary:

Pants: Black, (no denim), non-pleated for males

Belt: Black or white with plain belt buckle

Shirt: Long or short sleeved white button up with squad patch on left sleeve, EMT patch on right sleeve, and American flag over left Breast.  
FVRS Polo Shirt is allowed May 1<sup>st</sup> – September 1<sup>st</sup>, or when heat index >100° F

NOTE: FVRS Long sleeve or short sleeve T-shirts are NOT permitted at any time

Boots: Black, hard-soled shoes or boots (preferably steel-toed) may be purchased from Red Wing Shoes or Heroes

Jacket: Regulation style black

NOTE: Members will be loaned a squad jacket to wear until their probationary period has expired. At that time, a new jacket will be ordered. Active AIC's and Drivers will be issued a new Jacket which must be returned to the squad when they become inactive.

Hat: (optional) Black ball cap with FVRS or Forest View Rescue embroidered on the front

Watch: a watch with a second hand should be worn when riding in order to obtain vital signs while on duty.

### Secondary:

Jumpsuit: Black coveralls with reflective striping and FVRS reflected lettering on back. This is optional and is available for individual purchase from Heroes.

NOTE: the jumpsuit may be worn when riding after 2200 until EOT, when pulling extra duty without 24 hours advance notice, and during sever inclement weather.

## **General Appearance:**

- Make sure your uniform is clean, unwrinkled and in serviceable condition before you report to duty. No other patches, pins, or insignias, except for squad service pins, may be worn on uniforms.
  - Uniforms are supplied by Heroes Uniforms. FVRS sweatshirts, polo shirts, and T-shirts are available through FVRS fund drives.
  - DO NOT wear perfume, cologne or aftershave. Many people have severe reactions or may develop nausea and vomiting.
  - Do maintain proper personal hygiene
  - Make up is allowed, but should look natural and not over-done
  - Long Hair must be kept securely tied back. Unsecured hair may be pulled by patients, entangled in equipment, or become dirty from blood, vomit, and other bodily fluids.
  - Jewelry should be conservative, no dangling or hoop earrings as they could be pulled out accidentally or intentionally while on a call.
  - Large rings could tear gloves, increasing risk of exposure to bodily fluids
  - Do not wear expensive Jewelry, it may get lost or damaged
  - Bring a spare change of clothes in case yours become wet, soiled, or contaminated.
  - During inclement weather, dress warm by layering your clothing. (White or Black turtle neck shirts are permitted to be worn under your squad-issued shirt)
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## WHAT TO EXPECT WHILE ON DUTY (And what is expected of you)

**BE ON TIME** – you should arrive 30 minutes before the start of your shift

**Equipment Check** - Each member is responsible to help check out the unit. Checking equipment helps new members become familiar with the location of the equipment and ensure that the unit is stocked properly and all equipment is in good working order. The unit cannot be marked up until it is properly checked out.

**Unit Maintenance** - Please make sure the unit is clean at all times. All equipment and supplies should restocked and be put away in its proper place after EVERY call and before the end of your tour. DO NOT empty trash located in RED biohazard bags at the squad or at the hospital unless it is emptied into a RED trash can that is labeled BIOHAZARD. If biohazard trash is found in non-biohazard waste bins, the squad (or hospital) can be fined thousands of dollars for mishandled biohazard waste.

**Meals** – you may bring your own food, but most members elect to eat out. Bring money. You may also want to bring a snack in case it is too busy to eat right away. For weeknight shifts, plan on eating dinner while on duty. For weekend shifts, plan on eating breakfast, lunch and dinner. Eating with your crew helps build camaraderie – whether you prepare your meal in the station or dine out.

**Training:** Ongoing training should occur on every shift. This is your time to ask your AIC questions and practice skills or learn how to use or maintain a specific piece of equipment

**Phones** – Personal phone calls on squad phone lines should be limited to 5 minutes. When answering the phone, be professional and say “Forest View, Station (1,2, or 3), this is (YOUR NAME), how may I help you?” Do not give out member phone numbers to non-members, if requested. Simply take a message and contact the

member yourself. Personal cell phones may be carried and used when not on a call. When in public, maintain a high level of professionalism.

**911 Calls into the station:** if someone calls the station requesting an ambulance for an emergency, there are certain things you need to find out and steps to take:

1. Name of the caller
2. The Address of the Caller
3. Phone number of the caller
4. Nature of the problem (ex. Chest Pain, shortness of breath, weakness, etc)
5. Advise the caller to call 911
6. Contact the non-emergency dispatch number and give them the information received from the caller (they will dispatch the closest available unit)
  - a. Chesterfield Dispatch: 804-748-1431
  - b. Richmond Dispatch: 804-254-1116

(Note: if you are uncomfortable with this task, ask the provider or driver to take the call)

**Internet Use** – the internet is available for use on station computers and should be limited to training or squad business. Wi-fi is available for personal computers/laptops. Please use social networks (Facebook, Twitter, My-Space) responsibly. Posting information regarding calls may be a HIPAA violation. Under no circumstances should you take or post pictures of patients, accident scenes or FVRS equipment, documents or personnel, nor should you post comments regarding calls to which you respond.

**Security** – lock your purse or any valuables in your car. The squad is not responsible for any lost or stolen items.

**Station Maintenance** – Each member is responsible for cleaning up after him or herself. This includes the following: wash dishes that you have used, empty all full trash cans or ones with food in them, straighten the dispatch and day room areas, and make your bed. Place dirty linen in proper receptacles and on weekend duties, wash all dirty linen. Please be courteous. Others do not want to clean up after you.

**Sleep** – you may get some sleep while on duty – there is never a guarantee. In case you do, you may want to bring a sleeping bag, pillow, toothpaste and toothbrush. Separate dorm rooms are available for male and female members.

## WHAT TO EXPECT ON A CALL

- When your unit receives a call, the station tones will go off. Quickly respond to the ambulance
  - When the ambulance is moving, either to a call or just to dinner always be sitting down with your seatbelt buckled. While responding to a call, the driver may need to stop or turn suddenly. If you are not buckled up, you may get hurt in the back of the ambulance. There will be time to organize and gather supplies once the ambulance has stopped on scene.
  - The AIC will tell you what equipment and or bags to bring into the call. Help carry in equipment, or if possible, load it all onto the stretcher. Never leave the unit without gloves and wear them on ALL calls. It is a good idea to have an extra pair in your pocket in case one pair becomes torn or contaminated.
  - Do not exit the unit on scene until the driver and AIC have exited. Be careful when getting out of the unit especially on accident scenes or calls on the interstate. You may be walking near traffic and many drivers are watching the accident. Call and not where they are going. Wait for the driver or AIC to instruct you as to which door you should exit from.
  - Always listen to your AIC on scene. They are the ONLY person in charge of the crew during a call. They need to know where you are at all times on scene so stay with them unless they ask you to do something else. Never wander off on scene of a call.
  - Always be aware of the big picture” while on a call. If a situation becomes hazardous or violent, the crew will need to leave immediately. If you notice something that may be a hazard or potentially violent (i.e. Gun, knife, or any other weapon on scene) tell the AIC so that they may decide on the best course of action. If you need to leave the scene in a hurry, leave all equipment behind, your safety is much more important than material goods.
  - Always be especially aware of your surrounding on potentially violent or hazardous calls. Potentially violent or hazardous calls include:
    - Assaults

- Shootings or stabbings
  - Domestic violence
  - Suicide attempts
  - Psychiatric patients
  - Intoxicated patients
  - Large crowds
  - Fires
  - HazMat incidents
  - Interstate calls or busy traffic
- 
- On many of these calls, our crews are NEVER the first to intentionally enter the unsecured scene. The ambulance will stop a safe distance away and wait for the dispatcher to say the scene is secure. This is known as “staging”. Police will handle all calls with potential violence first, and they will tell us when we can safely enter. The fire department/HazMat teams will first enter any fire/HazMat scene and determine the safest place for our crew.
  - While on scene of any call, the only reason to talk to family or bystanders is if the AOC asks you to find out pertinent medical information on the patient. If the family or anyone else asks about the patient’s condition, never give your impression. Be supportive to family members and friends, but don’t give false hope. If asked repeatedly about a patient’s condition, simply say something like “I am not a doctor, but we are taking him or her to the hospital so that they can see what is wrong” or “we are doing everything we can.”
  - Never talk to any member of the media while on a call or at the hospital. The only person allowed to speak with the media is the President of FVRS. Defer all questions to him/her but be polite.
  - When the AIC determines the patient needs to go to the hospital, the third will generally get the stretcher and set it up. Make sure there is a pillow, a sheet, and a blanket. Ask for help if you cannot get the stretcher to the patient by yourself. Always make sure there are enough people to safely lift the patient, and always use proper lifting techniques to avoid injury. When the patient is on the stretcher, make sure you are always holding on with two hands.
  - When the patient is in the ambulance, the AIC may ask you to assist with such things as: taking vital signs, setting up oxygen, IV’s controlling bleeding and many other tasks. If you are asked to do something that you are not comfortable with, let the AIC know. They will either ask someone else to do it or do it themselves. Never pretend that you know how to do something when you don’t. Ask for help! Never make up vital signs! If you are not sure what you got ask someone else to check behind you.

- Let the AIC talk to the patient while en route to the hospital. They have lots of questions to ask the patient while filling out the PPCR. If you notice something that the patient needs immediately, tell the AIC, but never second guess the AIC's patient care in front of the patient, family member or ER staff. IF you have a question about what they are doing, ask after the call unless the patient's health is in immediate danger.
- Once at the hospital, the thirds need to assist the crew in transferring the patient to the ER stretcher. Upon completion, the thirds is responsible for cleaning and decontaminating the unit and stretcher and placing clean linen on the stretcher. All supplies need to be restocked. Make sure to restock exactly what was used. If the oxygen from the blue bag was used, make sure it is above 1000 psi. If below 1000 psi, the oxygen tank needs to be exchanged with a full one. Make sure the trash is emptied and that biohazard waste is properly disposed of in RED biohazard bags/cans.
- Once the unit is ready, go inside and wash your hands. At this time, you may get a drink, use the bathroom, etc. Make sure your crew knows where you are in case of a call. Thirds have been left at the hospital before.
- After the call, when you are back in the ambulance or at the building, you may ask any questions about the things that you did not understand or do not know how to do. Remember that being a third is a learning experience and the best way to learn is to ask questions. Use your crew for learning; they are a valuable source of information.

## PATIENT CONFIDENTIALITY

All information about every call and every patient is confidential. Do not discuss the call with people not directly involved with the situation. You are encouraged to discuss the call with your crew, especially for high stress or anxiety calls. CISM is available at any time.

Do not speak with members of the press or TV crews. Only the President or the Chief is designated to do this.

Do not discuss the patient's condition with family members. If the family member insists, then refer them to the AIC.

All requests for copies of call sheets for legal purposes must be obtained through a subpoena; refer such requests to the President or the Vice President.

**REMEMBER: WATCH WHAT YOU SAY AND WHERE YOU SAY IT. YOU NEVER KNOW WHOSE FRIEND OR FAMILY MEMBER IS SITTING NEARBY.**

For further information, refer to the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II)

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Acronym	Stands For	Refers to
AED	Automated External Defibrillator	Device used in cardiac arrest to perform a computer analysis of the patients cardiac rhythm and deliver defibrillatory shocks when indicated.
AIC	Attendant in charge	Refers to the person on the ambulance who is the primary care provider for the patient and is in charge of the crew on the ambulance.
ALS	Advanced Life Support	Care provided to patients with use of drugs, advanced invasive airway procedures using cardiac monitor defibrillators, and advanced knowledge and judgment; these skills are generally reserved for pre-hospital care providers trained above the EMT-Basic level
BBVRS	Bensley-Bermuda Volunteer Rescue Squad	A volunteer rescue squad in the Southern end of Chesterfield county
BLS	Basic Life Support	The basic set of life support skills, including CPR, oxygen administration, spinal immobilization, splinting and hemorrhage control provided by a trained EMT-B or higher.
BP	Blood Pressure	
BSI	Body Substance Isolation	Isolation of substances that are excreted from the body to prevent the spread of communicable diseases through the use of gloves, masks, eye shields, gowns, etc.
BVM	Bag Valve Mask	Aka AMBU-BAG, used to assist with ventilating a patient, available in pediatric and adult sizes
CID	Cervical Immobilization Device	Used to immobilize the head and neck when an injury is suspected
CISD	Critical Incident Stress Debriefing	See CISM (below)
CISM	Critical Incident Stress Management	A professional group to help those involved with high stress incidents in order to cope with their feelings; used to debrief after a high stress incident such as an MCI, death, or a major injury.
CFD	Chesterfield Fire Department	
CF&EMS	Chesterfield Fire and EMS	
CJWCC	Chippenham-Johnston Willis Chippenham Campus	
CJWJWC	Chippenham-Johnston Willis – JW Campus	
CPD	Chesterfield Police Department	
CPR	Cardio Pulmonary Resuscitation	
EMT-B	Emergency Medical Technician (Basic)	Basic level of emergency medical technician education as identified by the Department of Transportation (DOT) guidelines; provides basic emergency medical care
EMT-I	Emergency Medical Technician (Intermediate)	EMT with additional education in assessment over the EMT-B Level; trained to provide IV therapy and a limited selection of medications
EMT-P	Emergency Medical Technician (Paramedic)	The most advanced level of pre-hospital emergency care provider; has advanced assessment skills and is trained in a wide variety of invasive interventions; the EMT-P can use a variety of medications, IV solutions, and other advanced treatment techniques
FRV	First Response Vehicle	(See QRV)

<b>FVRS (aka FVRS)</b>	Forest View Volunteer Rescue Squad	The wonderful organization that you have just joined that provides coverage in Chesterfield County and the City of Richmond
<b>HDH F/P/R</b>	Henrico Doctors Office Forest, Parham Campus or Retreat	HCA hospitals located on the North Side of the James in Henrico County
<b>HEAR</b>	Hospital Emergency Access Radio	A VHF radio; used to call the hospital to give a patient report
<b>HazMat</b>	Hazardous Materials	Chemical substances that are toxic to humans
<b>ICS</b>	Incident Command System	System used by EMS, Fire and Police used to control an emergency scene and complex emergency operations
<b>Jump Seat</b>		The seat in the back of the ambulance located directly behind the driver
<b>KED</b>	Kendrick Extrication Device	A piece of equipment used at an accident to immobilize the patients head and upper torso in an effort to remove them from a vehicle or other sitting position to a stretcher
<b>MCI</b>	Mass Casualty Incident	Any incident involving one or more patients that cannot be handled by the first responding units to the scene
<b>MCV</b>	Medical College of Virginia	Old name for VCU Health System located in downtown Richmond
<b>MRMC</b>	Memorial Regional Medical Center	A Bon Secours hospital located in Hanover County
<b>MVA</b>	Motor Vehicle Accident	
<b>MVC</b>	Motor Vehicle Collision	
<b>MVAH</b>	McGuire Veterans Affairs Hospital	AKA the VA, located in South-side Richmond
<b>MVRS</b>	Manchester Volunteer Rescue Squad	A volunteer rescue squad serving the central portion of Chesterfield County
<b>NC</b>	Nasal Cannula	Used to deliver low flow oxygen; available in adult and pediatric sizes
<b>NRB</b>	Non-Rebreather Mask	A mask used to deliver high concentration of oxygen to patients in acute respiratory distress; has a reservoir bag and a one-way valve to prevent rebreathing ; available in adult and pediatric sizes
<b>O2</b>	Oxygen	
<b>OPA</b>	Oropharyngeal (Oral) Airway	An airway adjunct designed to prevent airway obstruction by the tongue in unconscious patients
<b>PMH</b>	Past Medical History	Significant past medical illnesses or traumatic injury that the patient has experienced
<b>Packaging</b>	Aka Patient Packaging	Preparing the patient for transfer to the ambulance
<b>PPCR</b>	Pre-hospital Patient Care Report	AKA "Call Sheet"; used to document patient information
<b>PR</b>	Pulse Rate	Number of heart beats per minute
<b>QRV</b>	Quick Response Vehicle	Usually staffed by ALS providers to assist a BLS ambulance; Also used in inclement weather to obtain access to a patient where 4-wheel drive is needed
<b>RAA</b>	Richmond Ambulance Authority	A paid ambulance service for the City of Richmond; also dispatches calls to FVRS units marked up in the city
<b>RASI</b>	Richmond Ambulance Services, INC	Former name for RAA –the name has stuck and is commonly used
<b>RCH</b>	Richmond Community Hospital	A Bon Secours hospital located in the City's Church Hill area

<b>RFD/RFES</b>	Richmond Fire Department	AKA Richmond Fire and Emergency Services
<b>RPD</b>	Richmond Police Department	Manages the Department of Emergency Communications in The City; serves as the public safety answering point for the City of Richmond
<b>RR</b>	Respiratory Rate	How many times per minute the patient completes one full Cycle of inspiration/expiration (breathing in AND out)
<b>Signal 33</b>		MAYDAY used only if you or your partners life is in immediate Danger; the orange button on the hand held radios and EMERGENCY buttons in the units are used to notify dispatch of a Signal 33
<b>SOP</b>	Standard Operating Procedures	
<b>SFMC</b>	St. Francis Medical Center	Bon Secours hospital located off of 288 and Lucks Lane in Midlothian
<b>SMMC</b>	St. Mary's Medical Center	Bon Secours hospital located in the near west end, off of Monument Avenue
<b>THIRD</b>		The third (or fourth) person on the unit; provides support to the AIC; helps maintain the unit while on duty
<b>WEVRS</b>	West End Volunteer Rescue Squad	Volunteer rescue squad providing services in the City of Richmond



Name: \_\_\_\_\_  
 Crew: \_\_\_\_\_ Lieutenant \_\_\_\_\_

### FVRS New Thirds Checklist

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Check boxes should be checked as followed: = Skill mastered (also initial)    I = Needs Improvement    =Not competent

**Safety: Practices safety/proper BSI precautions**

Lieutenant's signature when skill mastered

BSI – Wears gloves							
Exits truck safely on MVA							
Wears a vest on MVA's							
Stays with crew on calls							
Demonstrate Backing Techniques							

**Equipment: Demonstrates knowledge of ALL equipment on truck**

Arrives early for check out							
Locates items on truck							
Locates equipment on calls							

**Cleaning:**

Cleans stretcher after calls							
Cleans truck after calls							
Helps keep station clean							
Restocks supplies after calls							
Knows where hampers and stockrooms are at hospitals							

**Vitals:**

Blood Pressure							
Pulse							
Respirations							
Blood Glucose							

**O<sub>2</sub> Supplies:**

Nasal Cannula							
Non-Rebreather							
Nebulizer assembly							
Switch out small O <sub>2</sub> tank							

Switch out Lg O <sub>2</sub> tank							
Assemble BVM							

**ALS Supplies:**

Set up /placement of 4 lead							
Set up of 12 lead ECG							
Assembly saline lock							
Able to set up IV line							
Assembles saline lock <u>kits</u>							

**Backboarding/Splinting**

Holds C-Spine properly							
Assist with backboarding							
Assist with vacuum splints							
Assist with board splints							
Assist with stairchair							
Properly uses stretcher							
Knowledge of KED use							
Reverses Stretcher							
Knowledge of Traction Splint							

**Operations: Score as /knowledgeable: Y=Yes N=No**

Knows chain of command							
Understands radio traffic							
Able to call/clear a mayday							
Answers phone correctly at station							
Knows how to call <u>communications if needed</u>							
Knows how to navigate <u>website/schedule</u>							
Knows location of all three <u>stations</u>							

AIC Comments \_\_\_\_\_  
 \_\_\_\_\_

Lieutenant Comments: \_\_\_\_\_  
 \_\_\_\_\_

Has mastered all skills in primary checklist \_\_\_\_\_

Lieutenant Signature



Name: \_\_\_\_\_ Crew \_\_\_\_\_  
 Lieutenant: \_\_\_\_\_

## Advanced Thirds Checklist

This sheet is a *guide* to assist you in *preparation* to precept AIC. Everything on this list must be completed in order to be considered for preception. Your Lieutenant must also feel you have demonstrated you are ready to precept. She/he will sign the bottom of the sheet when it is completed and she/he feels you are ready. The sheet must then be turned into the training team in order for you to be considered for the AIC preception process.

Check boxes are for each time the skill is completed, all of the boxes do not need to be checked if the third has mastered the skill before all of the boxes have been checked. The Lieutenant decides and will sign off on the skill off when she/he believes the third has mastered their technique. There is no time limit to this checklist, but the list must be completed before the sheet is turned in to the training team.

Check boxes should be checked as followed: = Skill mastered    I = Needs Improvement    =Not competent

Skills	Lieutenant's signature when skill mastered						
King Airway							
Combitube	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Standing backboard							
Palpated BP							
Automatic AED use -Zoll							
AED use on Lifepack							
C-Pap assembly							
Radio Traffic							
Knowledge of TAC use							
Map Reading							
PPCR – Visual Fire							
MIVT – fill out							
Autopulse – band change							

Classes to be taken:

Certificates (if applicable) must be turned into the training officer, and signed by that officer.

Class Name	Date Taken	Training Officer's Signature
CPR Certification – up to date		
EMT – Basic		
HAZMAT		
NIMS (IS 700) (internet)		
IS 100 (internet)		
IS 200 (internet)		
AIC class at FVRS		

\_\_\_\_\_ has all items on this list.

\_\_\_\_\_ Date \_\_\_\_\_  
 Lieutenant's signature

\_\_\_\_\_ Date \_\_\_\_\_  
 Training officer's signature



# Understanding Vital Signs

## INSIDE THIS ISSUE:

Why are Vital signs Important?	1
Pulse	2
Blood Pressure	3
Respirations	4
Pain Scale	4

## Why are Vital signs Important?

Vital signs are an important component of patient care. They determine which treatment protocols to follow, provide critical information needed to make life-saving decisions, and confirm feedback on treatments performed. Accurate, documented vital signs are a very important part of EMS.

Vital signs are VITAL! They give health care professionals a quick, easy way to determine if someone is sick, or how sick they are.

So what are they?

**Heart Rate:** Simply, how many times your heart beats per minute. The normal range for an adult HR is typically placed at 60-100 and can be further described as weak/strong, regular/irregular, etc.

**Blood pressure:** A measure of many things - how much blood or "volume" a person has, how a person's heart is working, and how the rest of the body is responding to those things. Normal blood pressure should be less than 120/80. Of course, this guideline is meant to classify high blood pressure, and LOW

blood pressure is also dangerous!

**Respiratory rate:** How fast a person is breathing in breaths per minute. The normal range is about 12-20 respirations per minute - AT REST.



## Normal Vital Signs

Vital signs include the heart beat, breathing rate, temperature, and blood pressure. These signs may be watched, measured, and monitored to check an individual's level of physical functioning.

Normal vital signs change with age, sex, weight, exercise tolerance, and condition.

Normal ranges for the average healthy adult vital signs are:

- Blood Pressure: 90-130 systolic is considered acceptable. 130-140 is 'pre-hypertension'
- Breathing: 12 - 18 breaths per minute

Pulse: 60 - 80 beats per minute (at rest)

Temperature: 97.8-99.1 degrees Fahrenheit (Average 98.6 degrees Fahrenheit)

### Quick Summary to Taking a Pulse:

Place Index finger and Middle finger just below thumb and feel for throbbing of radial artery.

Count for 15 seconds and multiply by 4 or count for 30 seconds and multiply by two.

See. Picture below:



To find pulse on neck place same two fingers just below corner of jaw and press finger in corner where jaw meets the neck.

See picture below:



## Pulse

A pulse is created as blood is pushed along through the arteries. The artery contracts and relaxes periodically to rhythmically force the blood along its way circulating throughout the body. This coincides with the contraction and relaxation of the heart as it pumps the blood through the arteries and veins. Therefore the pulse rate is also known as the heart rate.

-joint as well as just above your big toe. Most of these are a little more difficult to locate for the lay person. The apical pulse is taken by listening through a stethoscope over the heart.

### Relax and Count

Once you find your pulse in your wrist, relax and take a few deep breaths. Rest your hands comfortably on your abdomen on chest and using a watch or clock with a second hand, begin counting the beats

### Radial Pulse

The radial pulse is taken over the radial artery in the wrist. The index and middle finger are used for this. You should not use a thumb as the thumb has a pulse as well and could give false readings.

### Don't Use Your Thumb

Press your index and middle finger into the groove along the inside of the wrist. You may need to move your fingers up or down the arm a few centimeters until you find

(throbbing). You need to count for at least 15 seconds. For a more accurate pulse rate you should count for a whole minute.

### Multiply to Get the Rate

If you counted for 15 seconds, you'll multiply the number of beats you counted by 4 to determine the pulse or heart rate. Pulse rate is recorded as the number of beats in one minute. So if you counted 15 beats, the pulse rate would be  $15 \times 4 = 60$  beats/minute. If

the best spot to feel your pulse. You may have to press a little harder if you don't feel it. But don't press so hard that you obliterate the pulse.

### Other Arteries You can Palpate for a Pulse

Your pulse may also be felt along the carotid artery in the side of you neck just below your jaw; and in such places as in your groin, behind your knee, on top of your foot just below the ankle- Cont'd

you counted 18 beats the pulse rate would be  $18 \times 4 = 72$  beats/minute.

### The Resting Pulse Rate

The normal resting pulse rate for an adult will range from 60 to 80 beats/minute. If you have just climbed a set of stairs, run a mile, or been performing other activities, you would expect your heart rate/pulse to be faster.

### Reasons for a Fast Pulse

If not due to recent activity, a rapid pulse rate may be due to such things as a fever. If the person is anemic or dehydrated (hypovolemic) the pulse rate would also be faster. A rapid pulse can also be due to drugs such as caffeine, nicotine, cocaine,

or theophylline.

### Slow Heart Rates

Athletes may have slow heart rates. Patients taking drugs such as beta-blockers, or calcium channel blockers may also have slow heart rates. During sleep or deep relaxation, your pulse rate will slow as well.

## Blood Pressure

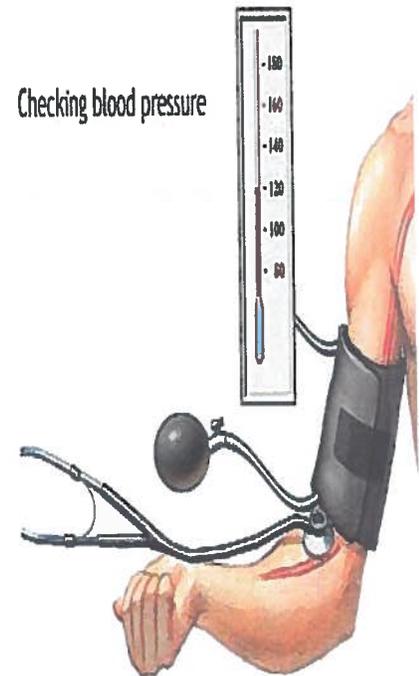
Blood pressure is the pressure exerted on the wall of the artery or vein as blood is pumped through the body. Blood does not flow readily; it surges along with each beat of the heart. The wall of the arteries is thicker than the veins and as such much more force is generated allowing us to record that pressure.

As the blood is pumped through the vessels

turbulence is heard. These sounds are created by turbulence as the blood begins to flow through the arteries after the blood pressure cuff has temporarily stopped the flow by the pressure exerted as it was inflated. When the sound is first heard, this is the systolic pressure; and when the sound ceases as the turbulence ends, the diastolic pressure is determined.

### Systolic and Diastolic pressure

As blood is pumped through the body it exerts pressure on the veins and arteries. The systolic pressure is the pressure as the heart contracts and pumps the blood. The diastolic pressure is the pressure in the vessels when the heart is at rest between beats. Blood pressure is recorded as a fraction such as 110/70. The systolic pressure is the top number and the diastolic number is the bottom number.



### Influencing Factors:

Factors that can influence blood pressure readings include proper cuff size for the size of the arm, activity, emotions, posture, medications, alcohol consumption, temperature and diet.

### Taking the BP

To take a blood pressure, the person should be sitting comfortably and relaxed. Sleeves are pushed up or the shirt removed to reveal a naked arm as clothing can

interfere with the pressure of the inflated cuff as well as hearing the Karotkoff sounds.

The sphygmomanometer is placed on the upper arm. It is centered over the brachial artery which is located in the crook of the elbow. The gauge should be placed so it can be easily read. There is usually a place on the cuff to clip it on. Once the cuff is secured, raise the arm to heart level, place your arm underneath it to support it and ask the

person to relax their arm.

Palpate (feel for) the brachial pulse and place the diaphragm of the stethoscope over this spot. Place the ear pieces on the stethoscope into your ears. Listen to the brachial pulse.

Close the valve on the bladder of the cuff and begin to squeeze the bulb. Continue squeezing until the needle on the gauge reads at least 180 or until it is 10mmHg above where you last heard the pulse as you inflated the cuff. Cont'd

### Some Precautions

Never take a blood pressure in an arm with:

- An IV line or heparin lock in place
- A dialysis or other fistula or shunt.
- On the same side as a mastectomy.
- An arm that has a traumatic injury.

Some people cannot hear this and so it is usually pumped up to 180-200mmHg on the gauge.

Open the valve slowly and allow the cuff to deflate by 5mmHg/second while you listen to the artery. When you first hear the Karotkoff sound this is the systolic pressure. Continue deflating the cuff until you

no longer hear the Karotkoff sound. This is the diastolic pressure. At this point you can open the valve completely to allow the cuff to deflate rapidly. If you did not hear clearly, wait at least one minute before repeating the procedure.

In general, optimal blood pressure is considered

less than 120 systolic and 60 -70 diastolic. According to the [American Heart Association](#), a blood pressure of less than 120/80 is optimal. Blood pressure of more than 140 systolic or 80 diastolic is considered to be high and should be evaluated.

## Respirations

Oxygen is exchanged in cells for carbon dioxide which is carried back to the lungs to be exhaled from the body. Respiration is essential to life.

Information obtained from:

Quan, K. (2006). Vital Signs: Assessing pain, pulse, Blood Pressure, Respirations. *Suite101.com*, Retrieved from [http://healthfieldmedicare.suite101.com/article.cfm/vital\\_signs\\_\\_counting\\_respirations](http://healthfieldmedicare.suite101.com/article.cfm/vital_signs__counting_respirations).

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### Respiration is controlled by Your Brain

When more oxygen is needed, or an excess of carbon dioxide needs to be exhaled, the brain signals the lungs to increase the respiratory rate and/or to increase the volume of air exchange by breathing deeper. Sometimes an underlying disease process interferes with this signal or the lung's ability to cooperate.

Breathing is an involuntary act controlled by the brain. It can be temporarily controlled consciously such as holding your breath, or purposefully breathing deeper or slower.

### Counting Respirations

To count respirations, you need a clock or watch with a second hand. Respirations should be counted when you (or the patient) are at rest. Try to distract the person from knowing you're counting respirations as sometimes this awareness can cause the person to change their breathing pattern.

Often the nurse or doctor will count your pulse first and continue to hold your wrist while it rests on your chest or abdomen. You think they're counting your pulse the whole time, and they've counted both your pulse and respirations.

### Don't Double Count

One respiration involves one inhalation and one exhalation. If you're watching the chest rise and fall, you need to count either the rising or the falling only. Count for a whole minute to obtain an accurate respiratory rate.

### Average Respiration Rates (at rest):

Newborn to 1 year ; 40 to 60 per minute  
 1 to 6 years: 18-30 per minute  
 7 years to Adult: 12 to 24 per minute

These rates can vary with underlying illness or disease.

## Assessing Pain

Pain is often called the fifth vital sign. In conjunction with temperature, pulse, respirations and blood pressure, pain can reveal a tremendous amount about the health status of a person. Pain also affects the quality of life through its effect on such things as mood, activity, appetite, sleep, hygiene, and the ability to focus and concentrate.

### Numerical Pain Scale

The numerical pain scale, (from Margo McCaffrey RN, MS, FAAN and Chris Pasero RN, MSNc in their book, *Pain Clinical Manual, 2nd edition*, 1999, p.63) uses a scale from 0 to 10; where 0 represents no pain and 10 represents the worst pain imaginable.

In addition to the pain scales, health care professionals will ask questions to determine the quality of the pain and how it affects your functioning. These include:

- Where is the pain?
- When did it start?
- What makes it worse?
- What helps to ease it?
- Is it sharp, dull, aching, throbbing, shooting, burning?

### How does the pain affect your life:

- Sleep patterns
- Eating
- Activity patterns
- Your mood and emotions
- Is it affecting your family?
- Does the pain affect your physical appearance, your



# Thirds Skills

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Safety	1
Oxygen	2
Back Boarding	2
Splinting	3
Cleaning after calls	3
Operations	4
Communications	4

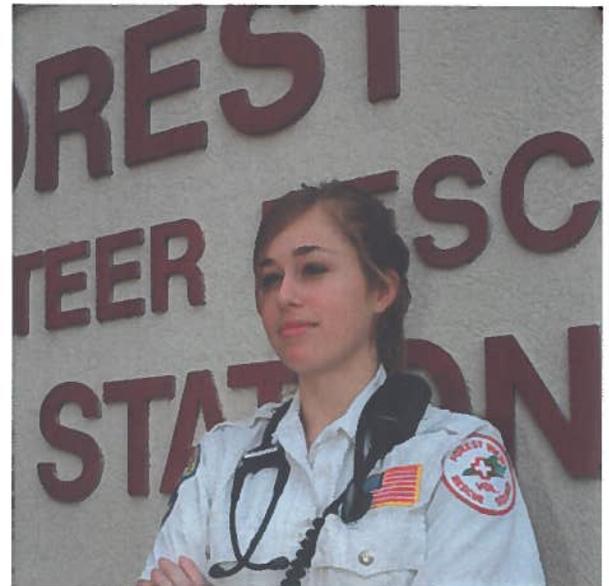
## What is a Third?

On an ambulance there are several positions that can be staffed to respond to calls:

1. Driver- Responsible for operating the vehicle to the call.
2. Attendant in Charge (AIC) or Provider- The officer of the ambulance in charge of the crew and patient care.
3. Third- The assistant to the ALS or BLS provider (AIC) who gathers vitals and helps with patient care.

The position of third is very important to the delivery of efficient and effective patient care. Thirds are very involved in treating patients and offers exposure to many parts of EMS.

A third; however, has to follow the same rules as



the crew. So what does this mean? This means the Third must wear their safety vest whenever operating in a highway or street. They must show up to duty on time, which means 15-20 minutes prior to duty to check out the unit. The third should participate in crew functions: cleaning, training, and other activities. Thirds play a vital role to the team and are an extra set of hands

that is needed when the going gets tough.

You should take pride in being a third. Not only can you provide accurate information to the AIC, but you can be a part of saving a life. Take the information you learn and become an expert because this is the first step in becoming a future AIC or Driver.

## Safety

Safety is the number one concern of our members. You should make sure you are always listening to your provider, aware of your surroundings, and using the safety equipment that is available to you in all appropriate situations.

-Make sure you are wearing gloves on all calls that you respond to. This is to protect you from any body substances.

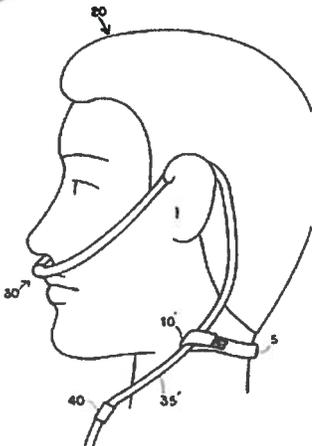
-Always wear your safety vest when operating in lanes of travel. i.e. highways, streets, and parking lots.

-Make sure you stay

with the crew at all times. Do not wander off for any reason. You should only leave the crew to retrieve a piece of equipment and or to set something up in the ambulance after being instructed to do so.

### How to apply a Nasal Cannula:

1. Make sure the oxygen bottle is full and turned on (Remember: Righty tighty, lefty losey)
2. Connect tubing to oxygen tank
3. Make sure the two nose prongs are pointed towards the patient.
4. Wrap tubing behind and ears so that it meets underneath the chin.



### Oxygen, Donnahue, 2009

A **nasal cannula** is a plastic tube with two small prongs that are inserted into the victim's nose. This device is used to administer oxygen to a breathing victim with minor breathing problems. Oxygen is normally delivered through a nasal cannula at a low flow rate of 1 to 6 LPM. Nasal cannulas also can be used if the victim does not want a mask on his or her face.

A **resuscitation mask** with an inlet valve may be used with emergency oxygen to give rescue breaths to breathing and non-breathing victims.

The recommended flow rate when using a resuscitation mask is 6 to 15 LPM.

### Backboarding

A **long spine board (LSB)**, or **backboard**, is a medical device used for the immobilization and transportation of patients with suspected spinal injuries. Backboards are used to prevent movement of the spine which may cause permanent injury. They are most often used by prehospital care providers such as EMTs and Paramedics.

Spine boards are typically made of wood or plastic, although there has been a strong shift away from wood boards due to their higher level of

A **non-rebreather mask** is an effective method for delivering high concentrations of oxygen to a breathing victim.

Non-rebreather masks consist of a face mask with an attached oxygen reservoir bag and a one-way valve, which prevents the victim's exhaled air from mixing with the oxygen in the reservoir bag. Flutter valves on the side of the mask allow exhaled air to escape freely. As the victim breathes, he or she inhales oxygen from the bag.

Because young children and infants may be frightened by a mask being placed on their faces, consider a blow-by technique. The rescuer, parent or guardian should hold a non-rebreather mask approximately 2 inches from the child's or

infant's face. This will allow the oxygen to pass over the face and be inhaled.

The **reservoir bag** should be sufficiently inflated (about two-thirds full) by covering the one-way valve with your thumb before placing it on the victim's face. If it begins to deflate when the victim inhales, increase the flow rate of the oxygen to refill the reservoir bag.

The flow rate when using this device is 10 to 15 LPM.

A **Bag Valve Mask (BVM)** can deliver an oxygen concentration of 90 percent or more.

A BVM can deliver up to 100 percent oxygen to a breathing or non-breathing victim when attached to emergency oxygen.

Squeezing the bag as the victim inhales helps deliver more oxygen. BVM flow rates should be set at 15 LPM or more.

maintenance required to keep them in operable condition and to protect them from cracks and other imperfections that could harbor bacteria. There are also Short Spine Boards, but the short spine board is rarely used now due to the presence of superior equipment such as the Kendrick Extrication Device.

Backboards are designed to be slightly wider and longer than the average human body to accommodate the immobilization straps, and have handles for carrying the patient. Most backboards are designed

to be completely X-ray translucent so that they do not interfere with the exam while patients are strapped to them.

Backboards are almost always used in conjunction with the following devices:

- a cervical collar with occipital padding as needed;
- side head supports, such as a rolled blanket or head blocks made specifically for this purpose, used to avoid the lateral rotation of the head;
- straps to secure the patient to the long spine board, and tape to secure the head

## Splinting, Willis Lamm 2005

In treating fractures, an unhurried and careful approach is best. Few fractures are life threatening unless mishandled. Check the patient for any more serious injuries. Ensure your patient is breathing and that excessive bleeding is controlled and that all open wounds are protected as best you can from contamination. After these elements are

satisfied you can deal with stabilization of the fracture.

In general, don't try to reposition fractured limbs. Unless you know what you are doing, you could sever an artery or nerve. If out on the trail with help a long way off, practicality may necessitate slight repositioning in order to accommodate make-do splinting. In such

situations if a limb has no pulse or is turning purple, repositioning may relieve some unnatural pressure which is pinching off an artery, however the rescuer must consider that a mishandled attempt could result in a jagged bone end severing the compressed artery, making a bad situation much worse!



*"Always know where all the equipment on the ambulance is located. You will be called upon as an expert to grab equipment wherever it may be."*

## Splinting,

Willis Lamm 2005

To put this tricky situation in perspective, Brady's *Emergency Care*, 6th Edition states:

"Angulations make splinting and transport more difficult. They can pinch or cut through blood vessels and are painful for the patient. They must, however, be repositioned so they can be splinted. **Not** to splint would be more dangerous."

**DO NOT** try to straighten

angulations of the wrist, ankle or shoulder or attempt to straighten any dislocated joint!

Long bone fractures in the legs and arms can benefit from mild traction when splinting. For arm fractures where you have help during splinting, one person can grasp the arm above and below the fracture site and apply a smooth, steady pull until your helper can apply the splint. If you encounter a

firm resistance, crepitus or the patient experiences a significant increase in pain, do not attempt traction. Do the best you can to splint in the position found. Once you successfully apply traction, do not release it until the splint is securely supporting the limb, otherwise the retracting bone end will cause additional tissue damage and possibly injure a nerve or artery.

## Cleaning after calls!

Units should be ready to respond to calls at all times. This means that once we drop patients off at the hospital the cleaning should begin right after the patient is turned over to the ER staff. This includes:

-Cleaning the stretcher after calls.

-Cleaning the ambulance after calls.

-Restocking the ambulance after calls,

-Knows where the hampers and stockrooms are at hospitals.

This is not the only part of cleaning. The ambulance should be wiped down at the beginning of the shift

and between patients.

This ensures that germs are not passed between patients. The units should also be washed at the beginning of the shift.

These steps will ensure that we have clean ambulances inside and out.

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Lamm, Willis. (1995). "FRACTURES AND SPLINTING". Retrieved from <http://www.whmentors.org/saf/fracture.html>

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## Operations

...we strive to deliver high quality, pre-hospital emergency medical care and rescue services... Sound familiar? It should, it is part of our mission statement. Emergency medical response; everything else we do is to support this. Our operations structure is not unlike many other public safety organizations. It is considered a "para-military" organization. We have a Chief, two Deputy Chiefs, a senior operations Lieutenant, Lieutenants for each shift, and one for our Associates. Along with those officers, we have two Safety Officers, two Infection Control Officers, two Information Technology Officers, a Logistics Officer, a Communications Officer, and a Building and Grounds Officer.

We follow a specific chain of command to identify who we report to. This is especially important during a call for service. Delays in treatment as a result of communication problems can have adverse effects on our patients. Organization is imperative to making a chaotic situation manageable. Remember, things are supposed to get better when we arrive on scene and begin the steps of patient care. As a new member, your officer will be the Lieutenant of the crew you are assigned to. As soon as you are placed on a unit, you will report to the AIC (while on that ambulance or medic unit).

Forest View Rescue Squad is a large entity with many assets, a large coverage area, and room for many volunteers to help deliver service. We're glad you have decided to join our team, and we are committed to helping you achieve your goals. It is our hope that you strive to become part of the Operations team in the future.

## Communications

Communication is more than sending a message. It also involves receiving, understanding, and sometimes responding to the message. How we communicate determines how well things run, or don't run in all organizations. The methods of communication we use depend on the situation. They are radio, pager, telephone, text messaging, e-mail, Facebook, and yes, even face-to-face conversations!

We will be discussing acceptable methods of communication throughout our time together, but for now, let's break the subject into two pieces. The first is communicating while on a call, and second is all the other times. Make sense? OK...

On a call – We receive our call information via the radio, computer, or pager. Once on scene we must listen for information from dispatch or other responding units. Among our crew and other responders on the scene it is face-to-face. We try to be nice by asking for things, but it is really an order, and we expect it to get accomplished quickly. There will be plenty of time after the call to discuss feelings and question decisions. However, in front of the patient is not that time. Please remember there is a time and place for everything.

All other times – Some of the most important communications you will have are with your crew lieutenant. It is very important to have a regular dialogue with him / her on duty assignments. Leaving voice mails and unconfirmed texts or e-mails is no way to communicate an absence. If you are unable to work on your shift night, communicate that to your officer. Same goes for late arrivals or early departures. Remember that we work together as a team. If your team doesn't know what you're doing, or where you are, you have let them down by not communicating effectively. They are depending on you to do what you say, just as you are depending on them for the same thing.



# Assisting the AIC, ALS vs. BLS

## How can you be an efficient and effective third?

by, cvtips.com

### INSIDE THIS ISSUE:

Being an Effective Third	1
What is ALS and BLS?	2
What is an IV?	2
How to set up a 12 lead	3
Checking a patients Glucose	3

We have all heard the old saying 'there is no I in team'. Aside from the chuckles that this slogan can get out of people, it is actually a wise piece of advice that many people would be wise to heed and follow. Being a team player is not something that takes away from the value of the individual, but rather increases it dramatically. We would like to use this article to make the case for the huge value in being a team player.

Let's first look at the dynamic of the team concept- in the ideal team, people of varying talents and interests share their abilities in a common cause for the benefit of the team itself as well as the benefit of the members of the team. As an example, albeit a simple one, consider the concept of moving a



couch from one room in a house to another. If one person tried to do this, the results could be counterproductive at best and painful to the body at worst. Anyway, in the couch example, let us assume that a muscular bodybuilder, an expert in special relationships and an interior decorator got together to accomplish the moving of said couch.

Using the muscles of the bodybuilder, the knowledge of the spatial relationship expert to determine the best use of the available space, and the color matching talents of the interior decorator, the couch can easily be placed in the best space possible.

In the end result, the three team members have a comfortable place to sit and share the story of their success! Taking this example and applying the team concepts to say a job of a third. If you can demonstrate your skills and abilities you will have a greater chance of being an efficient and effective third. Make sure

you are able to carryout specific tasks in a timely manner, rather than glibly saying 'I m a team member'...blah, blah, blah!

At the risk of sounding like an underachiever, people with marginal abilities can participate in a team setting and improve their skills with the help and cooperation

of others. The team setting can in fact become a training experience for those who have the drive and ambition to listen and learn from others.  
Cont'd p. 2

*“For success, attitude is equally as important as ability.”*

~ Harry F. Banks

Many teams actually employ a mentoring feature, in which they invite an apprentice into the team to learn valuable skills, not the least of which is the value and practice of teamwork. For the right person, it is a priceless opportunity.

If the positive attributes of teamwork aren't convincing enough, consider the negatives if teamwork fails or does not exist at all. Without teamwork, people could

be aimlessly trying to achieve everything on their own, with little or nothing to show for the end product. This only reinforces the assertion that teamwork is extremely worthwhile and valuable for many different situations.

In closing, enough truly cannot be said for the value of teamwork. Give it a try and watch the results. Do expect to be amazed and chances are you will be. If you never

try it, we can guarantee the results.

## What is Advanced Life Support and Basic Life Support?

Simply put:

Advanced life support (ALS) is medical care provided by paramedics trained to assess a patient's condition, administer drugs, defibrillate without an AED and provide advanced airway management prior to transportation to the hospital.

Basic life support (BLS) is a level of care provided to patients. BLS does not include extensive medical supervision or treatment, including the use of drugs and invasive procedures.

The difference between the two is the invasive procedures that ALS providers use such as:

1. IVs
2. Cardiac monitoring

3. CPAP and so on

BLS providers also use some interventions and they are:

1. 12 lead EKGs
2. King Airways
3. Glucose checks
4. Oxygen
5. Back boarding

The challenge is you must be ready to assist both types of providers with whatever they may need.

## What is an IV?

Intravenous therapy or IV therapy is the giving of liquid substances directly into a vein. It can be intermittent or continuous; continuous administration is called an intravenous drip. The word intravenous simply means "within a vein", but is most commonly used to refer to IV therapy.

You must be ready to use a 60 drip (micro drip) or a

10 drip (macro drip) set. The difference between the two is the set amount of fluids they are designed to deliver to the patient.

**You will need several pieces of equipment to set up an IV:**

- tubing
- a bag of normal saline
- a three way stopcock
- IV start kit (some units may have pre-made packets on them if not it includes the following)

-Alcohol prep

-tourniquet

-tape

-and a IV site dressing

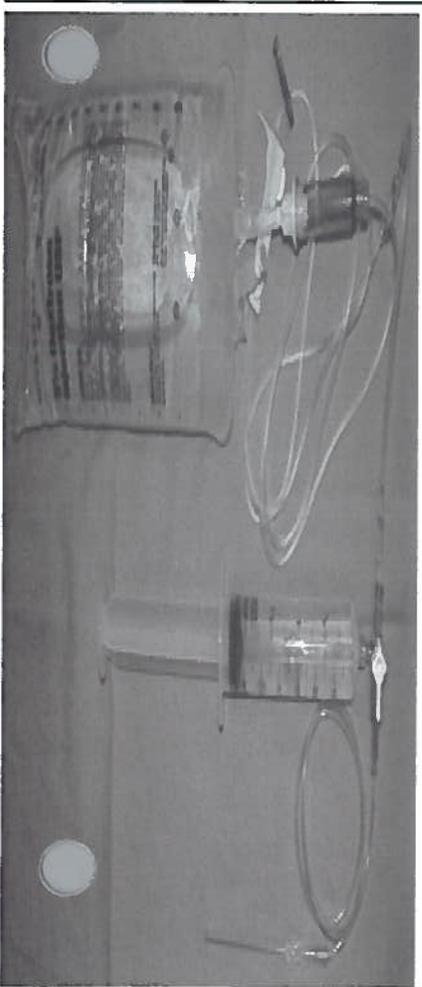
**If they only want a lock setup you will need:**

-A pre-filled saline syringe

-IV catheters, usually 18 gauge or 20gauge (ask the ALS provider what they want)

-The IV T-connector (Pig tail)

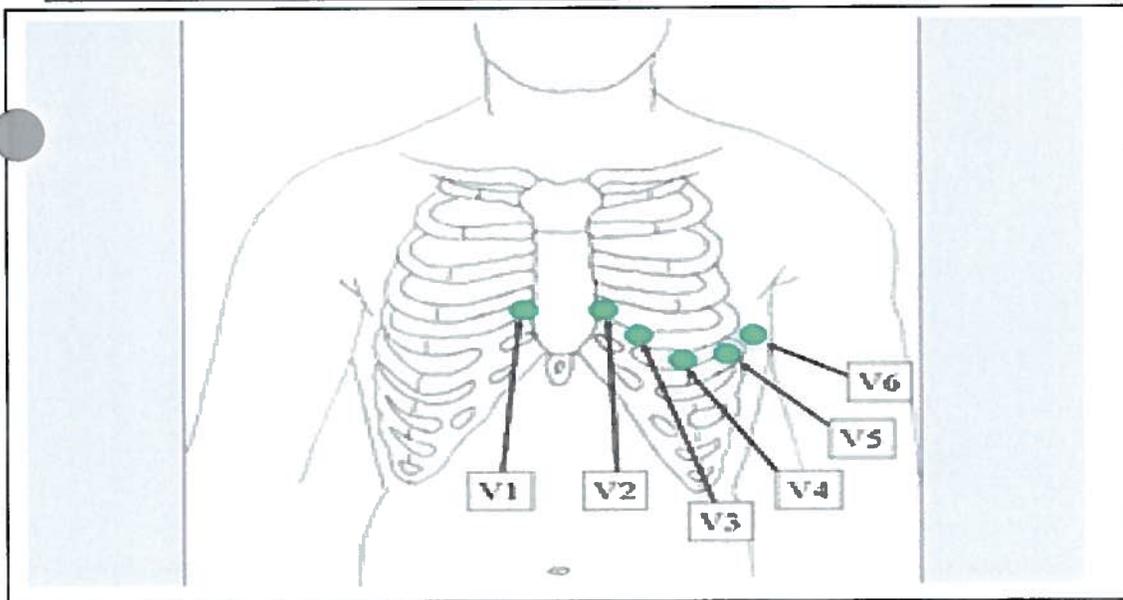
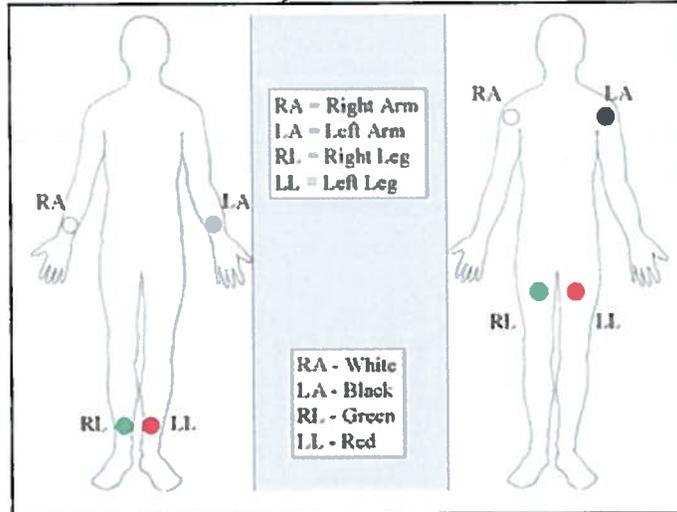
-and IV start kit (See prior if no kits are available)



## How to set up a 12 Lead EKG, LaYanowitz

An electrocardiogram (ECG / EKG) is an electrical recording of the heart and is used in the investigation of heart disease.

The most important thing for a third to know is how and where to place the leads in order to assist the provider. Protocols have recently changed that allows BLS providers to use this procedure in the suspected case of a heart attack. So how do you place the leads on a patient?



Lead placement for the diagram to the left:

V1: Patient's right 4<sup>th</sup> intercostal space

V2: Patient's left 4<sup>th</sup> intercostal space

V3: halfway between V2 and V4

V4: left 5<sup>th</sup> intercostal space, mid-clavicular line

V5: horizontal to V4, anterior axillary line

V6: horizontal to V5, mid-axillary line

## Checking a patient's glucose

Diabetes is a problem with the blood glucose level in the body. Blood glucose is essentially the energy that we supply the body with so that it can function. This might be things you never think about, like antibodies healing cuts and bruises or it might be the energy your body uses to play a squash game.

It is one of the most important skills that a third helps with. It is imperative that you know how to check someone's blood sugar. You can check the blood sugar very simply by:

- Making sure you are wearing gloves
- Prepare the glucose meter. Each type of meter works differently. There should be a standard meter that Forest View uses. However, there could be an older model on the unit, which is why it is important to know the equipment that is on your unit. Furthermore you should practice with the meter under the supervision of someone that is familiar with the device on your crew.
- Choose your spot. Don't check on the same finger all the time. Choose a different finger every time you check. Prick the side of the fingertip, not right on top. The side hurts and is less likely to bruise.

Cont'd to page 4

### Information obtained from:

CVTIPS.COM. (2008). *Being Part of a team at work*. Retrieved from [http://www.cvtips.com/working\\_as\\_a\\_team.html](http://www.cvtips.com/working_as_a_team.html)

LaYanowitz, MD, Frank. (2008). *The Standard 12 Lead ECG . The Alan lindsey learning center*. Retrieved (2009, October 26) from <http://citationmachine.net/index2.php?reqstyleid=2&mode=form&reqsrcid=APAOnlineEncyclopedia&more=&nameCnt=1>

White, Dan. (2008). *A Look at cpap for ems*. *EMS1.COM*, Retrieved from <http://www.ems1.com/ems-products/medical-products/articles/390898-A-Look-at-CPAP-for-EMS#>

American Association of Orthopedic surgeons. 1997, *SPINE IMMOBILIZATION - Random Reflections On Backboarding Mechanics* SAAOS text (5th) p. 684

**Making the Communities We Serve a Safer Place to Live**



[www.fvrs.org](http://www.fvrs.org)

### Cont'd Checking a patient's glucose

- Prepare the lancet; this is the finger-pricking device. Like meters, each finger-pricking device is different. Make sure you know how to use them and follow the safety instructions carefully.
- Place the finger-pricking device against the finger and push the button.
- Squeeze out a drop of blood. Some people have more trouble getting the blood out than others. If it's hard to get a drop of blood out, try having him/her hang his/her hand down and gently shake or squeeze the finger. If it is often troublesome to get a drop of blood, ask the provider to recommend a different lancet or finger-pricking device.
- Place the blood on the test strip.
- Wait for the results.
- **!!!Always remember to clean up after all calls and procedures!!!**

## Revisiting Back-boarding, AAOS

1. **Appreciate the risk.** When you tie a patient down on a backboard, you have compromised that patient's ability to clear his own airway if he vomits. **Aspirated vomitus can kill.** You have deprived your patient of the ability to save his own life. That job is now in the hands of the crew.
2. **Married to the head?** Once you have C-spine you are the Patient leader and responsible for manual C-spine immobilization until patient tie-down is complete. Once you grab hold, you're stuck on your knees at the patient's head, with both hands occupied. If you need to use your hands you have two options:
  - a. A hand-off to another rescuer is proper if executed competently.
  - b. Depending upon terrain and your footing, stabilizing the patient's head with your knees might be feasible.
3. **Verbal response.** With conscious patient, remember to insist that patient respond to you verbally; **NOT** by shaking his head.
4. **Logroll toward rescuers.** Always logroll the patient toward the rescuers. This increases stability for all concerned. If the patient is found prone (facedown), this means that the backboard is sitting in the rescuers' laps as the patient is rolled toward them.
5. **Overlap arms.** Logrolling rescuers should overlap their arms as they grab onto the patient. This increases stability and coordination. See AAOS text (5th) p. 684 for proper hand and arm position.
6. **3 logrollers.** You need three people on adult patient's to logroll effectively: 1 at shoulders and upper chest; 1 between mid-chest and pelvis; 1 between pelvis and feet. Remember: bystanders can be trained.
7. **Care in straightening patient's legs.** If the patient is semi-prone, his/her legs are probably supporting him/her in that position. Don't straighten the legs until everyone is in position and ready for the logroll. Otherwise, you may cause the patient to roll prematurely and without adequate support and control.



*Superbia in Muneris ut Aliis*  
"Pride in Service to Others"



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Welcome to Forest View Volunteer  
Rescue Squad  
May 1, 2012  
18:00

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**Welcome!**

- Introductions
  - Your Name
  - Your Background
  - What created your interest in volunteering
  - What you expect from the organization



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## Your Instructors

Kenneth Smith  
Phone: 804-690-3978  
Email: vaem2m@gmail.com

<p>Thomas Totty Phone: 804-564-3366 Email: romanlandude88@yahoo.com</p>	<p>Danielle Geriomo Phone: 804-239-5097 Email: danielle.geronimo@gmail.com</p>
<p>Mary Langford Phone: 804-814-0103 Email: mary@langfordfam.com</p>	<p>Matt Ellenburg Phone: 804-218-3255 Email: mattellenb@gmail.com</p>



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## History of the organization

- 1950's
  - In 1955 nine men met to discuss how to make their neighborhood a safer place to live. The Forest View Volunteer Rescue Squad was formally organized on July 14, 1955. These members purchased an old Buick hearse, which was converted into an ambulance. It was parked next to the squad's new donated building formally a "chicken house". The first president was Mr. R. L. Cavan.
- 1970's
  - In 1970, Forest View adds 2 new ambulances to its growing fleet. During the fall of this year, the squad builds the "Stew Building" to provide over 400 Gallons per year of delicious homemade Forest View Brunswick Stew to the community as a fundraising project.




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## History of the organization

- 1980
  - A new building for Station 2 was dedicated in June, 1981. Several of Forest View's members become some of the first volunteer Paramedics in the State of Virginia providing advanced life support to the community.
- 1990's
  - Forest View moves into their largest building and new headquarters, Forest View Station 3 located at 8008 Midlothian Turnpike in December of 1993.




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## History of the organization



- 2000's
- Over the years the squad has grown from a "Chicken House" and a "Horse Stable" to three operating stations, from 9 members to over 185 Senior Squad, Auxiliary and Junior members and from 1 converted hearse to 7 ambulances, a heavy duty rescue truck, a quick response vehicle and a chief's car. In 2008 Forest View's members responded to over 3,000 emergency 911 calls.



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**What does it mean to be a member of Forest View?**



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- Leaders in the state
- VAVRS
- Rescue Squad Hall of Fame
- Virginia Recruitment and Retention Network
- State office of EMS
- Local Hospitals
- ODEMSA
- Professional Development



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## "View" Our Culture



- Mission and Values
- Commitment
- Professionalism
- Uniforms and Appearance
- "We are a family"
- We act with absolute integrity, honesty and fairness
- Trust
- Most Importantly, HAVE FUN!



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## Standard Operations Guidelines

- Standard Operating Procedures:
- What are they?
- Who do they apply to?
- Where to find them?
- Do I need to read them?
- Where they are located?



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## How We Operate Here at Forest View:

- Chain of Command
- Operations Positions
- Requirements for positions



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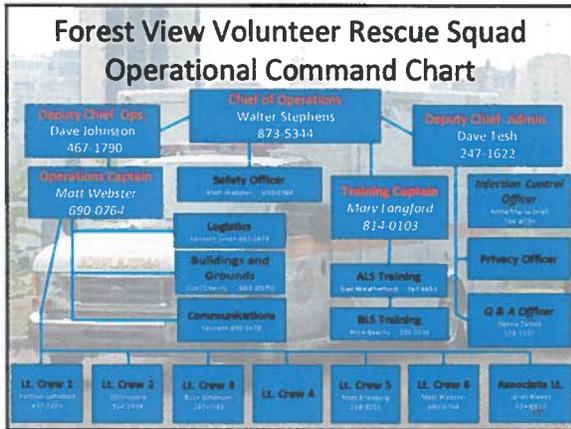
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### Chief of Operations

- Responsible for the day to day operations of FVRS
- Responsible for appointing and managing Operations staff
- Responsible for developing, tracking, and revising the annual budget
- Responsible for clearing AICs and Emergency Drivers
- Responsible for working with outside agencies to insure that the needs of the public and FVRS are met
- Authority to suspend members per the FVRS by-laws

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### Deputy Chiefs

- **Operations**
- Manages the following staff Operations Captain, Training Captain, BLS Coordinator, ALS Coordinator, Quality Assurance Lead, and all shift Lieutenants
- Will act as Chief of Operations in the event that the Chief of Operations is unable to fulfill his/her duties

- **Administration**
- Manage the filing and storage EPCR documents.
- Oversees filing system for lieutenants and ensures accuracy
- Assist with special projects
- Assist in preparation of budget
- Respond to inquiries and customer complaints
- Supervise customer services and respond to customer inquiries
- Assist with preparation of SOPs

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## Captains

- **Operations**
  - Will act as Chief of Operations in the event that the Chief of Operations or Deputy Chief is unable to fulfill his/her duties.
  - Responsible managing all crews and crew Lieutenants, Logistics, Public Relations coordinator, Buildings and Grounds Officer, and IT office
  - Assigns new members to crews
  - Manages the staffing of each crew, making changes where appropriate to insure the crews are evenly balanced
  - Manages the Associates Relations coordinator, insuring that associates fulfill their monthly and/or annual commitments to FVRS
- **Training**
  - Responsible for developing and maintaining a training program at FVRS
  - Design, update and distribute a calendar of internal and external training events to all members
  - Responsible for identifying new and emerging technologies that may enhance the quality of care provided to the public
  - Coordinate new protocols with OMDI
  - Work with Supply officer to research and purchase new products
  - Implement new/revised protocols to the organization
  - Responsible for clearing prospective AICs or providing additional assistance to those that need it
  - Will identify, appoint and manage, with the approval of the Chief, a BLS and ALS coordinator



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## Senior Operations

- **Safety**
  - Manages the Safety program at FVRS, including coordination with Training and Development
  - Manages the budgets for Safety and Communications
  - Identify and resolve any urgent safety issues observed or reported
  - Responsible for investigating and implementing new policies, technologies or procedures, with the approval of the Chief of Operations, that enhance the safety of the crews and the public
  - Respond to any incident involving equipment or personnel as directed by the Chief of Operations
  - Investigate and prepare a written statement of any incidents in accordance with SOP 6.06.4
- **Logistics**
  - Monitor the logistics budget and maintain records of receipts, expenditures and line item balances
  - Assist with final organizational budget recommendations and submit to the Chief of Operations
  - Assist in the development of apparatus and equipment specifications
  - Review manufacturer and contractor bid proposals and make recommendations to the Chief of Operations
  - Maintain inventories of operational supplies and equipment, furnish all stations with supplies
  - Coordinate the servicing and repair of all equipment and vehicles
  - Prepare reports on departmental fuel usage
  - Assist with projects and committees dealing with organizational purchases, communications and public services
  - Respond to emergency call backs after working hours and/or on weekends



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## Crew Lieutenants

- Lead one of six crews
- Responsible for staffing stations in accordance with SOP 2.04
- Responsible for training and developing new members
- Responsible for developing, in partnership with the Training Captain, regularly scheduled training events for their crews
- Required to attend the Operations and General Membership meetings unless excused in advance by the Chief of Operations
- May use a maximum of \$300 per year for retention activities while on or off-duty



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## Bylaws



- Our bylaws are the rules of how we conduct business at Forest View.
- They can only be amended by the membership.
- Where can you find the Bylaws?



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## The Thirds Class Schedule

- Tuesday and Thursday classes are from 6:00 till 10:00pm
- Saturday class is from 9:00 till 3:30 pm
- Tuesday May 1, 2012
- Thursday May 3, 2102
- Tuesday May 8, 2012
- Thursday May 10, 2012
- Saturday May 12,2012
- Tuesday May 15, 2012
- Thursday May 17, 2012
- Tuesday May 22, 2012
- Thursday May 24, 2012



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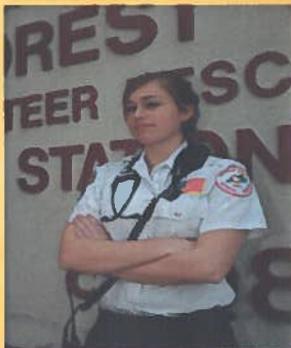
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## QUESTIONS



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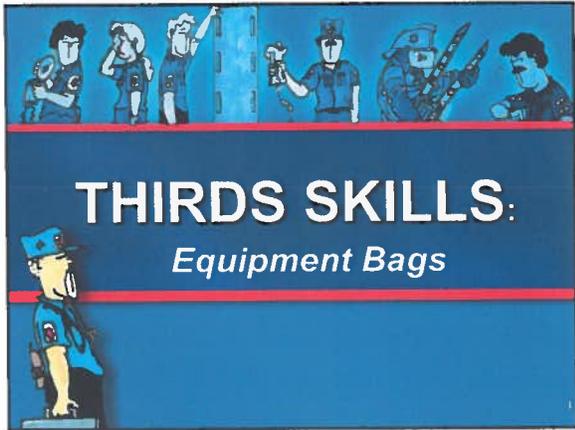
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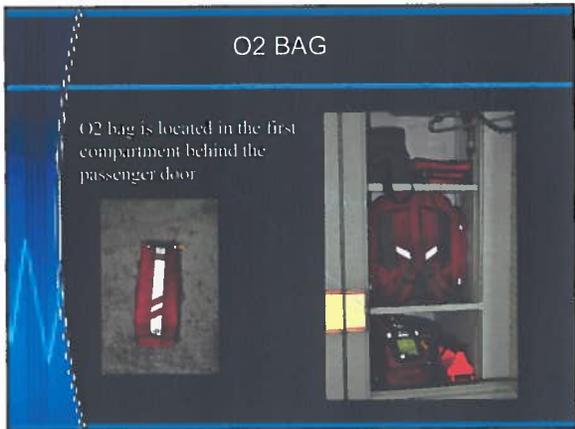
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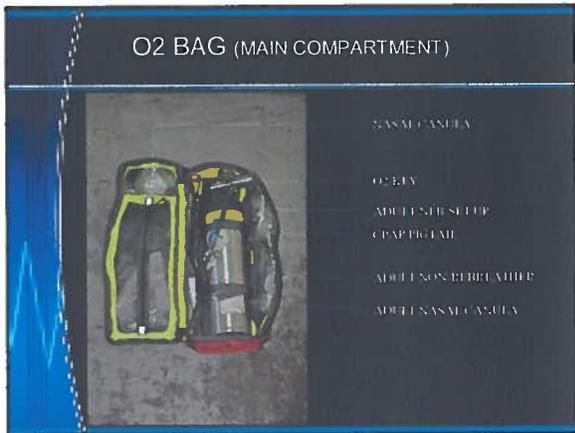
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### O2 BAG (INSIDE LID)

- PEDIATRIC NEUMASK
- PEDIATRIC SUBLIZER
- PEDIATRIC NASAL BRIDGEBATH
- PEDIATRIC BVM
- PEDIATRIC NASAL CANNULA
- ADULT BVM



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### "FIRST IN" BAG

"First In" bag is located in the first compartment behind the passenger door



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### "FIRST IN" BAG (LEFT SIDE POCKET)

- E.E. TUBES SIZES  
5.5, 6, 6.5, 7, 8, 9
- ETING AIRWAY SIZES 5



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"FIRST IN" BAG  
(RIGHT SIDE POUCH OUTSIDE POCKET)



CRAVAT (S)

ABDOMINAL PADS (S)

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"FIRST IN" BAG  
(RIGHT SIDE POUCH INSIDE POCKET)



3 x 3 PAPER GLOVES

1 PAPER GLOVES

1 PAPER GLOVES

30 x 6 GAUZE (10)

2 x 2 GAUZE (10)

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"FIRST IN" BAG (LID OF TOP POUCH)



ISOLATION PPE (LID)

AMPHIPHILIC LENS

(S)

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"FIRST IN" BAG (CENTER TOP POCKET)



HEAVY SCISSORS  
RING CUTTER  
AMBULATORY  
AMBLYSCOPE  
PLASTER  
GREAT GEL COAGULANTS  
GEL COAGULANT  
FOR 15-30 MIN  
PLASTER TOP CUT

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"FIRST IN" BAG (LID OF CENTER POUCH)



SYRINGE CONTAINER  
CHEST DECOMPRESSION  
NEEDLE (2)  
PRESSURE MEASURER  
RING AIRWAY #4  
RING AIRWAY #5  
ORAL AIRWAYS  
6.0mm, 7.0mm, 8.0mm, 9.0mm, 10.0mm,  
11.0mm  
NASAL AIRWAYS  
2.0, 2.5, 3.0, 3.5, 4.0, 5.0

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"FIRST IN" BAG (CENTER POUCH)



EASY ROLL  
TRAUMA PAD/BUILD  
SHELL OR ROLL  
INFLATION BOLL  
EVAC BAG

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### "FIRST IN" BAG (EX IO KIT)

EZ IO KIT LOCATED IN CENTER POCKET OF "FIRST IN BAG"



- 1 EZ IO KIT
- 1 15mm NEEDLE SET (CONTAINS 1)
- 1 25mm NEEDLE SET (CONTAINS 1)
- 1 45mm NEEDLE SET (CONTAINS 1)

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### "FIRST IN" BAG (I.V. MODULE)

I.V. MODULE LOCATED IN CENTER POCKET OF "FIRST IN" BAG



25g I.V. NEEDLE

1g I.V. AND 20g I.V. NEEDLE



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### "FIRST IN" BAG (I.V. MODULE)



I.V. START PACK DRIP SET

1000cc NORMAL SALINE

I.V. START PACK DRIP SET

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"FIRST IN" BAG (INTUBATION MODULE)



ISOLATION CANISTER



ADULT TUBE HOLDER

ETT TUBES (2)

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"FIRST IN" BAG (INTUBATION MODULE)

WATER SOLUBLE TUBE (2) PACKETS

PEDIATRIC CO2 DETECTOR

BASE

ADULT CO2 DETECTOR



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"FIRST IN" BAG (INTUBATION MODULE)

SMALL HANDLE

LARGE HANDLE

CUTLERY (2)

WATER BATTERIES (2)

SMALL HANDLE FORCEPS

LARGE HANDLE FORCEPS

DISPOSABLE BEAMERS

SMALL 2, 3, 4

SMALLER 2, 3, 4



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### FIRST IN BAG (INTUBATION MODULE)

2x10cm ZIESS  
ALCOHOL PADS (2)  
10cc SYRINGE (2)  
SCALPEL  
ITEMS PLACED IN A RED BAG



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### SUCTION KIT

Suction Kit is located  
in the first compartment  
behind the passenger  
door



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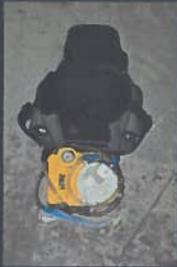
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### SUCTION KIT (CENTER POUCH)



SUCTION UNIT WITH TUBING  
ATTACHED

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### SUCTION KIT (LEFT POCKET)



SUCTION KIT  
100, 120, 140, 160, 180

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### SUCTION KIT (RIGHT POCKET)



REPLACEMENT SUCTION CUPS  
MEDICAL ASSESSMENT

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### EXTRICATION BAG

The "Extrication" bag is located in the rear compartment on the passenger side of the unit.



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EXTRICATION BAG (FRONT LEFT POCKET)

0012 CLIPSG



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EXTRICATION BAG (RIGHT FRONT POCKET)

2 TAPE GLOVES

CRAYONS

4 GAZE PADS

3 ROPS



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EXTRICATION BAG (REAR POCKET)

SPIDER STRAP



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EXTRICATION BAG (CENTER POCKET)

FOAM HEADPOCKETS (2)

ADULT ADJUSTABLE  
CERVICAL COLLAR (2)

PEDIATRIC ADJUSTABLE  
CERVICAL COLLAR (2)



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LIFEPAK 15



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LIFEPAK 15 (RIGHT MAIN POCKET)



ADULT DEFIB PAD (2)

PEDIATRIC DEFIB PAD

HANDGRIP CABLE

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### LIFEPAK 15 (RIGHT OUTER POCKET)



DISPOSABLE SKIN SENSOR  
DISPOSABLE  
PULSATILE OPHTHALMIC  
SENSOR  
TEMPERATURE CABLE

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### LIFEPAK 15 (LEFT OUTER POCKET)

ERGOLITHIUM BATTERIES



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### LIFEPACK 15 (REAR TOP POCKET)

PULSE OXIMETER  
CONNECTED  
FILTER LINE  
AMBU BAG SAMPLING  
SET  
PULMATIC COSMOPHON  
SET



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### LIFEPACK 15 (REAR BOTTEM POCKET)



PEDS DISPOSABLE PULSE-  
OX (2)

ADULT DISPOSABLE  
PULSE-OX (2)

STAFF PULSE-OX

PINPOINT PAPER

PULSE-OX CABLE

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PLEASE MAKE SURE ALL  
BAGS ARE STOCKED AT  
THE BEGINNING OF EACH  
SHIFT AND AFTER EVERY  
CALL



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## Any Questions ?



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