



# Health & Fitness

VOLUME 1, ISSUE 3

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## Upcoming Events within the county,

- 4th of July Events Throughout County
- Fill-The-Boot Drive Throughout County July 9th
- Oroville Hospital's Annual Health Fair OMC July 15
- Ignite the Fight 5K Bidwell Park October 22

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Partially reprinted from: <http://www.nifc.gov/FireFit/index.htm>

### What is Fitness?:

Fitness is defined as, "the body's ability to perform physical activity without distress or injury." Although most people rarely engage in arduous physical activity as part of their daily jobs, Wildland firefighters know that physical fitness plays an important role in our personal wellness and job performance. It's a proven fact that by incorporating a balanced fitness program into our daily work life, we enhance our health and safety, while mitigating our risk of injury and illness and increasing our ability to do work. Having said that, fitness continues to be one of the most important components of a well balanced wellness program. Like its counterparts, including nutrition and stress management, fitness has a life of its own, especially when it comes to the job performance of Wildland firefighters. According to Dr. Brian Sharkey in his book, "Fitness and Work Capacity, 2nd Edition", *for prolonged arduous work, fitness is*



PART 1, of a multiple part series

## Anima Sana In Corpore Sano "A sound mind rests in a sound body"

*the most important determinant of work capacity (the ability to accomplish production goals without undue fatigue, and without becoming a hazard to oneself or coworkers).*

### Getting Started – Before You Begin:

In preparation for exercise, it's important to incorporate a 'mental checklist' of correct procedures to make sure that you prepare yourself physically and mentally for the associated tasks. Most inter-agency Wildland firefighters will have completed a medical screening questionnaire and had some level of medical exam prior to engaging in Wildland firefighting activities. **It is important to make sure you complete some form of health screening and get clearance to participate from a medical practitioner prior to beginning training.** The following checklist will help to guide you in preparation for all levels of fitness activities:

- Consult with your physician
- Establish goals

- Make the commitment to yourself and your crew
- Get educated – the more you know, the healthier and safer you will be
- Have the appropriate footwear and apparel for exercise
- Adhere to your agency procedures for fitness and medical clearance. It is important to use appropriate apparel and foot wear for your activity. In other words, you should be discouraged from wearing basketball sneakers when running on the track or trail. The reason is due to the fact that all shoes are made differently and specific to the activity to be performed. It's equally important to wear clothing that is appropriate for the conditions. Additional items may include sunscreen, bug spray, eye

(Cont. on Pg. 2)



## NFPA annual report on firefighter fatalities in U.S. shows lowest number of on-duty deaths in 34 years

**Report shows drop in average number of deaths over 10 year period, but deaths from cardiac arrest remain steady.**

June 13, 2011 – The number of on-duty firefighter deaths is the lowest since 1977. The National Fire Protection Association (NFPA) today released its annual Firefighter Fatality Report at the NFPA Conference & Expo, which shows that a total of 72 on-duty firefighter deaths occurred in the United States in 2010. This is a sharp drop from the 105 on-duty deaths in 2008 and 82 in 2009 and it is the lowest annual total since the NFPA began conducting this annual study in 1977. "We are very pleased to see that the number of on-duty firefighter deaths

is at an historic low and continues to decline each year," said James Shannon the president & CEO of the NFPA. "We strongly believe that the advances in training, equipment and fire codes are a major factor in reducing the deaths of these brave men and women that make up the ranks of volunteer and career firefighters." This is the fifth time in the past 10 years that the total number of deaths has been below 100.

Source : NFPA News Release

While the number of total deaths has dropped sharply, the number of cardiac-related deaths has not. The number of such deaths has been remarkably stable over the past six years. The report found that the areas in which the deaths declined was diverse. 2010 saw the lowest number of fire ground deaths ever at 21, and the second lowest number of deaths while responding to or returning from alarms at 18 deaths. Deaths related to training activities and deaths while engaged in other non-emergency duties about matched the average

Continued on Pg 2

# Making Rehab a Requirement: NFPA 1584

By: Mike McEvoy

Courtesy of: FireRescue1

NFPA 1584, "Standard on the Rehabilitation Process for Members During Emergency Operations and Training Exercises," becomes effective in January. For the past four years, it has existed only as a recommendation but the NFPA began an overhaul of it just under one year ago. Its graduation to "standard" status gives NFPA 1584 a full set of teeth. Like other standards, 1584 includes a detailed annex which is not part of the requirements but serves to explain the standard and offers suggestions for compliance.

## Rationale for rehab

Firefighting has the greatest short-surge physiologic demands of any profession. Its abrupt requirements are equivalent to marathon running, often after awakening from a sound sleep and with little or no ability to physically warm up. Despite spending only 10 percent of our time on the fireground, virtually 50 percent of all firefighter deaths and 66 percent of injuries happen on scene.

There are three likely culprits behind these injuries and deaths: medical condition, fitness and rehab. NFPA 1582 set medical requirement standards for firefighting and NFPA 1583 set fitness standards. Rehab for fit, medically qualified firefighters is the next logical step in injury preven-

tion. We don't know how many on-scene injuries happen due to fatigue, but occupational studies of other professions suggest fatigue leads to them. That said, despite medical requirements and fitness standards, one need only look around their department to see that not all members are medically qualified for the rigorous demands of firefighter, nor are we all physically fit. In some cases, rehab may well be too little and too late. If NFPA 1584 is going to succeed at rehabilitation and regenerating work capacity, then medical screening and fitness initiatives are clear prerequisites.

## What's needed to comply?

The introduction of NFPA 1584 as a standard means every department must have SOGs outlining how they provide rehabilitation at incidents and training exercises. Rehab is also necessary at scheduled training exercises where firefighters are expected to work for one hour or more. Although somewhat weaker than OSHA, 1584 requires minimum BLS level transport capable EMS. In fact, this is nothing new: OSHA has long required transport capable EMS, dedicated to firefighters and preferably ALS, at every HazMat and fire scene. Lastly, rehab must be integrated into your Incident Manage-

ment System. For too long, accountability has focused on interior firefighters, but the time has come to know where every member on a scene is located. Expect to see other standards include similar language.

## We're adults — why require rehab?

No one flags a marathon runner down with an order to report to rehab; runners are athletes who know precisely how to hydrate, feed and rest themselves. 1584 started out prescribing a whole lot more than what you'll see in the final product, thanks to input from the fire service and the medical community. In fact, no one should have to tell a firefighter when, where and how to rehab, but the job of Incident Commander should be to provide firefighters with the tools they need to rehab themselves. The department should

(Cont. on Pg 3)



AP Photo/Sue Ogrocki

*Remember, it takes an average person 2 months to get into "good" shape, but it only takes 2 weeks of not working out to get out of shape.*

**NFPA** (Cont. from Pg 1)

numbers from the previous 10 years (11 and 18 deaths, respectively).

Other key findings in the report include:

- There were nine deaths in crashes of road vehicles in 2010, as well as in 2009, which is the lowest since 1983.
- There were 44 volunteer firefighters deaths in 2010, which continues a downward trend.
- The ages of all U.S. firefighters who died ranged from 20 to 86 with a median age of 52.5 years.

Each year, the NFPA collects data on all firefighter fatalities in the U.S. that result from injuries or illnesses that occurred while the victims were on-duty. The term "on-duty" refers to being at the scene of an alarm, whether a fire or non-fire incident; while responding to or returning from an alarm; while participating in other fire department duties. This annual report is considered the definitive source of on-duty firefighter deaths.

**FireFit** (Cont. from Pg. 1)

## Commonly Asked Questions From the Field:

1. *Why is fitness so important for Wildland firefighters?*

- Allows one to perform the arduous tasks required of a Wildland firefighter.
- Improves overall health and safety both on and off the fireline.
- Improves personal attitudes and crew cohesion.
- Helps decrease absenteeism and increase productivity in the workplace.
- Improves your chances of surviving a catastrophic incident.

2. *What do Wildland firefighters do that requires them to sustain good fitness levels?*

- Work long hours, utilizing muscle strength, muscle endurance, and cardiovascular capacity with little recovery time.
- Endure stress, fatigue, dehydration, and poor nutrition for long periods at a time.

- Work at optimal performance levels in poor environmental conditions.
- Understand the importance of working safely.

3. *Why can't I run in my fire boots?*

- Fire boots are not designed for running. All foot wear are designed for specific activities based on the foot movement (lateral, forward, etc.). By wearing shoes that are not designed for that specific foot motion, you can injure yourself, even seriously.

4. *Isn't it best to run everyday for PT to get in shape for fire season?*

- While running is a component of P.T., it should not be the only element. Running everyday, especially if you are running on hard surfaces, may lead to overuse injuries, but can also conflict with overall conditioning and lead to boredom and decreased morale. Running is considered an 'impact' exercise – every step you

## FireFit (Cont. from Pg. 2)

take while running, you are placing approximately 3.7 times your body weight on the joints of your body! Increase your mileage by 10% weekly to avoid overuse injuries and remember to cross train.

5. *Why are there so many injuries early in the fire season – especially knees and backs?*

- This is directly attributed to poor training programs and overuse – doing ‘too much’ too soon’.
- Contributing factors include: lack of adequate warm up and stretching, improper shoe wear, and imbalance of muscle strength (a result of improper muscle strength/endurance workouts).

6. *Why do Wildland firefighters need a special fitness program designed for them?*

- Wildland firefighters are a special breed of professionals that deal with complex, high stress situations that require not only muscular strength but also muscular endurance, cardiovascular conditioning, and flexibility for prolonged periods of time while under duress.

The FireFit program is broken down into three modules:

Module 1 = 8 Weeks of Prior to Fire Season

Module 2 = 24 Weeks of Fire Season

Module 3 = 20 Weeks of Post Season

Module 1 is meant to ramp up the individual in a gradual 6 week period and then a 2 week transition into Fire Season readiness.

Module 2 is meant to maintain the increased fitness level required for Fire Season.

Module 3 is meant as a recovery and rehab period and transitioning into a baseline maintenance for the winter period.

With Fire Season upon us this year (maybe?), if you did not prepare yourself during the spring months then you are already behind the power curve in regards to physical conditioning. The good news is that the sooner you do begin, the sooner you will be able to attain your goals. Over the next few issues, I plan on detailing all of the various components that make up the FireFit program. Of course, for those that do not like to wait, you can access all of the information on your own at :<http://www.nifc.gov/FireFit/index.htm>



*Station 36 crew, 2009, at the top of the “Sunrise Surprise Hike” across from the station.*

## Rehab a Requirement (Cont. from Pg 2)

educate its members to know as much about rest, hydration and endurance as a professional athlete does. Wouldn't you know, this is exactly what NFPA 1584 says! None of this is going to happen overnight, but keep this in mind when writing SOGs: no one likes to be told what to do, especially a firefighter. The intent of NFPA 1584 is three-fold, aiming to:

- Provide ongoing education on when and how to rehab
- Provide the supplies, shelter, equipment and medical expertise to firefighters where and when they need it
- Create a safety net for members unable or unwilling to recognize when they are fatigued

### Who's responsible for what?

Each department is responsible for developing and implementing rehab SOGs. On scene, the Company Officer or supervisor must assess his or her crew to determine members in need of rehab at least every 45 minutes. Individual firefighters and their supervisors should undergo rehab following use of a second 30-minute SCBA cylinder, after a single 45- or 60-minute cylinder, or after 40 minutes of intense work without SCBA. Supervisors are permitted to adjust these time frames depending on work or environmental conditions. In addition, EMS staff must have the authority to detain members in rehab or transport members when there are obvious indications preventing them from returning to full duty.

### How to implement 1584

There are nine key components of rehab required by NFPA 1584:

- 1. Relief from climactic conditions** — An area free of smoke and sheltered from extreme heat or cold is provided. This might be a non-fire floor in a high-rise building, a shaded area upwind from a brush fire or the heated fire apparatus cab during cold winter months. The theme is providing shelter from environmental extremes.
- 2. Rest and recovery** — Members are afforded the ability to rest for at least 10 minutes or as long as needed to recover work capacity.

**3. Cooling or rewarming** — Members who feel hot should be able to remove their PPE, drink water and be provided with means to cool off. Members who are cold should be able to add clothing, wrap in blankets and be provided with means to warm themselves.

**4. Re-hydration** — Fluid replacement. Fluid volume requirements were eliminated from the standard with the exception of pre-hydration with 500 ml (16 oz) of fluids consumed two hours prior to scheduled events. On scene, potable fluids must be provided so members can satisfy thirst. Fluids should also be provided to encourage continued hydration after the incident.

**5. Calorie and electrolyte replacement** — When appropriate for longer duration events such as incidents exceeding three hours duration or situations where members are likely to work for more than one hour. Of note, whenever food is available, means for members to wash their hands and faces must also be provided.

**6. Medical monitoring** — Specifies a minimum of six conditions that EMS must assess in each member during rehab:

- a. Presence of chest pain, dizziness, shortness of breath, weakness, nausea or headache.
- b. General complaints such as cramps or aches and pains.
- c. Symptoms of heat or cold-related stress.
- d. Changes in gait, speech or behavior.
- e. Alertness and orientation to person, place and time.
- f. Any vital signs considered abnormal in local protocol. The specific vital signs and what defines normal is entirely up to local medical control and department medical authorities. Vital signs listed in the 1584 annex include temperature, pulse, respirations, blood pressure, pulse oximetry and carbon monoxide assessment using either an exhaled breath CO monitor or a pulse CO-oximeter (i.e. a pulse oximeter designed to measure carboxyhemoglobin).

**7. EMS treatment in accordance with local protocol** — Available on scene for members who require treatment or transport. Note that medical monitoring is documented in the fire department data collection system. When EMS treatment or transport is provided, a medical report must be generated and included in the member's employee medical record.

**8. Member accountability** —The personnel accountability system must track members assigned to rehab by Incident Command as they enter and leave.

**9. Release** — Prior to leaving rehab, EMS must confirm that members are able to safely perform full duty.

### Changes in 1584

Some good things happened in revising (Cont. on Pg 4)





## Shrimp Fajitas

A festive, colorful dish combining vegetables and seafood. (Serves 4)

### Directions:

**SHRIMP MARINADE:** In resealable 1-gallon plastic bag, combine 1/4 cup of lime juice with garlic, red pepper flakes, 1 tablespoon of oil, 1/4 teaspoon salt, and 3 to 4 grinds of black pepper. Add shrimp, seal bag, and massage to coat with marinade. Refrigerate for 1 hour.

**VEGETABLE MARINADE:** Meanwhile, cut frying and bell peppers vertically into thin strips. Cut onion crosswise into 1/4-inch slices. Place vegetables in another plastic bag. Add remaining lime juice and oil, plus 1/4 teaspoon salt and a few grinds of pepper. Seal bag and massage to coat vegetables.

**FAJITAS:** Seal tortillas in foil, making two packages. Heat charcoal or gas grill to medium-high heat. Brush grill rack with oil. Or heat grill pan over high heat until a drop of water flicked into it dances. Drain and pat dry vegetables, discarding vegetable marinade.

Arrange them on grill at right angles to bars or pan ridges. When vegetables are well marked, about 2 minutes, remove onions to platter and turn peppers. When peppers are crisptender, 1 minute, add to onions. If necessary, clean grill, using wire brush.

Set wrapped tortillas on one side of grill to warm over indirect heat.

Pat marinated shrimp dry with paper towels. Discard shrimp marinade. String shrimp evenly on skewers, alternating curve to opposite sides. Grill shrimp until almost opaque in center, about 2 minutes. Turn skewers and grill until shrimp are opaque in center but still moist, about 1 minute. Remove skewers, and add shrimp to platter of vegetables. Open packets of warm tortillas and place cilantro sprigs on plate.

### Nutritional Info (per serving)

<b>Calories</b>	<b>289</b>
<b>Kilojoules</b>	1210 kj
<b>Fat</b>	10.1 g
<b>Sat Fat</b>	1.0 g
<b>Cholesterol</b>	129 mg
<b>Sodium</b>	349 mg
<b>Carbs</b>	30.7 g
<b>Fiber</b>	4.6 g
<b>Total Sugars</b>	3.9 g
<b>Protein</b>	21.1 g
<b>Calcium</b>	104 mg

### Ingredients:

- 1/3 cup fresh lime juice, divided
- 3 Cloves garlic, sliced lengthwise
- 1/4 tsp red pepper flakes
- 2 Tbsp canola oil, divided
- 1/2 tsp sea salt, divided
- 3-4 Grinds of black pepper
- 3/4 lb extra large (26-30 count) raw Shrimp, shelled and deveined
- 1 Large Cubanelle or frying pepper
- 1 Medium red or yellow bell pepper
- 1 Medium red onion, halved lengthwise
- 1 cup cilantro sprigs, loosely packed
- 8 Whole grain yellow corn tortillas
- 8 (8-inch) bamboo or metal skewers

Recipe courtesy of:



www.calorieking.com

### Rehab a Requirement (Cont. from Pg 3)

NFPA 1584, beyond moving it from a recommendation to a standard. Overall, the document is considerably meatier. Earlier versions included many prescriptions for treatment and definitions of "normal" for your members. These have either been moved out of the standard into the annex, or completely kyboshed when not supported by science or medical evidence. Also, some great additions appear in 1584: namely, pulse oximetry and rapid assessment of carbon monoxide levels in firefighters. Tools such as oximeters and exhaled breath carbon monoxide meters have been available for years. In 2006, a CO-oximeter came on the U.S. market for measurement of carboxyhemoglobin levels in the blood through a finger oximeter probe (RAD-57, Masimo Corporation). While no comprehensive data exist on normal CO levels in firefighters, two facts are widely known: CO is the most common poison in the world today, and dead firefighters often have significantly elevated CO levels. Many departments have already begun proactively screening members for CO during rehab to assure that no firefighter slips through the system with undetected CO poisoning in the line of duty.

### Where to from here?

Medicine will evolve, and so will NFPA 1584. We know very little about normal vital signs in rehab and even less about what measurements have any value in the rehab process. NFPA 1584 is a starting point to begin evaluating cause and ef-

fect relationships. As you move forward with implementation of 1584 during 2008, don't forget its main purpose: the firefighter. The job of firefighting requires world class athletes. Every firefighter must be attuned to their needs for rest, null recovery, hydration and protection from the elements. Every department must make the resources available for members to meet their rehab needs at every incident scene. Hopefully, the end result will be more firefighters coming home.

Mike McEvoy is the fire-EMS editor for Fire Engineering magazine and recently published a book titled "Straight Talk About Stress for Emergency Responders." Mike.McEvoy@firerescue1.com.



### Recent "Tail Gate Safety Topics" sent out to the Unit All TGSTs can be accessed via Outlook, under Butte: Training Bureau: Health & Safety: TGST

- TGST, June 19, 2011, Natl Fire/EMS Safety, Health, & Survival Week
- TGST, June 13, 2011, Lyme Disease Prevention
- TGST, June 3, 2011, Hearing Conservation
- TGST, May 22, 2011, Projectile Hazards

# CE Article: Helmet Removal Protocol

By: Steve Whitehead  
<http://theemtpot.com>

*To date, few EMS systems have developed protocols to address the removal of helmets from injured persons and for us that leaves a grey area for interpretation based upon the need for airway management and spinal immobilization and how those two factors sometimes work against each other. The following is a very good article on the when, why, and how's of removing helmets. -Mike*

The good news in the world of head trauma and brain injury is that we're seeing a lot more folks putting on helmets before they go out and do potentially dangerous, head crushing stuff. The good/bad news is that we're encountering more patients who are wearing helmets and need to be placed in full spinal immobilization. This brings up a controversial decision. Should we remove the helmet or leave it in place?

The leave it or remove it controversy has been around for as long as I've been in EMS and, like most controversies that remain unresolved for years, there are merits to both options. In these instances, it's easy to create blanket rules and then follow them mindlessly.

"Always leave the helmet in place, unless it obstructs the airway."

"Always remove the helmet before you put them on a backboard."

You're going to hear some folks spout these rules off like they've been long established treatment guidelines, written in stone and backed by The American Board of Something Technical Sounding. They're not. Whether you decide to remove a helmet is, and should be, a matter of clinical judgment. You're going to need to decide for yourself, using your own good judgment and assessment findings.

Let's help you sharpen your decision making scalpel so the next time you encounter a helmeted patient, you can proceed with confidence.

## 1) Helmets protect the head. They do not protect the neck.

If anything, that big helmet may have increased your patients risk for a neck injury. Don't fall into a false sense of security when you see a helmeted patient walking around on scene. They're still going to need a thorough evaluation of their neck and neurological status.

## 2) Athletic pads may need to remain in place or be removed in conjunction with the helmet.

This goes primarily for football players or anyone wearing shoulder pads or padding across their upper back. The back padding will often be equal to the added occipital padding that a helmet creates.

So if you decide to remove the helmet, take the pads off with them. If the helmet stays in place, leave the pads behind.

This is going to help you find that neutral position for the neck when the patient lays down supine.

## 3) If you leave the helmet in place, everything covering the airway needs to go.

On some motorcycle helmets, this may be as easy as flipping up the face piece. Other helmets have the face guard integrated into the helmet. If the helmet permanently covers the mouth, it needs to go. Not, "If there's a problem," *before* there's a problem.

You don't want to have to figure out how to get a helmet off after the patient that airway uncovered beforehand.

## 3) Trainers may have a bunch of

Cont. on Pg. 6

### New Technologies: Helmet Removal System



Neck and spine injuries are a life-altering peril that motorcyclists face each time we strap on our helmets. Shock Doctor, a leader in design and manufacturing of innovative sports protection technology, hopes to reduce the occurrence of spinal injuries with its **Shock Doctor Eject Helmet Removal System**. \$59.99

The system is designed to allow emergency medical technicians to easily remove the helmet of an injured rider, thereby reducing the chances of further neck or spinal cord trauma. The setup is

comprised of a thin, two-inch square air bladder that is situated inside the top of your helmet. It can be fitted between the inner liner and shell toward the center of the helmet. The bladder connects to an air tube that's routed inside the liner and down through the bottom of the right-hand side of the helmet. The intake air connector can then be fastened to the base of the helmet via its Velcro fastener. A yellow 'Eject equipped' sticker is then placed next to the intake to signal to medical personnel that the system is installed.

To activate, one needs to first detach or cut the helmet's chin strap, followed by removal of the riders' eyeglasses or goggles. Next, attach the air squeeze bulb assembly to the air intake connector (a compressed air removal device is available for EMT use only). Pump the bulb while guiding the helmet off the rider's head. Furthermore, Shock Doctor offers an Eject EMT/First Responder Helmet Removal Kit that can be

used when the injured rider's helmet is not equipped with the standard Eject Helmet Removal System. The Eject system can be used in all type of powersport helmets, both street and dirt/

The device is so simple and ingenious, it has already been mandated by the AMA (American Motorcyclist Association) and the IRL (Indy Racing League)!

### **The Eject EMT/First Responder Helmet Removal Kit \$89.99**

The kit includes a wand that allows the Eject System to be manually installed into the helmet at the scene.

*Only rescue personnel trained in spine immobilization should activate Eject after reading full instructions and practice. Do not activate Eject if you suspect an underlying head injury or if there is gravel, glass or other foreign material in the helmet.*

**Helmet Protocol** (Cont from Pg 5)

**useful tools for removing face-plates and helmet garb.**

So if you're responding at a sporting arena, try to get the trainer to stay around and help out. If you're going to want to leave the helmet on, ask them early if they have tools to remove the face-piece. They usually will.

They also know how all the pads lace and unlace so if you want to remove patient protective gear, get their advice. "Is there any way to remove these while he's lying down? Where does that thingy tie?" The trainer can be a really useful person to have helping out. And they usually appreciate not being ignored.

**4) Evaluate how well the helmet fits.**

There's no sense in securing the patients helmet to a board for c-spine if

their head is rattling around inside the helmet like a pinball between two bumpers. If the helmet doesn't fit snug, it's no good for c-spine. However, it will probably be a cinch to take off.

**5) You need two people to take a helmet off.**

It's not a one man job. You can do it on your own, but you can't do it right. Here's the technique.

I find it easier to do with the patient lying down. Have one rescuer hold the helmet from above while a second rescuer positions themselves at the patient's side, facing the head. The second rescuer places their hands on either side of the patients neck and slides their fingers up inside the helmet toward the patient's ears. When the second rescuer feels like they have a good grip on the patients head they can let the first rescuer know it's OK to remove the helmet.

With the head secured by the second rescuer, the first rescuer pulls out on the helmet at the ears and slides it up and off the patients head, then returns to help secure the head to the

board. Most open faced motorcycle helmets will need to tip slightly back during removal. Football and full-face helmets tilt slightly forward.

Olay! Your helmet worries are over. Hopefully, the next time you encounter a c-spine/helmet dilemma, you'll feel a little more at ease evaluating the situation and making a decision to leave the helmet on or take it off.

*Now it's your turn: Do you have a hard and fast rule about helmet removal? What things do you consider when faced with the c-spine/helmet dilemma?*



**CE Answer Sheet: Helmet Removal Protocol**

Complete this answer sheet from the previous CE article and forward it to the Training Office for grading and credit. (1 CE hours Credit for successful completion)

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

Station: \_\_\_\_\_

1. Helmets help prevent head and spinal injuries.

- True
- False

2. Athletic pads should be removed at the same time as the helmet if it is removed.

- True
- False

3. Trainers can be helpful at the scene of a sporting injury because:

- They are responsible for the patient.
- They have specialized tools.

4. If the airway is covered by the helmet, then the helmet should be removed.

- True
- False

5. Should a loose fitting helmet be left in place, if you are able to visualize the airway?

- No
- Yes
- Only if there is neck pain

6. Helmet removal is a one person skill

- True
- False

7. Does SSV have a helmet removal protocol?

- Yes
- No

8. More persons are wearing helmets than in the past.

- True
- False

9. The Eject Helmet Removal system can be used for all type of helmets?

- True
- False

10. Will this article help you in assessing and treating a helmeted patient?

- Yes
- No

Comments:

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**For Suggestions or Comments:**

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**"Let No Man's Ghost Say His Training Let Him Down!" -Unknown Author**