MEDICAL

OPERATIONS PLAN COMBINED WITH AFTER ACTION REPORT

Dennis Brodigan, Medical Services Manager

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Introduction

The 2001 Special Olympics World Winter Games ❄ Alaska Medical Advisory Board will provide the medical services required by the athletes, coaches and Heads of Delegation from the time of their arrival through their participation in the sporting events. In addition, medical services will be provided to the spectators, volunteers, the Games Organizing Committee staff, and officials of the Games.

The Medical Services Policy and Procedure Manual is intended to be used as a guideline for medical volunteers as they establish and operate their respective health care delivery systems throughout the Games.

- ***The 2001 Special Olympics World Winter Games ❄ Alaska Medical Advisory Board, the Medical Leaders and medical volunteers provided excellent patient care to those required medical attention throughout the World Winter Games.***

- ***There were, of course, many lessons learned and great insight and expertise gained from this experience and it is hoped that we can communicate the information so that future Games will benefit from our collective knowledge.***

Mission

Medical Services will provide professional health care services to all associated with the 2001 Special Olympics World Winter Games ❄ Alaska. While medical services will always be provided in the best interest of the individual, we will strive to return the athlete to the sporting event in an efficient and timely manner, and the non-participant will be provided a seamless transition into the community health care system.

- ***Medical Services accomplished its mission and its goals and provided professional health care services to all associated with the 2001 Special Olympics World Winter Games ❄ Alaska. We successfully provided a buffer between the Games and the existing health care community so that no organization or facility was inundated with ill or injured patients. And, while medical services was always provided in the best interest of the individual, we returned the athlete to the sporting event in an efficient and timely manner, and provided a seamless transition into the community health care system for all who sought medical care.***

Goals

- Provide professional health care services for the athletes, coaches, Heads of Delegation, officials, Games Organizing Committee staff, volunteers and spectators.

- Return the athletes to their respective competition as soon as medically prudent and feasible.

- Track and monitor all patient encounters throughout the medical services system.

- Provide a comprehensive after action report of Medical Services.

Overview: 2001 Special Olympics World Winter Games ❄ Alaska

The largest international sporting event in Alaskan history will bring approximately 2,750 athletes and coaches from 80 nations to compete in seven official winter sports March 4 – 11, 2001. Teams outside of North America will begin arriving in Anchorage February 28, 2001 to allow for added recovery time prior to competition for those traveling long distances. To date, 76 nations have officially registered for competition.
The 2001 World Games is significant for the Anchorage bowl, as more than 10,000 people are expected to attend the Games including athletes, coaches, family and friends, dignitaries, and spectators from across the globe.

Comparable in size to the Winter Olympics in Nagano, Japan, the 2001 World Games is truly an extraordinary event for the city, state, and athletes. Spread throughout 20 housing and sport venues between Anchorage, Eagle River, and Girdwood, Alaska, 29 languages will be spoken and 30,000 hotel room nights will be filled. Approximately 64,000-box lunches will be prepared for athletes, coaches, volunteers and officials during the event, an average of 5,500 per day. Traveling from as far away as Arabia, Bulgaria, China, Finland, Germany, Greece, Italy, Japan, Korea, Lithuania, Norway, Poland, Russia, Spain, and Sweden, among others, the 2001 World Games creates a rare opportunity for athletes and coaches to travel outside of their native homeland.

Medical Services will be provided at a variety of Venues from the time the athletes and delegations begin arriving in Anchorage to the time they depart at the end of the Games. An overview of the Venues is as follows:

Medical Services will be provide on-site teams at both the Domestic and International Terminals of the Anchorage International Airport as athletes arrive and depart Anchorage.

All athletes and delegation members will be bussed directly from the airport to the Welcome Center located at Alaska Seafoods International on Raspberry Road. Medical Services will provide a medical team to support the large influx of weary, and jet-lagged athletes.

The sports venues at the Games are as follows:

1. Alyeska Ski Area – Alpine Skiing
2. Federal Express Hangar Floor Hockey
3. Hilltop Ski Area - Snowboard
4. Kincaid Park – Cross-Country Skiing and Snowshoeing
5. McDonald Center – Speed Skating
6. Tesoro Center – Figure Skating

Medical Services will be offered to the athletes, coaches, delegation members and honored guests staying at the following Village Venues:

1. Best Western
2. Captain Cook
3. Days Inn
4. Hawthorn Suites
5. Hilton
6. Holiday Inn
7. Kenai Dorms
8. Matanuska Hall
9. Sheraton
10. West Coast International

The Games will have medical staff at the Joint Operations Command Center (JOCC) located at the City of Anchorage Emergency Operations Center – 1309 E Street, throughout the Games to ensure coordination, continuity and communications between Medical Services and all other aspects of the Games.

There will be several special Events that will require Medical Services, including:

1. Opening ceremonies & Closing ceremonies – Sullivan Arena
2. Special Olympics Town – Egan Center
3. Athlete Entertainment – ACPA
4. Family Reception - ACPA

The Medical Services timeline for the Games is as follows:

February 25-26 Set-up JOCC

February 27 - Begin staffing the:

1. JOCC (continue staffing until March 12)
2. Set-up the Polyclinic

February 28 - Begin staffing the:

1. Polyclinic (continue staffing until March 12)
2. Airport (continue staffing through March 3)
3. Welcome Center (continue staffing through March 3)

4. The Hilton, Holiday Inn, Kenai Dorm #2, and the West Coast International Village Venues (continue staffing through March 12)

March 1 – 3 - Athletes continue to arrive and locate at Village Venues

March 3 - Special Olympics Town opens to the athletes and the public. All Village Venues begin Medical Services staffing. Note: The Iditarod Dog Sled Race begins in downtown Anchorage.

March 4 - All sports venues begin in the morning and the Opening Ceremonies take place in the evening.

March 5 – 11 - The sports venues continue….

March 6 - Medical Services provide a medical team to the Family Reception at the Alaska Center for the Performing Arts.

March 7 & 9 - Medical Services provide a medical team to the Athlete Entertainment event at the Alaska Center for the Performing Arts.

March 11 - Medical Services provide medical services for the Closing Ceremonies.

March 12 - Athletes depart Anchorage.

Special Olympics, Inc.

- *Enhance the Athlete Registration package to include a more comprehensive medical history and consent for medical treatment forms.*
  - *The medical records should include more information than is collected currently i.e., instead of a check-mark for YES or NO for Heart Problems, Diabetes, etc., there should be additional specific information such as "Heart Problems: Myocardial infarction – 12/15/1998. Coronary bypass surgery performed January 10, 1999."*
  - *Consent forms should include release of medical records information to SOI and release of patient (at time of discharge) to SOI.*
- *The GMS should be more user-friendly and comprehensive for the medical aspect of the Games, including:*
  - *The GMS should allow for current medical information (for those medical incidents that occur during the Games) to be entered into the database (on a "real-time" basis) to store incidents that occur during the Games.*

- *A menu of medical reports would be very beneficial (i.e., Athlete Current Medications, Coaches Current Medications, Athletes Allergies, etc.).*

- *Require better protective equipment for Floor Hockey; specifically, elbow pads, hand/wrist protection and knee pads.*
- *Consider excluding athletes with positive atlanto-axial instability from competing in Floor Hockey; the sport is very physical and potentially dangerous to an athlete with AAI.*

Games Organizing Committee

- *Utilize an integrated project management and communications computer program such as Microsoft's Project, Windows 2000 and Outlook 2000 (or updated versions, thereof). This combination of software will ensure that all Functional Areas are fully integrated with the primary Venues (sports, villages and special events) and all aspects of the planning and implementation is fully communicated to all relevant staff members, volunteers, and SOI.*
- *Medical Services requires a larger staff than just one person; at a minimum, the medical services manager should have a full-time secretary and at least one full-time person (with medical experience) for recruiting and scheduling medical volunteer personnel.*
- *Have on-site Medical Services at all Venues when Athletes will be in attendance, including:*
  - *Sports*
  - *Villages (24-hour coverage)*
  - *Special Events*
- *Medical Services Manager should have an active involvement in the planning and implementation of any patient transportation system that is developed by your Games Organizing Committee so that Medical Services has top priority for transportation needs:*
  - *We sent 228 patients from Venues to the Poly Clinic, most of which were transported by our internal motor pool system. Some transports took as long a one and one-half hours for a transport vehicle to pick the athlete up.*
  - *Ensure that the medical transportation system operates 24-hours per day.*
- *Do not serve unhealthy food and beverages to the athletes in the first 48-hours of their arrival (i.e., Coca-Cola, candy, etc.); encourage athletes to drink plenty of water and to get sufficient rest.*

Medical Volunteer Guidelines

Job Duties:

Attire

Dress to accommodate the weather; dress in layers: Official 2001 Games uniforms are required; other types of "logo-wear" are highly discouraged. Wear comfortable **black** pants (or black ski-bibs if outdoors), socks and footwear. Bring a hat and gloves if your event is being held outdoors. A waist pack will be helpful for carrying personal items, as we cannot provide secure storage. Bring your Credential badge.

Attendance

We depend on each medical volunteer to show up to his/her assigned Venue, on-time and in uniform. Realistically, this is not always possible

Cancellation of shift: If you are not able to make your scheduled shift, notify the MCC as soon as you know you will have to cancel. The MCC telephone number is 343-1407 and should be located on the first page of the Medical Handbook.

Volunteer Check-In: All Volunteers must check in with the Volunteer Service Center at a designated area at the entrance to your specific venue. You will be given instructions as to where you can find your VML/AVML.

VMS Check-In: Locate your VML/AVML and sign the Personnel Sign-In Sheet.

Credentials/Accreditation

A Credential ID badge will be issued to identify the access available to a volunteer at each of the venues. The Credential badge must be worn at all times. In the event the Credential badge is lost, please notify the Volunteer Services Check-In representative to get a replacement badge.

As a general rule, medical volunteer personnel will have access to all zones within their respective Venue in the event of a medical incident or in the routine performance of their duties. There will be some zones from which medical volunteer personnel may be restricted if there is not an "official" reason for your presence (i.e., the VIP section, Honored Guest section, etc.).

Transportation/Parking

Unless otherwise designated, we must depend on you to find transportation to and from your assigned Venue. You may be well served to carpool with other volunteers or take the People Mover as parking will be limited at some venues. People Mover is expanding its route schedule and is providing free transportation to all Credentialed volunteers of the 2001 Special Olympics World Winter Games ❄

Alaska If you do drive your own vehicle, be sure to park in the area designated for volunteers. If you encounter transportation difficulties, please contact the Medical Command Center.

A Day in the Life…….

Eat a healthy and hearty meal that will provide good nutrition and energy prior to arriving on site for the day's event. Snacks and beverages will be provided. If you bring additional food, please note that we cannot provide refrigerators or microwaves.
Dress in the appropriate uniform and attire for the prevailing weather conditions.
Wear your Credential badge.
Park in the Volunteer parking section.
Check-in at the Volunteer Service Center
Check-in at the Venue Medical Station and report to your Venue Medical Leader (VML).
Briefing: The VML/AVML will provide venue specific information including number of athletes participating, competition schedule, overview of standing orders, high-risk conditions, importance of good hydration for athletes and staff, location of nearest warming station, breaks and lunch break schedule, and assignment for the day.
Equipment/Supplies: Medical supplies and communications equipment will be distributed. Complete the communication/equipment checkout log as needed.
Deploy to your area as assigned and verify communications are working properly (if applicable).
Breaks will be provided throughout the day and a meal will be provided for you in the Volunteer Lounge.
Debrief: Meet with the VML/AVML at the end of your assigned shift and give a report of your day's happenings. Complete and submit all forms. Help clean-up, re-stock, etc.
Review schedule: Check the volunteer schedule to verify your next shift time.

Paperwork

As with most any job, there is paperwork that must be completed to ensure a continuity of communications. This job is no different and it is very important that all required paperwork is completed fully, accurately, legibly and submitted on time. All patients encountered by medical personnel will be documented on a Medical Encounter Form and/or Medical Log. Any (non-medical) incident or unusual occurrence will be documented on an Incident Report form. The inventory of medical supplies and equipment will be documented on the Medical Supply/Equipment Inventory form. There may be other paperwork required by your VML and/or the Venue Coordinator.

Miscellaneous

Media Policy

Medical staff is free to discuss their participation from a personal point of view as a volunteer in the 2001 Special Olympics World Winter Games ❋ Alaska. Medical staff is not to engage in discussions with the media concerning any medical conditions of participants, incidences involving participants, or complaints. The only media representative to whom you may speak about medical incidents is the

Venue's Media Leader. It is the Media Leader's responsibility to conduct a press conference to inform the media of all Games-related incidents. When relaying information to the Media Leader, please include only the facts; do not speculate.

Emergency

An Emergency Action Plan at each site under the direction of the Venue Director will be implemented in the event of an emergency requiring evacuation or a mass casualty incident. Your VML/AVML will provide direction if the Emergency Action Plan is activated.

Biomedical Waste Products/Hazardous Materials

Both the Medical Venue Team and the Safety Venue Team will have established procedures for handling biomedical waste products and hazardous waist materials. Each VMS will be equipped with the appropriate disposal containers.

Weather Issues

Snow, and extreme cold temperatures are possibilities during the 2001 Games. Weather conditions will be monitored closely. The VML/AVML will be notified of weather problems and will direct appropriate action.

Personal Belongings

Please do not bring any more personal belongings than is absolutely necessary. Rather than carrying a purse or large bag, a fanny pack to store a few items will be more convenient. Remember, this is a world event and security will very comprehensive, including the check by Security personnel of bags, purses, backpacks, etc.

Personal Calls

Please do not make personal calls while on-duty. Most all Venues will have pay phones that may be used while you are on break. We ask that you not bring your personal c-phone with you to the Venue. If you need to make an "emergency" phone call, the VML and the Venue Support Center have telephones.

Smoking/Drinking

We ask that you please not smoke at your assigned Venue, even on a break. If you absolutely must smoke, please find an area far away from athletes and others who may have be sensitive to second-hand smoke. Needless to say, please do not drink alcohol at the venue.

Medical Services Delivery System

Overview

One of the stated goals of the 2001 Special Olympics World Winter Games ❄ Alaska is to return the athlete to the competition as soon as medically prudent and feasible. Thus, there will be comprehensive medical services on-site at each Venue to enhance the athlete's opportunity to participate fully in the Games. The on-site medical services are staffed by professional Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Paramedics, EMT's, Ski Patrol, Behavioral Specialists, and other members of the allied health care profession.

Another stated goal is to alleviate the impact of a large number of people accessing the local medical community over the period of the Games. To that end, medical services will be provided utilizing a multi-tiered system consisting of the following:

1. On-site medical teams will provide medical assessment, treatment and transportation decisions for those who require medical attention.
2. If the medical incident is minor to moderate in nature (non-life threatening), and the patient requires treatment above the scope of the on-site medical staff, the patient will be transported (non-emergency) to the Polyclinic.
3. If at any time the patient becomes serious/critical or beyond the scope of the Polyclinic, the Anchorage 9-1-1 system will be activated and the patient transported by EMS to a local hospital emergency department. The Polyclinic staff may deem to utilize a non-emergency transportation service for interfacility transportation of a non-emergent patient.

   The medical system will have four levels of care:

   1st Level

   First-aid field teams under the administrative direction of the Venue Medical Leader/Assistant Venue Medical Leader and clinical direction of a medical provider will provide first-aid and evaluation on or near the field of play. Roving first-aid teams will also cover the various special events such as the Athlete Entertainment at the ACPA.

   2nd Level

   Venue Medical Stations under the administrative direction of the Venue Medical Leader and clinical direction of a medical provider, will be tents, trailers or a specified room in a building located on or near the field of play. Venue Medical Stations will treat mild cold-related illnesses, dehydration, sprains, observation, etc. Each venue will be equipped with a semi-automatic defibrillator (AED) that can be deployed in case of an emergency pending arrival of a paramedic crew. Certain venues (i.e., Airport, ACPA, etc) will not have a Venue Medical Station.

3rd Level

The Polyclinics will provide advanced care for illnesses or injuries. The Primary Polyclinic is located at HealthSouth 4001 Lake Otis Parkway, Anchorage, and the Girdwood Polyclinic is located on Hightower Road in the Girdwood Town Square. All non-life-threatening illnesses and injuries as well as conditions that can be treated within the scope of the Polyclinics' usual practices will be treated at these facilities. Referrals will be made from the Venue Medical Stations and Village first-aid teams to the Polyclinics. All referrals for specialty care will be generated by the Polyclinics.

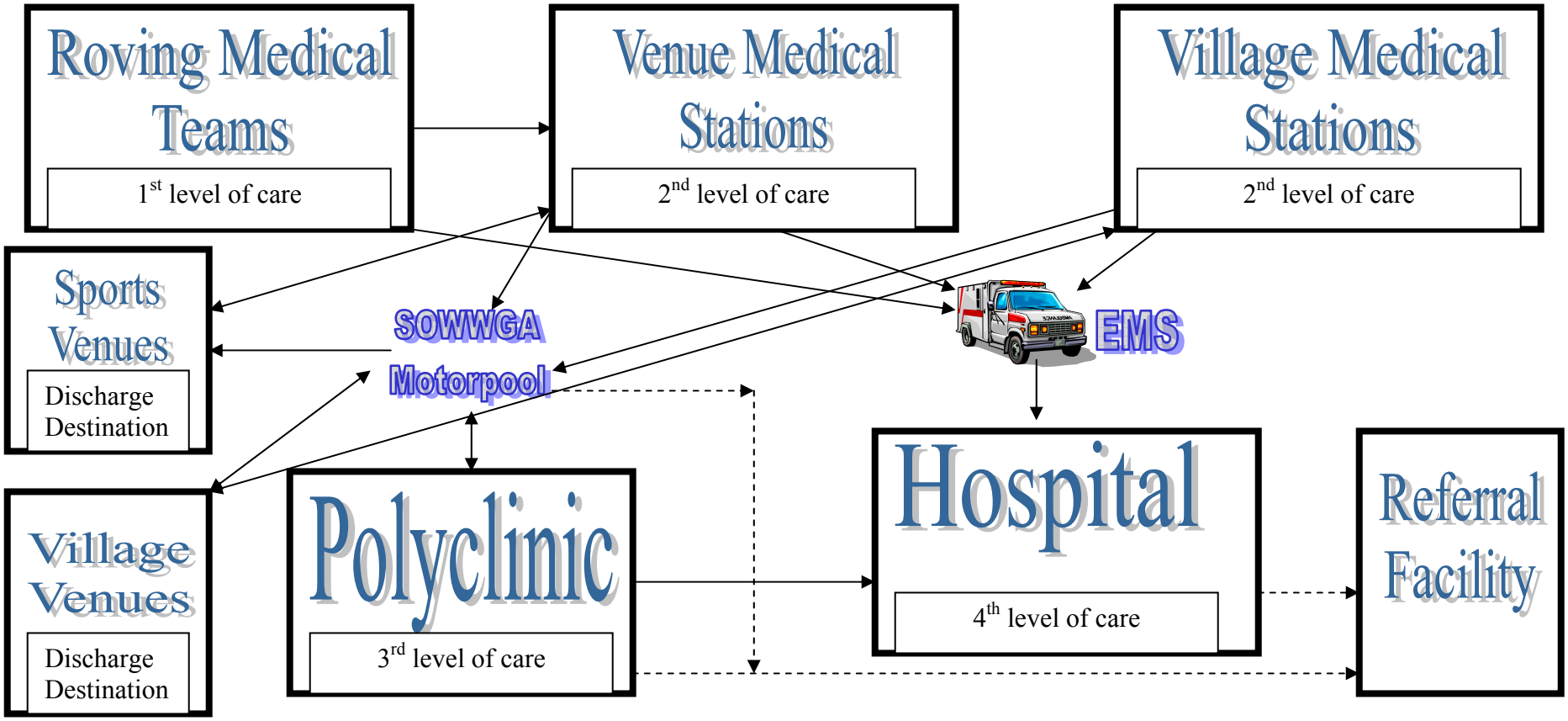
4th Level

Hospital services including emergency department and inpatient services will be provided by Providence Hospital, Alaska Regional Hospital, and the Native Medical Center. Other local hospitals may be used depending on the nature and scope of the illness/injury.

The figure on Page 10 shows a schematic of the medical care delivery system.

2001 Special Olympics World Winter Games ❄ Alaska

Medical Care Delivery System Diagram



Venue Medical Stations

Specialty care Venue Medical Stations will be in operation at seven (7) competition venues and four (4) non-competition sites. Field stations will be tents, trailers or specific rooms in a building equipped with medical supplies, cots, and medical personnel. These areas are designed to perform initial assessment of injury, to treat minor incidents, and to transport to one of the Polyclinics if the case is more serious. If the incident is life-threatening, the individual will be transported to the closest appropriate hospital by EMS units. Venue Medical Stations will be the communication point between the venues and Medical Command Center for command and control and for communicating medical records and other medical information.

The Venue Medical Stations will treat a variety of intermediate conditions including mild cold-related illness, dehydration, sprains, observation, etc. Each venue will be equipped with a semi-automatic defibrillator (AED) that can be deployed in case of an emergency pending arrival of a paramedic crew.

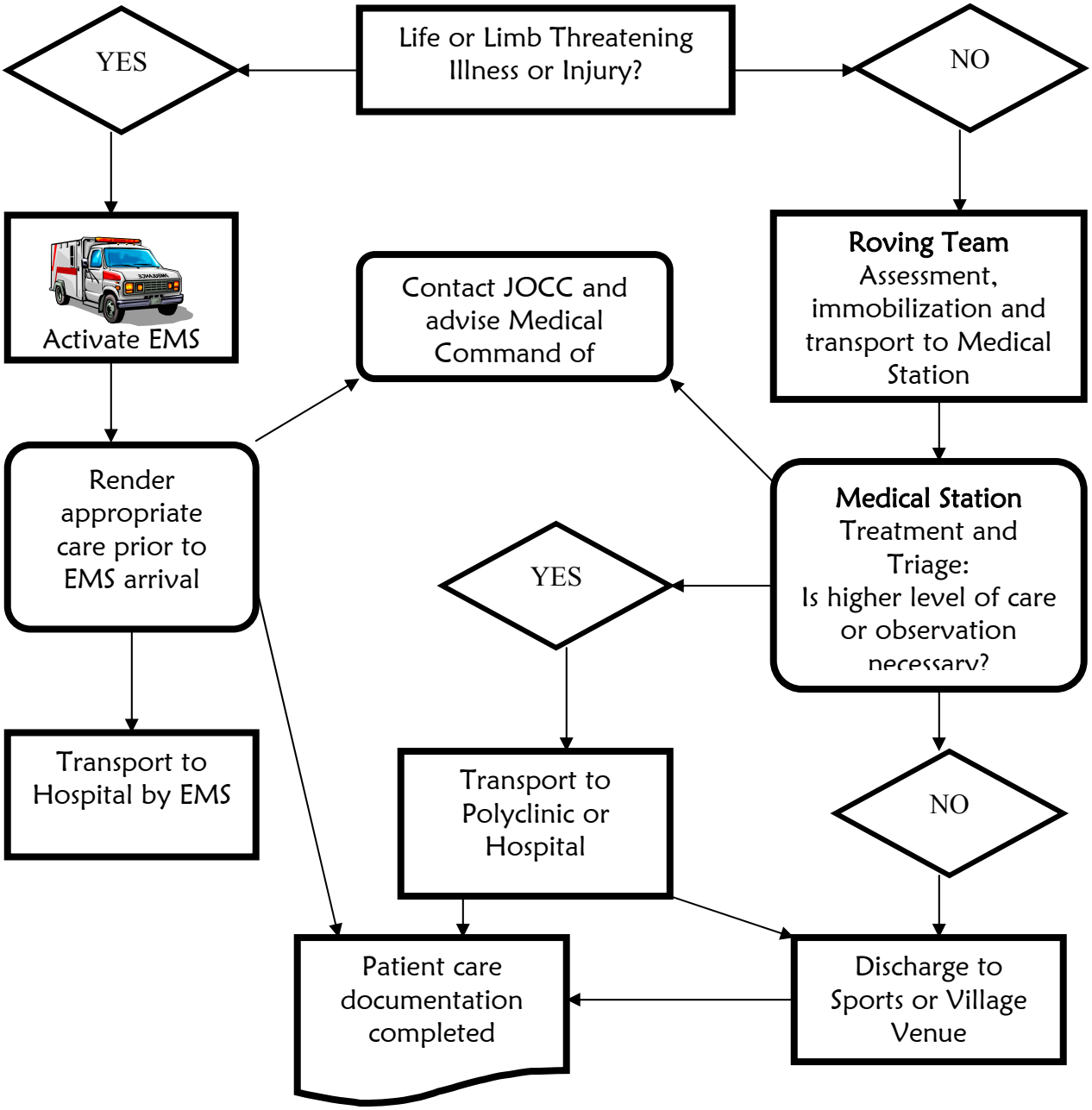
Each Venue Medical Station will have a team of medical professionals under the administrative direction of a Venue Medical Leader or assistant Venue Medical Leader. (See Appendix A for job descriptions for the Medical Team.) The VML/AVML will coordinate all medical activities at the venue. Most Venue Medical Stations will have a physician on duty or on call. First-aid field teams will provide first-aid and evaluation on or near the field of play for minor injuries or medical needs. If the condition requires the athlete to come off of the field of play, or is more serious, the athlete is taken to the Venue Medical Station for assessment and treatment. All members of the medical team maintain close contact and communication with each other.

- ***The combination of a static medical station and roving medical teams worked very well.***
- ***Staff each sporting venue with Athletic Trainers; their expertise is very beneficial. If possible, dedicate an area separate from the medical station to perform the athlete taping, etc. Also, order supplies specific to the Athletic Trainers needs.***
- ***Staff each sporting venue with Behavioral Specialist(s).***

The following diagram on Page 12 shows the triage algorithm.

Medical Care Delivery System

Venue Triage • Treatment • Transportation • Discharge Diagram



Polyclinics

The Polyclinics located at HealthSouth – 4001 Lake Otis Parkway, Anchorage and Girdwood Clinic, Hightower Road, Girdwood Town Square, will provide primary and urgent medical services for athletes and delegation members. The dates and hours of operation, communications, scope of medical services, etc. are described below.

a. Polyclinic - HealthSouth

The Anchorage HealthSouth Polyclinic will be in operation from February 28th through March 12th. Hours of operation are 24-hours per day. Prior to February 28th and after March 12th, participants may use the local area Hospital Emergency Departments of other medical clinics (urgent care centers) for urgent care during regular hours of operation (8:00 PM — 5:00 PM Monday through Friday).

Services include primary and urgent care for injuries, illnesses and/or medical conditions. Diagnostic services include lab testing and simple radiography. Medical supplies and services necessary to perform the defined level of care will be provided. Prescriptions will be filled and dispensed with appropriate patient education.

b. Polyclinic - Girdwood

The Girdwood Clinic will be available to athletes competing at the Alyeska Alpine Skiing Venue, March 4th – March 11th from 8:00am – 5:oopm. Prior to March 4th and after March 11th, participants may use the Girdwood Clinic for urgent care services during regular hours of operation.

Services include primary and urgent care for injuries, illnesses and/or medical conditions. Diagnostic services, including lab tests and simple radiology, are available as well as medical supplies and services necessary to provide the defined level of care. Prescriptions will be dispensed and patient consultation will be provided by the HealthSouth Polyclinic pharmacy.

- ***The Poly Clinics located at HealthSouth – 4001 Lake Otis Parkway, Anchorage and Girdwood Clinic, Hightower Road, Girdwood Town Square, provided primary and urgent medical services for athletes and delegation members. Services included primary and urgent care for injuries, illnesses and/or medical conditions. Diagnostic services included very limited lab testing and simple radiography. Medical supplies and services necessary to perform the defined level of care was provided. Prescriptions were either filled and dispensed with appropriate patient education from the Poly Clinic or called in to our primary pharmacy.***

Recommendations

- ***Establish as many Poly Clinics as necessary to serve the immediate needs of a geographical area (we had two, one in Anchorage and one in Girdwood 45 miles outside of Anchorage),***
- ***If utilizing an all-volunteer staffing plan, establish at least one leadership position in the Poly Clinic, 24-hours per day (i.e., provide extensive training to for the Medical Assistant position so that they may provide continuity from shift to the next),***
- ***Establish the following Auxiliary medical services, 24-hours per day, if possible:***
    - ***Laboratory services***
        - ***We utilized an outside laboratory only 7 times, but it was very important to have the diagnostic services available.***
    - ***Pharmacy services***
        - ***We filled 83 prescriptions on behalf of the athletes; this was a very important service.***
    - ***X-ray services***
        - ***We had 67 x-rays taken during the Games; very important.***
    - ***Medical Specialists***
        - ***Dental services***
            - ***We had twenty dental emergencies, some of which required minor oral surgery. The athletes were in a great deal of pain while waiting for these services, so try to establish 24-hour per day referral s, if possible.***
        - ***Behavioral Specialists***
        - ***Physical Therapy services***
            - ***We did not establish physical therapy services on a referral basis, and although I know of only two times it was requested, I was told by many that it is service that is expected by the delegations.***
        - ***Orthopedic Surgeon***
    - ***Other Services***
        - ***Public Health Department (CDC)***
        - ***Nutritional Specialists***
- ***Attempt to determine what the common illnesses will be in any geographical area for the time of year of your Games:***
    - ***We had 95 cases of upper respiratory problems (quite predictable for Alaska during the times the games were conducted).***
    - ***Have a complete supply of over-the-counter and prescription medicines for the common illnesses readily available at the Poly Clinic.***

Hospitals

Local hospitals will handle illnesses or injuries that cannot be treated at the Venue Medical Stations or Polyclinics. Whenever an athlete is taken to the Emergency Department (ED), the venue medical team or Polyclinic is to immediately provide the MCC with the patient's name, delegation, and description of the medical condition, including any known causes for the illness or injury. At the time the athlete is taken to the hospital, the ED staff is to be informed that the individual is a Special Olympics athlete. Providence and Alaska Regional Hospitals will set up special procedures for admitting, treating and tracking participants. The special procedures will be aimed at minimizing the time in the hospital, providing frequent updates on the participant's condition and coordinating care and discharge with the MCC. All participants, who are discharged from the emergency department or inpatient unit, will be discharged to the supervision of the respective Polyclinic for follow-up care as needed.

- ***Meet with key Medical Facilities and the key persons from all the key departments within the medical facilities (i.e. Administration, emergency department, billing department, admissions department, etc.):***
  - ***Determine how best to work within their systems of patient treatment, admissions, movement within their facility, and patient billing,***
  - ***Establish a system whereby the medical facilities know which patients will be covered by Special Olympics and which will be required to pay for their own services,***
  - ***We established a system whereby the patient must show his/her credential and then the facility called our Joint Operations Command Center (JOCC) to confirm and receive the sixteen-digit Participant ID Number for billing purposes,***
  - ***We also established a system whereby we could contact a key individual at any medical facility from the JOCC and get an update of the patient's status, in a very timely manner and with no unnecessary delays.***
  - ***We established a system to transmit patient records and consent forms directly to the appropriate emergency departments for those athletes that were being transported to the facility.***

Village Venues

Athletes and delegations will be housed in Village Venues that are made up of four (4) geographical clusters; North, South, East and West. There will be a primary Medical Station at one Village Venue at each of the clusters, each of which will be open starting February 28th, 24-hours per day, 7 days per week until March 12th, 2001.

a. North – Kenai Dorm #2

If medical care is needed by an athlete or delegation member residing at Kenai Dorm #1, Kenai Dorm #2, Kenai #3 or Matanuska Hall, the individual will report to the Kenai Dorm #2 Medical Station which is staffed 24-hours per day from March 2nd – March 12th. If the individual cannot physically report to the Kenai Dorm#2 Medical Station, the athlete may call the medical room directly for assistance. If the illness or injury is life-threatening, emergency services (9-1-1) will be contacted directly.

Medical coverage for the other North Village Venues (Kenai Dorms #1 & #2 and the Matanuska Hall) will be provided beginning March 3rd from 4:00pm until 8:00am. The medical personnel will be able to treat minor incidents at the Village Venue and, if the case is warranted, arrange transportation to the Polyclinic or the closest civilian Emergency Department. The medical teams will be accessed by walk-in traffic or by calling the medical room directly.

b. East – Holiday Inn

If medical care is needed by an athlete or delegation member residing at the Sheraton, Days Inn, or the Holiday Inn, the individual will report to the Holiday Inn Medical Station which is staffed 24-hours per day from February 28th – March 12th. If the individual cannot physically report to the Holiday Inn Medical Station, the athlete will call for assistance. If the illness or injury is life-threatening, emergency services (9-1-1) will be contacted directly.

Medical coverage for the other East Village Venues (Days Inn & Sheraton) will be provided beginning March 3rd from 4:00pm until 8:00am. The medical personnel will be able to treat minor incidents at the Village Venue and, if the case is warranted, arrange transportation to the Polyclinic or the closest Emergency Department. The medical teams will be accessed by walk-in traffic or by calling the Medical room directly.

c. West – Hilton

If medical care is needed by an athlete or delegation member residing at the Captain Cook, Hawthorn Suites or Hilton, the individual will report to the Hilton Medical Station which is staffed 24-hours per day from February 28th – March 12th. If the individual cannot physically report to the Holiday Inn Medical Station, the

athlete will call the Medical room for assistance. If the illness or injury is life-threatening, emergency services (9-1-1) will be contacted directly.

Medical coverage for the other West Village Venues (Captain Cook & Hawthorn Suites) will be provided beginning March 3rd from 4:00pm until 8:00am. The medical personnel will be able to treat minor incidents at the Village Venue and, if the case is warranted, arrange transportation to the Polyclinic or the closest Emergency Department. The medical teams will be accessed by walk-in traffic or by calling the Medical room directly.

d. South – West Coast International

If medical care is needed by an athlete or delegation member residing at the Best Western, or the West Coast International, the individual will report to the West Coast International Medical Station which is staffed 24-hours per day from February 28th – March 12th. If the individual cannot physically report to the West Coast International Medical Station, the athlete can call the room directly for assistance. If the illness or injury is life-threatening, emergency services (9-1-1) will be contacted directly.

Medical coverage for the other South Village Venue (Best Western Barrett Inn) will be provided beginning March 3rd from 4:00pm until 8:00am. The medical personnel will be able to treat minor incidents at the Village Venue and, if the case is warranted, arrange transportation to the Polyclinic or the closest Emergency Department. The medical teams will be accessed by walk-in traffic or by calling the Medical room directly.

Only four of the Villages medical stations were staffed 24-hours per day (with three, 8-hour shifts), and the same four Village Venue medical stations were the only Village medical stations available during the Host Team Program.

The medical station staff called up to the rooms of athletes who were taking prescribed medications to remind them to take their medications, in an effort to prevent illnesses secondary to not taking prescribed medications. The Village Venues encountered the largest number of "no-shows" of medical volunteers.

Recommendations

- ***For the Village Venues that are housing athletes and coaches, establish a Medical Station in each Village and staff all them 24-hours per day from the time the first delegations arrive until last delegations leave,***

- ***Consider utilizing two, 12-hour shifts instead of three, 8-hour shifts.***
- ***The Nurse-EMT-Medical Assistant staffing model worked very well.***
- ***The illness prevention system worked extremely well, we had no known illnesses secondary to non-compliance of medications regime.***
- ***The follow-up system worked very well for athletes who were treated at other venues and required follow-up at the Village medical station.***
- ***Consider providing the Medical Leader (and even the entire medical team assigned to that Village) with a room(s) at the Village. Benefits: 1) leadership on-site and readily available, 2) consistent medical team with knowledge of the athletes staying at that Village leading to a better continuity of care.***

Special Olympics Town – Egan Center
Healthy Athletes Program

The Healthy Athletes Program is an educational program for those athletes participating in the 2001 Special Olympics Winter World Games Alaska and its main purpose is to educate and to conduct screenings or provide other non-invasive services to the athletes:

The Healthy Athlete Program's practitioner's, for the most part, are not at Special Olympics Town to provide medical treatment, the medical well-being of the athletes is the responsibility of the Medical Services personnel. The Healthy Athlete Practitioner's have been advised to use common sense in determining the best course of action for treating an injured or sick athlete, always remembering that the athlete will be better served if Medical Services is involved.
If an athlete arrives at the Healthy Athlete booth with an injury, or sustains an injury while there, the first thing the practitioner will do is to assess the seriousness of the injury. If it is on the order of a minor cut or bruise, the Healthy Athlete practitioner will provide whatever treatment is required (if possible), then make sure that athlete's coach/guardian is aware of the injury and what was done to treat it. The practitioner will also let Medical Services know what happened, should they want to follow-up with the Athlete.

If the injury is more serious, the practitioner will either escort the athlete to the Medical Services area in the Egan Center, or have somebody from Medical Services respond to the site of the patient, if it is advisable not to move the athlete.

If the practitioner can provide the appropriate treatment, but it appears to be more involved that treating a minor injury, the practitioner will work with the Medical Services staff to devise the best course of treatment. Medical Services personnel may request that the practitioner continue to provide the treatment (especially if the practitioner is an MD, or higher level licensure), and the practitioner will make sure to receive permission from Medical Services personnel in making treatment decisions.

Sharing Medical Supplies

Although the Healthy Athletes Program and Medical Services are two different Functional Areas within the Games, Medical Services will assist the Healthy Athletes Program with re-supply of disposable medical supplies, if requested by a Healthy Athletes Practitioner. Durable medical equipment such as blood pressure cuff, AED, etc. will not be given to the Healthy Athletes Program. Please refer such requests to the JOCC - 343-1407.

Dental Emergencies

a. Athletes presenting with dental injuries, infections, or other acute problems will be evaluated at the site of presentation by a trained member of the Venue Medical Team (VMT) who will make the following judgments:

1. If the VMT determines that the athlete has a potentially life threatening dental emergency, the patient will be sent to the emergency department at Providence or Alaska Regional Hospitals.
2. If the VMT determines that the athlete is in need of immediate dental care, the Venue Medical Leader will contact the Polyclinic (HealthSouth) immediately. The Physician will determine the most appropriate location to send the athlete for dental care. The VMM will call the MCC as soon as the patient is dispatched with the patient's name, delegation, nature of the injury and the name, address and phone number of the provider of emergency dental services.
3. If the VMT determines that the athlete does not require immediate care, the patient may be referred to the Polyclinic for further evaluation and referral to a dentist as necessary. A listing of dental care referrals will be available through the JOCC and Polyclinic.
4. Any questions regarding dental care for Special Olympics athletes that cannot be addressed by the Polyclinic may be addressed to the MCC.
5. The charts in Appendix F describes dental injury and trauma.

b. A special dental program called "Special Olympics, Special Smiles" will be operating at Special Olympic Town (Egan Center) from March 1st – March 10th. This program, which provides education and screening only, is not related to the Medical Committee or its mission, but is a special program sanctioned by Special Olympics, Inc. as a component of the "Healthy Athletes Initiative." No referrals are to be made from the Medical Team to the "Special Olympics, Special Smiles" program.

Specialty Care

Limited specialty care such as orthopedic and ophthalmology services will be available. If a venue medical provider determines that such services are required, they should record their recommendations as "Other Discharge Instructions" on the encounter form. All referrals for specialty care except for emergency dental care will be generated by the Polyclinics.

Behavioral Support

a. Behavioral Support staff will be provided by North Star Behavioral Center and will have Behavioral Specialists at selected venues. When not present, Behavioral Support will be accessible by phone by calling the MCC or Polyclinic.

b. The role of the Behavioral Support Team is strictly consultative. They will advise medical staff on how best to handle situations involving behavioral concerns and related mental health issues involving athletes. In crisis situations where more intensive intervention is required, the Behavioral Support staff will assist the medical team in determining the most appropriate course of action. Mental health professionals with specialized training can be accessed in these crisis situations (e.g., psychiatrist, grief counselor, etc.).

c. Each Behavioral Support Specialist will be paired with another Specialist (when possible). One Specialist will be identified as lead. This person will be responsible for ensuring that the Behavioral Support Intervention Checklist is completed whenever behavioral supports concerning a specific individual are required.

d. North Star Behavioral Center, located at 2530 DeBarr Road will act as the referral center for all behavioral situations requiring more definitive care.

Joint Operations Command Center

The medical system will be supported by a Joint Operations Command Center (JOCC), in which is housed the Medical Command Center and Medical Control. The JOCC is located within the City of Anchorage Emergency Operations Center at 1309 E Street, Anchorage. The main telephone number is (907) 343-1448 and the FAX line is (907) 343-1444.

Medical Command Center

The Medical Command Center (MCC) is the central internal operational support for the Medical and Operational Leaders, and the volunteer medical professionals during the 2001 Special Olympics World Winter Games ❄ Alaska. The purpose of the MCC is to ensure that the medical operations at all of the venues have the oversight and resources needed to provide professional, time-efficient medical services. The direct telephone number to the MCC is (907) 343-1407.

Responsibilities of the MCC

- Assist the medical operations at each of the Venues by providing direction, logistical support, or acting as a resource for issue identification or clarification.
- Monitor the status of each Venue identifying such situations as: event start time and expected closure, personnel levels and information pertinent to the operations of that respective site.
- Monitor and re-deploy personnel levels and equipment needs among the various Venue sites.
- Provide rapid liaison with other functional operations such as security, transportation, logistics, language services, the local health care community, etc.
- Provide rapid access to resources not available on-site at the Venue.
- Trouble-shoot and handle situations that can (and should) be solved at an administrative level.
- Clearinghouse for all medical records and information:
  - ➤Maintain, disseminate and update medical records requested by authorized medical personnel.
  - ➤Collection point for all medical records, historical and contemporary (Patient Encounter Forms, Patient Refusal Forms, etc.).
  - ➤Maintain a log to track all medical incidents that occur during the Games.
  - ➤Assist the Games Media Department with public relations or media briefings.

Staffing of the MCC

The MCC will be staffed 24-hours per day by a volunteer capable of managing multiple priorities and knowledgeable of local resources. The Medical Services Manager and/or a Co-Commissioner will be present or "on-call" for additional support.

Joint Operations Command Center

The Joint Operations Command Center (JOCC) is the command and control structure for the 2001 Special Olympics World Winter Games ❄ Alaska. The JOCC is responsible for operation of the 2001 Games and ensuring coordination among and between functional departments (e.g.,

Security, Transportation, Medical, Logistics, etc.). A representative of each functional area will participate in the JOCC. The Center will be linked with all Venues by Network computers, radio communications, fax machine, and telephone lines.

The JOCC hours of operation once the Center is operational are 24 hours per day, 7 days per week. The operational time-line is as follows:

Activity	***Hour***	***Date***
Set-up	0800	February 25
Operational	1200	February 27
Stand Down	1200	March 13

The JOCC shifts are as follows:

Time	***Shift Name***
0800-1600	Red
1600-0000	Blue
0000-0800	White

Responsibilities of the JOCC

There are three basic JOCC functions:

1. Receive Information
2. Analyze Information
3. Distribute Information

In that context, the JOCC will:

- Handle situations between functional areas that cannot be coordinated at specific Venue sites.
- Track all major incidents that may effect multiple functional areas.
- Collect pertinent records or information from all departments (Daily Venue reports).
- Provide for the sharing of information or resources available to all functional areas.
- Make command decisions in the best interest of the Games Organizing Committee.

Staffing

A volunteer with sufficient knowledge to coordinate medical needs at the various venues will staff medical. This may include scheduling or directing appropriate athlete medical records to medical service providers, reassignment of additional medical volunteers, obtaining and directing the delivery of additional medical supplies, and communicating with Venue Medical staff, hospitals, and clinics. The medical volunteer will also maintain incident logs and prepare daily reports of activities.

The JOCC had a Medical Command Station (MCS) that was staffed 24-hours per day by one position to act as a resource for all the venue medical stations, issue medical incident numbers, maintain medical records and to transmit all medical records and consent forms to local area medical facilities in the event an athlete was transported to a facility.

Recommendations

- ***Regardless whether the GOC establishes a multifunctional JOCC, there must be a Medical Command Center to coordinate a variety of medical activities throughout the Games.***
- ***The Medical Command Station (MCS) should be staffed by the following personnel:***
  - ***Two call-takers/medical incident processors,***
  - ***One clerical person***
  - ***One Staffing coordinator***
  - ***One Medical supplies coordinator (optional)***
- ***Staff the MCS with same personnel, to the extent that it is possible. The major benefits to doing this are:***
  - ***It will be easier to conduct MCS training and orientation with a smaller group of persons,***
  - ***The MCS staff will be more familiar with the Games, available resources, etc., and there will be more consistency in the MCS procedures,***
- ***It would be most beneficial to have at least one vehicle and driver available to the MCS to run essential errands (delivering medications, transporting volunteer personnel from one Venue to another, emergency supply delivery, patient transportation, etc.),***
- ***The MCS should have a minimum of three telephone lines and one dedicated FAX machine for incoming faxes and one for outgoing faxes.***
- ***The MCS should have a minimum of two computers with a shared printer.***
- ***Attempt to capture as much patient information on a "real-time" basis as possible:***
  - ***Utilize a database program in the JOCC that is specifically written to capture the medical information you require,***
  - ***Staff the JOCC with at least three medical personnel (I would really recommend more) to accomplish the variety of tasks that must be performed, one of which is to capture as much patient treatment information as possible. (The medical incidents will happen at a frantic pace),***
  - ***Complete development and test this database program at least two months prior to the Games.***
- ***If a fully-functional JOCC is established by the GOC, all essential Functional Areas should be represented in the JOCC, 24-hours per day (i.e., Transportation, Information Technology, GOC Director, Security, Language Services, etc.).***

Medical Records

A. Content of Medical Records

1. Medical records will be available for the following persons participating in the Special Olympics World Games:
   a. Athletes
   b. Game Organizing Committee Staff and Officials
   c. Coaches and Heads of Delegations

2. Athlete medical records in English will consist of the following:
   a. Background and Emergency Contact Information (Form E).
   b. Medical Record (Form E) includes history of diseases, problems, immunizations, allergies, etc.
   c. Medical Examination (Form E) includes medications and Physician Information Special Release For Athletes with Atlanto-Axial must be submitted with Form E if an athlete has atlanto-axial instability present. Waiver and Release of Liability Statement (Form F) If the athlete or athlete's parent does not want to sign this document for consenting to emergency medical treatment then they must submit the Special Provisions Regarding Medical Treatment form with Form F.

3. Medical records of Coaches and Heads of Delegations (HOD) will be in English and will consist of the following:

1. Background and Emergency Contact Information Medical Record includes history of diseases/problems, immunizations, allergies, special diets, medications and physician information.

It should be noted that Coaches and Heads of Delegations might not have their medical records with them. If that is the case, Medical personnel are still responsible for treating them.

5. Medical records of the GOC /Officials and Coaches! Heads of Delegations contain the identical information; however, the two forms will be distinguished by the title and location of the logo. The Logo for Coaches/Heads of Delegations is located at the bottom of the right hand corner. GOC/Officials' logo is located at the top right hand corner of the medical record. An example of the GOC/Officials medical record is at the end of this section.

B. Location and Storage of Medical Records

1. Athlete medical records will be stored at the Medical Command Center (MCC) both as hard copies and electronically. The hard copies will be filed by country. In addition, electronic copies of the records will be kept at the Polyclinics for the Polyclinics' use only. Electronic copies of the record will contain only Form E Information. The athletes' coaches should have copies of the athletes' records with them.

2. GOC/Officials medical records will be stored at the Medical Command Center and filed only as a hard copy.

3. Coaches/HOD medical records will not necessarily be the responsibility of the MCC. It will be the responsibility of each Coach or Head of Delegation seeking treatment to have their respective medical record with them.

C. Access To Medical Records

1. During competition, the most recent and updated copy of the Athlete's record can be obtained from the network server via the computer at the VSC. Should the network fail, or in cases where medical records cannot be computerized, hard copies will be faxed. As back-up systems, the computer located in the VSC has the medical records on a CD-ROM or the Venue Medical Station will have a hard copy in a 3-ring binder. Coaches have been requested to have athletes' records with them during the games (those who have serious medical problems, only); however, situations may arise in which the coach does not have the records. Coaches should be asked if they have a copy before calling the MCC.

2. GOC/Officials copy of records can be obtained from the MCC via fax or accessed on CD-ROM at the VSC.

3. Medical records for Coaches/HOD will need to be obtained from them. Keep in mind that there may be the possibility that they will not have their records at the time of contact. If not, contact the MCC for their records.

4. If limited information is needed from the medical record or information is needed quickly from the record, information can be accessed by having the MCC phone operator read it to the site.

D. Other Medical Information

2. Each athlete will have an accreditation badge. The accreditation badge will have a Participant ID number (#). This ID # will also be on the Medical Record. The number is a unique identifier for the athlete and it will be used to link data from medical encounters to athletes' medical records. For those athletes that have preexisting conditions noted on their medical records, their accreditation badge will have alpha code(s) below the Participant ID number that will denote the following type conditions:

Pre-existing Condition	Code
Allergies	A
Diabetes	D
Seizures	S
Heart Problems	H
Asthma	I
Bleeding Problems	B
Atlanto-Axial Instability	X
Hearing Impaired	E

The codes for the pre-existing conditions will be posted at the Venue Medical Stations for quick reference.

2. Documented medical encounters will become a part of the medical record as they occur. Completed encounter forms, Supplemental Sheet for Logs and Encounters, Behavioral Support Intervention Checklist and Polyclinic Consultation Record forms will be appended to the medical record. Use of these forms is addressed below in Medical Tracking of an Athlete.

E. Confidentiality of Medical Records

All medical records information and any other medical information related to an athlete, GOC staff, HOD, Officials and Coaches must be kept confidential. Those who can have access to the medical information are staff at MCC for purposes of managing records, faxing records, data entry, etc., medical personnel involved in treating athletes and those who are assisting medical personnel in the treatment of athletes, i.e., administrative assistants.

- ***The most efficient method to store and access medical records and consent forms is to have all documentation contained within a database system (preferably the GMS database). The ability to print or fax the documentation rapidly is very beneficial***.

- ***"Real-time" tracking of an ill or injured athlete, coach, Head of Delegation, official, etc. was documented in one or more of the following ways:***
    - ***Patient Log: Venue Medical Station***
    - ***Patient Log – Master: Medical Command Center***
    - ***Patient Encounter Form: All Venues, all patients***
    - ***Supplemental Sheet for Logs and Encounter Forms***
    - ***Patient Refusal forms***
    - ***Behavioral Support Intervention Check List***
    - ***Poly Clinic Consultation Record***

And then faxed to the JOCC to be entered into the medical incident tracking system database.

- ***The medical incident tracking system would be more effective and efficient if 1) the database program were written specifically to capture pertinent medical information, and 2) incorporated into the GMS database system. Benefits include:***
    - ***Records are maintained and updated with all other Games-related information,***
    - ***SOI has greater control over the records,***
    - ***Reports and statistics will be comprehensive and consistent from game-to-game.***

Medical Tracking of an Athlete

A. General Information

1. Each time an athlete, coach, Head of Delegation, official or a member of the GOC has an encounter with the medical system, a host town medical provider or other designated medical provider, contact will be documented in one or more of the following ways. (With the exception of athlete, others named above will be referred to as others throughout.)

    - Patient Log: Venue Medical Station
    - Patient Log – Master: Medical Command Center
    - Patient Encounter Form: All Venues, all patients
    - Supplemental Sheet for Logs and Encounter Forms
    - Behavioral Support Intervention Check List
    - Polyclinic Consultation Record

Instructions and examples of Forms are located at the end of this section.

2. An athlete or others may have multiple contacts with medical sites and other medical providers for the same problem. An encounter form is used for each instance. For example, an athlete that is injured during a game, requiring follow up visit at the Polyclinic, needs to have a medical encounter form completed for each contact.

3. If an athlete needs to seek treatment from a medical provider in a host town for other than a minor illness or injury, the medical provider will contact the Medical Command Center (MCC). Staff answering the phones at the MCC will obtain the information requested on the MCC Encounter Form from the Medical Provider.

4. In a host town if an athlete receives a serious injury, develops an illness that requires hospitalization and/or extensive follow up, the physician's on-call through the Physician Oversight System will need to be contacted. Contact information for the physicians will be available at the MCC.

5. If an athlete needs emergency dental treatment from a medical provider, the medical provider will contact the Medical Command Center (MCC). Staff answering the phones at the MCC will obtain the information requested on the MCC Encounter Form from the Dental Provider.

6. Every athlete will have a unique Participant ID number that will need to be recorded on all tracking forms. The Participant ID number can be obtained from the athlete or the coach. This Participant ID number will be important for purposes of generating computer reports and linking data from encounter forms to the athlete's medical record.

B. Patient Log and Encounter Forms

1. All medical sites including the Polyclinics, roving teams, etc. are to document all medical encounters by athletes and others on the Patient Log. This includes those encounters that will additionally need to be documented on the specific encounter forms. Patient logs are faxed to the MCC at the end of each day.

2. Medical encounters by athletes or others for basic first-aid or basic interventions by athletic trainers that do not require medical assessments by licensed medical personnel can be documented on the Patient Log. Examples of such situations would be providing a Band-Aid, taping of an ankle, over the counter medications such as Tylenol, ASA, Ibuprofen, etc.

3. Encounters that require the assessment of licensed medical personnel will be documented on the Patient Log and on the specific encounter form depending on whether the assessment is for an illness or an injury.

4. Behavioral Supports' Intervention Checklist will be completed when the help of a Behavior Support volunteer is required for a specific individual. The Behavioral Support Specialist will be responsible for completing the form and submitting it to the appropriate medical venue staff for filing and faxing to the MCC. The Behavioral Supports Intervention Checklist is faxed to the MCC when the encounter form is faxed or if no assessment was completed it is faxed when log is faxed at the close of Venue Medical Station at the end of the day.

5. Though not normally treated by the venue Medical Team, if a volunteer or spectator needs minor treatment, document the request on the Patient Log. If an assessment is required, document the request on the Patient Log and the assessment on a Safety Encounter form obtained from the Safety Team.

6. Filing

   a. Patient logs are filed by date at the venue where generated.
   b. Patient Encounter Forms and Behavioral Support Intervention Checklists are attached

to the front of the medical record, if available, and filed by date at the venue where generated.

C. Tracking

1. Medical sites fax completed Patient Encounter Forms to the MCC as soon after completion as feasible. If the encounter results in emergency transport to a local hospital, the encounter form should be faxed as soon as possible after the EMS has left the site and the MCC has been notified by phone/radio.

2. Once the MCC receives the encounter forms, the computer data entry volunteer will enter the information into the computer.

3. Reports on the status of athletes will be faxed as follow.

   a. Competition venues will receive a report before the start of the first game each day.
   b. Polyclinics will receive reports twice a day: 5:30am and *5:30pm.*
   c. Center for Delegations at each village will receive copy of reports once a day. Reports will be faxed to the Centers some time after closing of the last game each evening.
   d. The Joint Operations Command Center will receive copies of reports prior to 8:00 each morning and evening.
   e. Hard copies of current reports will be kept at the phones for volunteers at MCC to refer to if needed.

D. Supplemental Sheet for Logs and Patient Encounter Forms

1. The Supplemental Sheet is used for documenting any additional medical information not entered on the Patient Log or Patient Encounter forms. The judgment of whether or not to use this supplemental sheet is up to each medical staff volunteer. The forms can be used for supplementing information on the patient encounter forms and/or patient logs. An example is at the end of this section.

2. The supplemental sheet can be faxed with the patient encounter form that it is augmenting or, if it supplements a log it can be faxed at the close of the site with the log.

3. The Supplemental Sheet will be attached behind the patient encounter form that it is augmenting or the patient log it supplements and filed at the venue where it is generated.

E. Medical Referrals

1. Only Polyclinic medical providers may refer patients to specialists, i.e., orthopedist, ophthalmologist. Field venues or other medical sites may not initiate a medical referral to specialists.

2. If the Polyclinic medical provider refers a patient to another provider, JOCC should be contacted by phone.

3. There is a specific form, Polyclinic Consultation Record, to use when making referrals to other medical providers. An example is at the end of this section.

4. Once the referred provider has seen the patient, the Polyclinic will fax the completed consultation record to the JOCC.

Communications

A. Venue Medical Leader (VMM) Communications

Under optimum conditions the VML/AVML will have **a** cellular phone and **a** two-way radio.

1. Cellular Phone

The VML/AVML will have a cellular phone. This will allow the VML/AVML to communicate directly with the MCC, the Venue Medical Station, the Medical Services Manager or the Polyclinic (Medical Director). It will also allow the VML/AVML to communicate directly with any EMS unit assigned for stand-by duty at the venue. In the event no EMS unit is assigned stand-by duty at the venue and emergency transportation is needed, the VML/AVML can utilize the cellular phone to dial 9-1-1 directly and request an ambulance.

2. Hand-Held, Portable Radios

The two-way radio is capable of local communications within the venue and wide area communications. The local communications channel is to be used to communicate with the field teams, medical tent, etc. Other local communications channels will allow the VML/AVML to communicate with the Security Leader and other venue leaders.

The VML/AVML two-way radio will also have the ability to switch to a wide area frequency that will allow the VML/AVML to communicate with the Medical Command Center (MCC) and the Joint Operations Command Center (JOCC).

RADIO GUIDELINES

General Rules

- Stay on your assigned channel (talk group). Never lay your radio down unattended. Do not lose your radio.
- Never give your radio to anyone else. You are responsible for your radio until returned.
- Report all lost or stolen radios the Radio Communications Leader immediately.
- Report all maintenance problems to the Radio Communications Leader immediately.
- Never give confidential information over the radio…use a telephone.
- For **non-emergency** concerns - contact your leader.
- For **Medical Emergency** – call for Medical Leader on Channel 1 or switch to Channel (2) Medical Net and call for assistance.
- For **Security Emergency** – call for Security Leader on channel 1 or switch to Channel (3) Security Net and call for assistance.

Radio Etiquette

- Never use profanity. It is a violation of FCC regulations.
- Be professional. Radios are a tool to help you do your job, NOT make social commentary.
- Only one person can talk on the radio at a time. It is not a telephone.
- Remember there are many other radio users on your fleet who will hear you talking and would like to use the radio for their business needs.
- Think about what you want to say before you push the talk button.
- Be brief. Five (5) seconds is the target time limit.
- Speak slowly and clearly. Be concise but give complete factual information.
- Keep the volume at an easy level for you to hear but not disturb others near you.
- Volume down in **QUIET ZONES**!

Radio Operation

- Turn radio on.
- Set assigned channel (talk group).
- Adjust volume for easy listening.
- To talk:

  Hold radio up to your face in a vertical position.

Place microphone opening about 2 inches from your mouth.
Press the push-to-talk button all during your transmission then release to listen.

Radio Protocol

- **LISTEN** before you talk. Only one person can talk at a time.
- To make a radio call, sat the person's name you are calling, your name, then OVER.
  Example: Joe this is Rachel, OVER.
- To end a radio call, say the word OUT or CLEAR so others know its OK to begin their call.
  Example: This is Joe; I'll take care of that now, CLEAR.

Radio Terminology:

- **THIS IS** -who is making the call.
- **OVER** -I'm finished talking, you can talk now.
- **OUT or CLEAR** -I am ending this radio conversation.
- **SAY AGAIN** -Repeat your last transmission, I did not understand.
- **STAND BY** -Wait a minute while I finish other business.
- **COPY** -I understand.
- **BREAK** -Used to interrupt a conversation in case of emergency.

B. SOWWGA Motor pool Non-Emergency Transport Units

SOWWGA dispatch will have real time knowledge of the status and location of SOWWGA transport units via cellular telephone or SOWWGA radios. This will allow Motor pool dispatch to track SOWWGA vehicles and make informed decisions regarding relocating Motor pool resources as the need arises.

1. Cellular Phone

   SOWWGA transport units will have a cellular phone to communicate with Motor pool dispatch, the VML/AVML and others as needed. Motor pool units assigned to venues will report to the VML/AVML upon arrival at the venue. Motor pool units will consist of a driver and a medical provider and are charged with the mission of transporting athletes, Heads of Delegation, coaches, Officials and GOC staff in non-emergency situations to the Polyclinics or other location as appropriate.

2. Radio

Motor pool units will also have two hand held radios. One will be issued to the driver and one will be issued to the medical provider for the purpose of communicating with each other. This will allow the Motor pool driver to stay with the vehicle and the Motor pool medical provider to assist the VMI/AVML until the need arises for Motor pool non-emergency transport. At that time the VML/AVML would dispatch the Motor pool transport unit on site via cellular phone. Motor pool personnel will then use their radios to contact the other person and report back to their vehicle for transport.

C. EMS Units at Venues

1. EMS units will be staged at some venues. Those units will be on standby to transport emergency patients from the venue to area hospitals. When arriving on scene, EMS unit personnel will report to the VML/AVML. EMS will transport any medical emergency requested by the VMI/AVML. This includes athletes, coaches, delegation members, volunteers and the general public.

2. EMS will also have their own EMS radios to facilitate contact with local EMS Dispatch and area hospitals.

3. Venues that do not have EMS units assigned for standby will utilize the VML/AVML to contact EMS via 9-1-1 for any emergency transport.

D. Venue Field Medical Teams

Field Medical Teams at each venue will communicate with the VML/AVML via two-way radio on the venue local frequency. Radios will be issued to field medical teams by the VML/AVML.

E. Physician Oversight Communications

The physicians having medical oversight responsibilities will have pagers, cellular phones and wide area capable two-way radios under optimum equipment availability. They will be available for consultation 24 hours a day during the games. The VML/AVML, MCC, and MOC can contact the medical oversight physicians via cellular phone, two-way radio or pager.

F. Behavioral Support Personnel

Behavioral support personnel will be available 24 hours a day during the games and can be contacted via pager or cellular phone by the MCC.

G. Other Communications

Other types of communications include fax machines, personal computers with modems, pagers, and hard-wire telephone. Fax machines, personal computers and hard-wired telephones at venues are the responsibility of the technology committee. Pagers will be issued as appropriate to certain personnel.

H. Communications Equipment Check Out *I* Check In

The VML/AVML assigns communications equipment at the beginning of each shift. The volunteer is responsible for completing the communication equipment checkout log as needed. An example of the log follows this section.

- ***Develop plans and procedures for every type of communications that will be utilized (i.e., radio's, fax machines, computers, telephone, cellular telephones, etc.),***
- ***If radio's are to be utilized, test their effectiveness at each Venue prior to the Games,***
- ***A written telephone directory of all essential phone numbers is most beneficial during the Games (i.e., all GOC staff, essential Functional Area Leaders, each Village Venue medical station and fax machine, Language Services interpreters, etc.)***

I. Shift Change/Assignment Arrival Procedures

The following is a guideline to ensure a smooth and complete shift change for those Venues that have multiple shifts.

When You Arrive at a Medical Station:

1. Locate the medical station and report to the people you are relieving. Be sure to get the keys for the locks and any other information needed.

2. Sign in and radio or call the Medical Command Center (907) 343-1407.

3. Become familiar with your supplies, documentation, equipment, medications and their locations.

4. Complete change over log of medications and drugs where appropriate.

5. Check the daily schedule to familiarize yourself with events and or special events that may be occurring in your area of responsibility.

6. If there are enough medical personnel available, establish teams and assign rotation from roving to station on an hourly basis. This will help limit exposure to the cold and/or prevent burnout and allow everyone an opportunity to see more aspects of the Venue.

When You Dispense Medications:

1. If you are approved to dispense over the counter medications, if you are not sure contact the JOCC or the Poly Clinic.

2. Identify the proper patient and consult their medical records for allergies and past history, if in doubt contact the JOCC or the Poly Clinic.

3. Before Dispensing ask the appropriate questions:
   a. Confirm proper dosage.
   b. Confirm proper medication
   c. Confirm proper route.
   d. Confirm correct patient.
   e. Confirm correct time.

4. Complete the Venue Patient Log by logging your encounter on the form.

Incident Reporting

An Incident Report Form shall be completed when:

a. An incident or accident occurring during the Games, including exposure to Bloodborne pathogens,
b. When a patient is injured or harmed during the Games while a volunteer is providing care,
c. To report lost or stolen equipment and/or supplies,
d. Any unusual occurrence that may have consequences (immediate or future).

Procedure:

1. When a volunteer is involved in an incident, they are to alert the Venue Medical Leader, Security or the Venue Coordinator, immediately via portable radio.
2. The VML, Security or VC (or designee) responds to the scene to investigate, if appropriate photos and statements are taken.
3. The volunteer(s) will complete the Incident Report Form in full, including signature.
4. The Incident Report Form is turned in to the VSC by the end of shift.
5. Security, VML or the VC completes the report and submits the original form to the JOCC prior to the end of the shift.

Supplies & Equipment

A. Medical Site Equipment

Each VML/AVML assessed their assigned venue and identified all equipment needed to make the Venue Medical Station functional. This list was developed as though the VMS was totally bare even if some equipment/furniture was in place. For example, if using an existing room that is outfitted with a table and chair, the table and chair were included on the equipment list. The Logistics Department will deliver the identified equipment to the designated room or trailer. Each Venue Medical Leader is responsible for setting up their respective Venue Medical Station before the venue opens either on a day before events are scheduled or early enough on the first day of events. The VML/AVML will verify the availability of all needed equipment prior to the start and on a daily basis thereafter.

B. Medical Supplies

Medical supplies that are needed to provide primary first-aid are available at each venue. Supplies have been organized according to their use and packed into clearly labeled bins. The bins are General, Medications, Doctor, Suture, IV and Emergency. A list of supplies in each bin or box will be located on the outside for quick reference. The list of medical supplies is in Appendix B.

1. Initial stock

Medical supplies will be delivered to the venue prior to the start of the Games' competition. The VML/AVML will verify the availability of all needed supplies prior to the start and on a daily basis thereafter.

2. Reordering Procedures

a. Routine Re-Supply of Medical Supplies

1. If reorder is needed, Venue Medical Leader or Assistant Venue Medical Leader completes Request Form and faxes it to the Central Warehouse no later than 6:00pm (1800 military time). An example Medical Supply Request Form is at the end of this section.

2. Central Warehouse reviews requests for accuracy.

3. Central Warehouse prepares venue specific restock bin with requested supplies.

4. SOWWGA delivers supplies to the Venue before the start of the next day's competition

b. Emergency Re-Supply of Medical Supplies

1. Venue Medical Leader or Assistant Medical Leader checks with adjacent site (if applicable) and borrows supplies until routine re-supply request can be made (Each venue is responsible for reordering supplies.)

2. If supplies cannot be borrowed or there are no adjacent venues, Venue Medical Leader or Assistant Medical Leader completes Request Form, marks it EMERGENCY, faxes it to Medical Command Center and then calls the Medical Command Center to confirm receipt of the request

3. The Medical Command Center will explore options to provide each venue with needed emergency supplies

3. Disposal of Used Materials

Each venue will have established procedures for handling waste products including hazardous waste products. Each VMS will be equipped with the appropriate disposal containers. Protocol will be posted as appropriate.

4. Disposal of Unused Materials

All unused materials are to be inventoried using the list of supplies located on the outside of each bin and packed into the appropriate bin for pick-up at the completion of the Games. Unused medical supplies are not to be distributed to anyone.

- ***Contact manufacturers and vendors to have medical equipment and supplies donated to the greatest extent possible.***
- ***If possible have the Games logo (and the manufacturers/vendors logo) appear on medical supply items and provide them as "give-aways" to volunteer medical staff (i.e., personal protective equipment, fanny packs, etc.***
- ***We placed all equipment and supplies into 100-quart, plastic bins and delivered the supplies to each Venue in these bins; the bin system worked very well.***
- ***Have all medical supplies and equipment in the warehouse and ready for distribution at least one month prior to the start of Games, if possible. For each Venue, we placed all bins and equipment for that Venue on a wooden palate and wrapped it with plastic "shrink-wrap" material for delivery; this system worked very well.***
- ***Have dedicated vehicles and drivers for the re-supply of all Venues; be flexible as medical supply requests may come in at all hours of the day and night.***

Pharmacy Policy & Procedures

A. Routine Medications

Many Special Olympics Athletes take chronic, maintenance medications. Some others will be taking short courses of medications such as antibiotics during their visit here. The following policy applies to dispensing such medication:

1. Athletes, who while at home, take responsibility for self-administration of medications will continue to do so;

2. Athletes who are assisted by a parent, guardian, or other responsible person when taking medications will be assisted by the guardian who accompanies them to the 2001 Special Olympics World Winter Games ❄ Alaska. This may be their coach, a parent or a chaperone. It is the responsibility of each delegation to make its own arrangement concerning administration of medications.

3. The VMS's and Polyclinics will not assume responsibility for administration of routine, chronic or short-term medications.

4. In the event that an athlete loses his or her supply of maintenance medications, these will be replaced through the Polyclinic. A supply sufficient to last through March 15th will be dispensed. If the identical drug is not available in the US, the closest equivalent will be dispensed. If the Polyclinic does not have the drug in stock, then they will contact a local Pharmacy to deliver it, along with the drug monograph, to their site.

B. Point of Care Drug Administration

Initial doses of common medications will be maintained at each VMS and the two Polyclinics. Medications will be available 24-hours per day at the Polyclinic from medical staff on duty, as needed. Medications will only be dispensed by RN's, PA's, NP's DO's and MD's.

C. New Prescriptions

If a course of medication is indicated, a "starter pack" sufficient to last until the following morning will be dispensed (if it is one of the more commonly used medications). The physician ordering the drug will complete a prescription, which will be faxed to the appropriate Polyclinic. The Polyclinic will prepare the prescription, and the athlete and chaperone will pick up the prescriptions at the Polyclinic or arrange to have it delivered to their Village Venue.

If dental prescriptions are required after a dental visit, the athlete and chaperone can go directly to a local Pharmacy to have the medication dispensed.

D. Managing Pharmacy Stock

The Medical Leader at each competition venue and non-competition site will have oversight for dispensing and inventory control of pharmaceuticals. A locked box and Controlled Drug Log will be available at each site where controlled substances are stocked. When a controlled substance is dispensed, record the patient's name, the name of the drug, the date and the name of the person dispensing. An example of the Controlled Drug Log is at the end of this section. At the close of each day, the Medical Leader will inventory drug stock and fill out a Medical Supply Request Form. This should be faxed to (907) 277-2866**.** The warehouse will prepare a packet for each site's needs for delivery by the morning supply run.

At the closing of the sites on March 11th (or march 10th), the Medical Leader will do a final inventory of all supplies including all drugs using the list of supplies located on the outside of each bin. Unused drugs along with the completed Controlled Drug Log are packed into the appropriate bin for pick-up at the completion of the Games. Unused medical drugs are not to be distributed to anyone.

E. Lost Medication

If medication is lost on arrival or during the Games, the athlete or his chaperone should contact the MCC for guidance in securing replacement medications.

1. Medication being taken will be identified by the chaperone or from information on patient's medical record.

2. If the drug is not recognized, contact one of the Polyclinic for assistance — (907) 562-8588. If for some reason they cannot be reached, contact the MCC at (907) 343-1407.

3. Once the drug or a suitable counter part is identified, have a physician write the prescriptions with a sufficient quantity to last until March 15th. The prescription should be written on a prescription blank with all the physician's information included on the blank, including the DEA number. The prescription must be legible.

4. Fax to the appropriate Polyclinic to be dispensed. For the HealthSouth Polyclinic, the fax number is (907) 561-7395 or (907) 562-1319 *** if faxing to the Polyclinic, call them to inform them the fax is on the way: phone — *(907) 562 -8588.* Athlete and chaperone will pick up the prescription at the Polyclinic or arrangements can be made to have it delivered to the Village Venue.

5. If the medication has to be delivered to the Polyclinic, allow sufficient time for this to occur when telling the athlete and his chaperone when the prescription will be ready.

6. If a suitable counterpart cannot be identified, then MCC should be contacted at (907) 343-1407____ to order the drug. This may take 2-4 days, depending on the type of medication needed. The closest substitute in the US will have to be used during this waiting period if the benefits outweigh the risks of not taking any medication.

F. Host Town Instructions

1. See the instructions for lost medication.

2. The Polyclinic will be open 24-hours per day for the Host Team Program. The athlete may have to find his/her own transportation to the Polyclinic however during the Host Team Program. The Special Olympics athlete must present his or her participant ID badge.

3. For over-the-counter medications, consult with the Village Venue Medical Station located at the each respective Village cluster.

- ***Establish 24-hour availability for prescription medications throughout the Games duration and geographical areas.***
- ***Integrate the transportation system and language services into the pharmacy plan so that you may transport the medications and educate the patient in the proper use of the medication.***
- ***Develop a Games-specific physician prescription order blank to order medications and allow only the Poly Clinic to place the prescription order.***

Transportation

Two (2) levels of medical transportation have been arranged: Emergency Medical Services (EMS), and 2001 Special Olympics World Winter Games ❄ Alaska (SOWWGA) Motor pool (includes wheelchair transportation services). The choice of mode of transportation is the responsibility of the VML/AVML at the venues, villages and Polyclinics.

A. Emergency Medical Services (EMS)

Generally, EMS ambulances will be used for life-threatening situations and cases where the ambulance crew is necessary to provide patient care in route. The VML/AVML, or their designee will activate EMS transportation.

1. On-Site EMS

   If EMS is located on-site, accessing EMS will be directly through the existing 9-1-1 system, who will in-turn contact the EMS unit on-site by means of their existing EMS communications network. If EMS is shared among venues, the Medical Leader who dispatches the EMS vehicle will notify the Medical Leaders of adjacent venues when the EMS vehicle is dispatched.

   On site EMS transport teams will report to VML/AVML upon arrival. If assigned to more than one venue, EMS will report to the lead VML/AVML.

2. Off site EMS

   Dial 9-1-1
   Identify yourself, your location, and that request is for Special Olympics venue.
   For example, if you are in the FedEx Hangar and need Anchorage Fire Department EMS, you would say something like this:

   > *"This is Bill Clifford with the Special Olympics floor hockey venue at the FedEx Hangar. We have an emergency and need an EMS unit sent here immediately. (Depending upon the dispatcher protocols you may be asked a series of questions regarding injury, severity, state of consciousness, breathing, etc.).*

   Stay calm and answer questions. The important thing is to be sure they know where you are, and a description of the emergency.

   Note: Public Safety committee personnel such as first-aid teams, Security, etc. should access EMS the same way if emergency transport is warranted.

B. SOWWGA Motor pool

Non-emergency medical transportation for athletes, coaches, Heads of Delegation, officials and GOC staff is provided by SOWWGA vehicles and is available when the individual is sick or injured and needs transportation from the Venue Medical Station to a Polyclinic or Village Venue or from a Village Venue to the Polyclinic. The VML/AVML or their designee will activate SOWWGA transportation. A member of the Medical Station team may be designated to accompany the patient to the Polyclinic or Village Venue (at the discretion of the highest level provider at the Venue Medical Station).

1. On-site SOWGGA

   One or more SOWWGA vehicles with a driver will be stationed at most competition venues. The SOWWGA crew includes a driver, only. In some instances where venues are adjacent, one vehicle will be stationed to cover multiple venues. The first priority of the SOWWGA driver is medical transport. SOWWGA vehicles stationed at venues are under the direction of the VML/AVML or their designee.

   SOWWGA driver will stay with unit and have cell phone and radio.

   On site SOWWGA transport teams will report to VML/AVML upon arrival. If assigned to more than one venue, SOWWGA will report to the lead VML/AVML.

2. Off-site SOWWGA

   Off-site SOWWGA vehicles will be available for patients at the Polyclinics, Village Venues and Competition Venues during the Games. To arrange for transportation contact the JOCC and ask for Transportation.

D. Back Fill (Replacement) Vehicles

EMS and SOWWGA units will be running under real time status management. Back filling will be case by case basis based upon such factors as location of other units, expected time until return of original unit, remaining time of competition at venue, weather, etc. Most non-emergencies can be kept at the Venue Medical Station until SOWWGA can return and transport.

E. Wheel Chair Vans

Wheel chair vans will be available by contacting the Transportation desk at the JOCC (for non-emergency, non-ambulatory transport, only).

F. Other Available Transportation

When non-emergency transportation is needed for incidents not covered above such as transportation from the Emergency Department to the Village Venue, please contact the Transportation desk at the JOCC.

- ***Special attention should be given to medical transportation needs during the Games. Medical transportation is very different from the transportation system (transporting athletes to and from Venues) established for a typical Special Olympics Games; medical transportation should be readily available throughout the Games,***
- ***Medical transportation should be available 24-hours per day, both non-emergency and emergency,***
- ***Prior planning with existing emergency medical transportation providers is essential,***
- ***All Special Olympics operated medical transportation vehicles should be equipped with communications equipment to communicate with the Medical Command Center to advise of location and status (i.e., when they arrive to pick-up athlete, enroute to medical facility, arrival at medical facility, arrival at Village Venue, etc.).***

Other

A. Weather Issues

Weather can be a problem during the games. Snow, freezing rain, high winds, and other inclimate conditions are all possibilities during the Special Olympics. Scheduling of events during these conditions can be a problem.

Medical Leaders need to keep a close watch on weather conditions such as temperature and wind chill, approaching storms and general conditions that could threaten the athlete. GOC staff will monitor weather conditions closely and there will be a procedure for alerting every one of weather problems and a procedure for action in the event it is necessary to delay, postpone or cancel events.

Medical Leaders do not have independent authority to interrupt play. If conditions exist that in the opinion of the Medical Leader, play should be interrupted, the Medical Leader will immediately notify the Venue Team Manager and then notify the MCC.

B. Death

Death Athlete On/Off Venue - Pre and Post Games

1. Applicable serious injury/illness response procedure is followed, including response by local law enforcement agency and EMS.

2. Upon being notified that the serious injury/illness has resulted in death the Director of Public Safety will immediately notify the JOCC to notify the remainder of the Crisis Management Team. The Crisis Management Team will immediately assemble at a secure

and private location to discuss the situation and consider an appropriate response.

3. The President & CEO will notify the Director for Public Relations to prepare appropriate press materials.

4. At the earliest reasonable time, normal operational procedures will be re-established as much as the situation and conditions permit.

5. Written information concerning the situation and the response will be gathered and submitted to the JOCC by the end of the day.

Death Team Delegate/Coach On/Off Venue - Pre and Post Games

1. Applicable serious injury/illness response procedure is followed, including response by local law enforcement agency and EMS.

2. Upon being notified that the serious injury/illness has resulted in death the Director of Public Safety will immediately notify the JOCC to notify the remainder of the Crisis Management Team. The Crisis Management Team will immediately assemble at a secure and private location to discuss the situation and consider an appropriate response.

3. The President & CEO will notify the Director for Media Relations to prepare appropriate press materials.

4. At the earliest reasonable time, normal operational procedures will be re-established as much as the situation and conditions permit.

5. Written information concerning the situation and the response will be gathered and submitted to the JOCC by the end of the day.

Death of a Spectator On Venue

1. Applicable serious injury/illness response procedure is followed, including response by local law enforcement agency and EMS.

2. Upon being notified that the serious injury/illness has resulted in death the Director of Public Safety will immediately notify the JOCC to notify the remainder of the Crisis Management Team. The Crisis Management Team will immediately assemble at a secure and private location to discuss the situation and consider an appropriate response.

3. The President & CEO will notify the Director for Media Relations to prepare appropriate press materials.

4. At the earliest reasonable time, normal operational procedures will be re-established as much as the situation and conditions permit.

5. Written information concerning the situation and the response will be gathered and submitted to the JOCC by the end of the day.

In the event of the death of a participant, MCC staff will have available resources on call in order to:

1. Provide specialists who are skilled in providing grief counseling. The MCC will notify the designated Critical Incident Stress Debriefing Team and/or North Star Behavioral Center, and will be responsible for accessing the most appropriate resources.
2. Provide religious contacts for support and for advice on customs concerning the remains.

C. Public Health Threats

The MCC will have direct contact with state Public Health officials. Public Health officials provided the MCC with instructions on certain diagnoses and conditions they want reported. The Medical Command Center, as the central point of all medical reported incidences, will monitor for those conditions and report occurrences directly to the Public Health official. The following Diseases/Symptom Complexes could possibly necessitate Public Health action:

- Febrile rash illness (e.g., rubeola; rubella; RMSF; group A streptococcal disease)
- Fever of Unknown Origin
- Meningitis (meningococcal; viral)
- Influenza-like illness
- Pertussis-like illness
- Bloody diarrhea
- Diarrheal illness occurring in two or more individuals with or without obvious common exposure
- Hepatitis
- Tuberculosis

However, anything that occurs in a Special Olympic athlete, coach, or other visitor that looks unusual and of an infectious nature is something that should be reported to the MCC.

D. Medical Services Confidentiality and Media Policy

Confidentiality of patient information should be maintained for all persons seen by medical services. This includes spectators and anyone else who presents for treatment at a spectator first-aid stations or athlete VMS.

Media contacts involving athletes will be coordinated through GOC's Media Committee. Please remember that members of the media will be looking for stories. That is their job. Our job is to insure that information is coordinated through the appropriate GOC channels, as that is their job.

Volunteer medical staff is not to engage in discussions with the media concerning any medical

conditions of participants, incidences involving participants, or complaints. Volunteer medical staff is free to discuss their participation from a personal point of view as a volunteer in the 2001 Special Olympics World Winter Games ❄ Alaska.

E. Emergencies

An Emergency Action Plan at each site under the direction of the Venue Team Manager will be implemented in the event of an emergency requiring evacuation or a mass casualty incident.

F. Biomedical Waste Products/Hazardous Materials

Medical Teams will be equipped to handle blood spills or needle sticks that might occur. Each venue will have established procedures for handling waste products including hazardous waste products. Each VMS will be equipped with the appropriate disposal containers for hazardous waste products. Protocol will be posted as appropriate.

H. Site Clean-up

The Venue Medical Station (tent, trailer, room) must be kept clean and neat. Sharps and hazardous waste, in particular, should be safely stowed.

I. Bloodborne Pathogens (HIV/AIDS/Hepatitis)

Medical Team volunteer staff will be equipped to handle blood spills or needle sticks that might occur. All medical/first-aid personnel will use universal precautions. The American Red Cross protocols have been adopted for the Games. These protocols are found in Appendix C, INFECTION CONTROL GUIDELINES FOR PROTECTION AGAINST BLOODBORNE PATHOGEN TRANSMISSION.

The American Red Cross infection control guidelines, also called "universal blood and body fluid precautions," are recommended for all health care staff working during the Games.

In the event that a health care worker or others working as members of the Medical Teams have an exposure to blood or other body fluids that might pose a significant exposure, the individual must be advised to go immediately to the emergency room at Providence Hospital (i.e., within 2 hours of exposure). The emergency room will provide rapid testing, medical personnel who can make a judgment regarding the advisability of starting antiretroviral drug treatment, and the immediate availability of starting dose(s) of the drugs.

It is the worker's option whether or not to take this advice. If the exposed individual declines to pursue testing and possibly treatment, the exposed worker should also sign a statement to that effect. Document on the Patient Log, Encounter/Illness or Encounter/Injury forms, which ever is appropriate, that the patient refuses treatment. A Supplemental Sheet may be used if needed.

If the source person can be identified, consent for testing will be obtained in writing and the source person will be sent to emergency room at Providence, Native or Alaska Regional Hospitals for testing.

If the source person refuses consent for testing, notify the MCC immediately. Document on the Patient Log, Patient Encounter forms, which ever is appropriate, that legal consent cannot be obtained. A Supplemental Sheet may be used if needed.

J. Lost Athlete

Security and Information Services will work together to handle "lost" athletes. In the event a lost athlete presents at the Venue Medical Station, notify Information Services.

K. Treatment Preferences

Due to cultural differences, it is anticipated that some athletes will be uncomfortable with a medical provider of the opposite sex. In the event that a medical provider of the requested sex is not available at the VMS and the incident is not life threatening, the injured/ill athlete should be transported to the Polyclinic where medical providers of both sexes will be available.

L. Refusal of Medical Treatment

The Special Olympics makes provisions for instances when an athlete refuses treatment due to religious reasons. The athlete must:

1) sign a waiver (if a minor, his or her parent(s) also sign);
2) be accompanied by his or her parent(s), if a minor, or an adult friend or family member who can speak for the athlete in the event the athlete is incapacitated; and
3) carry a written statement describing their religious objections to treatment at all times.

If the parent(s) or adult friend is not present, the athlete may not compete. These individuals will have the code "NORX" at the end of the participant ID number on their credential. If an athlete is injured and the "NORX" code is on their credential, locate the responsible person to determine what level of medical intervention, if any, is permissible. It is possible that non-invasive interventions such as ice and compression are allowed but medications are not.

An athlete may refuse medical treatment for other reasons and will not have the "NORX" code on their credential. A coach, Head of Delegation, official or GOC staff may refuse treatment also. In those instances, follow the Patient Refusal Protocol found in Appendix F and then document on the Patient Refusal form found on the Patient Encounter forms, which ever is appropriate, that the patient refuses treatment. A Supplemental Sheet may be used if needed. If it is the professional opinion of the assessing medical staff that the athlete cannot compete without seriously jeopardizing his or her health, the Medical Leader should inform the Sports Manager that the athlete might not compete.

The Patient Refusal Form is translated into the following non-English languages:
Arabic
French
German
Russian
Spanish

Personnel Management

A volunteer force of licensed or certified health care professionals and unlicensed administrative support staff will provide medical services.

A. Classification

Medical teams consist of medical personnel and administrative support staff. Medical personnel are health care professionals with current Alaska licensure or certification, as appropriate. Members may be medical doctors, doctors of osteopathy, chiropractors, physician assistants, nurse practitioners, registered nurses, paramedics, emergency medical technicians, athletic trainers, massage therapists, physical therapists, and behavioral support specialists, with training and/or experience in the field of mental retardation.

Athletic Trainers from other states, who are nationally certified and licensed (if required in their state), may function without an Alaska license. Athletic Trainer students, from Alaska or other states, may also qualify as members of the medical teams, if a certified Athletic Trainer is also functioning at the same Venue and time.

Administrative support staff is non-medical personnel, which are assigned a variety of duties including answering the phone, faxing, and couriering messages and supplies and data entry. Administrative assistants may also be used in other non-medical ways as appropriate.

B. Credentialing

The current licensure or certification of medical professionals is ascertained through their respective licensing or certification boards or agencies by the health professional recruitment staff, except for the behavioral specialists whose ability to serve in this capacity will be determined by North Star Behavioral Center.

All volunteers are subject to a security background investigation conducted by the 2001 Special Olympics World Winter Games ❄ Alaska Security Team.

If a volunteer fails either one of these investigations, he/she will not be able to participate in the Games.

C. Credential ID Badge

The Games Organizing Committee prior to the Games credentials all medical team volunteers. At that time a Credential ID badge will be issued which identifies the access a participant is entitled to at each of the venues.

The Credential ID badge must be worn at all times. On entering a Venue, all volunteers must present their credentials to Volunteer Services, located at the entrance to the Venue. In the event that a badge

is lost please notify the Volunteer Services. A one-day credential may be issued; however, the volunteer must be re-credentialed as soon as possible.

D. Malpractice Insurance

Licensed volunteers provide professional medical care within the scope of their professional practice guidelines. The Special Olympics, Inc. maintains secondary malpractice insurance that covers all licensed professionals, with the exception of physicians who must maintain their own policy throughout the Games. In the event there is not primary insurance policy, the secondary policy becomes primary. Administrative Assistants are also covered by the Special Olympics, Inc.'s liability policy.

E. Training

Before working at the Games volunteers are required to attend three training sessions:

- Orientation to the Special Olympics
- Job Specific Training which includes Credential and Uniform Pickup, and
- Venue Specific Training, if possible and feasible.

Volunteers will be given advance notice of these sessions and will have the opportunity to choose from several scheduled training times. An alternative training during the Games is possible when, for serious reasons, medical volunteers are unable to attend the above training sessions.

- ***The person who will be responsible for managing the medical volunteer workforce during the Games should be the one who conducts the training for the medical volunteers.***
- ***Training should include:***
    - ***The overall vision and mission of the medical services for the Games,***
    - ***An overview of the Games, the Venues and key staff members,***
    - ***As many policies and procedures, as possible, including:***
        - ***When and how to contact the Medical Command Center***
        - ***How to complete medical care documentation and any other required documentation (and its importance),***
        - ***Medical care protocols, including "patient refusal" procedures,***
        - ***Over-the-counter medication distribution protocol,***
        - ***Communications protocols,***
        - ***Transportation protocols,***
        - ***Prescription medication referrals, etc.***
        - ***Medical training in specific areas common among Special Olympics athletes (i.e., mental retardation, Down Syndrome, atlanto-axial instability, etc.),***
        - ***Any and all "do's and don'ts."***
    - ***Specific information for the use of specialized equipment (i.e., radios, computers, etc.),***
    - ***An example of what a typical medical volunteer work shift will look like,***
- ***A significant percentage of the volunteer workforce should have completed the training program at least 3 weeks prior to the start of the Games,***

- ***If possible, place the training program on the Games web-site so that medical volunteers have the option to complete the training on-line. This would include all relevant documents also (i.e., Policy and Procedure Manual, Medical Handbook, etc.)***

F. Coordination with the Volunteer Services Committee

The Health Professional Recruiter coordinates recruitment and placement efforts with the Volunteer Committee. All medical team staff is identified to the Volunteer Services Committee but scheduling is handled separately. The scheduling information is provided to GOC Volunteer Services in order for it to be included in one master schedule of shifts and staff for each venue. During the Games, all volunteers' check in with Volunteer Services prior to their shift and check-in is based off the master schedule.

G. Scheduling

1. Staffing Plan

A comprehensive staffing plan, is developed by the Medical Advisory Board, which identifies the ideal number of medical personnel needed for each competition and non-competition venue.

Staffing levels are established based on a number of variables including the following:

- Sport or event occurs indoors or outdoors
- Climatic conditions including the availability of shelter
- Intensity of sport/event
- Time allotment for staging of athletes
- Threat of injury according to sport type/event activity
- Number of warm-up areas and assigned field of plays
- Numbers of athletes
- Proximity of sport venue or activity site to local hospital system
- Response time to site from local EMS Service

2. Assignments and Verification

Assignment of volunteers serving on the medical teams is made, based on the staffing plan and the availability of volunteers.

Assignment letters are sent to the volunteers in early January.

Venue Medical Leaders and assistant Medical Leaders receive two reports in February:
Personnel, listed by Venue, Date and Time; and an *Alphabetical listing of all Volunteers assigned to a specific venue* with information on how to contact them.

Medical Leaders, using these reports, contact each volunteer who has been assigned to their Venue in order to verify that each volunteer is either planning to comply with his/her assignment, or

needs to reschedule or cannot work. At the same time, attendance at both the general and job specific orientation is verified and alternatives discussed. Volunteers report changes in their ability to comply with their assignments to their Medical Leader through February 28th. Medical Leaders, on a weekly basis, will fax changes in personnel to the health professional recruiter on *a Change Reporting Sheet* provided to them. In turn, the health professional recruiter will send bi-weekly updates of both reports to the Medical Leaders.

After February 28th, changes will be reported to the Personnel Coordinator at the Medical Command Center, using the phone number: *907-343-1407*

- ***At least one full-time, medically-trained GOC staff person should be assigned to Volunteer Services to schedule medical volunteers for the Games,***
- ***It is important to keep in mind that there will be minor changes in the staffing schedule prior to and throughout the Games. If possible, complete all scheduling prior to the Games so that a written schedule for each Venue can be developed and disseminated to the Medical Leaders (and/or Venue Coordinators).***
- ***Where multiple shifts were required (i.e., Village Venues), having a built-in overlap of shift times for the purpose of information exchange between on-coming and off-going volunteer staff worked very well and to the benefit of the Games.***

- ***Approach each major health care provider and have that facility appoint a person or a committee to recruit volunteer medical personnel from within their organization.***
- ***Begin the process at least one year prior to the start of the Games.***
- ***Even though three months of recruitment efforts took place six months before the Games, a majority of the medical volunteers came forward as advertisements for the Games started appearing in the local media (television and newspaper) just a few weeks before the start of the Games; perhaps a larger-scale media blitz sooner will help recruitment efforts earlier in the process.***

3. Credentials for Multiple Venues

Volunteers assigned to work at more than one venue receive a credential for only one venue. These volunteers have been advised to contact the Medical Leader(s) of the other venue(s) and request that a day pass be issued for the days they are working at the other venue(s). The other Medical Leader notifies the Volunteer Services and Accreditation Leaders at the other venue that a day pass will be needed for the volunteer. The volunteer brings his/her original credential and picture ID and picks up the day pass when s/he checks in with Volunteer Services at the other venue.

H. Personnel Management During the Games

At the start of each shift, the Medical Leader or Assistant Medical Leader evaluates the volunteers who arrive by the specialties they represent and makes a decision on how to deploy each person. The ideal combination of specialties is contained in the *Needs Assessment Tables.* (See chart X-X) Not all specialties can be recruited in sufficient numbers, and some specialties are recruited in

excess numbers. Overstaffing of some specialties over and above the number indicated in the *Needs Assessment Table* is done for two reasons: 1) not all volunteers are able to serve on the specified dates and times and 2) in an effort to accommodate volunteers date and time preferences.

To ensure that the Medical Leaders and Assistant Medical Leaders have the latest schedules, each evening the Daily Staffing Schedule for the next day including all changes known up to 8:00 PM will be faxed to the venue. (The Medical Leader needs to ensure that the fax machine dedicated to medical is left on overnight. If that is not possible, notify the MCC of the situation so arrangements can be made to ensure that you receive the daily staffing schedule.) The MCC Personnel Coordinator will call with changes received after 8:00 PM in the morning or as soon as the change(s) is known. An example of the Daily Staffing Schedule without names is found at the end of this section.

After the volunteers have signed-in please mark those that are present on the Daily Staffing Schedule and fax it along with the Venue Opening/Closing Checklist to the MCC for the first shift. For the second or third shifts, mark those volunteers that are present and fax to the MCC at the beginning of the shift.

Efforts are made to provide a medical professional capable, within his/her scope of practice, of assessing injury and sickness and of administering medications. Doctors of medicine and osteopathy are included in this category. Physician assistants and nurse practitioners are also included through arrangements made with the Boards of Medicine and Nursing for them to practice under the supervision of a medical group situated in each city.

The Protocols for these professionals will be available on site at each Venue, are in Appendix D and, if possible, will be distributed to these health professionals beforehand. Registered nurses, in the absence of a doctor, physician assistant or nurse practitioner, can also function under a set of Standing Orders, developed by the Medical Advisory Board, a copy of which will also be available on site at each Venue and is in Appendix E.

If assistance is needed in determining how to deploy personnel, the VML/AVML consults with the Medical Command Center.

The Medical Leader or Assistant Medical Leader completes an assessment of personnel at the opening of each shift. In the event of staff deficiencies follow these steps.

Volunteer staff doesn't show up at venue

VML/AVML assesses whether staff is needed

VML/AVML calls MCC to report need

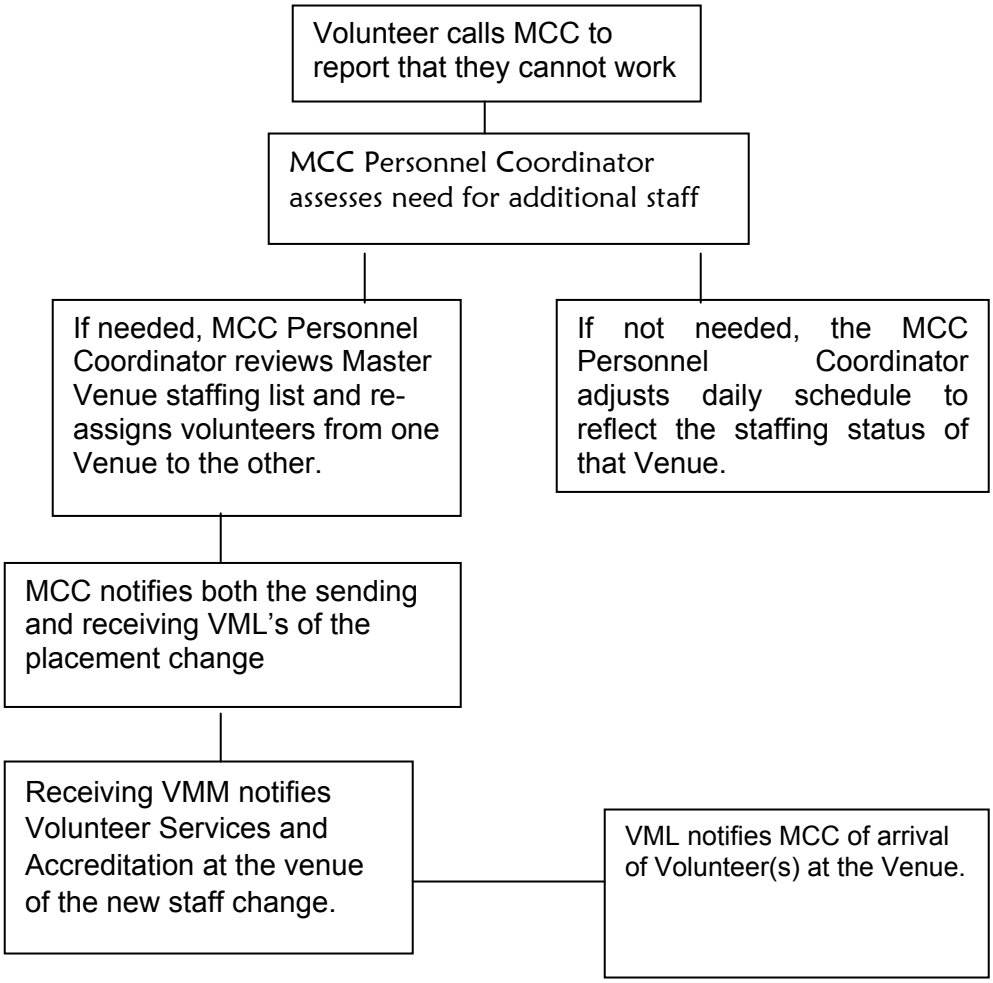
MCC Personnel

Coordinator identifies staff from another venue that can be moved

MCC notifies both the sending and receiving VML's/AVML's of the placement change

Receiving VML/AVML notifies Volunteer Services and Accreditation at the receiving venue of new staff

The following steps will be taken if a volunteer reports to the MCC personnel Coordinator that he/she cannot fulfill the volunteer commitment.



During each shift, the Venue Medical Leader is responsible for scheduling break and meal times and ensuring the well-being and relief for medical volunteers. Any personnel problems, including sickness and accidents, should be reported to the MCC Personnel Coordinator as soon as possible, and an Incident Report form should be completed before the end of the shift.

I. Food

Water, soft drinks, sports drinks, and snacks will be available to athletes at the athlete lounge, for officials, and volunteers at the volunteer lounge.

J. Attire and Identification

All Volunteers should dress for arctic conditions, regardless of whether they have been assigned an indoor or outdoor Venue. Those assigned to an indoor Venue may still have to respond outside the arena to provide medical care to a patient outside in the weather. It is advised that Volunteers dress in "layers." Volunteers must wear the official 2001 Special Olympics World Winter Games ❄ Alaska volunteer tee shirt or jacket as provided, which will identify the wearer as a member of the medical care team. You must wear **Black** pants (or ski bibs) whose appearance will reflect positively on the Games and will be sufficiently warm enough for possible arctic conditions. Shoes or boots should be in good repair and provide the proper insulation from the cold conditions (especially for outdoor Venues). A warm hat and gloves are highly recommended, and a small waist pack for carrying personal items may prove to be beneficial.

K. VML/AVML Responsibilities

1. Daily Venue Checklist

A daily venue checklist is provided which lists the VML/AVML's responsibilities. An example follows this section.

2. Venue Opening/Closing Checklist

At the beginning and end of each day's events, the VML/AVML completes a Venue opening/closing checklist, which is faxed to MCC. An example follows this section.

3. Personnel Assignment Sheet

All Medical Team volunteers must sign-in on the Personnel Assignment Sheet. A copy is attached at the end of this section.

L. MCC Personnel Coordinator

The MCC Personnel Coordinator is located at the Medical Command Center from February 28th through March 11th - from 6:00am through 8:30pm and has the following roles:

- Assures that all Venues are staffed with at least the minimum number of medical professionals and administrative assistants necessary to insure adequate medical coverage of the Venue during each shift.
- Informs the Medical Leaders of any personnel change occurring after February 28th. This will be accomplished by Fax when, and as, changes are reported during the Games.
- Provides guidance, when needed, to the Medical Leaders and Assistant Medical Leaders in the deployment of the personnel that presents themselves during each shift.
- Stays informed of any altercation, accident or sickness experienced by the volunteers on the medical teams and, after venue management of the incident, takes whatever action is necessary.

Host Town Program

After arrival in Anchorage, for several days before the Games begin, athletes will be hosted in various locations across the City. The following describes the medical system in place for the Host Towns.

A. Local Host Town Committee Responsibilities

Visiting Delegation members will be advised of the following medical providers/services in the community:

- EMS Services (9-1-1)
- Area Hospitals
- The Polyclinic
- Host Town Medical Stations at Village Venues
- Pharmacy identified to provide medications to athletes
- Local Health Departments

Individual host families will be provided with basic information on handling medical emergencies. If medical treatment is necessary, the use of a translator is vital. Each delegation will have a member who speaks English and will be available to assist with any situation requiring translation.

B. Access to Medical Records

Each coach will have a copy of the athlete's medical record. In the event that the coach does not have the record, the local medical provider can contact the Medical Command Center (MCC) to obtain a copy.

The Medical Command Center (MCC will go "on line" as soon as athletes begin arriving from abroad. The MCC will open on Monday, February 27th. A medical desk will be staffed around the clock beginning February 27th. Medical information for all athletes will be available and can be transmitted via fax to any hospital or medical provider if the need arises.

C. Suggested Preventive Actions and Precautions

1. Jet Lag

Some of the athletes will have traveled for many hours prior to their arrival and will be sleep deprived and not yet adjusted to the time zone. In order to help them adjust quickly and to feel at home, show them to their room and offer them a light meal, a bath or shower, and a nap. Make it clear that you understand their need to have some time to themselves to relax, clean up, and rest before really getting to know their host town. By all means, avoid any planned activities, excursions, etc. on the day of their arrival. By the next day they'll be much more inclined to want to get out and explore.

2. Medications

Some athletes will be taking medications for chronic conditions. They should adopt a schedule based on local time as soon as they arrive (See below). In the event an athlete's medications are lost, call the MCC for instructions.

3. Acute Illnesses and Injuries

Use common sense, and treat these situations just as you would a medical problem with your own family or neighbors. If it appears that professional services are needed, you will be instructed to go to the nearest Emergency Department (ED). The staff there will have been informed by the Local Host Town Program prior to arrival of the Special Olympics Athletes as to the potential for receiving Special Olympics Athlete patients. (Instruct the ED staff to call the MCC with any emergency room visits to report the incident).

For more serious problems requiring rapid action, call 911 or your local emergency number, just as you would for yourself or your own family. Be sure to inform the ambulance crew that the patient is a Special Olympics Athlete. Ask the ED staff and the local medical representative with the local Host Town program to call the MCC. Make sure that a member of the delegation accompanies the athlete.

4. Seizures

A certain number of Special Olympics Athletes are prone to seizures and take medication to prevent this. However, breakthrough seizures do occur. They are more likely when a person is sleep deprived, dehydrated, and febrile (has a fever). Travel makes this more likely. You can do your part to prevent seizures by making sure your guest has adequate rest and fluids.

Another factor is inadequate medication. The athlete may have missed a dose during the trip. At any rate, he or she will need to adjust to the local time schedule. This should be done upon arrival. If he or she is used to taking the medication at 7 AM and 7 PM, then this should be continued using local time. In order to make the adjustment, it is better to take the next dose a few hours earlier rather than waiting several hours for the times to match. One additional dose will not cause any more harm than perhaps some drowsiness, but a missed or delayed dose may cause a seizure.

Even with adequate seizure medication and rest, breakthrough seizures may occur. If so, do not panic. All that is necessary is to lay the person down on their side so as to prevent them from injuring themselves during the convulsion. Then wait for it to run its course. This usually takes less than one minute. Do not attempt to introduce anything in the person's mouth to "help them breath." They may end up choking on the object, or bite the person who tries to put a finger in their mouth.

Most of the time, the convulsions will subside in less than a minute, and then the person will

regain consciousness over the course of several minutes. Call 911 or your local emergency number and request assistance if the convulsion does not subside shortly. Question the head of the delegation as to whether the seizure is a change in the athlete's usual seizure activity. If the athlete has a seizure that is a change from the usual seizure activity, notify the MCC of seizure activity so that they will be aware of the change in the athlete's status.

D. Medical Care During Host Town Visits

The following instructions apply to those situations in which athletes, coaches, or delegation members need medical care at times or places not covered by the system, which will be in place at the Games. Medical care during the Host Town visits will be provided in the following manner:

1. Moderate or minor illness or injury:

Render first aid. Call your local medical provider. Make sure to ask the local medical provider to report the incident to the MCC. If in doubt, call 911 or your local emergency number. *MCC personnel will give you further instructions, depending on circumstances. For instance may need to arrange visit with local providers for evaluation.*

2. Acute life or limb threatening illness or injury:

Render first aid, call 911 or your local emergency number from the nearest phone, and wait for assistance. The victim will be taken by ambulance to the nearest hospital (where previous arrangements have been made) Emergency Department (ED) for evaluation and stabilization. An English-speaking member of the delegation should accompany the athlete if possible.

3. Medical records and tracking:

Inform the triage nurse in the local emergency department that the individual is a 2001 Special Olympics World Winter Games ❄ Alaska delegation member and ask him/her to call the MCC at the number above. The MCC will fax a copy of the participant's medical record to the ED and request that the MCC personnel be apprised of the athlete's condition following initial evaluation.

4. Disposition:

Following evaluation and stabilization, three (3) possibilities:

- Discharge from the ED
- Admission to the Local Hospital.
- Transfer to a Medical Center

4. Billing Procedures

The 2001 Special Olympics World Winter Games ❄Alaska Medical Advisory Board has sent a letter to local hospitals explaining billing and notification issues. Billing for Services should be forwarded to:

American Specialties Companies, Inc.
142 North Main Street
Roanoke, IN 46783

Attention: Claims Department

E. Hospitalization

If the guest athlete's condition requires hospitalization, then he or she should be admitted to the local hospital for further treatment. Make sure that the hospital contacts the MCC at admission to coordinate the athlete's stay and discharge.

F. Outbreaks or Contagious Disease Reporting

If there is an incidence of food poisoning or contagious communicable disease, the medical provider must report this incident to the MCC, who will in turn notify the local health department.

Appendices

Appendix A – JOB DESCRIPTIONS

Appendix B – MEDICAL SUPPLIES

Appendix C – INFECTION CONTROL

Appendix D – VENUE STAFFING SCHEDULES

Appendix E – MEDICAL PROTOCOLS AND STANDING ORDERS

Appendix F – DOWN SYNDROME

Appendix G – ANTLANTO-AXIAL INSTABILITY

Appendix H – FORMS

Appendix I – AUTOMATIC EXTERNAL DEFIBRILLATOR (LIFEPAK 500)

Appendix J – CRISIS EMERGENCY MANAGEMENT PLAN

Appendix A – JOB DESCRIPTIONS

Medical Leader

Provides overall supervision and coordination for medical services at Sports Venues, Village Venues and/or special events of the 2001 Special Olympics World Winter Games Alaska.

Duties and Responsibilities:

- Attend all meetings relevant to the assigned Sports Venue, Village Venue or event.
- Ensures the medical services staffing of assigned Sports Venue, Village Venue or special event.
- Ensures the medical services-specific training for all assigned volunteer medical professionals.
- Ensures medical service volunteers are familiar with all aspects of the Sports Venue, Village Venues or special events to which they are assigned.
- Ensures adequate inventory of equipment and supplies at assigned Sports Venue, Village Venue or special event.
- Ensures the quality of clinical care provided by volunteer medical personnel at the assigned venue.
- Ensures the proper disposal of (potential) infectious waste.
- Ensures the accuracy and completeness of all required documentation.
- Coordinates medical services activities with other venue team leaders (sports, operations, transportation, volunteer, etc.) and the Joint Operations Command Center (JOCC).
- Will act as Public Information Officer (PIO) for medical situations at the on-site venue and will coordinate activities with SOWWGA Media Services.
- Report "incidents" to the JOCC immediately and submit the appropriate written report(s) to Medical Services Manager.

Qualifications:

- Committed to the success of the 2001 Special Olympics World Winter Games Alaska
- Excellent communication skills
- Proper radio and telephone etiquette
- Must be available to work during March 3-12, 2001.
- Supervisory or managerial experience helpful
- Systematic approach to problem-solving
- Excellent organizational, communications, and interpersonal skills
- Systems management experience helpful
- Diplomatic in dealing with persons of varying personalities
- Ability to coordinate and delegate tasks
- Special Olympics experience or understanding of persons with mental retardation helpful
- Games or large special event experience helpful
- Demonstrated ability to work under stressful conditions with limited resources
- Understanding of general sports competition

Commitment:

- Monthly meetings beginning September, 2000; more frequently as the Games approach.
- 10-30 hours a month and during all games time activities.

Medical Supplies Leader

Provides supervision and coordination of the advanced medical equipment and supplies inventory to be utilized at the venues, residence halls and/or special events of the 2001 Special Olympics World Winter Games Alaska.

Duties and Responsibilities:

- Attend all meetings relevant to Logistics, Warehouse, Medical Leaders, and as assigned.
- In conjunction with the Medical Services Manager and Logistics, coordinate the physical inventory, ordering, organization, packaging, distribution, re-supply, accounting, security and post-games recovery of the basic medical equipment and supplies utilized in the Games.
- Supervise volunteer staff members.
- Maintain inventory records of all equipment and supplies.
- Create and initiate contingency plans for distribution and re-supply of equipment and supplies.
- Ensures the accuracy and completeness of all required documentation.
- Coordinates medical services activities with other venue team leaders (sports, operations, transportation, volunteer, etc.) and the Joint Operations Command Center (JOCC).
- Report "incidents" to the JOCC immediately and submit the appropriate written report(s) to Medical Services Manager.

Qualifications:

- Committed to the success of the 2001 Special Olympics World Winter Games Alaska
- Excellent communication skills
- Proper radio and telephone etiquette
- Must be available to work during March 3-12, 2001.
- Supervisory or managerial experience helpful
- Inventory control or warehousing experience, helpful
- Systematic approach to problem-solving
- Excellent organizational, communications, and interpersonal skills
- Systems management experience helpful
- Diplomatic in dealing with persons of varying personalities
- Ability to coordinate and delegate tasks
- Special Olympics experience or understanding of persons with mental retardation helpful
- Games or large special event experience helpful
- Demonstrated ability to work under stressful conditions with limited resources
- Understanding of general sports competition

Commitment:

- Monthly meetings beginning September, 2000; more frequently as the Games approach.
- 10-30 hours a month and during all games time activities.

Medical Staffing Leader

Provides supervision and coordination for medical services at venues, residence halls and/or special events of the 2001 Special Olympics World Winter Games Alaska.

Duties and Responsibilities:

- Coordinate (in conjunction with the Volunteer manager) the recruiting of medical personnel,
- Coordinate (in conjunction with the Volunteer and Medical managers) the scheduling of medical personnel,
- Maintain a database of volunteer medical personnel and a rapid-access call system,
- Ensure compliance of staffing requirements at all venues, residence halls and special events.
- Attend all meetings relevant to volunteer staffing, medical leaders, and as assigned.
- In conjunction with Volunteer Services, coordinate the recruiting of qualified medical professional volunteers.
- In conjunction with the Medical Leaders, ensures the medical services staffing of all venues, village venues and special events, including contingency scheduling for no-shows and illnesses.
- Maintain the SOWWGA database of volunteer medical personnel for each sports venue, village venue and special event.
- Create a rapid-access call system for use during the Games.
- Ensures the medical services-specific training for all assigned volunteer medical professionals.
- Ensures the accuracy and completeness of all required documentation.
- Coordinates medical services staffing activities with other venue team leaders (sports, operations, transportation, volunteer, etc.) and the Joint Operations Command Center (JOCC).
- Report "incidents" to the JOCC immediately and submit the appropriate written report(s) to Medical Services Manager.

Qualifications:

- Committed to the success of the 2001 Special Olympics World Winter Games Alaska
- Excellent communication skills
- Proper radio and telephone etiquette
- Must be available to work during March 3-12, 2001.
- Supervisory or managerial experience helpful
- Systematic approach to problem-solving
- Excellent organizational, communications, and interpersonal skills
- Systems management experience helpful
- Diplomatic in dealing with persons of varying personalities
- Ability to coordinate and delegate tasks
- Games or large special event experience helpful
- Demonstrated ability to work under stressful conditions with limited resources

Commitment:

- Monthly meetings beginning September, 2000; more frequently as the Games approach.
- 10-30 hours a month and during all games time activities.

Appendix B – MEDICAL SUPPLIES

Appendix C – INFECTION CONTROL

INFECTION CONTROL GUIDELINES FOR PROTECTION AGAINST BLOODBORNE PATHOGEN TRANSMISSION

- Use paper towels to absorb the solution, and put the towels in the biohazard container.
- Dispose of bagged cleanup material according to local regulation.
- Wash hands after removing gloves.

Management of Exposure:

A worker may have accidental exposure to blood, either parenteral (such as a needle stick or cut) or by contact with a mucous membrane (such as a splash to the eye, nose, or mouth). The worker's skin may be directly exposed to large amounts of blood or may have prolonged contact with blood, especially when the exposed skin is chapped, abraded, has minor cuts, or is afflicted with acne or dermatitis, and that is why it is so important to wear gloves, safety goggles, and other protective equipment. In these cases, the following procedures should be followed:

1. Immediately following exposure, the affected area and surrounding skin or tissue should be washed thoroughly.
2. Antiseptic should be applied to any wound.
3. The exposed eye should be flushed with saline or water rinses.
4. Report to the Director of Health and Safety Services and document all of the exposures described in the above paragraph.
5. The exposed worker shall be offered the opportunity to be seen by a health care professional. A vaccine against hepatitis B and prophylactic antiviral agents for HIV or immune globulin may be medically recommended for the worker with the most beneficial effect occurring within, a short period of time after the incident. Therefore, the medical follow-up should be offered immediately after the exposure incident. It is the worker's option whether or not to take advantage of this offer. Document the prophylaxis offered and, if declined, the exposed worker should also sign a statement to that effect.

If the source of exposure is known, that person should be informed of the incident and, after consent has been obtained, referred for testing for serologic evidence of HIV and HBV infection. Arrangements will be made for the test results to be sent out to the designated health care professional.

- Wash and dry protective clothing and work uniforms according to the manufacturer's instructions. Scrub soiled boots, leather shoes, and other leather goods, such as belts, with soap, a brush, and hot water.
- Disposable linens and towels, if used, should be placed in heavy gauge plastic bags marked "biohazard" and disposed of according to local

regulations.

Wastes not contaminated with blood or other body fluids may be disposed of in regular trashcans. No special precautions are required.

Blood, urine, vomit, and other body fluids can be poured down a sanitary drain or toilet. (However, blood-soaked gauze should not be thrown in a toilet). Wastes contaminated with blood or other body fluids such as gloves, used bandages, gauze, or "4x4s", must be placed in heavy gauge plastic bags. These wastes should be disposed of according to local regulations. Incineration is usually an acceptable method.

Household bleach and chemical germicides that are approved for use as "hospital disinfectants" and that are capable of destroying the tuberculosis bacillus can be used to clean and decontaminate spills of blood or other body fluids. To be effective, these disinfectants must be mixed according to directions. A 1:100 solution of bleach (1/4 cup bleach to one gallon of tap water) is acceptable for use in emergency aid stations.

(Note: Never pour undiluted bleach straight from the bottle directly onto spills of blood, urine, sputum, or vomit. Dangerous levels of toxic chlorine or nitrous oxide gases could result.)

Chlorine bleach solutions should not be prepared more than 6 hours before using. The following procedures should be used to clean and decontaminate spills of blood or other body fluids:

- Wear gloves and other appropriate protective equipment when cleaning spills.
- Clean up spills immediately or as soon as possible after the spill occurs.
- Use tongs, broom and dust pan, or two pieces of cardboard to clean up spills mixed with sharp objects, such as broken glass or needles.
- Dispose of absorbent material used to collect the spill in a Labeled biohazard container (heavy gauge plastic bag).
- Flood the area with the disinfectant solution, and allow it to stand at least 20 minutes.

These general principles of cleaning and disinfection should be followed:

- Personnel involved in the handling of contaminated linen or clothes should wear gloves.
- All patient-use equipment must be clean and free of obvious organic matter or other environmental contaminants.
- Disposable gloves must be worn when handling equipment contaminated by blood or other body fluids.

- Hand washing procedures must be followed after handling dirty equipment, even if gloves are used.
- Equipment that cannot be decontaminated on site should be cleaned and transported to a proper handling facility in heavy gauge plastic bags labeled "Contaminated - To Be Cleaned." Medical equipment, such as wheelchairs, stretchers, blood pressure cuffs, and crutches that are soiled with blood or other body fluids should be pre-cleaned of visible material, and then cleaned with a germicidal chemical: EPA registered: hospital disinfectant chemical germicide that has a label claim for tuberculocidal activity or commercially available hard-surface germicide or solution containing at least 500 ppm free available chlorine (1/4 cup bleach per gallon of tap water).

Although soiled linen has been identified as a source of large numbers of certain pathogenic organisms, the risk of actual disease transmission is negligible. However, the following guidelines are recommended:

- All soiled sheets, pillowcases, towels, and blankets are to be changed after every use.
- Uniforms and other clothing that have been soiled with blood or other body fluids should be changed as soon as possible.
- Linens soiled with blood or other body fluids should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen.
- All soiled linen should be placed in heavy gauge plastic bags at the location where it was used. It should not be sorted or rinsed in patient care areas. These bags must have label or warning signs such as "biohazard", to eliminate or minimize exposure of workers.
- Linen soiled with blood or body fluids should be transported to laundry facilities in heavy gauge plastic bags that prevent leakage.
- Normal laundry cycles should be used according to the washer and detergent manufacturer's recommendations.

Personal Hygiene:

Personal hygiene habits, such as frequent hand washing, are important in preventing infection as using personal protective equipment. Hand washing procedures should be followed even if gloves have been worn. If an emergency situation precludes proper hand washing, hands should be washed as soon as possible after exposure.

Any skin surface that comes in contact with blood or other body fluids should be cleansed using the same procedures used for hands. Hands should be washed:

- Immediately and thoroughly on contact with any blood or blood fluids.
- Before and after contact with a patient.
- Before and after touching open wounds (even if gloves are worn).

- Before and after eating
- After removing gloves
- After handling soiled or contaminated items and equipment
- Before and after using the toilet
- After handling scissors, tweezers or other instruments

The method used for correct hand cleaning with water and plain soap is to --

1. Use utility or restroom sink
2. Wet hands
3. Lather hands, preferably with liquid soap
4. Rub repeatedly for at least 15 seconds
5. Rinse
6. Turn faucets off with dry paper towel

When hand-washing facilities are not available, remove obvious soil with a wet towelette. Then use a waterless antiseptic hand cleaner, following manufacturer's directions for the product. Avoid eating, drinking, smoking, applying cosmetics or lip balm, handling contact lenses, and touching the mouth, nose, or eyes in work areas where exposure to infectious materials may occur.

Equipment Cleaning and Disinfecting:

It is important to clean and disinfect equipment to prevent the spread of infections. The precautions described below must be followed for the care of all equipment. Proper disinfection procedures should be followed to decontaminate reusable medical equipment. Disposable equipment meant for single use should be discarded after use.

The following infection control guidelines are based on the recommendations of the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control. These precautions, also called "universal blood and body fluid precautions", are recommended for all paid and volunteer staff working in Red Cross First Aid stations. The procedures should be used to minimize infectious diseases, including HIV and Hepatitis B, and to protect patients from infections. It is important to remember that a medical history and examination cannot readily identify all patients infected with HIV or other Bloodborne organisms. Therefore, these precautions must consistently be used for all patients.

Protective Equipment:

Staff should

- Wear disposable (single-use) gloves when in contact with blood or other body fluids (urine, stool, semen, vomit, wounds, etc.), mucous membranes, or non-intact skin is anticipated. These gloves do not have to be sterile.
- Wear gloves when handling contaminated items (such as clothing or linen) or surfaces soiled with blood or other body fluids.
- Change gloves between each patient and dispose of them in an infectious waste

container. **Do not** clean or reuse disposable gloves.

- Discard gloves that are peeling, discolored, torn or punctured.
- Avoid handling items such as pens, combs or radios when wearing soiled gloves.
- Cover any cuts, scrapes or skin irritations on workers with protective clothing and/or bandages.
- Wash hands immediately after gloves are removed.
- Masks and protective eye wear or face shields are to be worn during procedures that are likely to disperse droplets of blood or **other body fluids.**
- Gowns **or** aprons are to be worn during procedures that are likely to generate splashes of blood or other body fluids.
- Remove soiled protective clothing as soon as possible and discard appropriately.

There is no evidence that HIV or Hepatitis B virus (HBV) have been transmitted during mouth-to-mouth resuscitation. However, disposable resuscitation masks with a one-way valve are available for use whenever CPR or rescue breathing is administered. After resuscitation is complete the devices are discarded.

Appendix D – VENUE STAFFING SCHEDULE

Appendix E – MEDICAL PROTOCOLS

Southern Region EMS Council, Inc.
Regional EMT I-III Standing Orders

The following protocols are for use by medical personnel at the EMT I-III level. These protocols are intended as guidelines for consistent, appropriate patient care. Medical personnel will contact the receiving emergency room physician or their physician medical director before deviating substantially from these orders. In the event that medical crews are unable to establish radio contact, they should proceed as per these protocols and notify the hospital or physician sponsor of the actions taken at the first opportunity to establish radio contact. Transportation to a hospital or appropriate medical facility should proceed without undue delay.

It is the responsibility of all emergency medical service personnel operating under these standing orders to become familiar with, and practice according to these orders.

It is the responsibility of all emergency medical service personnel operating under these standing orders to be familiar with the practices of Universal Precautions, or Body Substance Isolation (BSI) and to utilize them in accordance with their respective departments Bloodborne Pathogen Policy.

These orders may change as new techniques are developed or new data are brought to light. It will be the responsibility of all medical personnel to remain abreast of such changes and to guide their actions accordingly.

Gilbert B. Dickie, M.D. Southern Region EMS Medical Director	Kathryn A. Griffin, NREMT-P Assistant Training Coordinator

FEBRUARY 2000

Table of Contents

I. Patient Assessment

A. Scene Size-up

Use appropriate Body Substance Isolation (BSI)
Determine Scene Safety
Check mechanism of injury (MOI) /Nature of illness (NOI)
Determine number of patients
Request additional help if necessary
Establish C-spine stabilization early, if indicated by MOI

B. Initial Assessment

General impression of patient (good or poor)
Identify apparent life threats/chief complaint.
Assess the level of consciousness (**A**lert, **V**erbal, **P**ainful, **U**nresponsive) & Glasgow Coma Scale (p. 43)
Assess and secure the airway (p. 6)
Assess and manage breathing (p. 6)
Oxygen therapy (p. 6)
Assess circulation (pulse, skin color, temperature, condition)
Identify and control major hemorrhage
Identify priority patients/make transport decision

C. Focused History/Physical Exam or Rapid Assessment

Determine which exam to be used
Perform specific exam (**Focused** or **Rapid**)
Obtain vital signs
Obtain SAMPLE history (**S**igns/Symptoms, **A**llergies, **M**edications, **P**ast medical history, **L**ast oral intake, **E**vents leading up to illness or injury)
Focused: Perform the exam focusing on the injury or illness
Rapid: Perform a rapid head-to-toe survey only treating life-threatening findings

D. Detailed Physical Exam

Usually performed enroute and if there is adequate time
Only performed if life threatening injuries and conditions have been effectively managed
Performed using more detail and time than a rapid trauma assessment
Injuries will be managed when identified
* * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor, Lead II if indications of possible respiratory or cardio-pulmonary component recognized or any medications are to be given

E. On-going Assessment

Repeat Initial Assessment
Reassess vital signs
Repeat components of focused history
Reassess any interventions

II. Airway Management

A. Open Airway

If mechanism of injury suggests spinal injury, assume c-spine injury and maintain c-spine stabilization

Use jaw thrust or chin lift maneuver if patient is unconscious

B. Airway Adjuncts

Use oral airway if unconscious and no gag reflex

Use the tongue blade technique when inserting an oral airway in a child or infant

Use nasal airway if gag reflex is intact, but patient cannot maintain airway

Lubricate nasal airway before insertion (xylocaine if available)

* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *

Consider use of orotracheal intubation or multilumen airways to secure the patient's airway if the patient is unconscious and has no gag reflex

C. Suction

Suction as needed to maintain a clear airway

Apply suction for not more than 15 seconds

Aggressively oxygenate patient via NRB or BVM hyperventilation before and after suctioning

D. Oxygen

10-15 LPM via pocket mask, BVM, or Flow Restrictive Oxygen Powered Device for apneic patients or those with inadequate respiratory effort

10-15 LPM via non-rebreather for general trauma or medical

1-6 LPM via nasal cannula if mask not tolerated

If pulse oximeter is available, goal is to keep oxygen saturation at 92% or greater

Never withhold oxygen from a patient

E. Positioning

If patient is alert and showing signs of respiratory distress do not lay patient flat

If patient is unresponsive and patient may vomit, lay patient on side if possible

Ask the patient to position themselves (position of comfort) if possible

F. Bag Valve Mask

Ventilation is very important for all patients with inadequate respiratory rate, volume, or depth

BVM must be hooked up to high flow oxygen in order to properly oxygenate the patient

III. Medical Emergencies

A. Abdominal Pain

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Gather history (see p. 50 for specific medical questions)
Gather orthostatic vital signs as indicated (if patient is hypotensive supine, do not stand)
Place the patient in position of comfort.
Shock protocol as appropriate (p. 16)
NPO (nothing by mouth) (Do not allow the patient to eat or drink)
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Establish IV access (p. 16)
Attach pulse oximeter.

B. Allergies and Anaphylaxis

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Gather history (See p. 50 for specific medical questions.)
If shock and/or respiratory distress is present and with physician approval, administer patient's **prescribed** Epi-Auto injector (p. 37)
Shock protocol as needed (p. 16)
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Establish IV access (p. 16)
Consider administration of 0.3 – 0.5 mg Epinephrine (1:1,000) SQ, IF the patient shows signs and symptoms of shock and/or respiratory distress, and has no previously prescribed Epi-Auto Injector
Attach pulse oximeter if available
In Pediatric Patient: dose for Epinephrine SQ is 0.01 mg/kg.

C. Behavioral and Psychiatric

Ensure scene safety at all times
If scene is not safe **DO NOT ENTER**
Once contact is made with the patient stay with them at all times, unless they pose a danger to you or the other EMS responders
Request police assistance if indicated
Perform initial assessment from a distance if necessary
Attempt to establish rapport
Gather history as available
If able, assess vital signs
If patient is suicidal-do not leave patient alone **unless** they become a danger to responders
Remove all dangerous objects
If there are concerns about suicide: Ask the patient the following three questions:

- "Were you trying to hurt yourself?"
- "Have you been feeling that life is not worth living?"
- "Have you been feeling like killing yourself?"
- If the answer is "yes" to any of the above questions, the patient should be transported to a medical or psychiatric facility.

Look for and gather pills and bottles or record medication name, date prescribed, doctor issuing, and number of pills left

Make sure to assess and treat medical conditions and injuries found. Remember hypoglycemia, hypoxia, shock, drug ingestion, and head injuries, …can cause a behavioral/psychiatric emergency

Transport in a calm, quiet manner and provide supportive care

D. Cardiac Arrest *(See p. 32-33 regarding terminating resuscitation.)*

Verify pulselessness and begin CPR.

Apply AED and use as designated in your local AED Protocol.

Airway management protocol and oxygen therapy. (p. 6)

Contact other ALS responders and Medical Control as soon as possible.

* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *

Secure Airway. Endotracheal Intubation or Combi-tube is the preferred methods (p. 6)

Obtain IV access (p. 16)

* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *

Cardiac Monitor, Lead II

Follow Appropriate ACLS Algorithm

E. Non-Traumatic (cardiac suspected) Chest Pain

Airway management protocol and oxygen therapy (p. 6)

Perform patient assessment (p. 5)

Gather a complete history when appropriate. (See p. 50 for specific medical questions.)

Obtain vital signs

If systolic BP is 100 or higher and patient has own prescribed nitroglycerin (NTG), obtain permission from medical control to administer one tablet or spray sublingually every 3 to 5 minutes up to 3 doses or patient experiences relief or systolic BP falls below 100 mmHg. (p. 41)

Consider giving patient 2 chewable baby aspirin if not allergic

Do not allow the patient to walk

Transport the patient as soon as possible

* * * * * * * * * * * * * * EMT-2/3* * * * * * * * * * * * * * * *

Establish IV access (p. 16)

Attach pulse oximeter if available

* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *

For patients not previously prescribed NTG, administer NTG following the same parameters as above

Cardiac Monitor, Lead II

Follow ACLS protocols for treating rhythm and patient condition found

Consider giving baby ASA x 2 if non-allergic

F. Diabetic Emergencies

Airway management protocol and oxygen therapy (p. 6)

Perform patient assessment (p. 5)

Use Dextro stick/Chem. stick evaluation if available

If there is any possibility of hypoglycemia and the patient can swallow, administer one tube of oral glucose gel (p. 38) or alternative sugar source

Obtain vital signs

Obtain a complete history when appropriate (see p. 50 for specific questions.)

If patient is unresponsive, request other ALS support if available

Transport as indicated

* * * * * * * * * * * * * * EMT-2/3* * * * * * * * * * * * * * * *

Obtain IV access (p. 16), and draw blood according to local protocol
If blood sugar level is low, or unknown, and the patient has decreased LOC, assure IV patency and give 25g $D_{50}W$ via IV. Make sure to flush line afterwards. Watch for infiltration and tissue necrosis at IV site.
Note: IV access can be difficult on diabetics. Do not waste time on scene to repeat attempts

G. Respiratory Distress

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
If pulse oximeter is available, goal is to keep oxygen saturation at 92% or greater
Never withhold oxygen from a patient
Assess lung sounds frequently (Absence of abnormal lung sounds may indicate no air movement- a dire emergency)
Obtain complete history when appropriate (see p. 50 for specific medical questions.)
Assist patient to position of comfort--do not force the patient to lie flat
Treat specific cause as indicated below
If patient goes into **respiratory failure** control the airway and assist ventilations with high flow oxygen (p. 6)

ASTHMA/COPD

Perform as stated in respiratory distress.
If patient has own prescribed metered dose inhaler, obtain permission from medical control to administer as directed (p. 35)
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
Contact Medical Control as soon as possible
If available to service consider nebulized Albuterol (p. 35) or SQ Epinephrine 1:1,000 (p. 37)

CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA

Perform as stated in respiratory distress
Place patient in high Fowler's position (sitting upright with legs dependent) if no other contraindications exist
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Avoid excess fluids
Contact Medical Control as soon as possible
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II
Morphine 2-5mg slow IV push and titrate to patient response (p. 40)
Administer NTG (p. 41) if chest pain present following Chest Pain protocols (p. 8)
If patient goes unconscious perform endotracheal intubation (p. 6)
If available to service consider Lasix (p. 38)

H. Seizures

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Protect patient from further injury. Restrain as necessary
Obtain complete history (see p. H for specific medical questions.)
Search patient's location for medications
Use Dextro stick/Chem. stick evaluation if available. If Blood Sugar is low treat for Diabetic Emergency (p. 8)
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
If Blood Sugar is low administer $D_{50}W$ (p. 36) and treat for Diabetic Emergency
Contact Medical Control as soon as possible
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II
Consider IV or rectal Valium if available (p. 42)

I. Stroke/Brain Attack

Airway management protocol and oxygen therapy. (p. 6)
Perform patient assessment. (p. 5)
Obtain complete history when appropriate. (See p. 50 for specific medical questions.)
Assess for changing neurological deficit throughout transport and record any changes
Perform Glasgow Coma Scale (p. 43) and repeat throughout transport, record any changes.
Elevate head of bed 30 degrees if not contraindicated by other factors
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
Contact Medical Control as soon as possible
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.

J. Toxic Ingestion or Poisoning

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Try to determine amount, type, time, and intent of ingestion
Save any emesis if able
Collect medicine containers if possible and bring to hospital
Gather a complete history (see p. 50 for specific medical questions.)
Contact Medical Control with the following:

-status of gag reflex (present or not)
-level of consciousness (GCS p. 43)
-type of ingested material
-time ingested
-amount ingested
-weight of patient
-ETA to receiving facility.

If appropriate, obtain orders for Activated Charcoal administration (1 gram/kilogram). (p. 35)
Assess for suicide risk and take appropriate precautions.
Request other ALS support if available.

Transport without delay.
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

K. Unconscious Unknown

Aggressive airway management and oxygen therapy (p. 6)
Perform patient assessment. (p. 5)
Gather all pertinent information but do not delay treatment or transport.
Request other ALS support if available.
Transport as indicated.
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV Access (p. 16)
Perform Dextro stick/Chem stick evaluation. Assure IV patency and give 25 g $D_{50}W$ via IV. Make sure to flush line afterwards. Watch for infiltration & tissue necrosis at IV site (p. 36)
Consider administration of up to 2.0 mg Narcan IV titrated to reversal of respiratory depression if opiate use suspected
Note: Narcan may be repeated in 2-3 minutes. Drugs that respond to Narcan will stay in the body longer than the effects of Narcan. Monitor the patient's respiratory effort carefully and contact Medical Control for additional Narcan contact Medical Control as soon as possible
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

L. Syncope

Airway management protocol and oxygen therapy. (p. 6)
Shock protocol as appropriate. (p. 16)
Perform patient assessment. (p. 5)
Assess for fall-related trauma and take necessary precautions.
Obtain complete history. (See p. 50 for specific medical questions.) Pay particular attention if possible pregnancy, abdominal pain, or palpitations are present
Request other ALS support if available.
Transport as indicated.
Be prepared with AED
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Run at level to treat for shock if indicated (p. 16)
Check Blood Glucose level and administer $D_{50}W$ if indicated. (p. 8, 36)
Contact Medical Control as soon as possible.
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.

IV. Trauma

A. General Principles

Secure airway appropriate to patient's LOC, and provide aggressive oxygen therapy (p. 6)
Perform patient assessment (p. 5)
If rapid assessment is indicated, **do not delay transport**

Note: Patient assessment may be completed en-route if patient's condition is unstable or is unknown

Control gross bleeding (arterial or major venous)
Spinal immobilization if mechanism of injury suggests spinal injury or is unknown
Shock protocol as indicated (p. 16)
Keep patient warm.
Give nothing by mouth (NPO).
Record your findings and each repeat examination of the patient.
Consider requesting other ALS support if available.
Transport as indicated.
Remember to consider possible medical causes or complications of injury
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.

B. Amputations

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Shock protocol as indicated (p. 16)
Control bleeding using direct pressure, elevation, and pressure points. Tourniquet may be considered as a last result; after all other methods have failed
Wrap amputated part in a sterile, **dry** dressing
Place part in plastic bag and seal, label the bag
Place bag in cool solution
Never immerse the part or put it in ice, **prevent from freezing or getting waterlogged**
Transport the amputated part with the patient if at all possible
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
If patient becomes unconscious with no gag reflex, protect the airway with endotracheal intubation or a multilumen airway. (P.6)
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.
In isolated limb trauma without head injury or respiratory compromise, Morphine 2-5mg slow IV push (SIVP) may be administered for pain control. Contact Medical Control before administering and titrate to effect. Watch for respiratory depression.

C. Chest and Abdominal

Airway management protocol and oxygen therapy. (p. 6)
Perform patient assessment. (p. 5)
Shock protocol as indicated. (p. 16)
Manage specific injuries as stated below:
If necessary request other ALS support if available
Transport as indicated

Open chest wound- Cover with an occlusive dressing taped on three sides. Observe closely for signs of a developing tension pneumothorax

TENSION PNEUMOTHORAX- **IF WOUND HAS BEEN SEALED, TEMPORARILY UNSEAL THE WOUND AND ALLOW THE AIR TO ESCAPE AND THEN RE-SEAL. IF LOCAL PROTOCOLS ALLOW, PERFORM CHEST DECOMPRESSION**

FLAIL CHEST- **STABILIZE THE FLAIL SEGMENT WITH A DRESSING AND TAPE, SANDBAG OR PILLOW OR WITH MANUAL PRESSURE**

EVISCERATIONS-
COVER WITH STERILE MOIST DRESSINGS
Do not remove any impaled objects; stabilize and immobilize with bulky dressings
Keep patient warm and quiet.

PENETRATING INJURY-
If the object is still in place, secure in place.
Do not remove penetrating object.

* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Run at level to treat for shock if indicated (p.16)
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

D. Extremity Trauma

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Most isolated extremity trauma is not life threatening
Always document pulse, motor and sensory function distal to injury before and after any care
Gentle realignment of uncomplicated fractures not involving joints is permitted to improve immobilization and comfort
Fractures involving joints may be gently repositioned only if distal circulation is absent
Attempt to contact Medical Direction before joint repositioning if possible.
Splinting, elevation, and cold packs (no direct skin contact) may improve patient comfort.
Transport as indicated
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Run at level to treat for shock if indicated. (p. 16)
* * * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.
In isolated limb trauma without head injury or respiratory compromise, Morphine 2-5mg slow IV push (SIVP) may be administered for pain control. Contact Medical Control before administering and titrate to effect. Watch for respiratory depression.

E. Eye Trauma

Significant eye injuries should always be considered an emergency.
Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Estimate visual acuity if able: patient ability to see light, dark, shapes, finger counting or to read newsprint
Consider other ALS support
Transport as indicated
* * * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Run at level to treat for shock if indicated (p. 16)

Treat specific eye injury as follows:

FOREIGN BODY IN, OR ABRASION TO THE EYE (NON GLOBE PENETRATING)
IRRIGATE FOR AT LEAST 15-20 MINUTES WITH NORMAL SALINE OR STERILE WATER

PENETRATING: (DO NOT REMOVE)
Stabilize with whatever means are effective (paper cups, bulky dressings etc.).
Watch uninjured eye to minimize eye movement
Transport in position of comfort if no contraindications are present

BLUNT TRAUMA TO EYE
COVER BOTH EYES LIGHTLY WITH METAL EYE SHIELD TO PREVENT ANY PRESSURE ON EYE
Transport with head elevated if tolerated

CAUSTIC SUBSTANCE IN EYE
Immediately flush eyes and surrounding areas with copious amounts of water or normal saline for at least 20 minutes
Remove contact lenses if present
Patch affected eyes if tolerated

F. Head Trauma

Airway management protocol and oxygen therapy (p. 6). If patient requires ventilator support, ventilate normally with 100% oxygen (A: 12 bpm, I/C: 20 bpm), unless signs of brain herniation are present
If signs of brain herniation (GCS<9, posturing, dilated/unequal/blown pupils) are present hyperventilate at these rates: Adult: 20 bpm, Child: 25 bpm, Infant: 30 bpm
Maintain O_2 Saturation > 90%
Maintain BP > 90 mmHg
Perform patient assessment (p. 5)
Always suspect spinal injury-stabilize and immobilize
Evaluate and record mental status or level of consciousness often (GCS p. 43)
Consider other ALS support
Transport as indicated with head elevated ∠30°if no contraindications are present
* * * * * * * * * * * * * * * EMT-2 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) Run at level to maintain BP of at least 90mmHG.
Attach Pulse Oximeter (if available) & maintain saturation at > 90%
Note: Even a single incident of BP < 90 mmHg or SaO_2 < 90 has been directly linked to poor patient outcome in patients with traumatic brain injury

* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

G. Sexual Assault

Introduce yourself immediately and explain why you are there
Notify appropriate law enforcement agency
Speak directly to the patient, not someone at the scene
Avoid judgmental statements or comments
Avoid "power positions"; position yourself at the victim's level if possible
Carefully explain everything you will be doing
Ask permission before touching the victim
Offer to contact the local rape crisis center or Sexual Assault Team if applicable and available
Provide professional, compassionate treatment
Encourage the patient not to bathe or change clothing to preserve evidence
If the patient has already changed, try to bring along the clothing worn at the time of the assault in separate paper bags
Assess and treat injuries as appropriate
Request other ALS support if needed based on injuries found
Carefully document physical exam and scene size-up

H. Hypo perfusion/Shock

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Control hemorrhage
Follow appropriate trauma guidelines and procedures
Elevate lower extremities 8-12 inches as appropriate (shock position or Trendelenburg.)
Maintain patient body heat.
Give nothing by mouth.
Consider MAST protocol as appropriate if no other methods are available (p. 30)
Consider requesting other ALS support if available
Provide rapid transport.
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
Bolus adults with 500cc fluid challenge or 20cc/kg in pediatric patients and reevaluate
Run at level to treat for shock if indicated.
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * *
Cardiac Monitor Lead II.
Note: Tachycardia is a compensatory mechanism for shock.

I. Intravenous Access

The method chosen for obtaining IV access should be based on patient condition
Saline locks are recommended for patients who do not require immediate fluid therapy
Do not waste time on scene with repeated attempts to obtain IV access on critical patients
Monitor drip rates carefully to prevent unintentional fluid dump
Hemodynamically unstable trauma patients need 2 large bore IVs, followed by a fluid bolus (A: 500cc, I/C: 20cc/kg) then reassess patient condition
Flush the IV line or port following IV medication administration and reassess the patient

J. Spinal Trauma

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Stabilize spine in neutral alignment at all times
Assess and document any changes in pulse, motor, and sensory function
Extricate as appropriate using KED or rapid extrication
Immobilize on long spine board with appropriate strapping devices.
Note: tachycardia may be absent in neurogenic shock. If the patient has a systolic BP less than 80 mmHg and other signs of shock, consider inflating MAST
Request other ALS support if available
Transport as indicated
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

V. OB/GYN

A. Vaginal Bleeding

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Get a detailed menstrual/pregnancy history
Consider other ALS support
Shock protocol as appropriate (p. 16)
Transport as indicated
* * * * * * * * * * * * * * EMT-2 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)

B. Complications of Pregnancy

GENERAL TREATMENT GUIDELINES

Remember the best way to treat the baby is to aggressively treat the mother.
High flow oxygen for all pregnant patients.
Pregnant patients may decompensate suddenly so treat all conditions aggressively

CONSIDER OTHER ALS SUPPORT IF NECESSARY

PREECLAMPSIA

Characterized by hypertension (Systolic BP>140-150mmHg) and fluid retention (edema, swelling)

Airway management protocol and oxygen therapy (p. 6) **High Flow O_2**
Perform patient assessment (p. 5)
Request other ALS support if available
Be prepared for seizures and take precautions
Transport as indicated. Regardless of mode, avoid lights, sirens or unnecessary stimulation during transport
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

ECLAMPSIA

Characterized by seizures in addition to the syndrome of Preeclampsia
Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Avoid lights or sirens during transport with seizure precautions
Provide seizure care as necessary (p. 10)
Protect the airway and the patient from injury
Transport without delay
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Cardiac Monitor Lead II

First Trimester Bleeding (0-3 months of pregnancy)

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Place absorbent pad in vaginal area
Treat for shock as needed (p. 16)
Save any passed tissue if possible
Document amount of blood loss
Transport as indicated
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)

THIRD TRIMESTER BLEEDING (6-9 MONTHS OF PREGNANCY)

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Obtain history (see p. 50 for specific questions)
Place patient on left side
Treat for shock as needed (p. 16)
Transport Left Lateral Recumbent as indicated
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)

TRAUMA DURING PREGNANCY

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Specifically check for vaginal bleeding, discharge, uterine contraction & fetal movement
Obtain history (see p. 50 for specific questions)
Spinal immobilize as needed
Tilt board to left 20 - 30 degrees to shift uterus off of the venacava for transport
Shock protocol as needed (p. 16)
Transport as indicated
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)

C. Childbirth

Assess for imminent delivery:

- regular contractions 2-3 minutes apart
- ruptured membranes (bag of waters)
- bloody show (passage of mucus plug)
- urge to push
- crowning

If delivery is imminent:

Prepare OB Kit or supplies

Document the color of the fluids (meconium stained fluid means a baby in distress)

Create a sterile field if possible for delivery

Prevent an explosive delivery by applying gentle, steady pressure over the baby's head and the mother's perineum

When the baby's head is delivered, assess the baby's neck for the presence of the umbilical cord. If present slip it over the neck. If the cord will not slip easily over the head, clamp the cord in two places and cut in between the clamps.

Suction the baby's mouth and then the nose

Glide the baby's body downward to deliver the upper shoulder and then upward to deliver the lower shoulder

Leave the baby at the level of the mother's perineum

Stimulate the baby by rubbing and drying baby off

Preserve warmth

After the umbilical cord stops pulsating (usually 20-30 seconds after delivery) clamp the cord 6 and 9 inches from baby and cut in between the clamps

Care for the newborn as described below

To reduce the mother's post-delivery bleeding, encourage the mother to breast feed and massage the mother's lower abdomen (uterine massage)

If mother prefers, mother may nurse infant if no distress is present

The placenta usually delivers within 20 minutes after delivery of the baby

Place it in a plastic bag and bring it with the patient

Place an absorbent pad to the mother's perineal area and assess for ongoing bleeding

If excessive bleeding is present, treat for shock (p. 16)

* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *

Cardiac Monitor Lead II.

D. Complications of Delivery

PROLAPSED CORD

Presentation: occurs when the umbilical cord falls down into the pelvis and is compressed between the fetus and the body pelvis. The cord may be seen in the vaginal area.

Reach into the vagina with sterile gloves, push the presenting part off of the cord and remain in this position during transport.

Attempt to palpate the cord for pulsations.

Place the mother in Trendelenburg or knee-chest position.

Airway management protocol and oxygen therapy. (p. 6)

If assistance is available, apply a dressing moistened with sterile saline to the exposed cord.

* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *

Obtain IV access (p. 16)

* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *

Cardiac Monitor Lead II.

Breech and other abnormal presentations

Presentation: presenting part is feet or buttocks-breech; an arm or leg presents-abnormal presentation

If breech delivery occurs and field delivery is unavoidable, allow the entire body to be delivered with contractions only while you support the infant

If the head does not deliver and the baby begins to breathe spontaneously, place a gloved hand in the vagina with the palm toward the infant's face

Form a "V" with the index and middle finger on either side of the infant's nose

Push the vaginal wall away from the infants face

If necessary, continue during transport

If the presenting part is an arm or leg, vaginal delivery is very unlikely.

Airway management protocol and oxygen therapy (p. 6)

Transport immediately and safely

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Obtain IV access (p. 16)

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Cardiac Monitor Lead II.

E. Care of the Newborn

Ensure the infant's airway is kept suctioned clear

Keep the baby well dried and warm and cover the baby's head to prevent heat loss

Keep the ambient room heat up

If the baby is not breathing after a few seconds of tactile stimulation, begin ventilations immediately with 100% oxygen at a rate of 40-60 breaths per minute

Approximately 30 seconds after stimulation, the baby should be pink (except possibly extremities), respirations should be strong, and the pulse should be at least 100 per minute.

If color alone is the problem, provide blow-by oxygen and monitor

If the baby's heart rate is initially below 80 but above 60, provide ventilator assistance

If the heart rate then increases, provide ventilator assistance as needed

If the baby's heart rate is initially 60 or below, begin chest compression's and CPR

Monitor respirations and pulse frequently

Determine and record APGAR score (p. 44) 1minute after delivery and 5 minutes after delivery if time allows

If mother prefers, mother may nurse infant if no distress is present

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If infant is in respiratory or cardiac arrest, or infant distress, try to establish an IV of Normal Saline at TKO rate. It is likely that Intraosseous access will have to be used.

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Cardiac Monitor Lead II as indicated.

VI. Pediatric Emergencies (Infants and Children)

A. Fever (Rectal temperature is most accurate)

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Gather history (see p. 50 for specific questions)
Remove excess clothing
Every child with unexplained fever should be evaluated to rule out sepsis/meningitis (especially < 3 months)
If meningitis is suspected, masks should be worn and follow-up with ER physician regarding need for drug prophylaxis
Signs and symptoms of possible meningitis or sepsis: fever, altered level of consciousness, irritability, lethargy, vomiting, seizures, and bulging fontanel assessed in a seated (rather than supine) patient, hemorrhagic rash.
Additional cooling such as sponge bathing are not indicated in pre-hospital setting without direct contact with medical control
Transport as indicated. Infants <3 mo. with a temperature >101 F must be evaluated
* * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
In the infant or child with altered level of consciousness, obtain IV access (p. 16). **Be careful not to overload the infant or child with fluids.** Carefully document fluid volume given.
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Consider Cardiac Monitor Lead II.

B. Respiratory Emergencies

Airway management protocol and oxygen therapy (p. 6)
If the oxygen mask is not tolerated, blow by oxygen may be utilized
If airway is obstructed, clear it
Consider Nebulized Albuterol (p. 35) or SQ Epinephrine (1:1,000) (p. 37)
Do not insert anything into the mouth
Transport in position of comfort and to decrease excitability
Perform patient assessment as deemed necessary (p. 5)
Assess for nasal flaring, retractions, accessory muscle use and other signs of severe distress
Attempt not to over stimulate the patient
Monitor heart rate and respiratory rate frequently
Pulse oximeter if available, goal is to keep saturation levels at or above 92%
If patient is wheezing and has own prescribed metered dose inhaler, obtain permission from medical control to administer as directed (p. 35 or NA) use of spacer device is preferred
Transport as indicated
* * * * * * * * * * * * * * EMT-3 * * * * * * * * * * * * * * * *
Consider Cardiac Monitor Lead II.

C. Seizures

Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment. (p. 5)
Perform a Dextro Styx.
Obtain history. (See p. 50 for specific questions.)
Supportive care as needed.
If child is in status epilepticus, has been seizing repeatedly, or has respiratory depression in the postictal period, ALS rendezvous should be requested if available.
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
If the pediatric patient's condition is critical and IV access is not possible, an IO infusion should be initiated
Consider IV or rectal Valium (p. 42)

D. Dehydration

Moderate dehydration: dry, mucous membranes, and absence of tears
Severe dehydration: tachycardia, **prolonged capillary refill**, cool extremities, tachypnea and increased depth, decreased level of consciousness, depressed fontanel, prolonged skin turgor. **Do not wait for a drop in BP!**
Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment (p. 5)
Elevation of extremities may be needed in severe cases
Supportive measures as needed
Transport as indicated
* * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * *
Obtain IV access (p. 16)
If the pediatric patient's condition is critical and IV access is difficult, consider IO infusion.
Bolus with 20cc/kg and reassess
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Cardiac Monitor Lead II.

VII. Hypothermia/Cold Injuries & Cold Water Near Drowning

A. General points

In the cold patient, a rectal temperature on a hypothermia thermometer is one of the vital signs: **A-**airway, **B-**breathing, **C-**circulation, and **D-**degrees
The simplest assessment of a patient's body temperature may be performed by placing an gloved hand against the skin of the patient's back or chest. If it feels warm, hypothermia is unlikely. This does not provide a reliable estimate of the patient's core temperature
Rectal temperatures with a low reading thermometer are more accurate than body core temperatures
Signs and symptoms of hypothermia can be mimicked or obscured by alcohol, diabetes, altitude sickness, overdoses and other conditions; injuries and illnesses should be assessed carefully
Oxygen and fluids coming into contact with the patient should be warmed
Since cold skin is easily injured, avoid direct application of hot objects or excessive pressure

Through resuscitative efforts, keep a positive attitude

The ambulance and any rooms hypothermia patients are treated in should be warmed, ideally above 80°F (26.7°C)

CPR has no significant effect on survival of the hypothermic patient in the following situations, and, in accordance with state law, CPR should **not** be initiated when:

- Cold-water submersion patients have been under the water for more than 1 hour
- Hypothermia patients with a core temperature of less than 60°F (15.5°C)
- Obvious fatal injuries, e.g. decapitation
- Frozen patients, e.g. ice formation in the airway
- The chest wall is so stiff that compression is impossible
- Rescuers are exhausted or at danger

The patient with severe hypothermia should be handled very gently

The pulse should be checked for up to 45 seconds when assessing a hypothermic patient or a patient who has been removed from cold water

Recent legislation (1994 HB 39) has empowered EMTs, paramedics, and physician assistants to declare death in the field following 30 minutes of properly performed advanced life support, even when the patient is hypothermic. It is **recommended** in these cases, however, that resuscitations be continued for at least **60 minutes** and be **combined with** the **rewarming** techniques found in these guidelines before being terminated

B. Hypothermia

ASSESSMENT OF PATIENT:

Severe Hypothermia: If the patient is cold and has any of the following signs or symptoms, he is considered to have severe hypothermia:

- Temperature of 90°F (32.2°C) or less
- Depressed vital signs, such as a slow pulse and/or slow respirations
- Altered level of consciousness, including slurred speech, staggering gait, decreased mental skills, or the lack of response to verbal or painful stimuli
- No shivering in spite of being very cold. (Note: This sign is potentially unreliable and may be altered by alcohol intoxication.)

Mild to Moderate Hypothermia: If the patient is cold (90-98F) and does not have any of these signs or symptoms, he is considered to have mild hypothermia

BASIC TREATMENT FOR HYPOTHERMIA:

Prevent further heat loss. Insulate from the ground, protect from the wind, eliminate evaporative heat loss by removing wet clothing or by covering the patient with a vapor barrier (such as a plastic garbage bag), cover the head and neck and move the patient to a warm environment. Consider covering the patient's mouth and nose with a light fabric to reduce heat loss through respirations.

Treat and transport to a medical facility.

Do not give alcohol.

When administered, oxygen should be heated to 105°-108°F (40.5°-42.2°C), measured at the mouth, and humidified

Splinting should be performed, when indicated, with caution to prevent additional injuries to frostbitten tissues.

TREATMENT FOR MILD TO MODERATE HYPOTHERMIA

Treat patient as stated in above section.

If you are unable to get to a medical facility, rewarm the patient gradually by:

- Placing patient in a warm environment
- Increasing heat production through exercise and calorie/fluid replacement
- Rewarming passively through application of insulated heat packs to head, neck, underarms, sides of the chest wall, and groin, and heavy insulation to prevent further heat loss.
- Consider warm bath or shower if patient is conscious
- Place the patient in a sleeping bag and providing contact with a warm body should be considered as a last resort as it may endanger the rescuer and is less efficient than other methods
- Encourage the patient to drink warm fluids as soon as they are capable of swallowing and protecting their airway.

TREATMENT FOR SEVERE HYPOTHERMIA WITH SIGNS OF LIFE (PULSE AND RESPIRATIONS PRESENT)

Obtain a core temperature (rectal).

Treat the patient as outlined in above sections except:

- Do **not** put severely hypothermic patients in a shower or bath
- Do **not** give a patient oral fluids unless he or she is capable of swallowing and protecting his or her airway

Transport patient to a medical facility as soon as possible

Avoid rough handling

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Obtain IV access (p. 16) and give **warmed** IV fluids

Treatment For Severe Hypothermia With No Life Signs

Treat as above.

If no pulse (after checking for up to 45 seconds) and no respirations and CPR is indicated, begin CPR

Use mouth-to-mask breathing

If the rescuers are authorized to use an AED and the device states that shocks are indicated, one set of three stacked shocks should be delivered. If the core temperature of the patient cannot be determined or is above 86°F, treat the patient as if normothermic. If the patient's core temperature is below 86°F, discontinue use of the AED after the initial three shocks

If resuscitation has been provided in conjunction with rewarming techniques for more than 60 minutes without the return of spontaneous pulse or respirations, contact medical control for recommendations. If contact is impossible, consider terminating the resuscitation in accordance with HB 39

C. Cold Water Near Drowning:

GENERAL POINTS:

Cold water is defined as being less than 70°F (21.1°C)

Anyone submerged long enough to be unconscious should be transported to the hospital, even if they have regained consciousness

If the person has been under water for **less** than one hour, full resuscitative efforts should be employed. If the person has been under water for **more** than one hour, resuscitation efforts are usually unsuccessful unless they show signs of life

Recent legislation (1994 HB 39) has empowered EMTs, paramedics, and physician assistants to declare death in the field following 30 minutes of properly performed advanced life support, even when the patient is hypothermic. **It is recommended in these cases, however, that resuscitations be continued for at least 60 minutes and be combined with the rewarming techniques found in these guidelines before being terminated**

If the length of submersion it is not known, consider it to be less than one hour with full resuscitative measures taken

Because hypothermia is rarely profound (below 85°F (29.4°C) in cold water near drowning, the hypothermia aspect of the problem is less critical than the pulmonary or coagulation aspects. Thus, rewarming is done very cautiously and gradually, without the need for invasive warming techniques (e.g. peritoneal lavage or AV shunts)

Accumulation of fluid in the lungs (non-cardiogenic pulmonary edema) may develop 6 - 24 hours after submersion; therefore **all surviving patients of an immersion episode should be transported to the hospital**

EVALUATION AND TREATMENT:

The Heimlich Maneuver should be used only when a foreign body airway obstruction is suspected.

CPR must be started immediately when the patient is determined to be pulseless after a pulse check of up to 45 seconds.

Assess carefully for associated injuries.

Follow the section on Hypothermia on page 25-27 for additional therapy as needed.

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Obtain IV access (p. 16)

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Cardiac Monitor Lead II.

D. Frostbite

General Points:

Hypothermia and other life threatening conditions may be present in the patient with frostbite and must be evaluated and treated immediately

If transporting a patient with frostbite, which will not be rewarmed in the field, the provider should protect the frostbitten parts from additional injury and temperature changes

Prevent refreezing

Superficial frostbite affects the dermis and shallow subcutaneous layer of the skin and is recognized by white or gray colored patches. The affected skin feels firm, but not hard. The skin initially turns red and, once frostbitten, is not painful. No tissue loss will occur when treated properly

Deep frostbite affects the dermal and subdermal layers and may involve an entire digit or part.
The skin feels hard and cold and the affected tissue is white or gray
A pulse cannot be felt in the deeply frostbitten tissue and skin will not rebound when pressed.
Large blisters on the frostbitten area indicate that deep frostbite has partially thawed
Treatment of deep frostbite is usually extremely painful and best accomplished in a medical facility.
If you can get the patient to a medical facility within a reasonable amount of time, or do not have the capability to rewarm the tissues properly or cannot prevent refreezing, you should transport the patient rather than attempt to rewarm the tissue in the field. Advice should be sought from medical control before electing to rewarm frostbitten tissue in the field, whenever possible
In most circumstances, the risks posed by improper rewarming or refreezing outweigh the risks of delaying treatment for deep frostbite
Tissue, which is thawed and then refrozen, almost always dies
If rewarmed in the field, frostbitten extremities cannot be used for ambulation
Do **not:**
- rub the frozen part
- allow the patient to have alcohol or tobacco
- apply ice or snow
- attempt to thaw the frostbitten part in cold water
- attempt to thaw the frostbitten part with high temperatures such as those generated by stoves, exhaust, etc.
- break blisters, which may form.

Frostbitten tissues should be handled extremely gently before, during, and after rewarming.

EVALUATION AND TREATMENT:
Anticipate, assess and treat the patient for hypothermia, if present
Assess the frostbitten area carefully since the loss of sensation may cause the patient to be unaware of soft tissue injuries in that area
Obtain a complete set of vital signs and the patient's temperature
Obtain patient history, including the date of the patient's last tetanus immunization
If there is frostbite distal to a fracture, attempt to splint the fracture in a manner, which does not compromise distal circulation
Determine where rewarming will take place (e.g. in the field, at the hospital, or clinic)
If transporting, protect the tissue from further injury from cold or impacts
If the decision is made to rewarm frostbitten tissue in the field, you should prepare a warm water bath (approximately 100°- 106°F or 37.8°- 41.1°C) in a container large enough to accommodate the frostbitten tissues without them touching the sides or bottom of the container
A source of additional warm water should be available
Remove jewelry and clothing from affected area
If possible, consult a physician regarding the administration of oral analgesics, such as acetaminophen, ibuprofen, or aspirin or morphine
The water should be maintained at approximately 100°- 106°F or 37.8°- 41.1°C and gently circulated around the frostbitten tissue until the distal tip of the frostbitten part becomes flushed.
Pain after rewarming usually indicates that tissue has been successfully rewarmed

After rewarming, let the frostbitten tissues dry in the warm air. Do **not** towel dry
After thawing, tissues that were deeply frostbitten may develop blisters or appear cyanotic
Blisters should not be broken and must be protected from injury
Pad between affected digits and bandage affected tissues loosely with a soft, sterile dressing.
Rewarmed extremities should be kept at a level above the heart, if possible
Protect the rewarmed area from refreezing and other trauma during transport. A frame around the frostbitten area should be constructed to prevent blankets from pressing directly on the injured area
Do not allow an individual who has frostbitten feet to ambulate except when the life of the patient or rescuer is in danger. Once frostbitten feet are rewarmed, the patient becomes non-ambulatory

VIII. Burn Guidelines

A. Burns Requiring Specialized Care in a Recognized Burn Center or Unit:

Partial and full thickness burns of greater than 10% TBSA (total body surface area) in patients less than 10 years of age or more than 50 years of age
Partial and full thickness burns of greater than 20% TBSA in all other age groups
Full thickness burns totaling 5% TBSA or more in any age group
Partial and full thickness burns with serious threat of functional or cosmetic impairment involving the face, neck, eyes, ears, hands, feet, major joints, genitalia, and perineum
Electrical or Chemical burns
All burns associated with inhalation injury
Circumferential burns of the chest or extremities
Burns associated with major trauma
Burns in patients with pre-existing medical disorders or in the very young or the very old

B. Management of Major Burn Injury

Perform scene survey!
Airway management protocol and oxygen therapy (p. 6)
Perform patient assessment and gather history (p. 5)
Stop the burning process with application of wet sterile dressing
After the burning process is stopped, change dressing to dry sterile dressing to prevent hypothermia
Remove all clothing and jewelry (do not pull burned clothing from the wound.)
Elevate burn injury if possible to reduce swelling
Flush chemical burns with water for 15-20 minutes
Protect yourself from contact with corrosive material or electric current!
Complete Focused History and Physical Exam
Estimate the area of burn injury (TBSA). See "The Rule of Nines" in appendix. (p. 48)
* * * * * * * * * * * * * * EMT-2/3 * * * * * * * * * * * * * * * * *
Obtain IV access (p. 16) and give a fluid bolus. Do not start IVs in burned areas. Use Kling or gauze wrap to hold the IV in place if it is near a burned area or on a burned extremity
Patients with major burns require large amounts of fluid. Carefully document fluid volume given.

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In the stable patient, administer Morphine 2-10mg SIVP for pain management, titrated to effect.

Watch for signs of respiratory depression. Contact Medical Control before giving Morphine.

Cardiac Monitor Lead II.

C. Transfer of Burn Patients:

Contact area burn center physician as soon as possible. May be referred to clinic authorities if time doesn't permit.

Information to be given to burn center physician at initial contact:

Age and sex of victim.
Size (% of TBSA), depth and location of burns.
Mechanism and time of burn injury.
State of ABC and whether patient has or will need to be intubated.
Resuscitative measures being carried out and patient's response.
Relevant medical history.
Presence of associated injuries.

Information to accompany patient at time of transfer:

Copies of all medical records, laboratory data, X-rays, EKG's, etc.
A history of the injury and how it occurred, and of known pre-existing disease and allergy.
Accurate recordings of all fluid volumes and medication dosages given, and of frequent vital signs and urinary output.

IX. MAST Protocol

A. Guidelines

The American College of Surgeons states in their Advanced Trauma Life Support Guidelines that the efficiency of MAST in the rural setting remains unproved, in the urban prehospital setting, controversial. Currently, there is a great deal of research concerning the optimum systolic blood pressure to be achieved and maintained during trauma resuscitation efforts

These protocols specify 90 mmHg as a target for the patient's systolic blood pressure

B. Indications

Pelvic or multiple leg fractures. If patient is normotensive, inflate only until fractures are immobilized

Signs of shock are present and systolic blood pressure is less than 90 mmHg

C. Contraindications

Pulmonary edema

Special precautions: DO NOT inflate the abdominal section if the patient is obviously pregnant, has eviscerated bowels, an impaled object in the abdominal area, or known diaphragmatic rupture

Special precautions for inflation with any uncontrolled hemorrhage outside the confines of the garment, e.g. thorax, upper extremity, scalp, face or neck

If an abdominal aortic aneurysm is suspected, contact medical direction prior to inflation

If a penetrating chest injury exists, contact medical direction prior to inflation

D. Special Points

The MAST should be inflated on the basis of the patient's signs and symptoms and blood pressure and not the pressure within the suit

DO NOT DEFLATE the MAST in the field except if severe respiratory difficulty develops and in the patient in cardiogenic shock who develops pulmonary edema and /or worsening vital signs. In this case, seek advice from medical control

Be alert for pressure changes caused by altitude and temperature variations

A traction splint can be applied over inflated MAST if time allows

E. Application and Inflation Procedure

Airway management protocol and oxygen therapy (p. 6)

Perform patient assessment (p. 5)

Control external hemorrhage if present

Listen for bilateral breath sounds for presence or absence of pulmonary edema

Remove shoes, belt, and pants

Apply MAST and inflate leg sections simultaneously until suit is tight but easily dented with finger, or until Velcro fasteners begin to crackle, or pop-off valves release, or until systolic BP is 90 mmHg.

Recheck vitals and lung sounds (NOTE: if systolic BP is initially less than 70 mmHg, inflate all sections at this time without rechecking vitals in between sections)

If needed, inflate abdominal section as described above

Recheck vitals and lung sounds

F. Deflation Procedures

Only deflate upon orders from medical control

Disconnect the stopcock from the abdominal section tubing of the foot pump

Slowly open the stopcock and allow a small amount of air to escape. Reassess vital signs every 5 minutes

If the BP has dropped by more than 10 mmHg systolic, pulse increases by 10, or the patient's condition has worsened, discontinue deflation procedure

If the patient's condition permits, slowly deflate each leg segment. Leave the deflated MAST in place until further care is provided

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DO NOT deflate the MAST unless you have 2 IVs of Normal Saline established (p.15)

X. Special Guidelines

A. Death in the Field (A.S. 18.08.089)

Always attempt to contact medical control when making pronouncement decisions!

The EMT may withhold resuscitation efforts when the patient has

Injuries incompatible with life, including cardiac arrest accompanied by:
- incineration
- decapitation
- open head injury with loss of brain matter
- or detruncation

Cardiac arrest accompanied by rigor mortis or cardiac arrest accompanied by the presence of post mortem lividity

ALS is not available, the patient is not hypothermic, proper CPR has been performed for at least 30 minutes and the patient has not developed spontaneous respiration or pulse.

The EMT may terminate resuscitation efforts when:

ALS is not available, the patient is not hypothermic, proper CPR has been performed for at least 30 minutes and the patient has not developed spontaneous respiration or pulse.

ALS has been properly provided for at least 30 minutes to a patient without restoring spontaneous respiration or pulse; or

The patient is hypothermic and the patient has received at least 60 minutes of properly performed cardiopulmonary resuscitation in conjunction with rewarming techniques as described in the Hypothermia and Cold Water Near Drowning Guidelines without the patient developing spontaneous respiration or pulse

When in doubt attempt resuscitation

If the Death was Pronounced Enroute:

Reattempt radio communications with on-line medical control, if appropriate

Transport the deceased to the clinic or hospital; contact the law enforcement agency, which has jurisdiction for further guidance

IF THE DEATH WAS PRONOUNCED AT THE SCENE:

Notify medical examiner (907) 269-5090 and/or law enforcement personnel

Notify survivor, if appropriate

Treat the scene as if it were a crime scene

Protect scene until medical examiner and/or law enforcement personnel arrive

Minimize the number of personnel at scene

Personnel exiting the scene should retrace the same route they took to enter, if possible

If in a residence or building:

Remember what you've touched and your entrance route

Avoid touching objects

Avoid using the residence telephone

Be prepared to describe the condition of scene, e.g. placement of objects, etc., when you arrived.

Leave tubes and IV lines in place

Don't disturb clothing, jewelry, the contents of pockets, and other personal effects, particularly if this case is likely to be reviewed by the Medical Examiner

COMFORT ONE PROGRAM©/DNR ORDERS:

Comfort One© enrollment or DNR orders will be:

Respected by all EMS personnel

Must be complete and on-hand to be considered valid

Documented on the run sheet

When in doubt, begin resuscitation as needed

Verifying eligibility includes confirming the identity of the patient and determining whether the patient has a valid DNR order

Protocols:

If the patient does not have a valid DNR order, the standard treatment and transport protocols including CPR, should be employed

If the patient **DOES** have a valid DNR order, resuscitation efforts should not be initiated or, if already in progress, terminated immediately

Health care personnel should provide comfort care as appropriate for the patient and within their scope of practice

Recommendations:

Appropriately trained and equipped health care workers **may** provide comfort for the DNR patient by:

- suctioning the airway
- administering oxygen
- assisting the patient to a comfortable position
- providing emotional support
- contacting hospice, home health agency or attending physician
- providing pain medication (ALS personnel with standing orders)

Health care workers **should not:**

- use advanced airway devices, such as an ET tube or multilumen airway
- initiate cardiac monitoring
- administer cardiac resuscitation drugs
- defibrillate
- provide ventilator assistance

Contact law enforcement as stated above

Those patients who arrest en route with valid DNR orders should be transported to the receiving facility. Contact the hospital prior to arrival and advise them of the patient's status

DOCUMENTATION:

A physician must certify the pronouncement of death within 24 hours after the EMT makes the pronouncement

The EMT should complete the EMS run report

The EMT must provide, to the person signing the death certificate, the following information:

- the presence of a contagious disease, if known
- date and time of death

Providing the EMS run report to the person signing the death certificate may be helpful.

B. Reporting Requirements

TYPE INCIDENT

- Child abuse or neglect
- Vulnerable adult abuse or neglect
- Elderly abuse or neglect
- Bullet wound, powder burn, or other injury caused by firearm
- Injury by knife, ax, or other sharp or pointed instrument unless clearly accidental
- An injury that is likely to cause the death of the patient
- Burns partial and/or full thickness covering 5%, or more, of the patient's body
    - Burns to patient's upper respiratory tract or laryngeal edema due to inhalation of superheated air

TO WHOM

- Division of Family and Youth Services, 907-276-1450, if not possible to the nearest law enforcement
- Division of Senior Services, 1-800-478-9996 in Anchorage 563-5654-within 24 hours after first having cause for the belief
- Division of Senior Services, 1-800-478-9996 in Anchorage 563-5654-within 24 hours after first having cause for the belief
- Oral report promptly to Department of Public Safety (DPS), written reports within 3 days to DPS on provided form
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Appendix F – DOWN SYNDROME

What Is Down Syndrome?

Down syndrome is a genetic disorder that includes a combination of birth defects including some degree of mental retardation, characteristic facial features and, often, heart defects, visual and hearing impairment and other health problems. The severity of all of these problems varies greatly among affected individuals. Down syndrome is one of the most common genetic birth defects, affecting approximately one in 800 to 1,000 babies. It generally is caused by an extra chromosome, the structures in cells that contain hereditary information. In this country, there are approximately 350,000 individuals with Down syndrome, according to the National Down Syndrome Society. Life expectancy among adults with Down syndrome is about 55 years, though life span varies.

What Causes Down Syndrome?

Normally, each egg and sperm cell contains 23 chromosomes. The union of these creates 23 pairs, or 46 in total. Sometimes, an accident occurs when an egg or sperm cell is forming, causing it to have an extra chromosome number 21. When this cell contributes the extra chromosome 21 to the embryo, Down syndrome results. The features of Down syndrome result from having this extra chromosome 21 in each of the body's cells. This is called trisomy 21 because of the presence of three number 21 chromosomes. Occasionally, the extra chromosome 21 is attached to another chromosome in the egg or sperm; this may result in what is called translocation Down syndrome. This is the only form of Down syndrome that can be inherited from a parent, who has a rearrangement of chromosome 21 called a balanced translocation that does not affect his or her health. Rarely, a form of Down syndrome called mosaic Down syndrome may occur when an accident in cell division occurs after fertilization. Affected individuals have some cells with an extra chromosome 21 and others with the normal number.

Do Children With Down Syndrome Have Special Health Problems?

From 40 to 50 percent of babies with Down syndrome have heart defects. Some defects are minor and may be treated with medications, while others may require surgery. All babies with Down syndrome should be examined by a pediatric cardiologist, a doctor who specializes in heart diseases of children, and have an echocardiogram in the first 2 months of life so that any heart defects can be treated. About 10 percent of babies with Down syndrome are born with intestinal malformations that require surgery. More than 50 percent have some visual or hearing impairment. Common visual problems include crossed eyes, near or far sightedness and cataracts. Most can be improved with glasses, surgery or other treatments. A pediatric ophthalmologist should be consulted within the first year of life. Children with Down syndrome may have hearing loss due to fluid in the middle ear, a nerve defect or both. All children with Down syndrome should have regular vision and hearing examinations so any problems can be treated before they hinder development of language and other skills. Children with Down syndrome are at increased risk of thyroid problems and leukemia. They also tend to have many colds, as well as bronchitis and pneumonia. Children with the disorder should receive regular medical care including childhood immunizations.

Can Down Syndrome Be Cured or Prevented?

There is no cure for Down syndrome. We are not certain how to prevent the chromosomal accident that causes Down syndrome. However, a recent study suggests that some women who have had a baby with Down syndrome had an abnormality in how their bodies metabolize (process) the B vitamin folic acid. If confirmed, this finding may provide yet another reason why all women who might become pregnant should take a daily multivitamin containing 400 micrograms of folic acid (which has been shown to reduce the risk of certain birth defects of the brain and spinal cord).

How Serious Is the Mental Retardation?

The degree of mental retardation varies widely, from mild to moderate to severe. However, most fall within the mild to moderate range, and studies suggest that, with proper intervention, fewer than 10 percent will have severe mental retardation. There is no way to predict the mental development of a child with Down syndrome based on physical features

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What Can a Child With Down Syndrome Do?

Children with Down syndrome usually can do most things that any young child can do, such as walking, talking, dressing and being toilet trained. However, they generally do these things later than other children. The exact age that these developmental milestones will be achieved cannot be predicted. However, early intervention programs beginning in infancy can help these children achieve their developmental milestones sooner.

Can a Child With Down Syndrome Go to School?

Yes. There are special programs beginning in the preschool years to help children with Down syndrome develop skills as fully as possible. Along with benefiting from early intervention and special education, many children can be fully integrated in the regular classroom. The outlook for these children is far brighter than it once was. Many will learn to read and write and participate in diverse childhood activities both at school and in their neighborhoods. While there are special work programs designed for adults with Down syndrome, many people with the disorder can hold regular jobs. Today, an increasing number of adults with Down syndrome live semi independently in community group homes where they take care of themselves, participate in household chores, develop friendships, partake in leisure activities and work in their communities.

What Does a Child With Down Syndrome Look Like?

A child with Down syndrome may have eyes that slant upward and small ears that may fold over a little at the top. His/her mouth may be small, making the tongue appear large. His/her nose also may be small, with a flattened nasal bridge. Some babies with Down syndrome have short necks and small hands with short fingers. The child or adult with Down syndrome is often short and has unusual looseness of the joints. Most children with Down syndrome will have some, but not all, of these features.

Who Has the Greatest Risk of Having a Baby With Down Syndrome?

Parents who already have had a baby with Down syndrome, mothers or fathers who have a rearrangement involving chromosome 21, and mothers over 35 years old are at greatest risk. The risk of Down syndrome increases with age, from about 1 in 1,250 for a woman at age 25, to 1 in 1,000 at age 30, 1 in 400 at age 35, and 1 in 100 at age 40. However, about 80 percent of babies with Down syndrome are born to women who are under age 35, as younger women have far more babies.

Can Down Syndrome Be Diagnosed Before the Child Is Born?

Yes. Prenatal testing using amniocentesis or a newer test called chorionic villus sampling can diagnose or, far more likely, rule out Down syndrome. As both procedures carry a small risk of infection and/or miscarriage, doctors generally offer them only to women at increased risk of having a baby with chromosomal or certain other birth defects. A doctor may suggest amniocentesis if a woman receives an abnormal result on a blood test (often called the triple screen) done around the 16th week of pregnancy. However, this blood test does not provide a conclusive diagnosis: it simply means that additional tests such as amniocentesis should be considered. Ultrasound also can detect many cases of Down syndrome. Any family with a mentally retarded child or a child with other birth defects can discuss these tests with their doctor or health professional. He or she may refer the family for genetic counseling to learn more about their particular problem and the risks involved in having another child.

What Is the Risk of Parents of a Child With Down Syndrome Having Another Affected Child?

In general, in each subsequent pregnancy, the chance of having another baby with Down syndrome is 1 percent plus whatever additional risk a mother has, based on her age. If, however, the first child has translocation Down syndrome, the chance of having another child with Down syndrome may be greatly increased. After birth, the doctor usually takes a blood sample from a baby suspected of having Down syndrome to do a chromosomal analysis (called a karyotype). This determines if the baby has Down syndrome and what the underlying chromosomal abnormality is. This information is important in determining the risk in future pregnancies. The doctor may refer parents to a genetic counselor who can explain the results of chromosomal tests in detail, including what the recurrence risks may be in another pregnancy.

Can People With Down Syndrome Marry?

Some people with Down syndrome marry. Although there have been rare exceptions, men with Down syndrome cannot father a child. In any pregnancy, a woman with Down syndrome has a 50-50 chance of conceiving a child with Down syndrome, but many affected fetuses are miscarried.

Is the March of Dimes Conducting Research on Down Syndrome?

Some March of Dimes grantees are investigating why errors in chromosome division occur, in the hope of someday preventing Down syndrome and other birth defects caused by abnormalities in the number or structure of chromosomes. Other researchers are seeking to improve the outlook for children with Down

syndrome by, for example, developing improved language intervention programs to help these children communicate more easily.

Where Can Families Affected by Down Syndrome Get Additional Information?

There are organizations across the country that provide information and support for families with children affected by Down syndrome. Two are:

National Down Syndrome Society

666 Broadway
New York,NY 10012
1-800-221-4602 or **(212) 460-9330**
National Down Syndrome Congress

7000 Peachtree-Dunwoody Road, N.E. Building 5, Suite 100
Atlanta, GA 30324

1-800-232-NDSC or **(770) 604-9500**

References:

Hassold, T., Patterson, D. (Eds.). *Down Syndrome: A Promising Future, Together*. New York: Wiley Liss, 1998.
ames, S., et al. Abnormal folate metabolism and mutation in the methylenetetrahydrofolate reductase gene may be maternal risk factors for Down syndrome. *American Journal of Clinical Nutrition*, volume 70, number 4, October 1999, pages 429-430.
National Down Syndrome Society, *About Down Syndrome*, New York, N.Y., December 1999.
Saenz, Rebecca. Primary care of infants and young children with Down syndrome, *American Family Physician*, volume 59, number 2, January 15, 1999, pages 381-390.
Stray-Gunderson, K. *Babies with Down Syndrome*. Rockville, M.D., Woodbine House, 1995.

Appendix G – ATLANTO-AXIAL INSTABILITY

Atlantoaxial Instability in Down Syndrome:

Controversy and Commentary

http://www.ds-health.com/http://www.ds-health.com/

by Dr. Len Leshin, MD, FAAP

http://www.ds-health.com/abst/pastlist.htmhttp://www.ds-health.com/abst/pastlist.htm

In 1984, the AAP issued its first position statement on Atlantoaxial Instability (AAI) in children with Down Syndrome (DS): http://www.ds-health.com/contact.htmhttp://www.ds-health.com/contact.htm

1. All children with DS who wish to participate in sports should have cervical spine X-rays.
2. When the distance on X-ray between the atlas (1st vertebra) and odontoid process (2nd vertebra) is more than 4.5 millimeters (mm), restriction on sports is advised.
3. Repeated X-rays are not indicated for children with DS who have previously had normal neck X-rays.
4. Persons with atlantoaxial subluxation or dislocation and neurologic signs should be restricted from "all strenuous activities."
5. Persons with DS who have no evidence of AAI may participate in all sports.

The American Academy of Pediatrics' Committee on Sports Medicine released a revised statement in July 1995 regarding Atlantoaxial Instability (AAI) in children with DS. This was published in the journal *Pediatrics*, 96(1):151-154. Here's the text, edited for brevity's sake:

"In 1984, the Amer. Academy of Pediatrics (AAP) published a position statement on screening for AAI in youth with DS. In that statement, the AAP supported the requirement introduced by the Special Olympics (SO) in 1983 that lateral (side view) neck X-rays be obtained for individuals with DS before they participate in the SO's nationwide competitive program. Those participants with radiologic evidence of AAI are banned from certain activities that may be associated with increased risk of injury to the cervical spine....The Committee on Sports Medicine recently has reviewed the data on which this recommendation was based and has decided that uncertainty exists concerning the value of cervical spine X-rays in screening for possible catastrophic neck injury in athletes with DS. The 1984 statement therefore has been retired. This review discusses the available research data on this subject.

BACKGROUND:

AAI denotes increased mobility at the articulation of the first and second cervical vertebrae (atlantoaxial joint). The causes of AAI are not well understood but may include abnormalities of the ligaments that maintain the integrity of the articulation, bony abnormalities of the cervical vertebrae, or both.

In its mildest form, AAI is asymptomatic and is diagnosed using X-rays.....Symptomatic AAI results from subluxation (excessive slippage) that is severe enough to injure the spinal cord, or from dislocation at the atlantoaxial joint.

Approximately 15% of youth with DS have AAI. Almost all are asymptomatic. Some asymptomatic individuals who have normal X-rays initially will have abnormal X-rays later, and others with initially abnormal X-rays will have normal follow-up X-rays; the latter change is more common....

The neurologic manifestations of symptomatic AAI include easy fatiguability, difficulties in walking, abnormal gait, neck pain, limited neck mobility, torticollis (head tilt), incoordination and clumsiness, sensory deficits, spasticity, hyperreflexia...and {other spinal cord} signs and symptoms. Such signs and

symptoms often remain relatively stable for months or years; occasionally they progress, rarely even to paraplegia, hemiplegia, quadriplegia, or death. Trauma rarely causes the initial appearance or the progression of these symptoms. Nearly all of the individuals who have experienced catastrophic injury to the spinal cord had weeks to years of preceding, less severe neurologic abnormalities....
Most importantly, symptomatic AAI is apparently rare in individuals with DS. In the pediatric age group, only 41 well-documented cases have been described in the published literature....
Asymptomatic AAI, which is common, has not been proven to be a significant risk factor for symptomatic AAI....
The efficacy of the intervention to prevent symptomatic AAI has never been tested. Sports trauma has not been an important cause of symptomatic AAI in the rare patients with this disorder; only 3 of the 41 reported pediatric cases had initial symptoms of AAI or worsening of symptoms after trauma during organized sports participation. Members of the SO Medical Advisory Committee think that more such sports-related injuries occur but that they are being overlooked because of a lack of information about the association of AAI and spinal cord injury among health care providers. This claim has not been substantiated with published research....
TENTATIVE CONCLUSIONS:
....it is reasonable to conclude that lateral neck X-rays are of potential but unproven value in detecting patients at risk for developing spinal cord injury during sports participation. It seems that identification of those patients who already have or who later have complaints or physical findings consistent with symptomatic spinal cord injury is a greater priority than obtaining X-rays. Recognition of these symptomatic patients is challenging and requires frequent interval histories and physical exams, including evaluations before participation in sports, preferably by physicians who have cared for these patients longitudinally. Their parents must learn the symptoms of AAI that indicate the need to seek immediate medical care.
The SO does not plan to remove its requirement that all athletes with DS receive neck X-rays. Pediatricians will therefore continue to be called on to order these tests. The information here can be used to interpret the results for family members...." *(end excerpt)*

Dr. Siegfried Pueschel wrote his opposition to the revised AAP statement in the Jan 1998 issue of the journal *Archives of Pediatric and Adolescent Medicine*.
Dr. Pueschel is the head of the DS Clinic in Providence, Rhode Island, and the author of several studies and textbooks on Down syndrome. In his article, Dr. Pueschel's main points are:

1. While the X-ray may not be as good of a screen as we'd like, there is currently nothing better.
2. AAI is not rare: it occurs in children with DS (10-30%) and symptomatic AAI may reach up to 1 to 2% of all children with DS.
3. Symptomatic AAI is a serious disorder, which justifies the work and expense required to detect it.
4. While it isn't known if asymptomatic AAI turns into symptomatic AAI, it hasn't been disproven yet, either.
5. To date, there have been no reports of spinal cord injury from any activity associated with Special Olympics, Inc. This may mean that such an injury *is* a rare occurrence, or it may actually show that SO's precautionary measures are effective at preventing such injuries.
6. If one waits for significant neurologic signs to appear, spinal cord damage may have already occurred. By waiting, an individual at risk with no symptoms will not be detected.
7. Further, lateral neck X-rays may also detect the less common but more serious atlanto-occipital instability, or degenerative changes in the cervical spine.

Dr. Pueschel concludes, therefore, that lateral neck X-rays are still an important part of optimal care for individuals with DS.

Also in the Jan 1998 issue of the journal *Archives of Pediatric and Adolescent Medicine* is an editorial by Dr. Bill Cohen on the controversy.

Dr. Cohen is the head of the DS Clinic of the Children's Hospital of Pittsburgh and co-chair of the Down Syndrome Medical Interest Group, a collective of health professionals dedicated to the care of individuals with DS. Dr. Cohen summarizes both the 1995 AAP statement and Dr. Pueschel's statement, and then addresses the controversy thusly:

"If in fact asymptomatic AAI is not the precursor to symptomatic AAI, the current protocol [X-rays at 3, 12, and 18 years of age] should be abandoned. I would suggest that the devastating nature of cord compression and the technical difficulties in assessing children with developmental disabilities has led to the current quandary. Few organizations would be willing to take responsibility, however limited, for a recommendation that might lead or be perceived to lead to steps that would fail to protect individuals with DS from a spinal cord injury."

Dr. Cohen goes on to cite a recent article addressing the technical aspects of measuring for AAI, and adds that in his opinion, children with DS who have a narrowed neural canal or evidence of marked AAI should receive an MRI of the neck before restriction of activity or any surgical procedure requiring anesthesia. He ends his editorial by calling for a consensus meeting involving representatives of all medical fields that this topic encompasses.

Addendum, 1/14/00:

This month, a valuable review on this topic was published by Dr. Douglas Brockmeyer, a neurosurgeon at Children's Hospital in Salt Lake City, Utah. In it, the author reviews the literature to date and gives solid recommendations for doctors for making decisions on the basis of X-rays. This paper, Down Syndrome and Craniovertebral Instability, is my Abstracted Paper for Jan 2000.

Appendix H – FORMS

VML/AVML DAILY VENUE CHECKLIST

PRIOR TO OPENING OF VENUE

- ❑ Check in with Volunteer Services
- ❑ Check in with Venue Coordinator; attend daily leader briefings
- ❑ Collect and sign out for radios, from Security
- ❑ Verify location and access to fax and copy machine
- ❑ Verify radios, cell phones, fax, copier, and hard-line phone are in working order

Verify Medical supply bins/boxes are on site and stocked

- ❑ Basic bins
- ❑ Medication bin (locked)
- ❑ Set up Medical area
- ❑ Emergency bin (locked)
- ❑ IV bin (locked)
- ❑ Ensure adequate oxygen supply

Verify Equipment

- ❑ Tables, chairs
- ❑ Other appropriate
- ❑ Coolers/ice replenished

Verify needed forms are available

- ❑ Patient Log
- ❑ Supplemental Sheet
- ❑ Supply Restock
- ❑ Equipment/Communications
- ❑ Patient Encounter Forms
- ❑ Behavioral Support Checklist
- ❑ Personnel sign-in and sign-out
- ❑ Check-out & Check-in

Items to cover prior to beginning of the day

- ❑ Make contact with Security Leader
- ❑ Check Volunteer schedule
- ❑ Verify level of training (RN, MD, EMT, AT, etc)
- ❑ Identify current CPR certified persons
- ❑ Make assignments for Volunteers (roving teams, Venue Medical Station, tent/trailer)
- ❑ Brief Volunteers on:
  - ❑ Specific team assignments
  - ❑ Number of athletes competing
  - ❑ Competition schedule
  - ❑ Overview of standing orders
  - ❑ Overview of Medical response **-** levels of care
  - ❑ Venue closing procedures (if applicable)
  - ❑ Emphasize importance of good hydration of all athletes and staff
  - ❑ Assign volunteer staff breaks and meal times
  - ❑ Need for debriefing (time, place, who attends, forms to be completed & turned in)
  - ❑ Checkout procedure
- ❑ Have teams get radios from Security (sign-out sheet)
- ❑ Assign equipment (sign-out sheet)
- ❑ Deployment of Medical Teams
- ❑ Verify radio communications
- ❑ Mark volunteers present on the Daily Staffing Schedule
- ❑ FAX the marked-up Daily Staffing Schedule to MCC
- ❑ Complete Venue Opening/Closing checklist- fax to MCC
- ❑ Contact MCC on operational status of Venue
- ❑ Verify cell phone communication

DURING COMPETITION

- ❑ Requesting EMS/Transport as required
- ❑ Notify MCC of need to transport
- ❑ Ensure completion of Encounter Forms/Illness and Injury; faxed to MCC by Medical Assistant
- ❑ Do safety rounds of the venue periodically
- ❑ Overseeing and ensuring quality medical services as provided by the staff.

POST SHIFT

- ❑ Debrief volunteers
- ❑ Verify completion of all Encounter Forms/Illness & Injury; faxed to MCC
- ❑ Have teams return radios to Security (sign-in sheet)
- ❑ Collect equipment (sign-in sheet)
- ❑ Verify next day schedule with personnel, as applicable
- ❑ Check supplies and order for next day's competition
- ❑ Clean Medical area; prepare for next shift/next day competition
- ❑ Ensure Biohazard bag has been secured:
- ❑ If full, contact BFI for pick-up —Lockup supplies/equipment
- ❑ Volunteers sign-out with VML/AVML
- ❑ Contact MCC that Venue is secured
- ❑ Debrief and checkout with Venue Coordinator
- ❑ Secure trailer/room

Date: _____/_____/2001 2001 Special Olympics World Winter Games ❄ Alaska **Venue Logo**

Patient Log

Entry #	Patient Name	Country Delegation	Time In	Patient Complaint	Name of Primary Medical Provider	Time Out	Discharge Status Code	Patient Type
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Discharge Status Codes:

1 = Able to compete – No follow-up
2 = Able to compete – Follow-up required
3 = Unable to compete – Follow-up required
4 = Transported to Polyclinic
5 = Transported to Hospital
6 = Patient Refused Treatment

Patient Type Codes:

A = Athlete
C = Coach
GOC = Games Organizing Committee
HD = Head of Delegation
O = Official
V = Volunteer
S = Spectator
HG = Honored Guest

Patient Log Instructions

The purpose of the log is to provide a mechanism to document all medical interventions and/or requests provided by medical staff. When encounters occur for requests for basic first aid or basic interventions by an athletic trainer that do not require medical assessment by licensed/certified medical personnel, the log will be used as the sole record of contact. Examples of such situations are providing a band-aid, taping an ankle, request for over-the-counter medications such as Tylenol, etc. When situations arise that require assessment of licensed/certified medical personnel, the information will be entered into the Log and a Patient Encounter form will be generated.

Patient Name: Print the name of the individual who is encountered. If you unable to ascertain a name of an athlete, attempt to obtain a Participant ID # located on their accreditation badge, instead.

Country Delegation: Print the name of the Country the athlete or delegation member is representing.

Time In: Print the time of the encounter.

Patient Complaint: Print the primary complaint of the patient or the reason the individual has contacted medical. For example, the patient may have been struck with a hockey stick to the wrist and complains of "wrist pain"" or an individual may simply "request an aspirin."

Name of Primary Medical Provider: Print the name of the primary medical provider. This should be the highest level of practitioner attending the patient.

Time Out: Print the time of the encounter ends and the patient is discharged and/or transported.

Discharge Status Code: Print the appropriate code(s) listed at the bottom of the Patient Log. There can be more than one code per athlete. For example, if the athlete fractured her leg and is unable to compete, and is transported to the Polyclinic, the Discharge Codes would be 3 and 4. Discharge Code 3 should only be used when the athlete can no longer participate in the Games (until follow-up is conducted and status is upgraded). If there is any question regarding an athlete's participation, then Discharge Code 2 should be used.

Patient Type: Print the appropriate Patient Type Code listed at the bottom of the Patient Log. There should be only one code per athlete. For example, if a Snowboarding athlete is at Alyeska watching the Alpine Skiing event as a spectator and is injured, the individual should be coded as a Spectator.

2001 Special Olympics World Winter Games ❄ Alaska

Encounter Form – Medical Command Center

Date: ____/____/____ **Time of Phone Call:** _____ **Participant ID#:** _____

Name: _____
Last First Middle

DOB: _____/_____/_____ **Sex:** ❑ Male ❑ Female **Country:** _____

Delegation: _____ **Village:** _____

Name of Person Reporting Information: _____

Phone Number: (_____) _____-_____ **FAX:** (_____) _____-_____

Medical Provider's Name: _____

Phone Number: (_____) _____-_____ **FAX:** (_____) _____-_____

Treating Physician's Name: _____

Phone Number: (_____) _____-_____ **FAX:** (_____) _____-_____

Injury ❑ **Illness** ❑ **Reason for Medical intervention:** _____

Current condition of Athlete: _____

Hospitalized: ❑ Yes ❑ No **If Yes, where:**
_____

Will Athlete be able to participate in the Winter Games? ❑ Yes ❑ No

If No, why? _____

Other pertinent information: _____

Patient Refusal Form

This will certify that I, _____, have refused to accept medical attention by the 2001 Special Olympics World Winter Games Alaska (SOWWGA), and/or emergency medical services (EMS) transportation to a local hospital. I acknowledge that I have been informed that it is the policy of 2001 SOWWGA to provide all citizens with medical attention and/or EMS transportation, regardless of my ability to pay for medical services.

I hereby acknowledge that I may sustain greater injury or illness as a result of my refusal to accept medical attention and/or EMS transportation.

I hereby agree to release, save, and hold harmless, Special Olympics, Inc., 2001 SOWWGA, its officers, agents and members from all claims, lawsuits, or liabilities of any nature whatsoever arising from any injury, harm or complication of any kind that might be suffered by me or any other person or to any property, whether directly or indirectly, by reason of my refusal to accept attention by the 2001 SOWWGA and/or EMS transportation to a local hospital.

_____ Time: _____
(Patient's Printed Name)

_____ Date: _____/_____/_____
(Patient's Signature)

_____ Date: _____/_____/_____
(Parent/Guardian/Coach/HOD Signature)

Relationship: ❑ Parent ❑ Coach ❑ Head of Delegation
❑ Other: specify
_____

_____ Date: _____/_____/_____
(Witness's Signature)

_____
(Medical Provider Name - Printed)

2001 Special Olympics World Winter Games Alaska

Polyclinic Consultation Record

Name: _____
(Last)

_____ _____
(First) (M.I.)

Participant ID#: _____

Country: _____

IMPRINT

Consulting Physician/Service:

_____

Requesting Physician/Provider:

_____

Reason for Consult:

_____

_____

_____

Consultation is needed: ❑ **Emergency** ❑ **Urgent** ❑ **Routine**

Consultation request communicated by: ❑ **Physician** ❑ **Nurse** ❑ **Other** **___/___/01** **_____**
(Date) **(Time)**

REPORT

Findings:

_____

_____

_____

Diagnosis:

_____

_____

_____

Recommendations:

_____

_____

_____

_____

Signature of Consultant
Date

Appendix I – LIFEPAK® 500 – Automatic External Defibrillator (AED)

How to Defibrillate

The LIFEPAK AED is easy to use because it gives prompts for each step in the defibrillation process. Read this chapter to understand why and how to do each step.

During the initial setup, the 500's operating features can be defined in various ways. Be sure to become familiar with the particular way you device has been set up. The procedure listed in this chapter is modeled after the default (factory) settings.

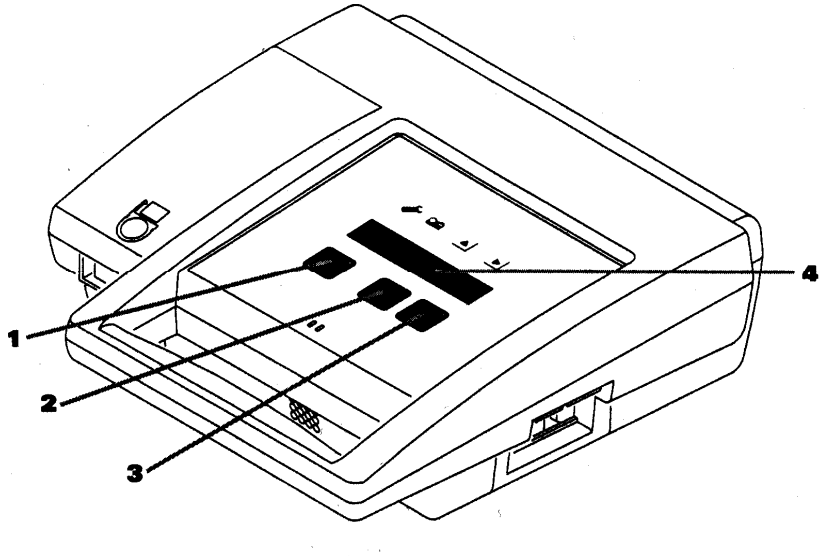
Note: This guide covers only the essentials of defibrillation using the LIFEPAC 500 AED. You must read the LIFEPAC 500 AED *Operating Instructions* to learn about other important information related to defibrillation. You should also study your local automatic defibrillation protocols.

Key Points

- Verify the victim is unconscious, breathless and pulseless.
- Turn on the LIFEPAC 500 AED and attach disposable electrodes to the victim
- Stop CPR and press the ANALYZE button.
- Follow the voice prompts and screen messages.

The LIFEPAC 500 AED

The LIFEPAC 500 automated defibrillator analyzes the heart rhythm and advises the operator if a shockable rhythm is detected. The operator must press the SHOCK button to deliver the shock. It is simple to use because it interprets the heart's ECG Signal and advises the operator what to do.

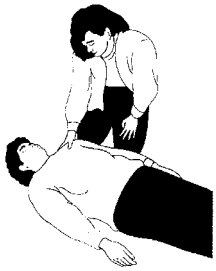


1. ON/OFF button
2. ANALYZE button
3. SHOCK button
4. Liquid Crystal Display (LCD)

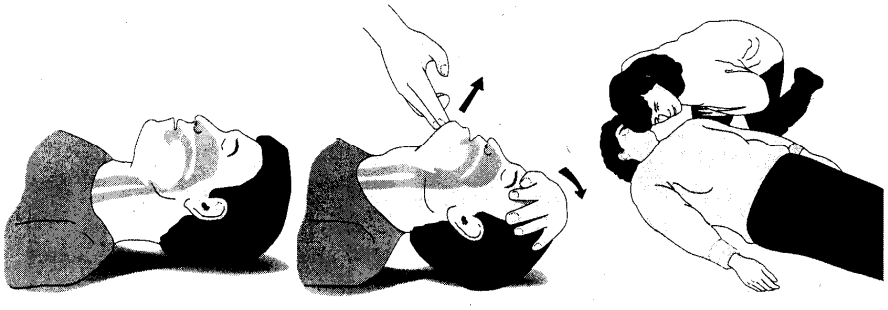
Step 1

Verify that the victim is unconscious, breathless and pulseless.

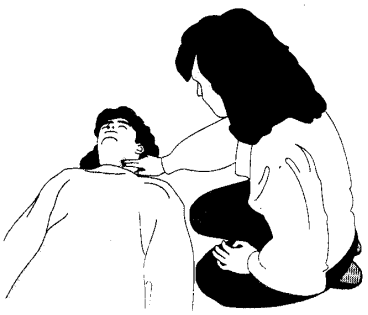
- The victim must be in cardiac arrest, which means he or she is unresponsive, not breathing and without a pulse. First, see if the victim responds to a firm shake at the shoulders and by shouting "Can you hear me?"



- If there is no response, call loudly for help, open the victim's airway, using the head-tilt chin lift and check for breathing. If you do not detect any breaths after 3 to 5 seconds, deliver two initial ventilations.



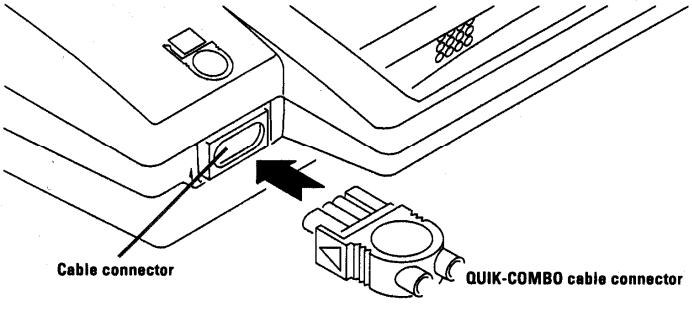
- Next, check the carotid pulse for 5 to 10 seconds. If there is no pulse, prepare the victim and AED for defibrillation. Place the victim on a hard, firm surface. This makes it easier to perform CPR and Defibrillation. Attach an AED only to someone who is unconscious, not breathing and pulseless.



STEP 2

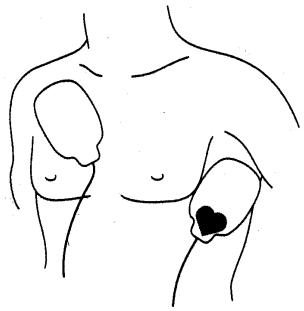
Turn on the LIFEPAC 500 AED and attach the disposable electrodes to the victim.

- Press the ON/OFF button. The green LED indicator illuminates when the device is ready to go. Speak to the device to give a verbal report if required by local protocols. Remove the disposable electrode pads from the packaging. Make sure the electrode cable connector is plugged into the 500.



Connecting the QUIK-COMBO electrode cable

- Bare the victim's chest. Remove anything that comes between the electrode and bare skin such as clothing, medication patches, sweat, moisture, a **thick** layer of chest hair. If possible, avoid placing the electrodes directly over surgically implanted devices such as internal cardioverter/defibrillators or implantable pacemakers. Remember, the electrode should touch only bare skin.



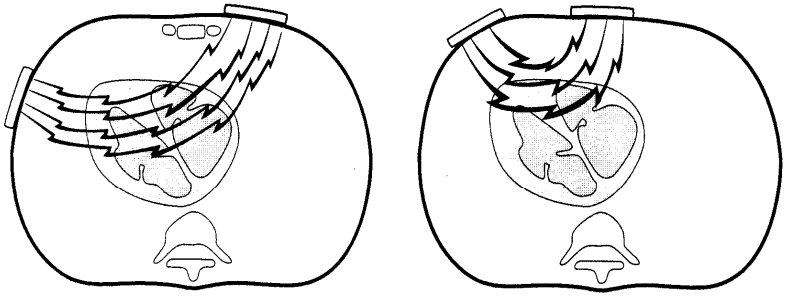
- Remove the self-adhesive backing and place the ♥ electrode on the victim's left ribs-between the nipple and the armpit. Press the electrode firmly to the skin.

- Place the other electrode above the victim's right nipple, below the collarbone and beside the breast bone. Do not place over the breast bone. Bone is a poor conductor of electricity. The AED will prompt PUSH ANALYZE, and this message will appear on the screen.

Electrode placement

Correct electrode placement allows more current to pass through the heart.

STEP 3



Correct electrode position
(Current passes through the ventricles)

Incorrect electrode position
(Current misses part of the ventricles)

Clear the area and press the ANALYZE button.

- Tell everyone to stand clear of the victim before you press the ANALYZE button. After pressing the button, wait about 6 to 9 seconds for the analysis to finish and the next message and voice prompt to occur.

- Once all motion has stopped, press the ANALYZE button to begin analysis of the heart rhythm. The ANALYZING NOW, STAND CLEAR message and voice prompt will occur.

Do not touch the victim and do not cause any victim movement during analysis.

STEP 4A

SHOCK ADVISED

The *SHOCK ADVISED* voice prompt and message occur when the unit determines the rhythm is shockable. The unit will automatically begin charging.

- Make certain no one is touching the victim. Do this by saying "I'm clear, you're clear, everybody's clear" and scan the victim from head to toe and observe the all is clear.

- Push the SHOCK button when the unit gives the *PUSH TO SHOCK* prompt.

The device will automatically analyze again after shocking to see the results of the shock.

The device will also automatically analyze after shocks 1 and 2, 4 and 5, etc. (e.g., after the first 2 shocks of each set of 3 consecutive shocks). Listen to the voice prompts and stand clear during analysis and shock.

- After a *NO SHOCK ADVISED* or 3 consecutive shocks the AED will prompt you to check the victim's pulse.

- The AED will prompt you to perform CPR for up to 1 minute if there is no pulse. It will then prompt you to check for a pulse after one minute of CPR, and if no pulse to re-analyze by pushing the ANALYZE button.

- Your local protocols may dictate a maximum number of shocks to give.

- IF the victim has a pulse, support airway and breathing. Monitor closely while awaiting transport.

- If advanced life support units arrive, they should take control of the resuscitation effort. Brief them with a short report covering the actions taken prior to their arrival. They may ask you to continue your defibrillation procedures.

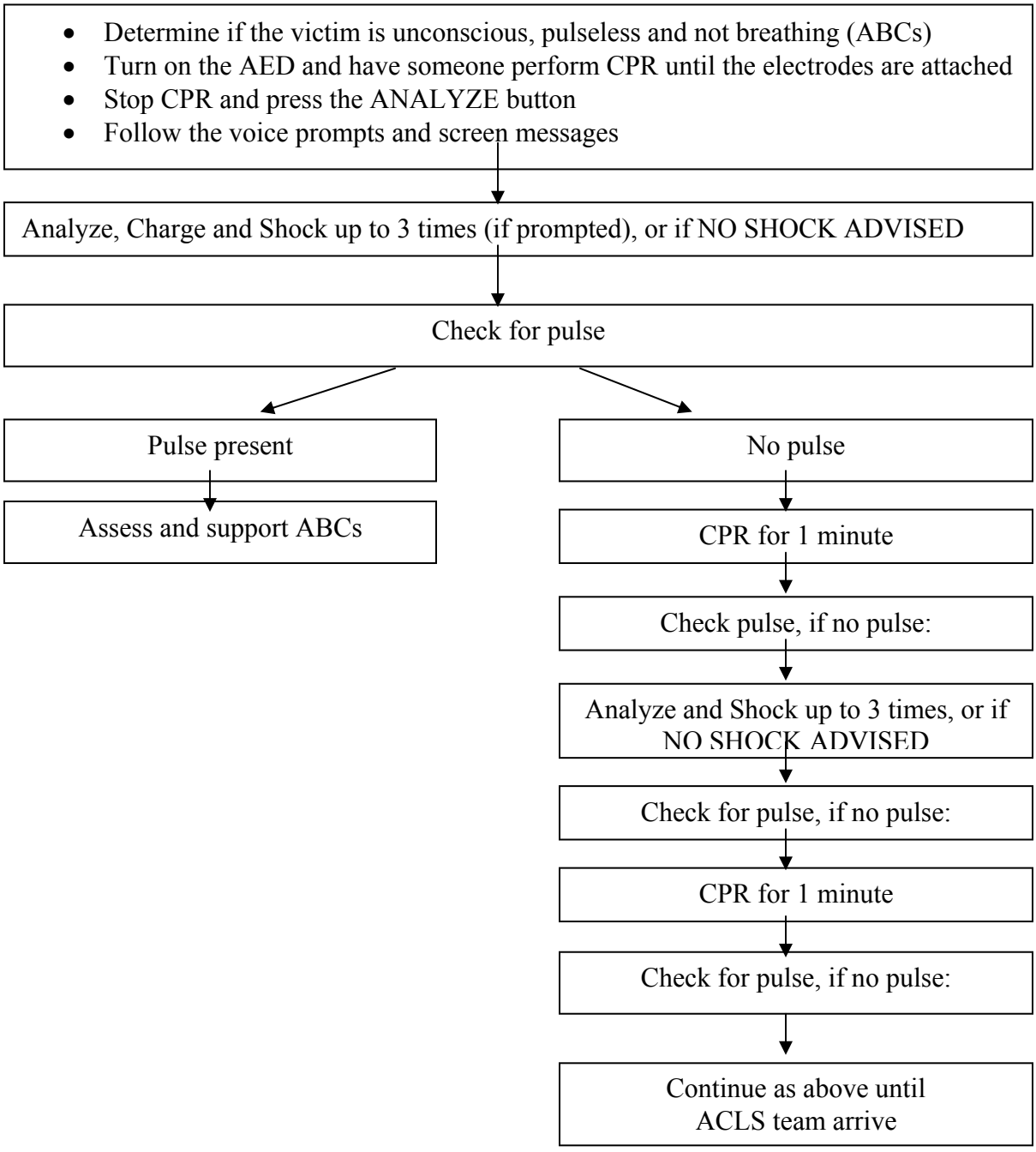
STEP 4B

NO SHOCK ADVISED

Not all heart rhythms of cardiac arrest require a shock. When the LIFEPAK 500 AED detects one of these rhythms it will give you a message of *NO SHOCK ADVISED*. The AED will prompt you to check for a pulse. Always check the victim's pulse when the defibrillator analysis results in *NO SHOCK ADVISED*.

- If there is no pulse, the AED will prompt you to perform CPR for 1 minute. Your local protocols will dictate how to proceed when the result you get is a repeated *NO SHOCK ADVISED* message.

Automated External Defibrillation Procedure



Continuous Patient Surveillance

The LIFEPAC 500 AED monitors the ECG—even when it is not analyzing. Sometimes the heart's rhythm will spontaneous convert from a non-shockable rhythm to a shockable rhythm. If the Continuous Patient Surveillance System (CPSSS) detects a potentially shockable rhythm, the AED will prompt PUSH ANALYZE.

In these situations, the LIFEPAC 500 AED is trying to warn you the rhythm has changed and it is possible the victim needs to be shocked. Stop all victim movement and check the pulse. If there is no pulse, press, ANALYZE.

Troubleshooting

If the CONNECT ELECTRODES message appears there is either an inadequate connection to the AED or the electrodes are not adhered firmly to the skin. Do a quick check of the connection to be sure the electrode connector is completely inserted into the AED.

If the disposable electrodes do not stick to a hairy chest, quickly shave the hair with a razor. Remove moisture with a cloth. Remove creams or ointments and medication patches that could come in contact with the electrodes.

Motion artifact is the EXG signal distortion created by movement of the victim or defibrillation cables. It can cause incorrect interpretation of the ECG. To prevent this situation, the LIFEPAC 500 AED has special circuitry that detects motion. The unit avoids analyzing the rhythm until all motion has stopped. It will display the *MOTION DETECTED* and *STOP MOTION* messages. It will not analyze the rhythm if motion is detected.

If the *MOTION DETECTED, STOP MOTION* message occurs, try to eliminate all sources of motion such as breathing assistance, CPR compressions, and electrode/cable movement.

Once motion stops, the AED will continue to analysis for 20 seconds. IF motion is detected for more than 20 seconds, analysis will stop. To restart an analysis, press the ANALYZE button again.

Low Battery Detection

When the battery symbol  is lit and the low battery message is displayed, the battery is low. Lithium batteries will provide approximately eleven more shocks. If they have been properly maintained, sealed lead acid (SLA) batteries will provide approximately six more shocks.

When the battery symbol  flashes on and off and the REPLACE BATTERY voice prompt and message occur, the battery is very low and should be replaced immediately.

Service Indicator and Message

When the service indicator  is on (but not flashing), you can still use the AED for therapy. Contact an authorized service person to correct the problem as soon as possible.

When the AED detects a problem that requires immediate service, the service indicator  flashes and the *CALL SERVICE* message is displayed. Turn the AED off, then on again. If the *CALL SERVICE* message is still displayed you will not be able to use the AED until the problem is corrected. Contact authorized service personnel immediately to correct the problem.

Cardiac Arrest Only!

Be certain the victim is unresponsive, breathless and pulseless. Remember:

- Shake and shout
- The ABCs:
    - open the **A**irway
    - check for **B**reathing
    - check **C**irculation (pulse)

The Safety Zone

Defibrillation can be dangerous if performed improperly. The good news is that AEDs are very safe if you take several important precautions. First—**never touch the victim when the device is analyzing or shocking.**

When analyzing or shocking maintain a buffer or *safety zone* around the victim. Imagine an invisible shield surrounding the victim. Allow no one to penetrate this zone.

Finally, check each time before shocking by saying "I'm clear, you're clear, everybody's clear" and looking to see that no one is within the safety zone..

Electrodes firmly adhered

Make sure the victim's chest has been wiped dry, excess hair removed, and the electrodes are firmly adhered to the victim's chest. Allow no air gaps between the electrodes and skin. Good technique when applying the defibrillation electrodes will minimize the possibility of a spark.

Defibrillation in the presence of oxygen

Use care when defibrillating in the presence of oxygen. Remove oxygen from the victim and place it well away from the rescue effort prior to delivering a shock.

Age Limit

Do not attach a defibrillator to anyone under eight (8) years of age (or the age recommended by your local protocols). The LIFEPAC 500 AED was not designed to deliver the lower energy levels required for children.

Appendix J – Crisis Emergency Management Plan

2001 Special Olympics World Winter Games Alaska

Crisis and Emergency Management Plan

March 4 – 11, 2001

INTRODUCTION

Having a Crisis Management Plan is an excellent way to assure that the 2001 Special Olympics World Winter Games Alaska – the 2001 Games staff and volunteers know what to do and how to properly communicate during a crisis. This plan is necessary because incidents (defined as an accident or event which may result in injury to a person, damage to property, or any allegation of negligence) involving athletes and volunteers are not uncommon during Special Olympics Events. For this reason, we must be prepared to handle any type of emergency situation.

The following information is meant to provide a broad overview in preparing a written plan that deals with crisis situations. It includes steps that are critical to building a solid foundation for an effective crisis plan.

PURPOSE OF THE CRISIS AND EMERGENCY MANAGEMENT PLAN (CEMP)

This document establishes recommended guidelines and basic incident management principles that will be utilized during a critical incident at the 2001 Special Olympics World Winter Games Alaska.

The CEMP document is designed to be used as an adjunct to the existing local, municipality and state Incident Command Master Plans. It is neither all exclusive nor exclusive and does not replace, change or otherwise affect existing policies, practices or procedures as identified for local, municipality and state emergency services.

TRAINING

All staff members should receive instruction as to their responsibilities during activation of the plan. Prior training of staff lessens the likelihood of confusion and duplication of effort during the emergency situation.

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XV. INCIDENT COMMAND (FLOW CHARTS)

I. DEFINITIONS

A) Incident:
An accident or event, that may result in injury to a person, damage to property, or an allegation of negligence.

B) Crisis:
When an issue or incident creates a temporary loss of control of some aspect of the 2001 Games' operations and causes a real or perceived health, safety, and social economic, environmental or cultural threat. A crisis has the potential to comprise the organization's credibility if not addressed properly.

C) Crisis Management Team (CMT):
The judicious use of means to accomplish an end to an unstable or crucial time or state of affairs whose outcome will make a decisive difference for better or worse. The CMT consist of the GOC Administration/Directors and will be supplemented by other staff members or outside professionals as necessary.

D) Emergency Response:
The timely implementation of a planned process to effectively bring an incident safely under control. It is the application of recovery procedures to allow the organization to function at some level of efficiency.

E) Venue Emergency Response Team (VERT):
The Venue Emergency Response Team that consists of key members of the Venue Management Team will coordinate all initial emergency efforts at the venue level.

F) Games Organizing Committee (GOC):
The 2001 Special Olympics World Winter Games Alaska organizing structure. The GOC will manage all area of operation utilizing paid and non-paid staff and contributions made available by sponsoring corporations and associations.

G) Special Olympics Inc. (SOI):
SOI is the governing body of the Special Olympics movement. SOI dictates policies and procedures to all national and international Special Olympics programs.

H) Venue:
For the purposes of this document, all facilities used for official 2001 Games' events (sporting & special events, accommodations, Special Olympics Town, etc.) are referred to as Venues.

I) Venue Coordinator:
The Venue Coordinator will be appointed for each venue and work with his/her respective Venue Team Leaders and staff to insure the venue meets the standards as set forth by the Games Organizing Committee. The Venue Coordinator is responsible for implementing the plan developed by the GOC staff, and to manage the venue team.

For purposes of this document, the term "Venue Coordinator" will be used for the lead manager of all competition and non-competition sites. The Venue Coordinator may be a paid or non-paid staff member.

In the event of an emergency situation, the Venue Coordinator is to act as a commanding officer of that incident until relieved by GOC management or the appropriate municipality or state official. Upon arrival of an appropriate official, the Venue Coordinator will provide that relieving authority with any pertinent information and the knowledge of any available resources.

J) Joint Operations Command Center (JOCC):

The JOCC will house key GOC leadership positions in support of all functional areas (Security, Medical, Delegation and Food Services, etc.). The JOCC will operate to assist all facilities and activities in support of the 2001 Special Olympics World Winter Games Alaska. Contact with the JOCC will allow Venue Coordinators and Venue Support Centers to gain access to cooperating agencies and programs external to the Games Organizing Committee. Such agencies will include local, state and federal law enforcement, SOI and DOD.

K) Main Media Center (MMCTR):

The Main Media Center is located at the Anchorage Hilton Hotel on the 2nd floor and will be a working center for visiting media and both SOI and GOC media communication representatives. Hours of operation will be from 7 a.m. to 8 p.m., March 1 – 3, 2001, and 7 a.m. to 11 p.m. daily, March 4 – 11, 2001, and 7 a.m. to 6 p.m., March 12, 2001.

The area will be divided into three sections to incorporate the following: 1. Working media area. 2. Working GOC/SOI communication center. 3. Press conference area.

Section 1 will provide a working room with desktops, Internet access, faxing capabilities and phone lines for media use. Attending media will use this area to file stories to their home office.

Section 2 will be utilized for preparing and disseminating information to the media on behalf of the Games and SOI. This will be a working center for the GOC and SOI, used to disseminate pre-prepared material and on-site media briefs, press releases, newsletters, arrange Honored Guest/celebrity interviews, etc., for use by the media, as well as document the Games via videography, photography and digital images. This area will be staffed with media savvy personnel who will be able to answer questions and assist the media.

Section 3 will be utilized daily for press briefings on the topics of interest and/or to address issues of emergency to the press.

In the instance of an emergency of any level, the JOCC will contact Ben Stevens to inform as to the nature of the emergency. The JOCC will then contact Melissa Anderson and then Nance Larsen to download the nature and level of emergency. Once the three main calls have been made, the JOCC will contact the Main Media Center to alert them as to the emergency. The Main Media Center will await a call from Melissa Anderson or Nance Larsen for directive as to the dissemination of the information to media, if necessary.

The level of emergency will dictate the course of action. See Section XII of this document for specific media communication outlines for plans of action for all levels of emergency.

L) Competition Venue:

Any facility or event location supporting a GOC/SOI approved sporting competition or activity/demonstration i.e. Kincaid Park-Cross Country Skiing, Alyeska Ski Resort-Alpine Skiing.

M) Auxiliary Venue:

Any facility or event location supporting a GOC/SOI approved function i.e. Receptions, Opening and Closing Ceremonies, Special Olympic Town, Poly Clinics, Alaska Center for the Performing Arts, etc.

N) Venue Support Center (VSC):

The Venue Support Center serves as the office for the Venue Coordinator and key functional area positions. The VSC also serves the entire venue team as the communications hub of the venue. It facilitates communication to and from the Joint Operations Command Center through the use of Base Station Operators. The VSC manages the internal and external communication of the venue by monitoring and directing radio transmissions, receiving and forwarding telephone calls, accepting requests for resources and passing the requests to the correct parties.

In the event of an emergency situation, the VSC may be utilized as the Incident Command Center (ICC).

O) Incident Command Center (ICC):

In the event of an emergency situation, the VSC may be utilized as the Incident Command Center as a temporary site where members of Venue Emergency Response Team, Crisis Management Team and law enforcement agencies would gather to discuss the emergency if they needed to report to the venue.

P) Village:

For the purposes of this document, all Hotels and Dormitories used for official 2001 Games' housing accommodations are referred to as Villages.

II. COMPONENTS OF THE EMERGENCY ACTION PLAN

In order for the venue to be prepared for a crisis situation, the Venue Coordinator will need to compile and maintain the following information:

Roster of Key Personnel
Designation of Assembly Sites and Evacuation Routes
Designation of the Venue Operations Center
Designation of Quiet Room
Public Address Announcements
Venue Contact Directory
Games Wide Contact Directory
Radio Assignments
Emergency Radio Codes

A) Roster of Key Personnel

The Venue Coordinator shall create and maintain a listing of functional area leaders and their assignments. Alternates to these key personnel must also be identified to ensure proper coverage and response.

Consideration must be given to venue teams without a full compliment of functional area Leaders. The Venue Coordinator will issue additional responsibilities to key personnel to ensure for proper coverage during a major incident.

Designation of Evacuation Routes and Alternate Assembly Sites

It is the responsibility of the Venue Coordinator, with the assistance of the Public Safety Manager, to establish evacuation routes for each venue, keeping in mind the shortest, safest method to reach any designated alternate assembly site(s).

The Venue Coordinator and Public Safety Manager will choose an alternate assembly site within close proximity to the venue. The alternate assembly site will serve as the gathering place of all involved persons in the event that evacuation is required. The alternate assembly site will allow for the taking of attendance and situation evaluation and will serve as the location wherein all involved parties will remain until instructed to relocate, the all clear is announced, or the venue is moved.

In some instances, due to the lack of a fixed permanent structure, buses or shuttles provided by the GOC Transportation Department will be used as assembly sites.

Alternate assembly sites should, if at all possible be covered and be large enough to accommodate the total number of involved persons as anticipated by normal attendance records. Designation of assembly sites should include the location of alternate venue operations centers and quiet rooms. Addendum A.

Designation of the Venue Support Center

The Venue Support Center may become the key location for initiating and controlling all necessary actions during an emergency.

The designation of the Venue Support Center must be included in each venue's copy of the Crisis and Emergency Management Plan.

Important overall element that must be considered when evaluating various locations for use as the Venue Support Center will include:

Ease of access into and out of the building
Building, room, or area size
Access to modes of communication (PA, telephone, radio, etc)
Access to restrooms
Access to records and documents
Controlled access into the area
Privacy for individuals
Available Parking

Local emergency services should be provided with a listing of these designated areas.

Designation of a Quiet Room

The Quiet Room is a location where any parent/guardian or family members may seek information, obtain assistance, and ultimately connect with the family members involved in the emergency situation.

Important overall elements that must be considered when evaluating various locations for use as a Quiet Room Include:

Controlled access
Building, room, or area size
Access to telephones
Access to restrooms
Privacy for individuals

Local emergency services should be provided with a listing of these pre-designated areas.

Public Address Announcements

Where available, public address systems should be utilized to inform all spectators of any necessary general announcements. General announcements pertaining to an emergency situation should only occur with the prior knowledge of the Venue Coordinator in agreement with the key personnel. Examples of emergency public address announcements are available in Addendum B.

Venue Contact Directory

A Venue Contact Directory for all sites must be created listing pertinent phone information (Cellular, Hard Line, Pagers, etc.) for all facility site representatives and their departments. This list is to identify outside resources, including local emergency services, available to each site.

Games Wide Contact Directory

A Games Wide Contact Directory will be created to provide all sites with the pertinent phone numbers (Cellular, Hard Line, Pagers, etc.) to all venues and support centers. The distribution of the Games Wide Contact Directory will occur prior to the start of the 2001 World Games and be available at the VSC.

Radio Assignments

A listing of all radio assignments is to be created for all functional area Leaders and their departments. The Games Organizing Committee will provide coordination of these radio assignments.

Emergency Radio Codes

Personnel Utilizing radio equipment at all 2001 Games sites should be sensitive to the general broadcasting of emergency situations. All staff should use the following emergency codes when reporting the below listed incidents.

- **CODE 1 Level 1 Emergency**
- **CODE 2 Level 2 Emergency**
- **CODE 3 Level 3 Emergency**

III. EMERGENCY RESPONSE TEAMS

The Crisis and Emergency Management Plan is designed to utilize the experience and expertise of the 2001 Games personnel. Certain positions will be used to form response teams critical to the decision-making process during emergency situations.

A) Venue Emergency Response Team (VERT)

The Venue Emergency Response Team (VERT) will coordinate all initial emergency efforts at the venue level. The VERT will consist of the following members:

Venue Coordinator
Security Leader
Medical Leader
Facility Representative

The Venue Coordinator has presiding authority over the VERT. At the point that the situation is deemed by the Venue Coordinator to have level two or three implications, the Crisis Management Team will be notified.

Crisis Management Team (CMT):

The President & CEO has presiding authority over the Crisis Management Team.

Ben Stevens – President & CEO
Melissa Anderson – Chief Operating Officer
Nance Larsen – Director of Public Relations
Loren Smith – Director of Operations
Joel Summers – Director of Sports
Leslye Langla – Director of Participant Services
Kara Capaldo – Director of Support Services
Gloria Allen – Director of Special Events
Mary DeWitt – Director of Finance
Heather Handyside – Director of Education and Cultural Exchange
Sean Halleran – Transportation Director
Jim Grimes – Public Safety Manager
Dennis Brodigan – Medical Services Manager
Lee Todd – Special Olympics, Inc.
Jon Paul St.Germaine – Special Olympics, Inc.
Colonel John Goodman – Military Support
Lieutenant Colonel – Bob Kean
American Specialties Risk Management Services

This team will be supplemented by other staff members or outside professionals as necessary to form the full Crisis Management Team needed to address the situation at hand. The CMT will meet twice daily in the Joint Operations Command Center.

Schedule of Meetings

February 26	0700 and 1800
February 27	0700 and 1800
February 28	0700 and 1800
March 1	0700 and 1800
March 2	0700 and 1800
March 3	0700 and 1800
March 4	0700
March 5	0700 and 1800
March 5	0700 and 1800
March 6	0700 and 1800
March 7	0700 and 1800
March 8	0700 and 1800
March 9	0700 and 1800
March 10	0700 and 1800
March 11	0700
March 12	0700

IV. EFFECTIVE UTILIZATION OF STAFF

When implementing procedures for addressing a major incident at the venue, the Venue Coordinator should deploy their personnel based upon their functional areas of assignment. The below listed information should be used as an initial guideline for deployment.

A) Public Safety Personnel will be utilized in areas of perimeter establishment and containment of an incident scene. Security may assist in the movement of persons away from the effected area. Safety Personnel will be utilized in areas of medical triage or spectator/volunteer movement. Safety personnel will respond to assist needs of individuals with physical disabilities.

B) Medical Personnel will be utilized in areas of medical triage and athlete movement.

C) Sport Team Personnel will be utilized in areas of athlete movement.

D) Transportation Personnel will assist facilitating the access of emergency vehicles.

V. CLASSIFICATION OF EMERGENCY LEVELS

Emergency situations have been categorized into three distinct levels.

A) Level 1 Emergency:

A Level 1 Emergency is defined as "a situation requiring internal emergency action which will not impact other venues or the function and image of the 2001 World Games."

Examples: Delayed Event Injured Participant

Members of the VERT who respond to Level 1 Emergency are:

PHASE 1

- Venue Coordinator
- Security Leader
- Medical Leader
- Facility Representative

PHASE 2

- Venue Coordinator
- Security Leader
- Facility Representative
- Logistic Leader
- Medical Leader
- Transportation Leader
- Communication Leader
- Media Leader

B) Level 2Emergency:

A Level 2 Emergency is defined as "a situation requiring internal emergency action may involve other venues or the function and image of the 2001 World Games".

Examples: Cancelled Event Missing Coach/Athlete

All level 2 Emergencies will involve the immediate notification to the Joint Operations Command Center, Director.

Members of the VERT who respond to Level 2 Emergency are:

PHASE 1

- Venue Coordinator
- Security Leader
- Medical Leader
- Facility Representative

PHASE 2

- Venue Coordinator
- Security Leader
- Venue Representative
- Logistic Leader
- Medical Leader
- Transportation Leader
- Communication Leader
- Media Leader

C) Level 3 Emergency:

A Level 3 Emergency is defined as "a situation requiring both internal and external emergency action which may impact other venues or the function and image of the 2001 Games".

Examples: Death of an Athlete Bomb

All level 3 Emergencies will involve the immediate notification to the Joint Operations Command Center, Director.

Members of the VERT who respond to Level 3 Emergency are:

PHASE 1

- Venue Coordinator
- Security Leader
- Medical Leader
- Venue Representative

PHASE 2

- Venue Coordinator
- Security Leader
- Venue Representative
- Logistic Leader
- Medical Leader
- Transportation Leader
- Communication Leader
- Media Leader

During a Level 3 Emergency, the Venue Coordinator may be subordinate to the reigning police, fire or emergency management official in command of the emergency scene.

VI. AUTHORITY TO ACTIVATE THE (CEMP)

For the purpose of the Games, the Venue Coordinator has immediate on-site authority to take corrective actions deemed necessary to resolve an emergency situation. The Venue Coordinator is ultimately responsible for all decisions related to emergency action for all level one emergency situation's.

- A Level 1 emergency situation is defined as "a situation requiring internal emergency action which will not impact other venues or the function or image of the games".

  Most level one situations will involve the notification of all members of the Venue Emergency Response Team. The Venue Coordinator should be made aware of all level one situations that occur on site and the reaction to those situations. In addition, the Venue Coordinator has first response responsibility for emergency action for all level two and level three emergency situations.

- A Level 2 emergency situation is defined as "a situation requiring internal emergency action which may have an impact upon other venues, the games or the reputation image of Special Olympics". All level two situations will involve the input of the Venue Emergency Response Team and the Crisis Management Team. Finally, the Venue Coordinator has first response responsibility for emergency action for all level three emergency situations.

- A Level 3 emergency situation is defined as "a situation requiring both internal and external emergency action which may impact other venues, the games or the reputation and image of Special Olympics".

  During a level three emergency situation the Venue Coordinator is subordinate to and shall respond to all orders as issued by the reigning police, fire or emergency management official in command of the emergency scene.

Whenever the Venue Coordinator will not be available an alternate should be designated to exercise authority in this regard. The alternate, in turn, should designate a second alternate to bear the responsibility should the alternate not be available. This sequence continues as conditions warrant.

Because it is not possible to predict when an incident may occur and staff members designated to act as key responders during the emergency response may not be available, all members of the staff should be briefed on the action steps required to initiate the emergency action plan.

The President & CEO of the 2001 Special Olympics World Winter Games Alaska is the official who is ultimately responsible for the Games. The President & CEO has the final authority to cancel the Games, make significant changes in the Games, and make any final decisions regarding crisis management. The President & CEO is aware of the Special Olympics mission and is best equipped to maintain Special Olympics desired profile. In the absence of the President & CEO, the Chief Operating Officer will carry the authority of the President & CEO.

Everyone involved with an event should be aware of the chain-of-command and these emergency procedures. This information should be given to all volunteers during the volunteer training session.

VII. PREPAREDNESS (For usage of the CEMP)

This CEMP is designed to serve as an adjunct to the normative work activity of Special Olympics World Winter Games Alaska – the Games Organizing Committee. Implementation of this Plan does not necessarily entail a different kind of work activity. Implementation merely involves staff action in addition

to that which is regularly performed. These additional obligations and tasks are attempted, of course, within pressured time constraints and on-the-spot decision-making.

These additional actions, no matter how unusual should pose no unmanageable predicament. A sound component of all staff training, both the formal and informal varieties, is the preparation to handle all situations, from the routine to the rare and unusual. Indeed, the situation, which staff personnel will be handling during an emergency, are both routine and unusual.

An important ingredient of the plan, however, is the advanced development of a permanent roster by the Venue Coordinator of the individuals who would be playing key roles during an emergency, should the Plan be activated. The Venue Coordinator shall create and maintain a listing of person's assigned specialized duties and their alternatives. The Venue Coordinator will, with the assistance of the Public Safety Manager, also prepare and maintain a listing of at least the minimum preparatory information required by the plan as outlined within this section.

a. Assignment of staff responsibilities
b. Alternate assembly sites
c. Command post location
d. Family reception area

The head start of planning time will place the staff members and the facility in an advantageous position when the emergency plan is activated.

VIII. Designation of Duty Assignments

Duty Assignments should follow normal job duties and responsibilities unless they are of a specialty nature.

The Venue Coordinator will make specialty duty assignments. One individual may handle several specialty assignments provided this does not result in a conflict toward completion of any of the duty goals.

Once the plan is activated all participants are at the direction of their immediate supervisors who in turn report to the Venue Coordinator. A permanent roster should be prepared and maintained which lists duty assignments. Persons who are assigned specialty tasks should receive advanced notification and instruction for responsibilities associated with the assignment.

IX. DOCUMENTATION

1) Documentation and proper record keeping is an essential part of a Crisis and Emergency Action Plan. All actions, occurrences, incidents or responses must be recorded and maintained in an organized and accessible manner and stored at a safe and secure location. The purpose of all incident reporting is to provide the 2001 World Games leadership structure with timely notification of significant or unusual incidents, accidents, property loss or damage that impact the well-being of Games participants, spectators and the Games Organizing Committee.

2) All incidents are reported immediately to the Venue Support Center. An Action Log is maintained for ongoing reporting. An Incident Report (with more detailed information) is to be completed by the on-site personnel to report an unusual occurrence/incident.
Emergency Information is immediately reported to the JOCC.

3) Incidental information is reported to the JOCC at the end of each operational day, where staff will review the report and follow up, as necessary.

The below listed report forms will be used to detail actions taken during an emergency response. Addendum C

A) Public Safety/Incident Report

Report forms to be used by Public Safety Personnel to document the security encounters of Athlete's, Coaches, Spectators, and Volunteers and Special Olympics family members. The Venue Coordinator and Functional Area Leaders will report any incidents they observe to the Public Safety Security Leader.

- Significant personal injury to participants or spectators
- Significant property damage to GOC valued at $500 or more
- Theft or loss of property to GOC valued at $200 or more
- Damage to the environment

Notification of details that might indicate potential harm to the integrity of the 2001 World Games or to the well being of the 2001 World Games participants, staff, and/or spectators.

B) Medical Reports

Report forms to be used by Medical Personnel to document the medical encounters of athletes, Heads of Delegations, coaches, officials and Games Organizing Committee members requiring an assessment by licensed/certified personnel at a medical field station or Polyclinic.

The forms will also be used to track an athlete's status as they move through the medical system.

C) Venue Daily Activity Report

Document to be gathered daily by the Venue Coordinator and faxed to the Joint Operations Command Center (JOCC) summarizing any issues occurring at their respective venue. Input from all functional area Leaders should be requested and expected. The JOCC Administration Assistants will summarize all the Venue Daily Activity Reports for the CMT meetings**.**

D) Transportation Accident Report

In the event of a vehicle accident, the Anchorage Police Department or Alaska State Troopers will submit the accident report to the Transportation Director. The accident report will be submitted to Joint Operations Command Center as soon as practical.

D) JOCC Summary Report

All reports received from the Venue Support Centers are entered into the Incident Event Tracking system. A summary of all open issues is discussed at the Crisis Management Team twice-daily meetings.

For each of the above reports factual, objective information is required to ensure the accuracy of all reports.

It is important to remember that confidentiality of all information is paramount!

X. COMPLETION OF REPORTS AND DISTRIBUTION

All incidents are to be communicated immediately to the Venue Coordinator. An Incident Report with more detailed information is to be completed by on-site personnel, when determined necessary by the Venue Coordinator or functional area manager.

Emergency information is reported to the Joint Operations Command Center as soon as practical.

Incidental information is captured in the Venue Daily Activity Report and submitted to the Joint Operations Command Center at the end of the day.

All information provided to the Joint Operations Command Center will be reviewed and disseminated for action, if appropriate.

XI. EMERGENCY NOTIFICATION PROCEDURES

The following guidelines should be utilized when reporting an emergency situation to the Venue Support Center, the Joint Operations Command Center, 911 or any other emergency agency.

- Immediately identify yourself to the operator. Be distinct, stating name, venue, position and location.
- State briefly the situation. Do not expand on any details, facts or information you have been directed to convey or have available. Do not speculate.
- Make notes. Make sure you know who is responding to your call.
- Note the date and time of your call.
- Remain calm. Your approach to the call is vital since the ability to assess further action is based on the information you will provide.
- Do not end the call until so indicated by the operator.

XII. MEDIA SPOKESPERSON

Following are the official crisis communication guidelines from the Games Organizing Committee in regards to dealing with any media, local, state, national or international, in relation to the 2001 Special Olympics World Winter Games Alaska, March 4 – 11, 2001. This media guideline specifically pertains to all volunteers, board members and staff associated with the event during an identified time of crisis.

During times of crisis, it is imperative that comments directed to the media be relayed by the GOC official spokesperson(s). No other personnel, staff, volunteer, athlete, coach or family member are authorized to comment to the media during times of crisis. Identifying a specific individual or a limited number of specific individuals who are authorized to speak on behalf of the Games during a time of crisis generates an atmosphere of confidence and preparedness.

For the GOC, there are three individuals who are identified as official Games spokespeople. They are, in order of preference during a crisis: Ben Stevens, President & CEO, Melissa Anderson, COO, and Nance Larsen, Director of Public Relations. Only these identified individuals are authorized to release statements to the media on issues of crisis leading up to and during the Games. How messages are delivered and when they are provided are crucial to overcoming negative scenarios, controlling sensitive issues and overcoming issues of crisis in order to move ahead in a positive manner for the remainder of the Games.

Specified, identified spokespeople:

- **Protects the agreed upon contract rights of the Games Organizing Committee.**
- **Insures a consistent, agreed upon message for the Games, Special Olympics, Inc., (SOI) and Special Olympics Alaska (SOAK).**
- **Provides a unified voice in the event of a crisis.**

- **Puts in front of the media individuals qualified and well versed on the overall organization, rather than just one area.**

Direction for comments to the media during times of crisis will be authorized by the identified spokespersons, based on the classification level of the emergency. Notification of a crisis or emergency situation during the Games will be disseminated through the JOCC. Once a call is received at the JOCC, calls will automatically be put into play to Ben Stevens, Melissa Anderson and Nance Larsen who will collectively determine the authorized flow of information.

Level I Emergencies:

Example: Delayed Event or Injured Participant.

The communication flow for a Level I Emergency will flow from the identified spokespersons to the media leader on-site at the venue in question. Authorization to release this information to media will be provided to the media leader by Nance Larsen on a case-by-case evaluation.

Level 2 Emergencies:

Example: Cancelled Event or Missing Coach/Athlete

The communication flow for a Level 2 Emergency will flow from the identified spokesperson to the media leader on-site on a case-by-case basis. What information, if any, is released to the media by the on-site media leader will be determined by the identified spokespersons. For example, in the event of relatively minor reason that may lead to the cancellation of an event, it may be necessary to inform the media leader on-site as to the reason for the cancellation so that this information can be quickly passed to media that may be on-site. A more likely scenario will be to disseminate a media alert stating the cancellation with an official statement that can be shared with the media leader on-site. For more serious issues, a special press conference may be appropriate to release information to the media, or, information may be shared on the topic with media at the next regularly scheduled press conference. The official spokespersons will determine the direction and need to react to a Level 2 Emergency with the media and direct the on-site media leader accordingly.

In the event of a missing coach or athlete, the official spokespeople will determine if and/or how this information is released to the media.

Level 3 Emergencies:

Example: Death of an athlete, bomb, evacuation, avalanche

In the event of a Level 3 Emergency, all communication will be directed by the official spokespersons via a press conference at the official press conference area or on-site at a venue depending on the nature of the Level 3 Emergency and the location of the official spokespersons. The GOC Crisis Management Team will determine the immediacy of how and when this information is disseminated. Communication for a Level 3 Emergency will flow through the JOCC to Ben Stevens, Melissa Anderson and Nance Larsen. Under no circumstances are representatives involved with the Games other than the official spokespersons allowed to speak to the media regarding a Level 3 Emergency.

XIII. INCLEMENT WEATHER CONDITIONS

Information from the National Weather Service (NWS) will be available through personal contact and the official NWS web page. The JOCC will provide pertinent information to the venues on all weather alerts,

warnings and watches. The JOCC will notify Ben Stevens, Melissa Anderson and Nance Larsen on all weather alerts. The Main Media Center will issue statements in regards weather issues.

XIV. ADDENDUMS

A) Public Address Announcements
B) Venue Contact Directory
C) Documentation Incident Report
    a. Medical Reports
    b. Public Safety Reports
    c. Venue Daily Activity Report

XV. INCIDENT COMMAND (FLOW CHARTS)

VENUE RESPONSE PROCEDURES

- Event Delayed
- Event Postponed
- Event Cancelled
- Change of Venue
- Venue Evacuation
- Bomb Threat
- Suspicious Package
- Missing Delegate – On Venue
- Found Delegate – On Venue
- Missing Delegate – Off Venue
- Found Delegate – Off Venue
- Missing Child – On Venue
- Found Child – On Venue
- Serious Injury/Illness Delegate – On Venue
- Serious Injury/Illness Spectator – On Venue
- Non-Serious Medical Incident
- Defection/Request for Political Asylum
- Mass Casualty/Illness Situation On Venue
- Death of Delegate
- Criminal Activity
- Inclement Weather