Wildland Fire Medical Orders

1. Stay informed of the location of the fire resources that you are responsible for.

2. Know what tactics your fire resources are using at all times.

3. Base your response (gear and training) on probable injuries and expected illnesses.

4. Identify patient extraction routes and patient transport rendezvous locations, and make them known.

5. Stage in an area that allows an appropriate response time to an incident within an incident.

6. Stay informed about probable patient destinations, care facility capabilities, and the availability of transportation to those destinations.

7. Verify that you have communications with your field supervisor and the incident communications or local dispatch center.

8. Provide clear instructions and ensure they are received and understood.

9. The fireground is dynamic. Listen for and observe changes, and adjust your response appropriately.

10. Having provided for your safety first, provide appropriate and timely care to the injured and ill.

Wildland Fire Medical Watchout Situations

1. Area of initial medical response not scouted and sized up.
2. Travel routes to fire resource work areas are not taken and timed.
3. Extraction and/or Transport methods not identified.
4. Unfamiliar with the plan to get a patient to definitive care.
5. Uniformed on patient extraction availability and capabilities, transfer of care (rendezvous) points, and/or landing zones.
6. Instructions and assignments are not clear.
7. No communications link with crew members and/or supervisor. Haven't heard any traffic on your assigned channels for over 2 hours.
8. Your staging area is more than 20 minutes from the bulk of the fire resources.
9. Accessing a patient without extraction gear and a plan.
10. No available communication with local medical control or online medical direction.
11. Estimated patient extraction times exceed one hour.
12. Entering the active fire area without having made contact with fire resources.
13. On a hillside where patient, provider(s), gear, and/or vehicles can roll.
14. Increase in minor heat-related medical issues and noticing trends in minor medical problems.
15. Wind and/or weather are altering patient extraction and/or transport plans.
16. Multiple patients from the same fire operation.
17. Terrain and fuels make patient extraction or transportation difficult.
18. Fatigue makes it difficult to recall details from events, the day, or the assignment.

Medical Incident Report

FOR A NON-EMERGENCY INCIDENT, WORK THROUGH CHAIN OF COMMAND TO REPORT AND TRANSPORT INJURED PERSONNEL AS NECESSARY.

FOR A MEDICAL EMERGENCY: IDENTIFY ON SCENE INCIDENT COMMANDER BY NAME AND POSITION AND ANNOUNCE "MEDICAL EMERGENCY" TO INITIATE RESPONSE FROM IMT COMMUNICATIONS/DISPATCH.

Use the following items to communicate situation to communications/dispatch.

1. CONTACT COMMUNICATIONS / DISPATCH (Verify correct frequency prior to starting report)

Ex: "Communications, Div. Alpha. Stand-by for Emergency Traffic."

2. INCIDENT STATUS: *Provide incident summary (including number of patients) and command structure.*

Ex: "Communications, I have a Red priority patient, unconscious, struck by a falling tree. Requesting air ambulance to Forest Road 1 at (Lat./Long.) This will be the Trout Meadow Medical, IC is TFLD Jones. EMT Smith is providing medical care."

Severity of Emergency / Transport Priority	☐**RED / PRIORITY 1 Life or limb threatening injury or illness. Evacuation need is IMMEDIATE** *Ex: Unconscious, difficulty breathing, bleeding severely, 2º – 3º burns more than 4 palm sizes, heat stroke, disoriented.* ☐**YELLOW / PRIORITY 2 Serious Injury or illness. Evacuation may be DELAYED if necessary.** *Ex: Significant trauma, unable to walk, 2º – 3º burns not more than 1-3 palm sizes.* ☐**GREEN / PRIORITY 3 Minor Injury or illness. Non-Emergency transport** *Ex: Sprains, strains, minor heat-related illness.*	
Nature of Injury or Illness & Mechanism of Injury		*Brief Summary of Injury or Illness (Ex: Unconscious, Struck by Falling Tree)*
Patient Location		*Descriptive Location & Lat. / Long. (WGS84)*
Incident Name		*Geographic Name + "Medical" (Ex: Trout Meadow Medical)*
On-Scene Incident Commander		*Name of on-scene IC of Incident within an Incident (Ex: TFLD Jones)*
Patient Care		*Name of Care Provider (Ex: EMT Smith)*

3. INITIAL PATIENT ASSESSMENT: *Complete this section for each patient as applicable (start with the most severe patient)*

Patient Assessment:

Treatment:

4. TRANSPORT PLAN:

Evacuation Location Patient's ETA to Evacuation Location:

Helispot / Extraction Site Size and Hazards:

5. ADDITIONAL RESOURCES / EQUIPMENT NEEDS:

6. COMMUNICATIONS: Identify State Air/Ground EMS Frequencies and Hospital Contacts as applicable

Function	Channel Name/Number	Receive (RX)	Tone/NAC *	Transmit (TX)	Tone/NAC *
COMMAND					
AIR-TO-GRND					
TACTICAL					

7. CONTINGENCY: ***Considerations:*** ***If primary options fail, what actions can be implemented in conjunction with primary evacuation method? Be thinking ahead.***

8. ADDITIONAL INFORMATION:

REMEMBER: Confirm ETA's of resources ordered. Act according to your level of training. Be Alert. Keep Calm. Think Clearly. Act Decisively.

HEMODYNAMIC ASSESSMENT FOR TRANSPORT URGENCY			
Observation	**Adequate Perfusion**	**Poor**	**Inadequate Perfusion**
Conscious*	Alert to time & place AOx4 (GCS 15-14)	Mildly altered, <AOx4 (GCS <13)	Significantly Altered, Unconscious
Speech	Clear and loud	Incomplete Sentences, difficulty with words	Quiet, will nod if extreme, slurring, no speech
Breathing*	12-20, normal	<8 or >20, distressed	No or <6, poor ventilation
Breathing Rhythm	Even & regular	Mild distress, Slightly Irregular	Major Distress, Significant Irregularity
Work of Breathing*	Diaphragmatic, Comfortable	Some difficulty, accessory muscle use	Using chest muscles, retractions on inspiration
Pulse	60-100/min Regular, Strong	<50-60/min, >110/min Bounding/Thready	Weak or no pulse
Skin*	Normal (pink, warm & dry)	Normal to pale, peripheral cyanosis, mottling	Widespread cyanosis, lividity
Appearance	Relaxed, normal	Slightly agitated, anxious	Flaccid, Posturing
Hypoxemia	SpO2 >/=92% (AV) No Oxygen required.	Mild SpO2 85-91% Severe SpO2 <85%	Administer Oxygen or BVM
BP	>100mmHg systolic MAP >70, <100	<90mmHg systolic MAP 60-70, >100	Unrecordable or <60mmHg MAP <60
Chest Sounds	Good air movement on inhale and exhale Clear, easily heard by stethoscope No abnormal sounds	**Asthma** Expiratory wheeze Dry cough +/- inspiratory wheeze **Heart Failure** Midzone course Crackles Cough may be present	**Asthma** Reduced volume of breath sounds Inspiratory-expiratory wheeze, end expiration **Heart Failure** Wet crackles (upper lobes) air through fluid **Obstruction** Upper airway stridor (high pitched) inspiration
Perfusion Index	>1.4%	1.0% to 1.4%	<1.0%

*Required Assessments for Classification

Provider discretion may be used.
Operational requirements may supersede medical request.
Emphasize desired time range for evacuation, not color category.

Immediate

1. Hypotension due to blood loss
2. Penetrating injury to neck or torso
3. Airway compromise; current or impending
4. Respiratory distress
5. Suspected Acute Myocardial Infarction
6. Epinephrine administered (anaphylaxis or asthma)
7. Unresponsive
8. Deterioration of mental status or vital signs
9. Suspected Stroke
10. Heat illness unresponsive to cooling or cooling not available.

Emergent (<8hrs)

1. Persistent/Recurrent hypotension after 500ml IV/IO/PO
2. Mechanism of injury consistent with potential major injury.
3. Suspected infection/open fracture without antibiotics.
4. Intractable abdominal pain.
5. Persistent altered mental status
6. Burns
   a. >10% 2nd degree TBSA
   b. Face, hands, foot, genitalia, perineum, major joints
   c. 3rd degree burn of any size
   d. Electrical burn

Urgent (8-24 hrs)

1. Condition not expected to improve without treatment.
2. Inability to maintain hydration with oral fluids.
3. Inhibits team from performing primary duties.
4. Open Fracture or suspected infection with antibiotics given.
5. Burn >1% <10% 2nd degree TBSA

Non-Urgent (reassess for recategorization)

1. Able to manage in current environment pending evacuation.
2. Management does not interfere with operations.

Patient Handoff Report

I – Identification
(Patient's name, age, gender, and date of birth)
M – Mechanism/Medical Complaint
(What happened? Nature of the illness or mechanism of injury)
I –Injuries/Information Related to the Complaint
(Description of injuries or relevant medical history and findings.)
S – Signs
(Vital signs (HR, BP, RR, Temp, SpO_2, GCS, BGL. Include any abnormal or deteriorating trends.)
T – Treatment and Trend
(What has been done so far - interventions, medications, oxygen, IV access, etc., and patient response to treatment.)
A – Allergies
(Known drug, food, or environmental allergies.)
M – Medications
(Any regular medications the patient takes, including recently administered ones.)
B – Background
(Relevant medical history (chronic conditions, surgeries, mental health, etc.)
O – Other Information
(Social situation, time of symptom onset, DNAR/Advance Directive, accompanying family, valuables, or anything not previously mentioned.)

Consider the following points when selecting a landing zone for a helicopter:

- Locate a flat area that is of sufficient size for the type of helicopter you are expecting.
    - Type 1 – Clear and level touchdown pad measuring 30 feet by 30 feet; safety circle measuring 110 feet in diameter.
    - Type 2 – Clear and level touchdown pad measuring 20 feet by 20 feet; safety circle measuring 90 feet in diameter.
    - Type 3 – Clear and level touchdown pad measuring 15 feet by 15 feet; safety circle measuring 75 feet in diameter.
- Choose an area clear of people, vehicles, and obstructions such as trees, poles, and, especially, overhead wires.
- The area must be free of stumps, brush, posts, large rocks, or anything over 18 inches high.
- Consider the wind direction. Helicopters land and take off into the wind.
- Choose an approach free of obstructions. Any obstruction you cannot eliminate should be relayed to the helicopter crew during initial radio contact.
- Remove or secure any loose items in and around the landing area, such as trash, blankets, hats, or equipment.
- Wet down the landing area if dusty conditions are present.

Helicopter Landing Area Safety

The following points should be considered when operating around an unimproved landing site:

- Always wear your personal protective equipment (PPE) when working near an operating helicopter (eye, hearing, head, etc.).
- Always get the approval of a flight crew member or the pilot before approaching an operating helicopter.
- Only approach and depart a helicopter as directed. Use a slightly crouched position. Do not run. Always keep in the pilot's field of vision.
- Never go near the tail of helicopters.
- When loading helicopters in uneven terrain, always approach and depart from the down slope (lower) side and do not hold equipment overhead.
- Remove or secure loose articles prior to working around an operating helicopter.
- Do not reach up for or chase after loose objects.
- Blowing dust, sand, or rocks caused by the helicopter's rotor wash can be hazardous. Institute dust abatement actions at the landing area if necessary.

Short-Haul/Hoist

The following information was compiled by the Intermountain Healthcare Life Flight Program, Salt Lake City, Utah, and is intended to assist those involved in mission planning for an emergency extraction.

Their website states, "A hoist rescue is a great tool for extracting patients from challenging environments. However, this type of operation does have some limitations. Good communication between the requesting agency and Life Flight is critical in creating a plan to best serve all agencies and the patient safely."

Minor revisions have been incorporated into the information to fit the audience.

Mission planning should begin with these types of questions:

- What is the nature of the intended short-haul/hoist rescue?
- What is the weather at the scene?
- What do you want the rescuer to do?
- What is the plan if the rescuer cannot complete the mission?
- Patient information (i.e., location, mechanism of injury, condition, anyone with the patient, contact).
- Is there a Command Post (location, IC contact, radio frequencies)?
- Is SAR at the scene or deployed?
- Is there a landing area (near the patient, near the Command Post)?
- Where is the nearest location for jet fuel?
- Is there anything else you want us to do before we leave the area?

Factors That Limit Hoist Operations:

- Winds are greater than 20 mph, poor visibility, or severe weather.
- If total weight of patient and equipment exceeds 450 lbs.
- Hoist operations are not conducted at night.
- Over water.

We may not be able to complete a short-haul/hoist mission if:

- There are unresolved communications issues or safety problems.
- Near dusk.
- Patient location requires technical rescue.
- There's avalanche potential at the patient location

Initial Short-Haul/Hoist Risk Assessment:

- Life-threatening injury or illness.
- Time-dependent injury.

- Ground evacuation may endanger the patient and/or other personnel.
- Ground evacuation would be time-consuming.
- Ground evacuation is not possible.
- No landing area near the patient.

TOMAS

Terrain: Alpine, forest, slope, snow, etc. When possible, establish a nearby alternate landing area.

Obstacles: Trees, cliffs, rock scree, loose debris, dust, wires, limited daylight, rotor wash, etc.

Method: Net, bag, litter, harnesses, tag line, etc. Logistics, type of insertion/extraction.

Alternatives: Standby and/or assist SAR with a ground rescue, land near the victim.

Safety: Team reviews available information and identifies concerns. Determines “Go/No-Go” decision and justifies why.

Short-Haul Operations

CAPABILITIES

- During an operational Short-Haul the helicopter is capable of inserting Short-Haulers into an area with tight canopy cover and/or technical terrain.
- Haul line lengths range from 100 feet to 350 feet.
- Short hauler and/or medical gear can be delivered to the medical scene even if extraction by short-haul is not necessary.

ORDERING

- EMT or Medical Incident IC determines medical extraction is required.
- Follow local established procedures and/or Medical Incident Report (MIR) in the IRPG.
- Confirm aircraft type, call sign, estimated time of arrival and frequency.
- Give site selection information when ordering: hazards (i.e. ash, smoke, snags, aerial), tree height, terrain, and patient transport configuration (supine or seated position). Repeat hazards and give updated weather conditions as well as brief patient update to responding helicopter.

PROCESS: The helicopter will fly to the coordinates provided. They will make contact with ground personnel on scene with the patient using an identified air-to-ground frequency. The helicopter will complete a short-haul recon and size up, gather patient update information and then fly to a landing zone (LZ) to configure for short-haul operations. The helicopter will be monitoring the appropriate air-to-ground, air guard and victor frequencies. From this point, ground resources should only contact the helicopter in case of an emergency. During the insertion and extraction process ground personnel must be clear of the area.

ON SCENE: EXPECT THE FOLLOWING

- 1 or 2 rescuers (at least one qualified as an EMT or higher)
- Backboard (if needed and not already on scene)
- All equipment necessary for patient extraction

The Patient Extraction Bag accommodates most backboards.
-A patient on a backboard, TRS, SKED or litter will be inserted into the bag.

The Seat Harness is used for patients not requiring the use of a backboard.

BK DPH, KNG-S, KNG/KNG2-P, KNG-M & BKR Pocket Card

When in doubt visit the Communications Unit!!

To SEND a clone to the DESTINATION clone radio:

FROM a legacy GPH/DPH (always retract any pen tip with legacy radios):

1. Turn the radio on.
2. Attach the GPH/DPH cloning cable end (with the red button) to the radio.
3. Press the **red button** and **FCN** button simultaneously and hold until it beeps and the display says "PRG" and “ID”.
4. **Enter six zeroes**, press **ENT**, then the star (*) key. Display will flash **PROG**.
5. Connect the other end of the cloning cable to the appropriate radio (following the appropriate directions on the left side of this page) and, when ready, press FCN to begin sending the clone to the destination radio.
6. If you receive a beeping tone and **FAIL** message, either one of two things has happened:
    a. You attempted to clone into a zone set to reject an incoming clone (this can only be fixed through software or try selecting a different zone in the destination radio).
    b. Your KNG or BI<R radio is not set correctly to receive a clone.

FROM a KNG-P150S:

1. Turn the radio on.
2. Attach the KNG end to the radio.
3. Attach the appropriate end to the destination radio.
4. Ensure the destination radio is set to accept the clone.
5. Press the **MENU** button, navigate to Cloning

FROM a KNG/KNG2-P150. KNG-M150. BKR5000 or BKR9000:

1. Turn the radio on.
2. Attach the radio-appropriate cloning cable end to the SOURCE radio.
3. Press the **MENU** button, then select **Cloning** and press **ENT**.
4. Select **Clone Active Zone** and press **ENT**.
5. Radio will display "UCG in Dest Group?" Select **UCG: Disabled**, then press **ENT**. Radio will say "**Cloning in Progress**", then "**Source Clone Complete**" is successful. (**NOTE**: selecting **UCG Enabled** is for when an assignment requires the user to work with an existing USFS or BLM radio system utilizing separate tones for each radio site for access).

To RECEIVE a clone from the SOURCE clone radio:

TO a Legacy GPH/DPH (always retract any pen tip):

1. Turn the radio on.
2. Attach the GPH/DPH cloning cable end to the radio.
3. Select the desired Destination zone.
4. Clone the radio from the Source radio.

TO a KNG-P150S:

1. Turn the radio on.
2. Attach the KNG cloning cable end to the radio.
3. Select the desired Destination zone.
4. Clone the radio from the Source radio.

TO a KNG/KNG2-P150LKNG-M150:

1. Turn the radio on.
2. Attach the KNG cloning cable end to the radio (For the M150, remove the mic and connect the round end of the cloning cable, **BEING CAREFUL NOT TO DAMAGE THE PINS ON THESE CONNECTORS - THERE IS A "KEYED" SLOT THAT MUST STAY AT THE TOP AS YOU GENTLY PRESS THE CONNECTOR INTO THE MIC PORT AND THEN SECURE WITH THE THREADS.**
3. Select the desired ***Destination*** zone. (15 or higher is usually OK).
4. From the **MENU**, select **Cloning**, press **ENT** (or press **ORANGE** button to navigate to "**CLONING**" if so programmed).
5. Press **NEXT** twice so that **Enter Dest Clone** is selected, then press **ENT**. Radio will now display, "**Destination Clone Mode Waiting**".

TO a BKRSOOO or BKR9000:

1. Turn the radio on.
2. Attach the BKR cloning cable end to the radio
3. Select the desired ***Destination*** zone. (15 or higher is usually OK).
4. From the **MENU**, select **Cloning**, press **ENT** (or press **ORANGE** button to navigate to "**CLONING**" if so programmed).
5. Press **NEXT** twice so that **Enter Dest Clone** is selected, then press **ENT**. Radio will now display, "**Destination Clone Mode Waiting**".

Keypad Programming (There are some differences in menu options on P150S)

1. Turn on the radio and access the Programming mode.
   - Press the **MENU** key, highlight **Keypad Prog,** and press the **ENT** key.
   - Enter the default 6-digit NIICD radio password (Radio default is 000000) and press the **ENT** key. Highlight ***Keypad*** and press the **ENT** key. (Skip this step on the P150S).
2. Highlight Channel and press the **ENT** key. "**Channels**" on P150S
3. Highlight "***Edit Channel***" and press the "**ENT**" key. Skip this step on P150S
4. Highlight and select the desired Zone/Group and press the "**ENT**" key.
5. Highlight and select the desired Channel to program and press the "ENT" key.
6. Highlight "Channel Label" and press the "ENT" key.
7. Press "**CLR**" or "**EDIT**" key, then enter the label using the keypad, and press "**ENT**" key.
8. Highlight "***RX Frequency***" and press "**ENT**", then press "**CLR**" and enter a valid RX Frequency and press "**ENT**".
9. Highlight "***RX Mode***" and press "**ENT**" select "***Analog***" and press the "**ENT**" key.
10. Highlight "***RX Guard***" and press "**ENT**", press "**CLR**" and enter a valid RX Tone and press "**ENT**".
11. Highlight "***Bandwidth***" and select "***Narrowband***" unless directed otherwise.
12. Highlight "***Tx Power***" and select "**Selectable Low".**
13. Highlight "***TX Freq***" and press "**ENT**", press "**CLR**", and enter a valid TX Frequency and press "**ENT**".
14. Highlight "***TX Mode***" and press "**ENT**", select "**Analog**" and press the "**ENT**" key.
15. Highlight "***TX Guard***" and press "**ENT**", press "**CLR**" and enter a valid TX Tone and press "**ENT**".
16. You can safely skip DTMF Live Dial unless told otherwise.
17. Press "**ESC**" once and select another channel to program repeating steps 6 through 17, or press "**ESC**" several times to exit the programming mode.

Keypad Locked?

GPH/DPH: Press and hold the "**FCN**" key to lock/unlock the keypad.
KNG/BKR: Rotate the collar switch on the base of the channel knob to Lock or Unlock or go to **MENU** to turn on/off.

Adding/Deleting Channels from Scan List:

Press the "**Menu**" key, scroll down to "***Chan Scan List***' using the "**Down/Up**" keys, and press the "**ENT**" key. Select the Channel to scan using the "**Arrow**" key and press the "**+/-**" key to add or delete from the scan list. Note: A "**Check**" indicates the channel is in the scan list. Press "**ESC**" key twice to return to normal operation.

Adding a COMMAND ZONE

1. Press **MENU** and navigate to **Keypad Prog**
2. Enter password "**000000**", press **ENT**.
3. Select **Keypad** and press **ENT**.
4. Select **Zone** press **ENT**.
5. Select **Add Zone,** press **ENT**.
6. Select **Command**, press **ENT**.
7. Radio will display "**Zone ## Added**".
8. You must add at least one channel to the added zone for cloning purposes.

Using a Command Zone

The **Command Zone (CZ)** is a zone that will allow you to program channels from any other zone in the radio and add it to a CZ to quickly build an "on-the-fly" ICS205 Comm plan. Take the following steps:

1.Navigate to your first desired channel in the radio and press **CHAN+** or go to the Menu and select **Chan Add/Delete**

2.Select the command zone you want to add it to and press **ENT**.

3, The radio will automatically choose the first open channel to place your selected channel in that slot unless you choose another. You can change the destination and/or press **ENT** to place the channel in memory.

4. Radio should display "**Channel Added**".
5. Return to Step 1 and repeat until your zone is built.

You can clone a CZ to another radio's CZ so long as there is at least one channel already programmed into that CZ. You CANNOT clone a CZ into a non-CZ-enabled
zone.

****NOTE**: Radio models with 16-channel stop, can access additional channels in a zone if "Channel" under Button Configuration/Keypad Select is selected (vs. Zone) in the BK Radio Editing Software. Then, if you need to access channels above #16, you can use the keypad on the face to enter the channel number directly (i.e., "17" then ENT)

Best Practices

1. Clone all radios from a LEGACY source
    a. Unintended changes (i.e., UCG) can be caused by cloning from KNG to Legacy unless you always select "UCG: Disabled" when cloning.
    b. No known errors with Legacy Source radios.
2. Check CH 00 settings in legacy radios after cloning from a KNG
3. Visit your Communications Unit staff when you have problems with cloning
4. Practice hand-programming your radios frequently.
5. For GPH/DPH legacy radios, power cycle your radio after receiving a clone to "set" the programming.
6. Check the clone against your Incident Communications Plan (ICS-205) in the IAP.
    a. Compare 205 to the previous day for changes or errors.
    b. Check the GRP/Zone label against 205 to make sure you have the most current version (usually on the current 205).
7. Check/test your operational channels for function after briefing or at tailgate briefing prior to starting operational assignment.

GAR Risk Calculation Worksheet

{Green – Amber – Red}

THE GAR IS BASED ON A TEAM DISCUSSION TO UNDERSTAND THE MISSION AND EVALUATE THE RISKS INVOLVED AND HOW THEY WILL BE MANAGED.

ACCURATELY ASSESSING AND MANAGING THE RISKS IS WHAT IS IMPORTANT; NOT THE ABILITY TO ASSIGN NUMBERS AND COLORS, THEY ARE TOOLS TO HELP YOU FACTOR AND QUANTIFY THE RISKS!

Assign a risk code 1 (minimal risk) through 10 (maximum risk) to each of the six elements below.

The discussion should start with the least experienced member speaking about the perceived risks for each category and should include the opportunity for team members to ask questions.

SUPERVISION: *off-site management / field leader(s) / qualifications / experience / communication tools*	
PLANNING: *details / clarity / emergency action plan / first aid / transportation / shelter / food and water*	
TEAM SELECTION: *training / qualifications / experience / aptitude / abilities / functionality / liabilities*	
TEAM FITNESS: *physical fitness / mental and emotional state / health concerns / rest & fatigue cycles*	
ENVIRONMENT: W*eather- temperature, wind, visibility, precipitation / terrain / water / remoteness / heights*	
EVENT & EVOLUTION COMPLEXITY: *details / step-procedures / task load / number of people-agencies*	
TOTAL RISK SCORE: Combine the risk score for each element and apply score to GAR evaluation scale.	

If there is a risk score of 8 or higher in any category, the mission may need to be canceled, rescheduled or delayed until proper resources, personnel and mitigation factors can be employed, consider not mobilizing assets and personnel, or sheltering in place.

GAR Evaluation Scale – Color Coding the Level of Risk

0 15 23	24 30 43	44 50 60
GREEN **(Low Risk)**	**AMBER** **(Caution)**	**RED** **HIGH RISK**

If the total falls in the GREEN zone risk is minimum, avoid becoming complacent.

If the total falls in the AMBER zone risk is moderate, adopt procedures and precautions to minimize the risk.

If the total falls in the RED zone avoid activating the mission until procedures, personnel and resources can be implemented or conditions change that will reduce the risk.

THE GAR MODEL SHOULD BE USED DURING PLANNING, TO ACCOMPMANY JOB HAZARD ANALYSES, TAILGATE MEETINGS, CONTINUALLY DURING OPERATIONS, WHEN CONDITIONS CHANGE, AND DURING DE-BREIFINGS OR MISSION/MISHAP ANALYSIS.

FIELD NOTES

If the Risk Assessment determines high or unacceptable levels of risk, the control options below may help determine if the risks can be reduced to an acceptable level or controlled for a period of the mission.

CONTROL OPTIONS

- **Spread-out:** Disperse the risk by increasing the amount of time between events, or by utilizing additional people, resources or assets.
- **Transfer:** If practical locate a better equipped team, asset or location to accommodate the mission.
- **Avoid:** Circumvent the hazard- wait for the risk to subside. (weather change, daylight, increased visibility)
- **Accept:** In some situations the benefit may be to accept the risk. In this situation thresholds need to be reevaluated and the level of risk monitoring and safety observer oversight must also increase.
- **Reduce:** Implement risk reduction. (PPE, additional training, rest and fatigue and stress reduction, remove time constraints or budgetary restrictions)