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Fire Line Newsletter



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From the Balcony: Lost and Found

Have you ever found yourself rummaging through a lost and found? My first experience with lost and found was when I was in grade school looking for a missing glove during the colder months, not really knowing if it was there or where I actually lost it in the first place, but I know that’s where my mom would tell me to look if I went home with only one glove. I remember being somewhat amazed at how much a lost and found could accumulate during a school year. Our neighborhood swimming pool had a very useful lost and found; especially when I needed goggles, a ball, or a towel to dry off.

So you may be wondering why the fire chief would be thinking about lost and found anyway. I believe during our careers there may be times when we end up in the lost and found. I have had a couple times when I know I ended up in the lost and found and each time someone stepped in and claimed me back so I was no longer lost. The first time I remember was just after I started out as a career firefighter and I felt lost and not part of the team. Thankfully I had a few shift partners who helped me stay the course and work on strategies to overcome the obstacles in front of me. They had similar struggles themselves and used their experiences to help me see things in a different way.

The next time was when I challenged a lieutenant’s exam and my written test score was not where I expected it to be.

I was bitter and blamed the test questions and the company that wrote the exam, but never looked in the mirror to identify my shortcomings. I was back in the lost and found! I was lucky to have some mentors who made me look at my preparation for the exam, what I did and more importantly what I failed to do in preparing for the test. It was then I was able to be taken out of the lost and found and the payoff was the next exam in two years where I placed first on the promotional list.

As a fire chief I have found myself looking through the lost and found and have had the opportunity to help individuals pull themselves out of the lost and found and get them back on track. Mentors are the ones who don’t mind rummaging around, looking for someone to who needs guidance, encouragement, support and care. It often takes someone to rummage around to find what is lost before it hits the bottom of the pile never to be recovered. We all can use someone who rummages around and pulls us out of those times when we get lost. Be that for each other and keep checking the lost and found; you may be surprised at what you will find and who you might impact along the way.

*Until Next Month,
Be Safe and
Be Well
Fire Chief
Peter O’Leary*



FOND DU LAC FIRE RESCUE OPERATIONS

By: Assistant Chief
Erick Gerritson



Fireground Basic Size-Up for the First-Due Engine: The initial report must paint a picture for others

One of the most stressful roles in the fire service is being an officer of the first-arriving fire company at a structure fire. Having to transmit an arrival report; assume command of the incident; and possibly be physically involved in performing company-level tasks are the ingredients for sensory overload. As incident commander, the first-arriving company officer has every responsibility of the highest-ranking chief officer on the fire department at the most critical phase of an incident but often does not have the luxury of directing operations from a stationary command post and is not physically involved in performing any tasks. Additionally, a first-arriving company officer in command may have to take immediate action with incomplete information. The transmission of the initial arriving size-up report is critical and may have a strong influence on the overall outcome of the incident.

Arriving on scene, he must consider a multitude of factors and observations in a very compressed time

frame. The initial report must “paint the picture” for the arriving companies. A clear, concise, and accurate report will give all responding companies and command officers a clear understanding of the situation. Having a standard approach to initial scene size-up is paramount to the start of a successful operation.

This article focuses on giving a scene size-up and some points to consider, staying with your department’s standard operating procedures (SOPs) regarding size-up. These tips hopefully will help your overall radio report.

A fire officer cannot effectively control an incident and his company if he cannot control himself. An effective officer must have the mental toughness to control his emotions and manifestations of stress. Thinking clearly and controlling our personal behavior will not only help you do to your job better but will set the example for others to follow. DO NOT yell, scream, or rush your

size-up; this will get everyone else “excited” and show that you, as the initial incident commander, may not be thinking clearly, which may cause you to lose your command and control of the incident.

When approaching the scene, have your driver slow down. This will give you a better overall picture of the scene. It also allows both you and the driver to visualize hazards such as overhead wires, exposure problems, potential rescues, hydrants, or parked cars that could limit outrigger spread on a ladder truck. Have your drivers pull past the structure to give a three-sided view, this will also give the engine the room it needs to deploy handlines and give the truck the front of the building for proper aerial placement.

When beginning your size-up, think about what you’re going to say before you say it. Based on your SOPs, your size-up should be a methodical, quick, and to-the-point evaluation of what you see, what



Fireground Basic Size-Up for the First-Due Engine: The initial report must paint a picture for others continued...

you're going to do, and possibly what you need. First, announce your arrival, then describe the building as residential vs. commercial, height, type of construction, and occupied vs. vacant. Next, describe what you see: "Nothing showing," "Fire showing," or "Smoke showing." Don't be overly wordy; keep it basic. Also, tell where you have the condition showing—second floor, through the roof, or whatever the situation shows. Do you have an exposure problem? Give your strategy—offensive, Transitional or defensive. Name your command. Every incident must have a named command by location. Describe what your actions are going to be, then give other companies assignments based on their arrival.

It doesn't stop there. You as the first-due officer must complete as best as possible a 360 of the fire building. If anything regarding the building, fire conditions, life hazard, or safety hazards has been found, you must report it over the radio.

Let's look at a sample size-up. Again, this is one way; whatever your department uses, make

sure it is easily understood by other responding companies.

"Engine 1 to Dispatch."

"Go ahead Engine 1."

"Engine 1 is on location of an occupied 2½-story wood-frame/balloon-frame residential structure. We have fire showing on the second floor, Side B with an exposure problem on Side B. This will be an offensive fire. Engine 1 will be Main St. Command. Engine 1 will be stretching a 1¾-inch handline for fire attack. Engine 2 lay a supply line from Main and Front St. for Engine 1. Truck 1, take the front of the building."

Dispatch should repeat this back, so everyone hears it again.

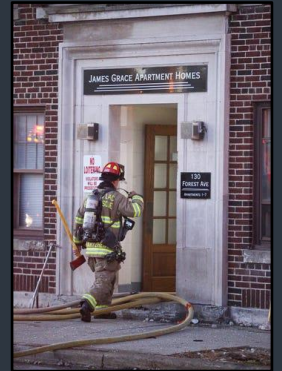
With this statement, the wheels are in motion for a successful start to an operation. Obviously, more orders must be given if dictated by your department SOPs. Remember also that a transfer of command should be made face to face but sometimes a radio transfer of command may take place.

A "CAN" report will benefit

arriving command officers as well as all incoming companies. It communicates three essential factors of information: the **Conditions** observed, the **Actions** performed by companies prior to the chief's arrival, and the **Needs** of companies to accomplish their mission. Whatever your department uses, be good at it, be calm with it, speak clearly, and have a strong command presence.

*Source:
Greg Sellers of
Fire Rescue Magazine*

**Until Next Month...
Be Safe!**



Operations by the Numbers

August, 2020	By Month		Year-To-Date	
	Last Year	This Year	Last Year	This Year
PREVENTION				
Total Inspections	248	254	2102	1477
Total Defects	205	105	1328	792
SUPPRESSION				
Alarms Involving Fire	10	5	75	85
Fire Mutual Aid Given	1	1	7	11
Fire Mutual Aid Received	0	0	0	3
Service/Good Intent Calls	45	46	346	395
False Alarms/False Calls	31	28	259	208
Other Calls	12	10	123	122
Total Fire Alarms & Calls	98	89	803	810
EMS				
Total Ambulance Calls	540	580	4177	4080
Total Fire/EMS Responses	638	669	4980	4890
Fire Property Loss	\$3,700.00	\$2,100.00	\$313,538.00	\$576,300.00
Fire Contents Loss	\$9,015.00	\$450.00	\$138,196.00	\$265,951.00
Engine Assisted EMS Calls	215	274	1818	1765

Birthdays, Employment Milestones, Upcoming Events

UPCOMING EVENTS

Fire Prevention Week

October 4th – 10th

Serve Up Fire Safety In the Kitchen

Fire Prevention Week Open House has been cancelled this year.

like us on
facebook

follow us on
twitter

~ Happy October Birthday ~

Brian Munson · Garth Schumacher ·
Andy Aird · Jake Fisher · Andrew Behnke

Did you know cooking is the No. 1 cause of home fires and home fire injuries?

— SERVE UP —
Fire Safety
— IN THE KITCHEN! —

Fire Prevention Week™
is Oct. 4-10.
Learn more
at fpw.org.





The Code Summary

By: Assistant Chief Todd Janquart

Back to Basics: Perfusion

The previous edition of Back to the Basics discussed the differences between ventilation and respiration. As long as those physiological processes are functional, pulmonary capillaries can suck up the available alveolar oxygen and inject carbon dioxide in the opposite direction. Now, that is all well and good, but what if blood never circulated out of the lungs? You guessed it ... *we still die*. Remember, cellular functions require continuous oxygen delivery and carbon dioxide elimination.

The dictionary defines perfusion as “the passage of fluid through the lymphatic system or blood vessels to an organ or a tissue.” Fine, but for us EMS types, let’s make this a little more tangible: “Air goes in and out, blood goes round and round, any variation on this is bad.” Perfusion is the necessary component to transport the goods of ventilation and external respiration throughout the body. Take CPR, for example. You can ventilate the lungs with as much air as they can hold, but if you’re not compressing the chest and circulating nutrients and oxygen, the patient’s brain and tissues still deteriorate.

Perfusion is composed of

what I call the Three Ps:

- The pump (heart)
- The pipes (blood vessels)
- The plasma (blood)

Normal perfusion moves blood to the cellular capillary beds, where internal respiration of nutrients and oxygen then takes place. After passing through the cell membrane, oxygen binds onto the electron transport chain (ETS) within the mitochondria. Glucose (the best energy source) has already been broken down through a series of steps during glycolysis and the Krebs cycle (the medics reading that just had a small seizure). The products of the Krebs cycle, NADH and FADH₂ pass their electrons through the ETS, where on the final protein complex, oxygen locks on – producing water, carbon dioxide, and finalizes ATP synthesis.

Each glucose molecule with oxygen present (aerobic metabolism) produces 32-34 ATP, providing energy to maintain cellular functions. Carbon dioxide diffuses from within the cell into the surrounding capillaries for its trip back to the lungs. It circulates through the venous system, and eventually into the

pulmonary capillaries. However, when perfusion deteriorates and oxygen is not present (anaerobic metabolism), only two ATP result. The resultant lack of energy compromises all cellular functions.

Additionally, metabolic (lactic) acidosis, potassium, calcium and sodium imbalances, cellular membrane damage, intracellular and intravascular fluid shifts, hypercarbia, and hypercoagulation within the surrounding capillaries commences. Preventing this disaster takes all three Ps running efficiently all day, every day. Here is how they do it.

PUMP – THE HEART

The average adult heart contracts between 60 and 100 times per minute. The stroke volume of each ventricular contraction averages 70 milliliters. Stroke volume is determined by preload (how much blood is available to fill the ventricle before contraction) and myocardial contractility. By multiplying the heart rate and stroke volume, the result is the amount of blood circulated per minute. This is cardiac output, which for the average adult is five to six liters per minute – supporting cellular oxygen

PERFUSION

Definition - circulation of blood through an organ structure

Perfusion delivers oxygen and other nutrients to the cells of all organ systems and removes waste products



Heart malfunction resulting from decreased contractility/ myocardial infarcts, chest trauma, hypertension, arrhythmias, infection or congenital defects, compromises adequate perfusion. (Photo/Getty Images)



Back to Basics: Perfusion Continued...



delivery and carbon dioxide removal.

Heart malfunction resulting from decreased contractility/myocardial infarcts, chest trauma, hypertension, arrhythmias, infection or congenital defects, compromises adequate perfusion. Fixing this problem requires the EMT to address the specific heart issue(s) as best as possible, seeking advanced care when necessary.

PIPES – THE BLOOD VESSELS

Normal blood pressure equals good perfusion (even though there are numerous debates as to what “normal” is). Determining blood pressure is trickier, in the sense that you take the average cardiac output and multiply that value to the afterload. Put in simplest terms, afterload, also known as systemic vascular resistance (SVR), is the resistance the heart must overcome during a ventricular contraction to push blood into the systemic circulation. Blood vessel length, blood vessel diameter, and fluid (blood) viscosity all factor into its value. Vessel length is constant at the adult stage, so in this context, let's discuss the other two.

As a vessel's diameter decreases, resistance (afterload) increases. Resistance is highest in the capillary beds and lowest in the aorta. If a vessel excessively narrows,

as in a chronically-hypertensive or pre-eclampsia patient, inadequate distal perfusion results. If the vessel does the opposite and over-dilates, as in spinal shock or anaphylaxis, afterload decreases, compromising blood pressure and systemic perfusion. The human body requires blood vessels to dilate and contract daily to maintain adequate perfusion. As you stand up, sit down, exercise, sleep, etc., various changes in body position and metabolism require vessels to adjust their diameter (also known as vascular tone). Like watchtower guards overlooking a prison yard, chemoreceptors and baroreceptors regularly monitor for perfusion changes, responding to keep the peace.

Chemoreceptors are located in the carotid arteries, aortic arch, and medulla oblongata. When blood oxygen and pH levels decrease, and carbon dioxide levels increase, these receptors activate. Their nerve impulses shut down parasympathetic nerves while at the same time increase the stimulation of sympathetic nerves. The result is increased heart rate and myocardial contraction force, equaling a rise in cardiac output. The same sympathetic stimulation also stimulates peripheral blood vessels to constrict, increasing afterload and preload. The result is improved perfusion, oxygen

delivery, and carbon dioxide elimination.

The primary baroreceptors are located in the carotid sinus and aortic arch. Unlike chemoreceptors, though, they dilate or constrict blood vessels based upon blood pressure changes. If blood pressure rises above normal, baroreceptors stimulate a shutdown of the vasomotor centers (blood vessels dilate) and activate the cardiac inhibition centers (cardiac output decreases). Once the blood pressure declines back to normal range, the baroreceptors cease transmission. Adversely, if the blood pressure drops below normal, baroreceptors shut off, causing the vasomotor centers to activate (blood vessels constrict) and the cardiac acceleration centers to activate (cardiac output increases).

PLASMA – THE BLOOD

Viscosity of the blood is the other variable that determines afterload. Perfusion deteriorates as viscosity increases. In other words, the more concentrated the blood, the higher the resistance, and the slower the flow. Think of it this way: You have a cup containing plain water and another cup containing a milkshake. When you suck through a straw, it is much easier to drink the water than the milkshake because of the concentration difference. The same holds true concerning the blood. COPD patients with excessive amounts of red blood cells, patients with leukemia and lymphomas (excessive white cells),

dehydrated patients, abnormal blood clotting, and hypothermia all cause the blood to “thicken.”

Something else of note: Blood belongs only in one place, and that is within the pipes, but pipes bust and patients bleed. If the pipes aren't busted, they can excessively leak plasma into surrounding tissues. Septic and burn patients are notorious for this, typically requiring support with vasopressors. Squeezing the pipes, along with fluid support, reduces the size of leaky capillaries and helps restore adequate perfusion.

Just like the “leaky” patient, when a patient is bleeding internally, externally, or both, the result can be fatal. Decreased circulating blood volume reduces preload, which is the amount of volume returning to the right atrium. Lower preload diminishes stroke volume and cardiac output. Declining cardiac output reduces blood pressure and overall systemic perfusion, resulting in the series of cellular events discussed earlier. The vast majority of patients require only direct pressure and perhaps a tourniquet to control and stop external bleeding. Easy enough, but if bleeding is internal, there is not much EMS professionals can do except R and R (recognize and run). These are surgical cases and need to be transported to the closest, appropriate facility. Even though advanced providers can infuse IV normal saline lactated ringers, blood, or plasma to restore



Back to Basics: Perfusion Continued...

preload, altogether, these measures may not be enough to restore adequate perfusion.

Now, let's walk away from the acute, isolated events that cause a patient to bleed and focus on everyday living. Just by being alive, our metabolism and bodily functions deplete intracellular and intravascular volume. The easiest way for the body to restore volume and maintain perfusion is by external fluid intake (i.e., drinking). Ever wonder why you feel thirsty? When you sweat, for example, plasma volume is lost, and the blood thickens. The resultant slower flow is detected by the hypothalamus, which in turn performs two actions. First, it sets off the thirst mechanism, hopefully making you drink. Once you drink enough volume to replace what was lost, the hypothalamus shuts it down. Second, it releases antidiuretic hormone (ADH) from the posterior pituitary. ADH travels through the bloodstream and goes to work on the kidney tubules, where fluid retention/secretion takes place. More on that in a minute.

How is it, then, the average human can go three to seven days without any fluid intake? To answer that, we need to discuss a little physiology.

The major organ that helps regulate blood volume is the kidney, and it *hates* to be under-perfused. So much, that it will use multiple hormones to restore adequate perfusion. This process is called the renin-angiotensin-aldosterone system (Yes, the medics are

probably seizing at the thought of this – again). Whenever renal (kidney) perfusion pressure drops below normal, its ability to properly filter out toxins, among other things, is compromised – big time. This is the stimulus that causes the kidney to release erythropoietin (EPO) and renin into the bloodstream. EPO circulates throughout the bloodstream and targets bone marrow, where it stimulates the production of red blood cells. Blood volume is partially restored, but its concentration has thickened. Increasing plasma/water volume is the other requirement, which is fulfilled by renin.

Renin is a hormone with one job – find its cousin from the liver, angiotensinogen. When the family reunion takes place in the bloodstream, renin and angiotensinogen combine and form angiotensin 1. Once angiotensin 1 reaches the lungs, an enzyme (ACE) converts it into the hormone angiotensin 2. Angiotensin 2 leaves the lungs and circulates back to the kidneys. During its journey, the mere presence of angiotensin 2 causes vasoconstriction and enhancement of the thirst mechanism. Its major action, however, takes place within the adrenal cortex, where its presence releases another hormone called aldosterone.

Aldosterone leaves the adrenals, travels through the blood, down to the kidney

tubules, and meets up with ADH. Remember, both of these hormones have ended up in the same place because of low renal perfusion, which likely resulted from poor systemic perfusion. In any sense, think of aldosterone as a vacuum and ADH as a key master. ADH circulates to a tubule, unlocks, then opens a closed “door” on the distal renal tubule, making it extremely permeable. Once the door is wide open, serum aldosterone sucks up as much sodium from the tubule as it can. The sodium shift from tubule into the bloodstream results in the endgame – water within the tubule follows sodium into the bloodstream and, given enough time, restores plasma volume to an adequate level.

The only downside is, it takes a long time to get from renin release to water retention. Like any hormone-based process, it is a series of multiple steps rather than one swift physiological reaction. Thus, if a patient is actively bleeding, severely dehydrated, or ailing from some other form of decompensated shock, the renin reaction is too slow to restore timely and adequate circulation. Other means, as discussed previously (fluids, etc.), need to be instituted for a positive patient outcome.

So that's it. I hope this discussion makes perfusion a little more understandable. There is much more to it,

but being able to assess for deficiencies of a patient's Pump, Pipe, or Plasma component will go miles to aid you in rendering the best care possible. Assess, reassess, and adjust. Patients with perfusion issues rarely stay in one place for very long.

About the Author: Chris Ebright, NRP, is an EMS education specialist with ProMedica Air and Mobile in Toledo, Ohio, managing all aspects of internal continuing EMS education as well as for numerous EMS systems in northwest Ohio and southeast Michigan. He has been a Nationally Registered paramedic for 25 years, providing primary EMS response, land, and air critical care transportation.

*The things that
will destroy
America are
prosperity-at-
any-price, peace-
at-any-price,
safety-first
instead of duty-
first, the love of
soft living, and
the get-rich-quick
theory of life.*

*Theodore
Roosevelt*

News from the Station



FF/P Dusten Hilgendorf



Congratulations to FF/P Dusten Hilgendorf and FF/P Nate Wilson who recently completed their one-year probation period and now have full membership status. Dusten and Nate received their badge, helmet, and congratulatory plaque from Chief O'Leary and was further congratulated by their Captain's, Lieutenants, and the rest of their Crew and the Command Staff. Dusten works on 2nd shift under the direction of Captain Ben Stephany. Nate is on 3rd shift working with Captain Joe Maramonte. A formal ceremony will be held at a later date.



Congratulations Dusten and Nate!



FF/P Nate Wilson



Well-trained people are the best defense against fire.

By: Assistant Chief of
Training/Safety
James Knowles III

Learning From Others' Experiences

Ask how you would have handled this situation before judging them.

What does it mean when we read or discuss events that happen in the fire service? We can read an article about an event that took place, or we can watch a YouTube, Facebook, or Twitter clip showing the actions of firefighters that took place on the "fireground" or at an incident worth calling attention to. This is all known as "Learning from Others' Experiences."

When you read an article or watch these videos, there should be lessons learned from those who were involved. It seems many times we are too quick to jump to conclusions about what took place or Monday morning quarterback what we saw. The thing to remember is to go to the source and ask questions. Remember, we may not have been there or have been in the mindset that we saw or read about.

All members of the fire service have different levels of knowledge or experience based on where we work, how much training we receive, and how much action we regularly see. Your fire department may be fully staffed, or your mutual-aid resources may be plentiful, whereas the fire department we are watching may not

have many of those resources available.

They are captured on film and now being viewed by thousands of firefighters who seem to watch these videos first thing in the morning at the kitchen table, sharing their thoughts with others in the firehouse. You should watch and compare your fire department to theirs and ask yourself how you would have handled this situation before judging them. Would you have done anything different? How would your actions differ from those in your rank? Does your fire department have any policies or procedures, general orders, standard operating procedures, standard operation guidelines, or best practices that would cover your actions or the actions displayed?

A lot of the actions that are captured show the fire department's level of training. Many may say they were to slow, where others may say they moved without regard to safety.

Remember, we should have all had basic training to join the fire service; many of us have advanced to learn more of this job, making it a career, or have the desire

and passion that we love what we do. But sadly, many may not see the fire service as you do—maybe because of monetary reasons or having to hold down a regular job five days a week and trying to raise a family and find time to take an interest in their children while you may be on a regular shift. Many others try to come when called at all hours of the day and night. What is their frame of mind? How much staffing do they have? Do they run with two on a rig or more? How much do you run with?

Who is watching out for them on the fireground? Do they practice accountability? Are their safety officers watching out for their well-being, doing that term firefighters don't like—risk management—with their actions? Who is in the staging area to provide relief when we want it or when the IC directs us over the radio that we need to take rehab?

There are so many angles that we could talk about, just like at the kitchen table, but here are the important things to walk away with. Contact that fire department that you are watching. You can call

them, you can send them an e-mail, drop them a line: Ask what happened and then ask your specific questions. What lesson were learned from what they did? What went right? What went wrong? Do they have department policies or procedures that they followed, or did they change things around? Will they continue to do the same thing?

Learning from others is a way to understand what challenges we could be faced with and how we might handle that type of situation. Watching a video or reading an article has many lessons to learn. Put them to good use and try to learn from them even if that fire department you read about or viewed would rather not talk about it. Look at the situation and sit down with your crew or invite other companies or stations to sit down and review how they would handle this. What you think and what another company officer or even chief officer thinks might differ. Hopefully, you can all agree on the way your fire department would handle what was just viewed.

Retrieved from:
www.firefighternation.com

Current Status of New Construction

- Tavern on the Avenue at 725 Fond du Lac Ave. – Building is under construction.
- Moraine Park Technical College at 235 N. National Ave. – Building is under construction.
- Carew Concrete at 244 W. Pioneer Rd. – Building is under construction.
- Fairfield Inn at 925 S. Rolling Meadows Drive – Building is under construction.
- Ducharme cottages at 100-400 Ducharme Parkway – Building 100, 200, 300 are complete and 400 is under construction.
- River Hills Mixed Use Development on S. Main St. – Buildings 1, 2, 3, 4, 5, 6 & 8 are complete and 7 & 9 are under construction.
- Demolition continues at Forest Mall.
- Badger Liquor – Warehouse is under construction.

Safety for Kids – Halloween Safety



Before Halloween arrives, be sure to choose a costume that won't cause safety hazards.



Kids love the magic of Halloween: Trick-or-treating, classroom parties and trips to a neighborhood haunted house. But for moms and dads, often there is a fine line between Halloween fun and safety concerns.

- All costumes, wigs and accessories should be fire-resistant
- Avoid masks, which can obstruct vision
- If children are allowed out after dark, fasten reflective tape to their costumes and bags, or give them glow sticks
- A responsible adult should accompany young children on the neighborhood rounds
- Tell your children not to eat any treats until they return home
- Teach your children never to enter a stranger's home or car
- Remind your children to keep their heads up and walk, don't run, across the street

Fire Prevention

The Bureau Never Sleeps

By: Division Chief
Garth Schumacher



How to Prevent and Put Out Kitchen Fires

Fond du Lac Fire/Rescue is teaming up with the National Fire Protection Association® (NFPA®) — the official sponsor of Fire Prevention Week for more than 90 years — to promote this year's Fire Prevention Week campaign, "Serve Up Fire Safety in the Kitchen!" The campaign works to educate everyone about simple but important actions they can take to keep themselves and those around them safe.

According to NFPA, cooking is the leading cause of home fires and home fire injuries in the United States. Almost half (44%) of reported home fires started in the kitchen. Two-thirds (66%) of home cooking fires start with the ignition of food or other cooking materials.

You can do a lot to prevent kitchen fires. Although you can't remove every possible source of a kitchen fire, you can minimize fire risks by removing hazards and maintaining your kitchen. Follow these prevention tips to keep your kitchen safe:

Keep appliances serviced, clean, and in good repair. Dump the crumb tray and clean out the toaster crumbs periodically from the toaster or toaster oven. Wipe out the microwave. Clean the oven. Unplug any appliances that start acting funny, then have them

repaired or replace them.

Unplug electric appliances when not in use. Toaster ovens, mixers, coffee makers, and so on, continue to draw electricity even when they're not turned on. So if the wiring is old or faulty, or if the thermostat overheats, a fire could break out.

Install a smoke detector near, but not in the kitchen. You don't want the small amount of smoke or steam that cooking sometimes generates to constantly trigger the alarm — but you do want it to sense an actual kitchen fire.

Use caution when lighting the pilot light or burner on a gas stove. Follow the manufacturer's instructions

Don't use metal in the microwave. The sparks can turn into fire or can seriously damage your microwave.

Don't overfill pots or pans with oil or grease. The hot oil or grease, like in this figure, can splatter and cause a fire.

Wipe up spills and don't cook on a dirty stove. Grease buildup is flammable. A clean stove is a fire-free stove.

Always roll up long sleeves and tie back long hair when cooking. You don't need your beautiful

flowing silk sleeves trailing in the spaghetti sauce, and you certainly don't need to catch on fire!

Never leave cooking food unattended. Stay in the kitchen, especially if you're cooking in grease or if the oven is at a very high heat. Turn off the burner or oven if you need to leave the house or get caught up in a phone call.

Keep dish towels, pot holders, and paper towels away from the stove. You might have left a burner on by accident, and built-up heat could ignite combustibles left near or on the stove or oven.

How to Put Out Kitchen Fires

When a fire starts in the kitchen, you need to act fast to keep the fire from getting out of control. But how you act depends on what kind of fire you have and where it is. Follow these instructions for putting out kitchen fires:

If you have a fire in the oven or the microwave, close the door or keep it closed, and turn off the oven. Don't open the door! The lack of oxygen will suffocate the flames.

If your oven continues to smoke like a fire is still going on in there, call the fire department.

If you have a fire in a cooking pan, use an oven mitt to clap

on the lid, then move the pan off the burner, and turn off the stove. The lack of oxygen will stop the flames in a pot.

If you can't safely put the lid on a flaming pan or you don't have a lid for the pan, use your fire extinguisher. Aim at the *base* of the fire — not the flames.

Never use water to put out grease fires! Water repels grease and can spread the fire by splattering the grease. Instead, try one of these methods:

- If the fire is small, cover the pan with a lid and turn off the burner.
- Throw lots of baking soda or salt on it. *Never* use flour, which can explode or make the fire worse.
- Smother the fire with a wet towel or other large wet cloth.
- Use a fire extinguisher.

Don't swat at a fire with a towel, apron, or other clothing. You're likely to fan the flames and spread the fire.

If the fire is spreading and you can't control it, get everyone out of the house and call 911! Make sure everybody in your family knows how to get out of the house safely in case of a fire. Practice your fire escape route!



— SERVE UP —
Fire Safety
— IN THE KITCHEN!™ —



**Did you know cooking is the No. 1 cause
of home fires and home fire injuries?
Fire Prevention Week™ is Oct. 4-10.
Learn more at fpw.org.**





SIRVA

Seguridad contra incendios

EN LA COCINA™



¿Sabía usted que cocinar es la causa #1 de incendios en el hogar y lesiones por incendios en el hogar?
¡Sirva Seguridad contra Incendios en la Cocina!™, es del 4-10 de Oct. Aprenda más en fpw.org





PEER FITNESS TIPS

By: Peer Fitness Trainer
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Fitness & Nutrition Tips from the Healthiest Countries

While the world finds itself in the midst of a public health crisis with the COVID-19 virus, there are still many things Americans can learn from the health and wellness habits of those who live in the healthiest countries in the world.

Each year, the Bloomberg Healthiest Country Index ranks 169 nations on several factors to determine their overall health. They evaluate countries on measures such as life expectancy, incidence of obesity and tobacco use as well as environmental considerations such as access to clean water and sanitation.

Topping the list in 2019 was Spain, with an average lifespan of 83.5 years. Rounding out the top five on the list were Italy, Iceland, Japan and Switzerland.

Unfortunately, the United States didn't break into the top 30 on the index last year, primarily because of the obesity epidemic that continues to plague the country. While Americans are exercising more than ever (up from 18.2% in 2008 to 24.3% by 2017), more than 42% are considered to have obesity, according to the Center for Disease Control and Prevention.

So, what can the U.S. learn from these global leaders in wellness and life expectancy?

Eat Simply

A person's overall health and wellness is determined largely by what he or she eats. In the U.S., average diets have grown in portion sizes, saturated fats and calories over the years and the desire for convenience has left many people eating more highly processed foods and beverages.

According to a study by researchers at George Washington University, "The rising obesity epidemic in the U.S., as well as related chronic diseases, are correlated with a rise in ultra-processed food consumption."

Conversely, many European nations have stayed true to their culinary traditions over the years and consume diets that include fewer processed foods, are lower in unhealthy fats and higher in vegetables, fiber and lean proteins.

On Bloomberg's list of healthiest countries, Spain and Italy's populations typically follow a Mediterranean diet, which has been shown to be one of the most nutritious globally because it focuses on healthy fats, vegetables, legumes, fish and seafood,

which promote heart health. In addition, Spain, as well as many other European countries, is known for tapas meals (small plates), which encourage right-sized portions.

While they are thousands of miles from the Mediterranean region, the populations of Iceland and Japan also follow traditional diets that center on whole versus processed foods and include fish, seafood and vegetables. Japan's style of eating encourages natural flavors in food rather than dousing it in sauces. Icelandic diets typically focus on lamb, seafood and dairy.

Finally, while Switzerland may be known for its rich and decadent cheese and chocolate, they also base their diets on eating real, unprocessed foods that create satiety and prevent overeating.

Move More

In each of the top five healthiest countries on Bloomberg's list, outdoor exercise reigns over indoor gyms. In Iceland, a country that moves more than any nation in Europe, outdoor hikes and swimming top the list of favorite workouts. Spain, Italy and Japan all have plenty of opportunities for walking, hiking and running outdoors, while Switzerland boasts some of

the finest skiing in the world in the Swiss Alps.

Overall, the healthiest countries have plenty of traditional indoor and outdoor exercise options, but they also maximize movement in the everyday activities of life, such as walking to the store or planting and working in a garden.

In addition to the nutrition and fitness trends, all these countries embrace - whole foods, smaller portions, regular exercise - they all have excellent air quality, fewer issues with opioid drug addictions and more walkable towns and cities, all of which contribute to a longer life expectancy according to the Bloomberg Index.

Americans are exercising more than ever but we're not making gains in the kitchen, which is so important to overall health. Taking a cue from our healthier neighbors, Americans would do well to get back to eating whole, unprocessed foods that provide a balance of macro and micronutrients. Combined with regular exercise, a change in diet would undoubtedly help the U.S. rise in global rankings of health and, more importantly, increase both quality of life and life expectancy for all its citizens.

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