

Paramedic Class Advisory Committee Report

March 12, 2015

We started EMS 212 with 32 students. Within the second week, one student suddenly withdrew and moved to Florida. Thirty one students completed EMS 212 and 213.

EMS 212 - Paramedic II - Medical Emergencies Part 2

Prerequisite: EMS 211 with a grade of "C" or better

This module covers A&P of the female reproductive system, gynecological emergencies, sexual assault, the physiologic changes of pregnancy, emergency childbirth, complications of pregnancy and delivery, and care/resuscitation of the newborn. Pediatric content includes priorities in providing care to children with medical and trauma emergencies with an emphasis on the pediatric SOPs.

Behavioral and psychiatric emergencies are discussed with an emphasis on patient and responder safety, types of behavioral and psychiatric conditions, general assessment and management, dealing with a suicidal or violent patients and conditions under which restraints may be applied.

The remaining classes cover acute and chronic disorders of the elderly, endocrine, GI, GU, neurologic, immune and hematopoietic systems. Also presented are toxicology and substance abuse, and environmental emergencies. Students have a written and oral project due relative to infectious and communicable diseases.



EMS 213 - EMT-P III - Trauma Emergencies; patients with special needs; operations

Prerequisite: EMS 212 with a grade of "C" or better

This section introduces the concept of kinematics and the forces that produce injury. Trauma to each body system is covered including injuries to the head, face, eyes, neck, spine, chest, abdomen, musculoskeletal, and soft tissues. Burns are differentiated into thermal, chemical, electrical, lightning, inhalation, and radiation trauma. Labs include BLS skills used in splinting, dressing, bandaging, selective spine motion restriction, hemorrhage control, irrigation, and helmet removal. Pleural decompression is introduced as an ALS skill and they continue to practice 12 L acquisition and interpretation.



This module also includes special patient populations such as those who are culturally diverse, victims of interpersonal violence, and those with special challenges such as patients with vision, hearing or speech deficits, autism spectrum disorders, arthritis, cancer, cerebral palsy, chronic neurological or muscular debilitating conditions, previous brain injury, and terminal illness. Responses to technology-dependent patients are presented with an intro to common devices and appliances used or worn by these individuals. Students are introduced to the concept of death and dying, use of the state DNR/POLST form, and grief management. It concludes with field experts presenting concepts multiple patient management incidents, situations involving weapons of mass destruction and terrorism; ambulance operations; and responses to hazardous materials incidents.

Formative assessments for EMS 212 & 213 – quiz scores

EMS 212	Range of scores	Average score
Quiz 8 (N=32)	81.5-98	92.2%
Quiz 9 (N=31)	78.8-100	90.5%
Quiz 10	80-100	94%
EMS 213		
Quiz 11	73.67-100	88.24
Quiz 12	88-100	94.24

Summative assessments

Students were provided with the blueprint for each written modular exam at least one week in advance of the test. The nature of the exam content, written, strip test, and practical exam stations are included on their student schedule.

	212	213
Written range of scores	87.3-98.7%	88-98%
Mean score (N 31)	93.8%	92.98%
Score distribution 90s	28 students	24 students
80s	3 students	7 students
ECG test range	86.6-100 (all passed 1 st attempt)	*Failed -100%
Mean score	97.7%	93.1%
Harper grades		
A (94-100)	13	10
B (87-93)	17	20
C (80-86)	1	1

***ECG strip test:**

While 13 students scored 100%, and eight students only missed one rhythm, five students failed on the 1st attempt due to the number of strips missed or they incorrectly identified a lethal rhythm. Each was given a detailed remediation packet to complete. The strips tested were classic examples of the rhythms, but the performance results show that the farther they get from the didactic presentations; the less some retain the information, even though they were supposed to be regularly reviewing ECG rhythms in the clinical units.

Two failed on the 2nd attempt – both missing the same lethal rhythm. Neither had appropriately measured the QRS complex duration which caused the errors in identification. Because neither of these students had failed ECG strip exams before and had passed all written and practical assessments, it did not seem reasonable to fail them for the entire course based on one missed ECG strip. Therefore, a 2nd retest was created and both passed on the 3rd attempt.

EMS 212 Practical exam - Psychomotor skills tested:

- Medical assessment
- Neuro patient assessment
- Capillary glucose assessment
- Peds measurement using Broselow tape + peds dose calculations
- Cardiac arrest team resuscitation

EMS 213 Practical exam – Psychomotor skills tested:

- Trauma assessment: Head or SCI
- Trauma assessment: Chest/abdomen
- Trauma assessment: Burn
- Cardiac arrest team resuscitation
- Acquire & transmit 12 L ECG – 1 student double failed this station and was allowed to take the System-entry lab on 12 L ECGs for remediation.

Outcomes: All ultimately passed

Homework assignments:

During EMS 211, 212, and 213, each student was expected to create 13 patient scenarios, document that patient in an Image Trend patient care report (PCR), and submit them electronically in PDF format by due dates listed on their student schedule. The assignments had a two-fold purpose: (1) evaluate the student's ability to use higher order thinking to apply didactic content when developing accurate patient presentations and treating them according to the SOPs and (2) to gain familiarity and precision in using the Image Trend software so they are proficient prior to starting the field internships.

Topics assigned:

Severe asthma	Anaphylactic shock
Acute pulmonary edema	Stroke
AMI with atrial or junctional dysrhythmias	Diabetic with hypoglycemia
Cardiac arrest	Hypovolemic shock
Uncomplicated delivery: Mom	Head trauma with GCS <M 13
Uncomplicated delivery: Newborn	Spinal cord injury with paralysis
Peds patient with fever and respiratory distress	

If the scenario submitted was not plausible, scene times were inconsistent with standards, did not accurately describe the nature of the patient accurately or critical information was missing or charted erroneously, the report was returned to the student with feedback describing the corrections to be made.

Examples of feedback given:

"You can't describe an injury in the comments section and then select normal under the physical exam section. Please redo this report to meet the expectations of the assignment."

"When describing an injury, we need to know an exact location. You described a 2 in head laceration but do not describe where - left or right side; front, side, top, back of head. A patient with a GCS of 12 or 13 would not typically have a fixed and dilated pupil. Their GCS should be much lower if they have herniation syndrome. It could be higher if this was due to a cerebral aneurysm that is leaking. Did the patient have a thunderclap headache prior to falling and hitting their head? Or were they struck on the head? It matters as to how the head injury was sustained. EMS is not allowed to give fentanyl by SOP in a patient with altered mental status. I would expect that OLMC may have not given the order in a patient with a blown pupil. If you want to keep Fentanyl in the meds given, it must be based on OLMC order only."

"Everything about this call is OK except for how you charted the dextrose in the medication section. What's on paper says that the patient got the first full bag of dextrose at 25 grams and then ANOTHER bag was hung and 7.5 grams was infused TKO. In reading the narrative, it appears that only a portion of the bag was run wide open (how many mL would tell you how many grams of dextrose to document here), and then I do not know how much of the rest of the bag was infused TKO - the amount of dextrose given by TKO would depend on how many mL infused before you got to the hospital. Please correct the dextrose dose given and I can accept this report."

EMS 214 – Hospital Clinical Rotations:

The CoA standards state: "*Paramedic Accredited programs typically range from 1000-1300 clock hours, including the four integrated phases of education (didactic, laboratory, **clinical**, and field) to cover the stated curriculum. Further pre-requisites and/or co-requisites may be required to address competencies in basic health sciences (A&P) and in basic academic skills (English and Mathematics) and together with the core content of the EMT-Basic and Paramedic curricula may lead to an academic degree.*"

Our program consists of the following:

Class hours	387
Lab hours	88 (will be extended this year during seminar hours)
Quiz/exam hours	40
Hospital clinical	200
Field internship	300-768
Total	1015-1483 (fully meet CoA requirements for hours)

Hospital clinical rotations continued concurrently with EMS 212 and 213

Hospital Unit/shift requirement minimums

ED	112 hours	14 shifts
ICU	8 hours	1 shift
Labor & delivery	16 hours	2 shifts
Operating room	16 hours	2 shifts
Pediatric ED	24 hours	3 shifts
Psych	8 hours	1 shift
Skilled nursing facility	8 hours	1 shift
Elective	8 hours	1 shift

Program policies require the clinical rotations be done (except for the elective) and paperwork to be submitted and approved before a student can begin EMS 215 (Field Internship). This DOES NOT mean that all required patient care contacts and competencies have to be accomplished before EMS 215 can begin. Hospital clinical shifts will be extended into EMS 215 if a student requires additional patient care contacts and/or opportunities to gain competency due to limited clinical unit availability and/or lack of patient opportunities. They will not be extended due to irresponsible student behavior or persistent failure to schedule and/or complete hospital clinical rotations during EMS 211, 212, or 213.

Evaluation forms for each clinical unit, listing all the assessments done/skills performed and authenticated by an RN preceptor or anesthesiologist, had to be complete and placed in the student's file for review by the Clinical Coordinator within one week of the rotation. The student was also expected to enter all patient care contacts and skills performed into **FISDAP**, consistent with their signed hospital clinical evaluations, within one week of completing the rotation. If the paperwork was incomplete and/or not submitted on time and/or the patient care contacts and skills performed were not entered on time, that rotation was not be credited toward graduation requirements and needed to be repeated. Inconsistencies in documentation between evaluation forms and FISDAP entries triggered a class-wide memo on 3-6-15 giving the students one opportunity to review their FISDAP entries and remove those that could not be corroborated by the clinical unit evaluation forms.

If a student was required to reschedule more than one clinical rotation due to late paperwork or computer submissions, that behavior was considered a failure of the affective objectives and was grounds for a meeting with the EMS MD and EMS Administrative Director. Two students needed to meet with us due to non-compliance with clinical paperwork requirements. Both had mitigating circumstances, both were given a short time to correct their over-due paperwork, and both successfully completed EMS 214.

The Clinical Coordinator confirmed completion of EMS 214 before any student was released to begin the field internship.

Preceptors

The Committee on Accreditation of EMS Programs is very specific in terms of the requirements for the field internship and preceptors:

"1) As part of the administration, organization, and supervision of the program, the Program Director must ensure that there is preceptor orientation/training. The training/orientation must include the following topics:

- Purposes of the student rotation (minimum competencies, skills, and behaviors)
- Evaluation tools used by the program
- Criteria of evaluation for grading students
- Contact information for the program

The training media may take many forms: written documents, formal course, power point presentation, video, on-line, or there could be designated trainers on-site that the program relies on. The program should tailor the method of delivery to the type of rotation (e.g. hospital, physician office, field).

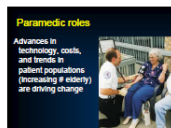
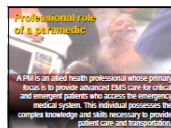
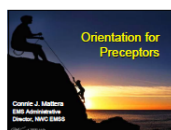
The program must demonstrate that **each field internship preceptor** has completed the training.

The program must provide evidence of the completion of the training of field internship preceptors by dated rosters of participants, on-line logs, signed acknowledgement by the field internship preceptor."

We fully met these criteria. The number of preceptor courses was expanded from two to four this year, given the changes/updates to the field internship expectations and paperwork.

The written handout and slides were all updated for the 2015 class.

NWC EMSS Preceptor Course 515
 Connie J. Matterna, MS, RN, EMT-P



NWC EMSS Paramedic Education Program
ORIENTATION FOR PRECEPTORS

Professional role of a paramedic under the 2009 Education Standards and National Scope of Practice Model
 A paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for sick and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation.

Paramedics function as part of a comprehensive EMT response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found in an ambulance. The paramedic is a link from the into the health care system.

Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an agency scene with transportation resources, arrive from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

Paramedics must demonstrate each competency within his or her scope of practice and for patients of all ages. Paramedic care is based on an advanced assessment and the formulation of a field impression. The Paramedic's role of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. The Paramedic provides care designed to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an appropriate health care facility.

Professional requirements: The paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the EMT, EMT, and AEMT. Because of the amount of complex decision-making, one of the eligibility criteria for licensure requires successful completion of a nationally accredited Paramedic program at the associate or associates degree level.

pected student outcomes following paramedic education

hospital competence	Ability to understand theoretical foundations of the profession.
technical competence	Technical proficiency in performing psychomotor skills.
critical competence	Understand how your practice fits within the greater whole of the healthcare continuum. Ability to use conceptual and technical skills in the right context, avoiding the "technical imperative".
integrative competence	Ability to take all the other competencies and put them all together. Med theory and practice.
adaptive competence	Ability to change with evolution in medicine (big picture) or modify care of a patient based on changing clinical presentations (move from one page of the SOP to another (immediate picture)).

Being negative about it won't change it. Champions Adapt. Billie Jean King

Professional identity

- Ethical standards
- Conscientious concern for improvement
- Motivation for continued learning

Achieving the affective objectives and demonstrating professional attitudes is just as important as academic and clinical success and is a requirement for graduation.

Behaviors to be evaluated: integrity, empathy, self-motivation, appearance and personal hygiene, self-confidence, communication, time management, teamwork and diplomacy, respect, patient advocacy, and careful delivery of service. Preceptors are asked to document passages of behavior plus external events.

Participants at each class signed in on a roster that has been forwarded to the Hospital EMSCs/educators facilitating the internships.

The program director has a master file of preceptor class attendance that goes back to 2007.

All preceptors, students, EMS Coordinators/educators and members of the Education Committee were given copies of the updated Field Internship paperwork that lists the criteria for evaluating the students. These documents were also sent as attachments to an e-mail sent to all System Chiefs, Provider EMSCs, hospital EMSCs and posted to the System website.

Each student has signed a memorandum of understanding relative to their participation at the assigned agency and each preceptor has submitted a signed application and preceptor agreement that includes language approved by attorneys representing a provider agency and NCH.

Students began EMS 215 the week of March 1st after all prerequisites had been met.

They need to be done on time to be eligible to take the NR practical exam to be scheduled at the end of June/ beginning of July.

Respectfully submitted,

Connie J. Mattera, MS, RN, EMT-P
EMS Administrative Director and Paramedic Program Director

Goal:
Complete requirements by
June 12, 2015

June 2015						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	Final written
14	15	16	17	Graduation		
21	22	23	24	25	26	27
28	29	30				