NWC EMSS Skill Performance Record

GENERAL (Medical) PATIENT ASSESSMENT

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: You are asked to assess the patient and call your findings in to the hospital.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Verbalizes needed body substance isolation precautions			
SCENE SIZE UP			
* Assess & secure scene safety			
* Determine nature of illness; scan environment for clues; apply appropriate BSI			
Determine number of patients & triage if necessary			
If a potential crime scene, make efforts to preserve evidence			
Determine need for additional assistance and call for help if necessary			
PRIMARY ASSESSMENT/RESUSCITATION (IMC)			
Form (verbalize) general impression (sick or not sick)			
*Determine responsiveness/level of consciousness			
***Airway**: assess for impairments			
*Verbalize interventions for airway access/control if necessary			
Breathing/ventilatory/gas exchange status; assess for impairment ☐ *Assess for spontaneous ventilations; general rate (fast or slow) ☐ *Assess WOB; symmetry of expansion; use of accessory muscles; retractions ☐ ***Assess gas exchange; apply SpO_2 monitor; assess for signs of hypoxia** ☐ Assess capnography number& waveform if ventilatory, perfusion, metabolic complaint ☐ *Assess breath sounds if in ventilatory distress ☐ *Initiate appropriate O_2 therapy based on SpO_2 and level of distress ☐ Resuscitate compromised breathing/ventilation (not applicable)			
Circulatory status; assess for impairment ☐ *Central and peripheral pulses for presence, general rate/quality/rhythmicity ☐ *CPR if indicated ☐ *Skin (color, temperature, moisture, turgor) ☐ Assess neck veins for distension ☐ *Verbalize need for ECG monitor if indicated ☐ Verbalize need for 12-Lead ECG if indicated ☐ *Assess for and control bleeding if present ☐ *Initiate appropriate vascular access and IV fluids for condition			
Disability if altered mental status ☐ *Assess glucose level (verbalizes) ☐ *Assess pupils for size, shape, equality, reactivity ☐ *Assess Glasgow Coma Score			
Exposure/environment ☐ Discretely undress patient to inspect appropriate body areas ☐ Protect patient modesty, maintain body warmth			
*Identify time-sensitive patients/makes appropriate transport decision			
SECONDARY ASSESSMENT			
Vital signs ☐ *Pulse: rate, quality, rhythmicity ☐ *BP; orthostatic changes prn ☐ *Resp: rate, pattern, depth ☐ Temp if high or low based on skin			
Obtain chief complaint/concern:			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
History of present illness ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/radiation ☐ *Time ☐ *Clarifying questions ☐ *Date of birth; approx. weight ☐ Associated complaints			
SAMPLE history ☐ *Allergies ☐ *Past medical hx ☐ *Events ☐ *Medications ☐ *Last meal/LMP			
PHYSICAL EXAM – must touch the patient			
Head ☐ *Inspect head, eyes, ears, nose, throat ☐ Palpate: skull, orbits, nasal and facial bones **Cranial nerves** ☐ *Visual acuity ☐ EOMs ☐ Hearing ☐ *Pupil size, shape, equality ☐ Facial sensation ☐ Gag ☐ *Pupil reactivity to light ☐ Facial symmetry **Mental status**: affect, behavior, cognition (verbalizes);GCS (scores using SOP)			
Neck ☐ *Inspect: jugular veins, edema ☐ Palpate: position of trachea			
Chest ☐ *Inspect: contour/shape; AP/lateral diameter; symmetry of expansion ☐ *Palpate ☐ *Auscultate breath sounds; heart sounds if applicable			
Abdomen/pelvis - in correct order ☐ *Inspect (contour, symmetry) (verbalizes) ☐ Auscultate bowel sounds ☐ *Palpate			
Lower extremities ☐ Inspect symmetry, edema, skin changes ☐ *Palpate ☐ Assesses SMV status of each limb			
Upper extremities ☐ Inspect symmetry, edema, skin changes ☐ *Palpate ☐ Assesses SMV status of each limb			
Back ☐ Inspect ☐ Palpate			
*State **paramedic impression**:			
Verbalize treatment plan			
On-going assessment enroute			
Repeat primary & secondary assessments			
Evaluate responses to treatments			
Repeat vital signs at least q. 15 minutes			
Report to hospital			
Identification ☐ *Hospital being contacted ☐ *EMS provider agency and unit #; call back number			
☐ *Age, gender, and approximate weight of patient ☐ *Level of consciousness (conscious/unconscious responds to ....)			
Chief complaint (list): ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/radiation ☐ *Time			
Associated complaints:			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
History ☐ *Allergies ☐ *Medications (current): time and amount of last dose if applicable ☐ *Past medical history (pertinent) ☐ Last oral intake, last menstrual period if indicated ☐ *Events leading up to present illness/injury (history of present illness)			
Vital signs: ☐ *BP: Auscultated ☐ *Respirations: rate, pattern, depth ☐ *Pulse: rate , quality ☐ SpO_2 ☐ Capnography			
*Physical examination; include pertinent positive and negative findings			
Treatments initiated prior to hospital contact (IMC) and patient response to treatment			
ETA			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

An assessment that is slow (over 10 minutes) or done with poor technique, disorganized, or performed out of order and any verbalized interventions with a high probability of causing patient harm will necessitate more practice and repeat of the station.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM 5/14 Assess

NWC EMSS Skill Performance Record

TRAUMA ASSESSMENT

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
SCENE SIZE UP			
*Assess and secure scene safety			
*Determine mechanism of injury; scan environment for clues; apply appropriate BSI			
Determine number of patients & triage if necessary			
If a potential crime scene, make efforts to preserve evidence			
Determine need for additional assistance and call for help if necessary			
Consider need for spine motion restriction (may or may not need it)			
PRIMARY ASSESSMENT/RESUSCITATION (ITC)			
Form (verbalize) general impression (sick or not sick)			
*Determine responsiveness/level of consciousness			
***Airway**: Assess for impairment			
*Verbalize interventions for airway access/control if necessary			
Breathing/ventilatory/gas exchange status; assess for impairment ☐ *Assess for spontaneous ventilations; general rate (fast or slow) ☐ *Assess WOB; symmetry of expansion; use of accessory muscles; retractions ☐ ***Assess gas exchange; apply SpO_2 monitor; assess for signs of hypoxia** ☐ Assess capnography number and waveform if ventilatory, perfusion, metabolic complaint ☐ *Assess breath sounds if in ventilatory distress ☐ *Initiate appropriate O_2 therapy based on SpO_2 and level of distress ☐ Resuscitate compromised breathing/ventilation ☐ *Assess for immediate life threats: tension pneumo; open pneumo; flail chest ☐ *Verbalize appropriate resuscitative intervention for life-threat			
Circulatory status; assess for impairment ☐ *Central and peripheral pulses for presence, general rate/quality/rhythmicity ☐ *CPR if indicated ☐ *Skin (verbalizes color, temperature, moisture, turgor) ☐ Assess neck veins for distension ☐ *Verbalize need for ECG monitor if pulse absent/irregular ☐ *Assess for and control bleeding if present ☐ *Initiate appropriate vascular access and IV fluids for condition ☐ *Assess for immediate life threats: Cardiac tamponade; blunt cardiac injury; shock ☐ *Verbalize appropriate resuscitative intervention for life-threat			
Disability if altered mental status ☐ *Assess glucose level (verbalizes) ☐ *Assess pupils for size, shape, equality, reactivity ☐ *Assess Glasgow Coma Score ☐ *Assess and verbalize the need for pain management			
Expose/environment ☐ Discretely undress patient to inspect appropriate body areas ☐ Protect patient modesty, maintain body warmth			
*Identify time-sensitive patients/make transport decision			
SECONDARY ASSESSMENT			
Vital signs ☐ *Pulse: rate, quality, rhythmicity ☐ *BP; orthostatic changes prn ☐ *Resp: rate, pattern, depth ☐ Temp if high or low based on skin			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
History / chief complaint: ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/Radiation ☐ *Time ☐ Associated complaints			
***Past medical history** from patient/family/bystanders ☐ Allergies ☐ Past medical hx ☐ *Events/MOI ☐ Medications ☐ Last meal/LMP ☐ Age ☐ Approx wt.			
Physical exam – must touch the patient			
Head ☐ Inspect: DCAP-BLS, drainage ☐ *Palpate: skull, orbits, nasal and facial bones			
Cranial nerves - depending on CC ☐ Visual acuity ☐ EOMs ☐ Hearing ☐ *Pupil size, shape, equality ☐ Facial sensation ☐ Gag ☐ *Pupil reactivity to light ☐ Facial symmetry/motion ☐ Stick out tongue **Mental status**: GCS (scores using SOP), amnesia			
Neck ☐ *Inspect: DCAP, BLS; jugular veins ☐ *Palpate: position of trachea; C-spines			
Chest ☐ *Inspect: DCAP-BLS ☐ *Palpate TIC ☐ *Auscultate breath/heart sounds ☐ Discover injuries: trauma to thoracic aorta; fractured ribs, hemothorax, pneumothorax			
Abdomen/pelvis - in correct order ☐ *Inspect ☐ Auscultate bowel sounds ☐ *Palpate ☐ Discover S&S of peritonitis (guarding, rigidity, evidence of rebound tenderness)			
Lower extremities ☐ *Inspect ☐ *Palpate ☐ *Assesses SMV status of each limb			
Upper extremities ☐ *Inspect ☐ *Palpate ☐ *Assesses SMV status of each limb			
Posterior thorax and buttocks ☐ *Inspect ☐ *Palpate			
*State paramedic impression:			
Verbalize treatment plan using appropriate SOP			
*Select appropriate receiving hospital based on trauma triage criteria			
On-going assessment			
Repeat initial (primary) assessment			
Evaluate response to treatments			
Repeat vital signs at least every 15 min			
Radio report			
Identification ☐ *Hospital being contacted ☐ *EMS provider agency and unit #; call back number			
☐ *Age, gender, approximate weight of patient ☐ *Level of consciousness (conscious/unconscious responds to ....)			
Chief complaint S&S: ☐ Onset ☐ *Region/radiation/recurrence ☐ *Provokes/palliates ☐ *Severity 0-10 ☐ *Quality ☐ *Time			
Associated complaints			
History ☐ *Allergies ☐ *Medications (current): time and amount of last dose if applicable ☐ *Past medical history (pertinent) ☐ Last oral intake, LMP if indicated ☐ *Events leading up to present illness/injury (history of present illness)			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Vital signs ☐ *BP: ☐ *Respirations: rate, pattern, depth, effort ☐ *SpO_2; capnography ☐ *Pulse: rate, regularity, quality			
*Physical examination; include pertinent positive and negative findings ☐ HEENT ☐ Abdomen ☐ Extremities ☐ Skin ☐ Chest ☐ Pelvis/GU ☐ Back			
Treatments initiated prior to hospital contact (ITC) and pt response to treatment			
ETA			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

An assessment that is slow (over 10 minutes) or done with poor technique, disorganized, or performed out of order and any verbalized interventions with a high probability of causing patient harm will necessitate more practice and repeat of the station.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

NEURO ASSESSMENT

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Assess respiratory rate, pattern, and depth. Describe abnormal patterns			
*Assess circulatory status: Recognize VS changes w/ ↑ ICP. (↑ BP; ↓ P; ↓ RR) *Recognize neurogenic shock (↓ BP; ↓ P; ↓ RR)			
Assess level of conscious by accurately reporting the Glasgow Coma Score.			
Mental status exam ☐ *Orientation (person, place, time) ☐Affect, behavior, cognition ☐ *Memory: immediate, recent and remote			
***CN II**: Assess visual acuity in each eye by reporting the pt's best ability: (sees light; shape/shadow/motion; count fingers or can read name badge)			
***CN III**: Assess pupils for size, shape, equality			
***CN II & III**: Assess both pupils for direct and consensual light response			
***CN III, IV, VI**: Assess eyes for EOMs & conjugate gaze by having pt. follow finger in all visual fields. (large H)			
***CN V**: Assess sensation to face across forehead, cheeks, and chin Assess strength of masseter muscles			
***CN VII**: Ask pt. to wrinkle forehead, close eyelids tightly, smile, frown, puff out cheeks, whistle			
CN VIII: Assess for lateralization of hearing loss			
CN IX & X: Assess gag reflex. Have pt. open mouth and say "ha, ha, ha"; look for palate to rise			
***MOTOR EXAM:** **Upper extremities**: Have pt. shrug shoulders, flex & extend elbows and wrists against resistance, abduct fingers against resistance, keep fingers open against resistance. Assess for pronator drift. Watch for one hand to turn palm down and drift downwards. **Lower extremities**: Have pt. flex knees, plantar & dorsiflex feet against resistance.			
CEREBELLAR EXAM: **Upper extremities**: Have pt touch their index finger to their nose and then reach out to touch examiner's finger; OR perform alternating movements by rapidly pronating and supinating hands; OR bring fingers to thumb in rapid succession. **Lower extremities**: Have patient slide heel of one foot rapidly up and down shin of opposite leg.			
***SENSORY EXAM**: Touch pt. with broken cotton swab to detect sharp/dull discrimination down back of legs, up anterior foot, leg, abdomen, chest, down inside of arm to back of hand, & up outside of arm. Describe any deficits/paresthesias. Draw a line on pt. at sensory demarcation line.			
Special sensory: Check for proprioception in pts. w/ SCI. With pt's eyes closed, move thumb and great toe up or down and determine if patient perceives position change.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

An assessment that is slow (over 10 minutes) or done with poor technique, disorganized, or performed out of order and any verbalized interventions with a high probability of causing patient harm will necessitate more practice and repeat of the station.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

MANUAL AIRWAY MANEUVERS

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard HEAD-TILT, CHIN-LIFT MANEUVER	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*Identify S&S of upper airway impairment.			
☐ *State indications for this maneuver (upper airway impairment) ☐ *Affirm no contraindications to this maneuver (no c-spine or jaw injury) ☐ Put on gloves			
*Position patient supine.			
Place one hand on pt's forehead; apply firm, downward pressure with the palm of the hand tilting the head backwards. Place fingertips of the other hand underneath the anterior mandible.			
*****Pull the chin forward, supporting the jaw and tilting the head backward as far as possible. **Do not compress the soft tissues underneath the chin; this may obstruct the airway.**			
Continue to press the other hand on the pt's forehead to keep head tilted backward			
Lift the chin so the teeth are brought nearly together. (may use the thumb to depress the lower lip; this allows the patient's mouth to remain slightly open)			
If pt has dentures; hold them in position, making obstruction by the lips less likely. (It is easier to maintain a seal when dentures are in place. If the dentures cannot be managed, remove them.)			
*****Assesses airway patency by looking, listening and feeling for unobstructed air movement and spontaneous ventilations.			
☐ If successful, state need for an OPA or NPA to hold airway open. ☐ If unsuccessful, state need to try patient repositioning, suction, or ALS interventions			

Performance standard JAW-THRUST MANEUVER	Performs w/o coaching	Performs w/ coaching	Needs additional practice
☐ *State indications for maneuver (upper airway impairment w/ possible C-spine injury) ☐ Affirm no contraindications to this maneuver (no jaw injury) ☐ Put on gloves			
*Position patient supine.			
*Kneel at the top of the patient's head. Place hands along each side of the patient's jaw.			
*Grasp the angles of the jaw on both sides. Without moving the neck, lift the jaw forward to pull the tongue away from the posterior oropharynx.			
Use thumb to retract the lower lip if the lips are closed.			
*Assesses airway patency: look, listen and feel for unobstructed air movement and spontaneous ventilations.			
☐ *****If unable to open the airway reposition the jaw and attempt again. ☐ If successful, state need for an OPA or NPA to hold airway open. ☐ If unsuccessful, state need to try patient repositioning, suction, or ALS interventions.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Unsatisfactory: Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

OROPHYARNGEAL AIRWAY (OPA)

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult appears unconscious with snoring respirations. You are asked to assemble the equipment, choose the correct size adjunct from those available, and insert an oral airway.

Equipment needed: Airway manikin; various sizes OPAs, tongue blades, suction catheters, BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
☐ *State indications for this airway (upper airway impairment; need for BVM assist) ☐ *Affirm no contraindications to this airway ☐ Intact gag reflex ☐ Oral trauma ☐ Epiglottitis			
* Apply BSI (gloves/goggles)			
Prepare patient Explain procedure to patient - even if unconscious			
* Position patient supine			
Obtain SpO_2 reading on room air if time permits			
* Use appropriate manual maneuver to open airway			
Clear mouth and pharynx of secretions, blood, or vomitus with suction prn			
* Confirm absence of gag reflex by assessing lash reflex or glabellar tap			
Prepare equipment: * Sizing: Measure vertical distance from front of teeth to angle of jaw			
Perform procedure Support pt's head with one hand; open mouth w/ cross-finger technique			
☐ *Depress tongue with a tongue blade. ☐ *Insert airway along curvature of tongue until it approaches posterior oropharynx and points downward. Distal end should rest behind the base of the tongue in the oropharynx. ☐ *Flange should rest on patient's lips. Verify that tongue or lips are not caught between teeth and airway.			
* Verify airway patency by closing nose and feeling for air movement through mouth. Auscultate bilateral breath sounds.			
Reassess VS and SpO_2			
Verbalize two complications: ☐ Induction of gag/vomiting ☐ Obstruction from malplaced airway ☐ Swelling of epiglottis ☐ Intraoral injuries			
Verbalize steps to take if patient gags: (remove airway and ready suction)			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

NASOPHARYNGEAL AIRWAY (NPA)

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult appears unconscious with snoring respirations. You are asked to assemble the equipment, choose the correct size adjunct from those available, and insert a nasopharyngeal airway.

Equipment needed: Airway manikin; various sizes NPAs, lubricant, suction catheters, BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications: upper airway impairment; need for frequent suctioning, BVM assist where gag is still intact			
***Affirm no contraindications** for inserting this airway ☐ Midface or above trauma/obstruction ☐ Anterior basilar skull fx			
* Apply BSI (gloves/goggles)			
Prepare patient Explain procedure to patient - even if unresponsive			
Obtain SpO_2 reading on room air if time permits			
* Use appropriate manual maneuver to open airway			
Prepare equipment: * Select appropriate airway length by measuring from tip of nose to ear lobe.			
* Lubricate airway w/ water-soluble jelly			
Perform procedure * Elevate tip of nose and gently insert tube into right nostril. Bevel to septum only applies to insertion on right side.			
* Advance gently along floor of nasal passage until flange is against nostril. If resistance is met, withdraw airway and attempt on other side.			
Open mouth to check airway position			
* Assess airway patency by closing mouth and feeling for air movement through the airway. Reassess VS & SpO_2.			
* Verbalize steps if resistance is met: (withdraw airway and try other side)			
* Verbalize at least two complications: ☐ Nasal bleeding ☐ Tissue trauma ☐ Gagging ☐ Vomiting ☐ Gastric distention if airway is too long			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

OROPHARYNGEAL SUCTIONING

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult's mouth is filled with blood. You are asked to assemble the equipment, choose the correct catheter from those available, and perform oropharyngeal suctioning.

Equipment needed: Airway manikin; various sizes suction catheters, suction unit, BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications for procedure: Secretions in mouth, nose or pharynx			
* Apply BSI (gloves/goggles)			
Prepare patient Explain steps of procedure to patient			
Obtain SpO_2 on room air if available and time allows			
* Preoxygenate patient prior to suctioning if time allows			
Prepare equipment: Inspect suction unit for power and proper assemblage			
* Select appropriate suction catheter (flexible or rigid); attach to suction tubing			
Perform procedure Open mouth using cross-finger technique			
Turn power on to high. Kink tubing and ensure that unit achieves vacuum of 300 mmHg.			
☐ Insert suction catheter no deeper than pharynx. ☐ If Yankauer tip, insert w/ convex side along roof of mouth.			
* Apply suction while limiting suction application to 10 sec on an adult.			
Refrain from jabbing catheter up and down while applying suction			
* Reoxygenate patient with O_2 15 L/NRM or BVM			
Verbalize that suction catheter should be flushed with NS or water between suction attempts to remove any material that could clog ports			
Verbalize 2 complications if suction were applied improperly or for too long: ☐ *Hypoxia ☐ Atelectasis ☐ *Bradycardia ☐ Hypotension ☐ Tissue trauma ☐ ↑ ICP			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM/DN: 5/14

NWC EMSS Skill Performance Record

TRACHEAL SUCTIONING

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is intubated. You note secretions in the ET tube. You are asked to assemble the equipment, choose the correct catheter from those available, and perform tracheal suctioning.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Universal precautions: Apply BSI (face shield/goggles)			
Verbalize indications for tracheal suction: secretions impairing airway in an intubated patient			
Prepare patient Explain steps of procedure to patient even if unconscious			
Obtain SpO_2 on room air if time allows			
* Preoxygenate patient prior to suctioning if time allows			
* Connect patient to cardiac monitor			
Prepare equipment: Inspect suction unit for power and proper assemblage. Set suction between 80-120 mmHg if suction source is adjustable.			
* Select appropriate size suction catheter (approx. ½ ID of the TT). Maintain sterility of catheter.			
* BSI: Put on sterile glove. Open suction catheter packaging using sterile technique.			
* Coil catheter in dominant hand, protecting tip from contamination.			
* Using non-dominant hand, connect catheter to suction tubing.			
* Turn power on to high			
Perform procedure * Insert catheter into ETT without activating suction. Advance catheter until resistance is met or pt coughs taking no longer than 2-3 sec to advance catheter.			
* Apply suction while withdrawing the catheter in a twisting motion limiting suction application and catheter insertion time to 10 sec.			
* Refrain from jabbing catheter up and down while applying suction			
* Reoxygenate patient with 15 L $O_{2/}$ BVM			
Verbalize at least 2 complications if suction were applied for too long: ☐ *Hypoxia ☐ Atelectasis ☐ *Bradycardia ☐ Hypotension ☐ Tissue trauma ☐ ↑ ICP			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

REMOVAL of FOREIGN BODY by DIRECT LARYNGOSCOPY

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is found unconscious, non-breathing with a pulse. Manual attempts to clear the airway have been unsuccessful. You are asked to assemble the equipment and perform direct laryngoscopy to remove the foreign body.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Continue manual attempts while preparing for direct laryngoscopy. Verbalize appropriate indications for performing this skill			
*Universal precautions: Put on gloves, goggles, and face mask			
Prepare the patient Place patient's head in sniffing position placing pad under occiput			
Assess SpO_2 on room air if time allows			
*Attempt to ventilate patient/BVM (Unsuccessful)			
Prepare equipment ☐ Assemble laryngoscope blade and handle ☐ Check light to be certain it is bright, tight and white ☐ Suction			
Removal ☐ Insert curved laryngoscope blade from the right, sweep tongue to left; seat distal blade tip in vallecula ☐ Insert straight blade down midline of tongue under epiglottis ☐ * Lift jaw at 45° to the floor of the mouth; avoid using upper teeth as a fulcrum			
* Visualize glottic opening and surrounding structures			
* If F/B is seen, grasp and carefully remove with Magill forceps and/or suction			
* Observe for residual F/B & return of spontaneous ventilations for 5 seconds			
Airway management when spontaneous ventilations resume ☐ Remove laryngoscope blade ☐ O_2 at 12-15 L/NRM ☐ * Continue to monitor VS & SpO_2			
Airway mgt when spontaneous ventilations DO NOT resume (verbalize) ☐ Attempt to ventilate with a BVM ☐ *Unable to ventilate: Attempt intubation using standard procedure ☐ *Unable to insert ETT: Attempt rescue airway ☐ *Unable to insert King or ventilate effectively: Cricothyrotomy			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

OROTRACHEAL INTUBATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is found in bed with apnea. No trauma is suspected. Prepare the equipment and intubate the patient.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
Prepare the patient *Place head in sniffing position: pad occiput to bring earlobe horizontal with xiphoid			
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline			
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Malampatti view, thyromental distance; overbite			
Insert NPA (preferred) or OPA unless contraindicated			
* **Preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Prepare equipment – Have everything ready before placing blade in mouth * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
* Choose correct size ETT (verbalize size of 5th finger)			
* Insert stylet so distal tip is proximal to Murphy's eye; form tube straight to balloon cuff then angle at 45° like a hockey stick			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate end of the ETT (verbalize) with water-soluble jelly as it is withdrawn from package			
* Assemble laryngoscope; check light source (tight, bright & white)			
☐ EDD, capnography, tube holder, head blocks, stethoscope ☐ Have alternative airway selected, prepped, & in sight (King LT)			
Pass tube: * (Allow no more than 30 sec of apnea) Have assistant apply external laryngeal pressure, lip retraction; monitor ECG HR & rhythm, O_2 sat, time elapsed			
☐ Withdraw tube from package; hold in dominant hand ☐ Open mouth w/ cross finger technique ☐ Insert curved blade from R, sweep tongue to the L & seat distal blade tip in vallecula ☐ Insert straight blade down midline of tongue under epiglottis **Every blade insertion is 1 attempt (max 2 attempts/pt)** ☐ *Lift blade up & forward; avoid using upper teeth as a fulcrum			
☐ *Visualize cords; insert ETT from R side of mouth; pass cuff through cords ☐ *If > 30 sec: remove ETT, reoxygenate X 30 sec; Change position, blade, or PM. May go straight to King LT if unable to visualize cords.			
* While holding ETT in place, remove blade from mouth & stylet from tube			
* **Confirm tracheal placement:** aspirate EDD; monitor capnography number & waveform			
* Ventilate with 15 LO_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ *If breath sounds present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion of blade ☐ *If ETT cannot be placed successfully; attempt rescue airway			
* Note ETT depth (diamond marking at teeth) (3 X ID of ETT)			
* Insert OPA; align ETT with side of mouth; secure with commercial tube holder; immobilize head; suction prn			
* **Reassess**: Frequently monitor capnography, tube depth, VS, SpO_2, (not helpful in cardiac arrest) & lung sounds to detect displacement, complications or condition change			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth or soft tissues ☐ Undetected esophageal intubation ☐ Mainstem intubation (R) ☐ Hypoxia, dysrhythmia			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

IN-LINE INTUBATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult with a possible c-spine injury is found apneic. Prepare equipment and intubate using the in-line technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
Prepare the patient Place head in neutral position with 1 rescuer manually maintaining c-spine motion restriction			
Assess SpO_2 on RA as time and personnel allow; auscultate breath sounds for baseline			
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Malampatti view, thyromental distance; overbite, etc			
Insert NPA (preferred) or OPA unless contraindicated			
* **Preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Prepare equipment – Have everything ready before placing blade in mouth * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
* Choose correct size ETT (verbalize size of 5th finger).			
* Insert stylet so distal tip is proximal to Murphy's eye; form tube straight to balloon cuff then angle at 45° like a hockey stick			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate end of the ETT (verbalize) with water-soluble jelly as it is withdrawn from package			
* Assemble laryngoscope; check light source (tight, bright & white)			
☐ *EDD, capnography, tube holder, head blocks, stethoscope ☐ Have alternative airway selected, prepped, & in sight (King LT)			
Pass the tube (Allow no more than 30 sec of apnea) ☐ *Intubator immobilizes head and body with legs. ☐ 2nd person holds maxilla & head in neutral alignment. Have assistant apply (gently), external laryngeal pressure, & lip retraction. ☐ Open front of C-collar			
☐ Withdraw tube from package; hold in dominant hand ☐ Open mouth w/ cross finger technique ☐ Insert curved blade from R, sweep tongue to the L & seat distal blade tip in vallecula ☐ Insert straight blade down midline of tongue under epiglottis **Every blade insertion is 1 attempt (max 2 attempts/pt)** ☐ *Lift blade up & forward; avoid using upper teeth as a fulcrum			
☐ Tilt upper torso back until cords seen; insert ETT from R side mouth; pass cuff through cords ☐ If > 30 sec: remove ETT, reoxygenate X 30 sec; Change position, blade, or PM. May go straight to King LT if unable to visualize cords.			
* While holding ETT in place, remove blade from mouth & stylet from tube			
* **Confirm tracheal placement:** aspirate EDD; monitor capnography number & waveform			
* Ventilate with 15 LO_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ *If breath sounds are present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe. ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion of blade ☐ *If ETT cannot be placed successfully; attempt rescue airway			
* Note ETT depth (diamond marking at teeth) (3 X ID of ETT)			
* Insert OPA; align ETT with side of mouth; secure with commercial holder; immobilize head; suction prn			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* **Reassess**: Frequently monitor $EtCO_2$, tube depth, VS, SpO_2, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change			
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth or soft tissues ☐ C-spine injury ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

DRUG-ASSISTED INTUBATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An awake adult with an intact gag reflex (non-traumatic cause) is in impending ventilatory failure. You are asked to assemble the equipment, choose the correct medications from those available, and intubate the patient using the drug assisted intubation technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Verbalize possible indications for DAI: ☐ Actual or potential airway impairment or aspiration risk (trauma, stroke, AMS) ☐ Actual or impending ventilatory failure (HF, pulmonary edema, COPD, asthma, anaphylaxis w/ RR <10 or >40; shallow/labored effort; or $SpO_2 \leq 92$) ☐ Increased WOB (retractions, use of accessory muscles) resulting in severe fatigue ☐ GCS 8 or less due to an acute condition unlikely to be self-limited (Ex. seizures, hypoglycemia, postictal, certain drug overdoses) ☐ Inability to ventilate/oxygenate adequately after insertion of OPA/NPA and/or via BVM ☐ Need for ↑ inspiratory or positive end expiratory pressures to maintain gas exchange ☐ Need for sedation to control ventilations			
Verbalize possible contraindications for DAI: ☐ Coma with absent airway reflexes or known hypersensitivity/allergy to a drug ☐ Use in pregnancy could be potentially harmful to the fetus; consider risk/benefit.			
* BSI: Gloves, goggles, facemask			
Prepare the patient * Tell pt each step of the process before it is done.			
*Place head in sniffing position: pad occiput to bring earlobe horizontal with xiphoid			
Assess SpO_2 on RA as time and personnel allow; auscultate breath sounds for baseline			
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Malampatti view, thyromental distance; overbite			
* **Preoxygenate** for 3 min w/ 15 LO_2/NRM or BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Apply cardiac monitor			
Prepare equipment – Have everything ready before placing blade in mouth * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
* Choose correct size ETT (verbalizes size of 5th finger)			
* Insert stylet so distal tip is proximal to Murphy's eye; form tube straight to balloon cuff then angle at 45° like a hockey stick			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate end of tube (verbalize) with water-soluble jelly as it is withdrawn from package			
* Assemble laryngoscope; check light source (tight, bright & white)			
☐ * EDD, capnography, tube holder, head blocks, stethoscope ☐ Have alternative airway selected, prepped, & in sight (King LT)			
Premedicate if applicable ☐ Benzocaine spray to posterior pharynx 1-2 sec spray, 30 sec apart X 2 (if + gag) ☐ Lidocaine 1.5 mg/kg IVP if head trauma or stroke ☐ Atropine 0.02 mg/kg IVP if child < 20 kg ☐ Fentanyl per SOP for pain			
Sedate * If SBP ≥ 90 (MAP ≥ 65)**: MIDAZOLAM 5 mg slow IVP/IN** If shock w/ hypotension, go to directly to etomidate			
* Etomidate 0.5 mg/kg IVP - wait for clinical response before passing ETT if possible			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Monitor VS; LOC; skin color; SpO_2 q. 5 min during procedure			
Pass tube: * Have assistant apply external laryngeal pressure, lip retraction; monitor ECG HR & rhythm, O_2 sat, time elapsed			
☐ Withdraw tube from package; hold in dominant hand ☐ Open mouth w/ cross finger technique ☐ *Insert curved blade from R, sweep tongue to the L & seat distal blade tip in vallecula ☐ *Insert straight blade down midline of tongue under epiglottis **Every blade insertion is 1 attempt (max 2 attempts/pt)** ☐ *Lift blade up & forward; avoid using upper teeth as a fulcrum			
☐ * Visualize cords; insert ETT from R side of mouth; pass cuff through cords ☐ If > 30 sec: remove ETT, reoxygenate X 30 sec; Change position, blade, or PM. May go straight to King LT if unable to visualize cords.			
* While holding ETT in place, remove blade from mouth & stylet from tube			
* **Confirm tracheal placement:** aspirate EDD; monitor capnography number & waveform			
* Ventilate with 15 LO_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ *If breath sounds are present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe. ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion of blade ☐ *If ETT cannot be placed successfully; attempt rescue airway			
* Note ETT depth (diamond marking at teeth) (3 X ID of ETT)			
* Insert OPA; align ETT with side of mouth; secure with commercial holder; immobilize head			
* **Reassess**: Freq monitor capnography, tube depth, VS, SpO_2, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change			
If pt begins to fight the ETT, give midazolam in 2 mg increments IVP as needed up to total of 20 mg for post-intubation sedation			
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth or soft tissues ☐ C-spine injury ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ Over sedation			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM/DN 5/14

NWC EMSS Skill Performance Record

DIGITAL INTUBATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult is found apneic. The patient has copious amount of secretions and the cords cannot be visualized. Prepare equipment to perform a digital intubation.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
Prepare the patient ☐ Confirm unresponsiveness & no protective airway reflexes ☐ Consider possibility of c-spine injury – if yes, manually open airway with spine motion restriction; assess breathing			
Assess SpO_2 on RA as time and personnel allow; auscultate breath sounds for baseline			
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Malampatti view, thyromental distance; overbite, etc			
Insert NPA (preferred) or OPA unless contraindicated			
* **Preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Prepare equipment – Have everything ready before beginning procedure * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
* Choose correct size ETT (verbalize size of 5th finger)			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate end of the ETT (verbalize) with water-soluble jelly as it is withdrawn from package			
☐ EDD, capnography, tube holder, head blocks, stethoscope ☐ Have alternative airway selected, prepped, & in sight (King LT)			
Pass the tube (Allow no more than 30 sec of apnea) ☐ Position self at pt's (left) side ☐ * Place OPA between molars to prevent pt from biting during procedure			
☐ * Withdraw tube from package; hold in dominant hand ☐ * Insert middle and index fingers of nondominant hand into pt's mouth. Walk fingers along back of the tongue until the epiglottis is palpated in the midline. ☐ * Palpate arytenoid cartilage posterior to glottis. Locate epiglottis with middle finger (flap of cartilage covered by mucous membrane)			
* Introduce ETT & guide into pharynx. Guide tip of ETT through vocal cords with index finger and advance into trachea			
* **Confirm tracheal placement:** aspirate EDD; monitor capnography number & waveform			
* Ventilate with 15 LO_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ *If breath sounds are present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe ☐ *If breath sounds only on right, withdraw ETT slightly and listen again ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion of fingers ☐ *If ETT cannot be placed successfully; attempt rescue airway			
* Note ETT depth (diamond marking at teeth) (3 X ID of ETT)			
* Reseat OPA; align ETT with side of mouth; secure with commercial tube holder; immobilize head			
* **Reassess**: Frequently monitor $EtCO_2$, tube depth, VS, SpO_2, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ Trauma to intubator's fingers			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

INVERSE or Face-to-face INTUBATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An apneic adult is found pinned behind the steering wheel. Prepare equipment and intubate patient using anterior technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications for procedure: A pt who requires intubation but has limited access or is unable to be moved to a position allowing the usual position for intubation			
* BSI: Gloves, goggles, facemask			
Prepare the patient ☐ Confirm unresponsiveness & no protective airway reflexes ☐ Consider possibility of c-spine injury – if yes, manually open airway with spine motion restriction; assess breathing			
Assess SpO_2 on RA as time & personnel permit; auscultate breath sounds for baseline			
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Malampatti view, thyromental distance; overbite			
Insert NPA (preferred) or OPA unless contraindicated			
* **Preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Prepare equipment – Have everything ready before beginning procedure * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
* Choose correct size ETT (verbalize size of 5th finger)			
* Insert stylet so distal tip is proximal to Murphy's eye; form tube straight to balloon cuff then angle at 45° like hockey stick			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate end of tube (verbalize) with water-soluble jelly as it is withdrawn from package			
* Assemble laryngoscope; check light source (tight, bright & white)			
☐ EDD, capnography, tube holder, head blocks, stethoscope ☐ Have alternative airway selected, prepped, & in sight (King LT)*			
Pass the tube (Allow no more than 30 sec of apnea) ☐ Position self in front of (facing) pt ☐ * Have assistants maintain spine motion restriction (if applicable); apply external laryngeal pressure, lip retraction; monitor ECG HR & rhythm, O_2 sat, time elapsed			
☐ Hold laryngoscope with curved blade in right hand (not left) ☐ * Insert blade down midline of tongue and pull forward (anteriorly) ☐ * Sight down blade to visualize vocal cords (anatomy will be reversed compared to standard intubation view)			
☐ * Insert ETT w/ L hand; pass cuff through cords w/in 30 sec. ☐ *If > 30 sec: remove ETT, ventilate X 30 sec; reposition blade, try new blade; have another PM attempt			
* While holding ETT in place, remove laryngoscope & stylet from tube			
* **Confirm tracheal placement:** aspirate EDD; monitor capnography number & waveform			
* Ventilate with 15 LO_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ *If breath sounds are present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe ☐ *If breath sounds only on right, withdraw ETT slightly and listen again ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion of blade ☐ *If ETT cannot be placed successfully; attempt rescue airway			
* Note ETT depth (diamond marking at teeth) (3 X ID of ETT)			
* Insert OPA; align ETT with side of mouth; secure with commercial tube holder; immobilize head			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* **Reassess**: Frequently monitor capnography, tube depth, VS, SpO_2, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change			
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth or soft tissues ☐ C-spine injury ☐ Undetected esophageal intubation ☐ Mainstem intubation (R) ☐ Hypoxia, dysrhythmia			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

NASAL INTUBATION

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult with altered mental status is breathing 4 times a minute. Prepare the equipment and intubate the patient using the nasotracheal technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
State indication for procedure: Spontaneously breathing pt who requires advanced airway where orotracheal intubation or use of a rescue airway is not possible			
***State 2 contraindications** to this intubation approach ☐ Apnea ☐ Midface and anterior basilar skull fx ☐ Deviated nasal septum or other nasal obstruction			
Prepare the patient ☐ Confirm need for intubation ☐ Consider possibility of c-spine injury – if yes, manually open airway with spine motion restriction; assess breathing			
Explain each step as it is performed even though pt appears unconscious			
Assess SpO_2 on RA as time & personnel permit; auscultate breath sounds for baseline			
Assess patient for difficult intubation; inspect nostrils with a penlight for nasal congestion/secretions, obvious obstruction			
Premedicate if applicable ☐ Benzocaine spray to posterior pharynx 1-2 sec spray, 30 sec apart X 2 (if + gag) ☐ Lidocaine 1.5 mg/kg IVP if head trauma or stroke			
* **Preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention			
Prepare equipment – Have everything ready before beginning procedure * Prepare suction equipment (Yankauer catheter); turn on to ✓ unit; suction prn			
☐ Choose correct size ETT (verbalize size of 5th finger). Select ETT with outside diameter just smaller than diameter of chosen nostril. ☐ Prepare ETT by curling around fingers into a circle (while in package) to increase curvature of ETT			
* Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
☐ NO stylet ☐ * EDD, capnography, tape, head blocks, stethoscope ☐ Lubricate ETT with water-soluble jelly as it is withdrawn from package (verbalize)			
Pass the tube Tilt up end of nose; *gently insert tube into largest unobstructed (right) nostril			
☐ Advance tube slowly but firmly into nasal passage along floor of nose with curvature of tube aimed down using slight rotation to aid passage into pharynx. ☐ If resistance encountered – STOP, withdraw slightly, aim toward floor of nasal passage, try again. Do not force tube. If resistance met again – withdraw tube; prep another ETT and try opposite nostril.			
Inspect mouth to see that ETT has passed through nasopharynx to the oropharynx			
* As tube is advanced, place hand near proximal opening to feel for exhaled air; observe for condensation in tube. Distal tip of ETT should be just over cords.			
* Ask conscious pt to take a deep breath. As patient inhales, apply gentle pressure over thyroid cartilage & advance tube through cords into trachea. (Verbalize that patient may cough as tube goes through cords)			
* **Confirm tracheal placement:** aspirate EDD; apply $EtCO_2$ detector/capnography			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Ventilate with 15 L O_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2			
☐ If breath sounds present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe. ☐ If breath sounds only on right, withdraw tube slightly and listen again. ☐ If NTT incorrectly placed: remove tube, ventilate 30 sec; repeat from insertion of tube			
* Note ETT depth (diamond marking at opening of nostril)			
* Secure with tape; immobilize head			
* **Reassess**: Frequently monitor SpO_2, capnography, tube depth, VS, & lung sounds to detect displacement, complications (esp. after pt movement), or condition change			
State at least 2 complications of this procedure ☐ Epistaxis ☐ Avulsion of an arytenoid cartilage ☐ Injury to nasal septum or turbinates ☐ Esophageal intubation ☐ Retropharyngeal laceration ☐ Sinus infections ☐ Vocal cord injury ☐ Intracranial placement if pt has a basilar skull fracture			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM/DN: 5/14

NWC EMSS Skill Performance Record

King LTSD Airway

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult is apneic and two attempts at intubation have been unsuccessful, contraindicated, or a less attractive choice. Prepare the equipment and provide an alternate airway using the King LTSD.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
State indications for extraglottic airway ☐ Need for an advanced airway where 2 attempts at ETI have been unsuccessful ☐ S&S of a difficult intubation make ETI less attractive ☐ Need for chest compressions makes alternate airway preferred over ETI			
*State 4 contraindications ☐ < 4 ft tall ☐ Intact gag reflex ☐ Aspiration risk ☐ Esophageal disease ☐ Caustic ingestion			
Prepare patient Explain each step as it is performed even though pt appears unconscious			
Preoxygenate with 95% FiO2 for 3 min w/ capnography sensor on BVM ☐ If pt spontaneously breathing, attempt preoxygenation w/ NRM ☐ If vent assist needed: Insert NPA/OPA and squeeze bag over 1 sec providing just enough air to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate at 10 breaths/min (1 every 6 sec) ☐ If Hx asthma/COPD: ventilate at 6-8 breaths/min			
Prepare equipment – Have everything ready before beginning procedure ☐ Prepare suction equipment (connect Yankauer); turn on to ✓ unit; suction prn			
TUBE: Choose correct size King LTS-D airway based on pt height ☐ 3 (yellow): 4-5 ft ☐ 4 (red): 5-6 ft ☐ 5 (purple): > 6 ft ☐ Test cuff (in pkg) by injecting 60 mL of air into cuffs (use syringe in kit) ☐ Remove all air from both cuffs prior to insertion ☐ Note cuff minimum & maximum inflation volumes (based on tube size) – look at numbers on side of tube ☐ Apply water-based lubricant to beveled distal tip and **posterior** surface of tube; avoid lubricant near anterior ventilatory openings.			
Confirming & securing equipment: EDD, capnography attached to BVM, tube holder, tape, head immobilizer, stethoscope (put around neck)			
Medications prn ☐ Head injury/↑ ICP: Lidocaine 1.5 mg/kg unless contraindicated ☐ Pain: Fentanyl – dose per SOP **DAI** ☐ Benzocaine per SOP ☐ If SBP ≥ 90 (MAP ≥ 65)**:** MIDAZOLAM 5 mg slow IVP/IN. ☐ If shock w/ hypotension, go to directly to etomidate 0.5 mg/kg (max 40 mg)			
INSERT the tube ☐ Hold King LT at connector with dominant hand ☐ *With non-dominant hand, hold mouth open and apply chin/tongue lift (hold "like a bass")			
For pt in spine motion restriction, assistant should prevent head movement by placing thumbs on maxilla & hands around head (in-line maneuver)			
*With the King LT **rotated laterally 45°-90°**so blue line is touching corner of mouth, introduce tip into mouth & advance behind base of tongue. If difficulty advancing tube: use gauze 4X4 to retract tongue. Never force tube into position.			
As tube tip passes behind tongue, **rotate tube to midline** (blue line faces chin).			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*Without excessive force, advance until clear tube is no longer visible outside of mouth & color adaptor is aligned with teeth/gums. Insertion depth is critical for a patent airway.			
Let go of tube. If "bounce back" occurs, tube is probably placed incorrectly into a pyriform fossa. Remove tube.			
☐ *__INFLATE__ cuffs with minimum inflation volume; do not overinflate (some research suggests that an overinflated cuff may put pressure on vascular structures in the neck) ☐ *Keep pressure on plunger until syringe removed from valve to assure full inflation ☐ Remove syringe from valve			
☐ Attach BVM with capnography sensor to KLTSD ☐ *Assistant places stethoscope over mid-axillary line. Listen for baseline sounds. ☐ *__AUSCULTATE__: While assistant is auscultating lungs; ☐ Gently squeeze BVM w/ 15 L O_2 at 10 BPM (__VENTILATE__); ☐ Simultaneously slowly __WITHDRAW__ KLTSD until breath sounds are heard and ventilation is easy/free flowing (lg tidal volume w/ minimal airway pressure)			
CONFIRM proper tube position (listed in order) ☐ Auscultation bilateral breath sounds over midaxillary lines & anterior chest ☐ Aspirate EDD (after cuff inflation, tube reposition, & lung auscultation) ☐ *$EtCO_2$ by capnography			
*If breath sound not heard, remove tube & ventilate with NPA/OPA & BVM			
*If air leak, add up to 20 mL of air to cuff to just seal volume. Avoid over inflating cuff.			
When good ventilations are established, note depth markings at proximal end of the airway aligned with the gums/upper teeth.			
SECURE KLTSD to patient (keeping tube midline in mouth) ☐ Use tape or commercial tube holder ☐ DO NOT cover proximal opening of gastric access lumen. ☐ Do NOT insert OPA (may put pressure on proximal cuff)			
*If gastric secretions or vomiting: size & insert 18 Fr Salem Sump NGT into gastric port and attach to suction			
REASSESS: Frequently to detect displacement and complications (esp .after pt. movement or pt. status/condition changes ☐ $EtCO_2$ ☐ SpO2 ☐ HR ☐ BP ☐ Lung sounds			
If protective reflexes return Remove in an area where suction equipment and the ability to rapidly intubate is present Deflate both cuffs completely prior to removal			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

Size	Patient height	Connector color	Inflation volume
3	4-5 feet	Yellow	45-60 mL
4	5-6 feet	Red	60-80 mL
5	Greater than 6 feet	Purple	70-90 mL

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NWC EMSS Skill Performance Record

SURGICAL CRICOTHYROTOMY

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult trauma patient has extensive facial injuries. Prepare the equipment and perform a surgical cricothyrotomy.

Performance standard	Perform w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
***Verbalize the indications for the procedure:** ☐ Cannot intubate ☐ Cannot insert a King airway ☐ Cannot ventilate w/ BVM			
* **Verbalize contraindications for procedure:** ☐ Children younger than 8; need OLMC order for ages 8-12 ☐ Pts with known bleeding disorders and/or anticoagulant therapy ☐ Laryngeal fx or trauma that causes distortion or obliteration of landmarks			
Prepare the patient Position supine with padding under shoulders to extend neck unless contraindicated			
Assess VS, ECG, SpO_2 as soon as time & personnel permit			
* Attempt to **preoxygenate** for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600mL) – avoid high pressure & gastric distention prior to performing procedure			
Prepare equipment – Have everything ready before beginning procedure ☐ #11 scalpel ☐ Chlorhexidine/IPA prep ☐ Forceps/spreader ☐ Stethoscope ☐ Tracheal hook (preferred) ☐ Sharp container ☐ Gauze pads 4X4 ☐ Full BSI ☐ NCN tube holder ☐ 10 mL syringe ☐ EDD ☐ Water-soluble lubricant ☐ Capnography ☐ BVM; oxygen source ☐ SpO_2 and ECG monitors ☐ Suction equipment; turn on to ✓ unit;			
* Choose correct size cuffed ETT (5.0 to 7.0) (one size smaller than OTI approach)			
*Check cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing			
Lubricate ETT with water-soluble jelly as it is withdrawn from package (verbalize)			
Perform the procedure * Palpate thyroid & cricoid cartilages anteriorly. Locate cricothyroid membrane.			
Prep skin with Chlorhexidine/IPA			
If right handed, position self on pt's right side. *While stabilizing trachea with non-dominant hand, make a 1" mid-line vertical incision through skin over membrane. Control bleeding with gauze pads. Suction site prn.			
* Remove scalpel; feel through incision with index finger; locate cricothyroid membrane			
* Make a horizontal incision through the membrane			
* Insert forceps or spreader next to scalpel blade. Withdraw scalpel and separate the cartilages. Place scalpel directly into a sharps container.			
☐ With forceps in place, insert 5th finger through incision ☐ Confirm tracheal penetration with finger; remove forceps ☐ Apply tracheal hook to anterior ring of cricoid cartilage			
* Insert ETT next to finger; advance toward chest until cuff is fully in trachea. Once catheter is advanced, remove tracheal hook.			
* **Confirm tracheal placement:** aspirate EDD; assess quantitative waveform capnography			

Performance standard	Perform w/o coaching	Performs w/ coaching	Needs additional practice
* Ventilate with 15 L O_2 at 8 to 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2.			
* If breath sounds present bilaterally, inflate cuff w/ up to 10 mL air & remove syringe * If breath sounds only on right, withdraw tube slightly and listen again. *** If ETT incorrectly placed: remove ETT, assess to determine error and take corrective action.** *****After 6 breaths, check $EtCO_2$ detector for color change (yellow/tan)			
* Secure ETT with commercial tube holder; immobilize head			
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change Monitor insertion site for complications			
Verbalize at least 2 early complications of the procedure: ☐ Prolonged execution ☐ Aspiration ☐ Hemorrhage ☐ False placement ☐ Sub-q emphysema ☐ Injury to neck structures ☐ Tube obstruction ☐ Asphyxia ☐ Dysrhythmias/arrest			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM/DN: 5/14

NWC EMSS Skill Performance Record

NEEDLE CRICOTHYROTOMY

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult has massive facial trauma. Prepare the equipment and perform a needle cricothyrotomy.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: Gloves, goggles, facemask			
Verbalize indications for the procedure: ☐ *Can't intubate ☐ Can't insert a King airway ☐ Can't ventilate w/ BVM			
* **List two disadvantages of the procedure** ☐ Does not allow for good elimination of CO_2 ☐ It is invasive ☐ Requires constant monitoring ☐ Does not protect airway ☐ Provides temporary relief (30-45 minutes) ☐ No suctioning of secretions			
Prepare the patient Position supine w/ padding under shoulders to extend neck unless contraindicated			
Assess VS, ECG, SpO_2 as soon as time & personnel permit			
* Attempt to preoxygenate for 3 min w/ 15 LO_2/BVM at 10-12 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec just to see chest rise (~400-600 mL) – avoid high pressure & gastric distention			
***Prepare equipment – Have everything ready before beginning procedure** ☐ 10 g needle ☐ 20 mL syringe ☐ Stethoscope ☐ 3 mL syringe barrel + 7.0 -7.5 ETT adaptor ☐ Peds BVM; O_2 source ☐ CHG/IPA skin prep ☐ Tape ☐ 4X4 ☐ Capnography; SpO_2, ECG monitors ☐ Suction ☐ Sharps container			
☐ Prepare equipment by inserting ETT adapter into barrel of 3 mL syringe (remove plunger) ☐ Remove hub from needle; attach 20 mL syringe to needle (acts like an EDD)			
Perform the procedure Palpate thyroid & cricoid cartilages; locate membrane; prep skin with CHG/IPA prep			
☐ Stabilize thyroid cartilage with nondominant hand ☐ * Insert needle through the membrane at a 90° angle until a "popping" sensation is felt			
* Aspirate syringe like an EDD to confirm tracheal placement			
* Angle needle tip downward (towards chest) and posteriorly at a 45° angle			
☐ Without removing needle, advance catheter over the needle to its hub (like starting an IV in the trachea; needle acts like a guidewire preventing catheter kinking) ☐ When catheter fully advanced, withdraw needle and place into a sharps container			
* Attach 3 mL syringe barrel to hub of catheter. Apply capnography sensor to ETT adapter. Ventilate 15 L O_2/peds BVM at 10/BPM. Allow 4 sec exhalation for each 1 sec inhalation.			
☐ Auscultate epigastrium, both midaxillary lines & anterior chest X 2 ☐ Assess quantitative waveform capnography ☐ If incorrectly placed: assess to determine error and take corrective action ☐ * If correctly placed, secure catheter in place using tape			
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, VS, & lung sounds enroute to detect displacement, complications or condition change; monitor insertion site for complications			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Evaluator

NWC EMSS Skill Performance Record

ADMINISTERING OXYGEN from a PORTABLE DELIVERY SYSTEM

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is hypoxic. You are asked to assemble the equipment and prepare an oxygen tank for use.
Equipment needed: Portable oxygen tank, pressure regulator, and wrench (if needed)

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
☐ Maintain oxygen tank stable away from heat ☐ *Place cylinder in an upright position if using a ball gauge			
Position self to face gauge when the regulator is attached			
Remove the protective cover from the cylinder valve			
Attach cylinder wrench to the valve			
* With spout pointing away from you, "crack" the tank by turning the wrench counterclockwise to open the valve slightly until the escape of O_2 is heard			
* When oxygen escape is heard, turn the wrench clockwise to rapidly shut off the O_2. This cleans valve of any debris.			
* Inspect regulator to assure that it is the right type and the washer is present and intact (intact gasket/any damage)			
* Apply pressure regulator to O_2 cylinder; secure tightly			
* Open valve on top of cylinder until the pressure gauge stops moving to check O_2 pressure in tank. Should be above 500 psi.			
* Open regulator valve to the desired flow rate in liters/minute			
* To D/C O_2: turn flow regulator until the flowmeter needle falls to zero			
Shut off main cylinder valve			
Bleed valves by opening the regulator valve and leaving it open until needle or ball indicator returns to zero flow			
Shut off the control valve			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

NASAL CANNULA

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in mild respiratory distress. You are asked to assemble the equipment and administer oxygen using a nasal cannula.

Equipment needed: Airway manikin; nasal cannula, portable oxygen tank; BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Verbalize two examples of patients who require a NC ☐ Nose breathing patient who needs minimum FiO_2 ☐ Mild ventilatory distress ☐ To provide extra O_2 during albuterol Rx by HHN			
* Apply BSI (gloves)			
*** Prepare equipment:** Open adult NC; unwind tubing to prevent kinks; connect to oxygen source.			
* Adjust oxygen flow rate to 4-6 L			
Prepare patient: ☐ Explain procedure to patient; instruct them to breathe through the nose ☐ Obtain SpO_2 on room air to confirm need for cannula vs. NRM			
Procedure: * Insert nasal prongs into patient's nostrils, oriented upward and posteriorly toward nasopharynx			
* Adjust catheter so each side loops over the ears comfortably. Slide plastic ring up under the chin to secure tubing.			
* Assess patient for discomfort and response to O_2 therapy			
Verbalize 1 precaution if cannula is used > 2 hours (drying of mucosa)			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

NON-REBREATHER MASK

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult with spontaneous ventilations is c/o dyspnea with a room air pulse ox reading of 90%. You are asked to assemble the equipment and administer oxygen via a non-rebreather mask.

Equipment needed: Airway manikin; adult & peds non-rebreather masks, portable oxygen tank; BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Determine the need for supplemental oxygen. Verbalize two examples of patients who require a NRM ☐ Spontaneously breathing pt. who is or may become hypoxic ☐ Prior to DAI			
***Prepare patient** ☐ Position patient for maximum ventilatory capacity ☐ Obtain room air SpO_2			
Assemble and prepare equipment * Apply BSI: gloves			
* Select proper size mask (Prepare adult size) and O_2 source Open mask and fully uncoil the bag and tubing.			
* Connect the female adaptor of the mask to the flow meter of the O_2 source			
* Open tank or turn on O_2 and set liter flow at 12 -15 L/min			
* Check that one-way exhaust valve is in place on at least one side of the mask and that they appear undamaged.			
* Fully inflate non-rebreather bag by pressing down on one-way inlet diaphragm inside of mask between mask and reservoir.			
Perform procedure * Apply mask apex over bridge of nose and base just below the lower lip to minimize air leaks.			
* Adjust elastic strap around head above ears.			
If metal strip across the mask nose, squeeze slightly to form the mask			
* Adjust O_2 so bag remains partially inflated during peak inspiration and completely refills prior to next inspiration (12-15 L/min).			
Verbalize steps if reservoir bag collapses on inhalation. (Increase L flow)			
Verbalize complication if O_2 source is removed (pt receives inadequate O_2)			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments:_____

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

BAG VALVE MASK

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult appears unconscious with inadequate ventilations. You are asked to assemble the equipment and assist ventilations with a bag-valve-mask.

Equipment needed: Airway manikin; adult & peds BVMs, OPA, NPA asst. sizes, portable O_2 tank; BSI

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Apply BSI (gloves/goggles)			
*Verbalize an indication for using a BVM ☐ Patient has inadequate ventilations/oxygenation			
Identify the correct size mask & bag to ventilate pt: adult, peds, neonate			
* Connect bag to oxygen source			
Fully extend O_2 reservoir tube per manufacturer's instructions			
* Set oxygen flow rate to 15 L			
* Open airway w/ appropriate manual maneuvers			
* Checks for gag reflex by performing glabellar tap or lash reflex ☐ No gag: Insert OPA ☐ Gag present: Insert NPA unless contraindicated			
* Apply apex of mask over patient's nose & base over mouth, w/ mask positioned in cleft of chin. Do not occlude nostrils. ☐ Place thumb over apex of mask ☐ Place index finger between the valve and lower mask cushion (forming a C with the thumb) ☐ Use 3rd, 4th, and 5th fingers to lift lower jaw between the chin and ear up into the mask ("E"). This may vary slightly based on the size of the rescuer's hands.			
* Maintain adequate mask seal and appropriate head position w/ hand			
If second person available: Have 1st rescuer hold mask on face with both hands. Have 2nd person compress bag & perform Sellick's maneuver to prevent gastric distention.			
☐ With other hand, squeeze bag w/ just enough volume to see chest rise (400-600 mL) ☐ Ventilate over 1 sec at 10-12 BPM (every 5-6 seconds) ☐ Asthma/COPD: ventilate at 6-8 BPM ☐ Verbalize that adequate breath sounds should be heard over all lung fields			
* Between breaths, release pressure on the bag; let patient passively exhale and the bag to refill from the O_2 source & reservoir			
Feel for lung compliance w/ each squeeze of the bag			
☐ **Can't ventilate:** Reposition head & jaw, suspect & treat F/B obstruction; consider other causes (tension pneumo) ☐ **Ventilates but no chest rise**: ✓ mask seal, open pneumo (?), ✓ airway misplacement (esophagus)			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM/DN: 5/14

NWC EMSS Skill Performance Record **C-PAP**				
Name:	1st attempt:	☐ Pass	☐ Repeat	
Date:	2nd attempt:	☐ Pass	☐ Repeat	

Instructions: An adult presents with severe dyspnea & ↑ work of breathing. Assess the patient for indication & contraindication criteria and apply C-PAP if indicated.

Equipment needed: Airway manikin or simulated patient; C-PAP mask, O_2 tank; BSI, drug bag

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Assess for indications: Must be alert w/ intact airway & ventilatory drive ☐ *Acute pulmonary edema ☐ Flail chest ☐ COPD/asthma w/ severe distress ☐ Near drowning			
Assess for contraindication criteria: (See full list on back) ☐ *AMS/aspiration risk; questionable ability to protect airway ☐ *Need for immediate airway control (intubation), ☐ *Ventilatory failure ☐ ***BP ≤ 90 & DBP < 60** ☐ Pneumothorax ☐ Facial anomalies ☐ Gastric distension ☐ Penetrating chest trauma			
Ask pt for subjective impression of dyspnea/work of breathing. Rate on a scale of 0-10.			
*Assess SpO_2 on room air if possible and capnography reading & waveform.			
If possible ACS: Obtain rapid 12L ECG with 1st set of VS			
Prepare C-PAP equipment *Connect O_2 tubing to O_2 source			
*Adjust mask settings to provide initial FiO_2 of 60% and PEEP of 5 cm H_2O			
Prepare intubation equipment			
Prepare patient *Position stretcher at 45° or higher unless contraindicated			
*Inform patient what you are doing and what it will feel like			
Mask application Integrate appropriate SOP & medications (unless contraindicated) while prepping mask ☐ *If HF: **ASA 324 mg** (4 chewable tabs 81 mg) PO and **NTG 0.4 mg SL** ☐ *If severe asthma: **Epi** (1:1000) 0.3 mg IM ☐ *If severe COPD: **Albuterol/ipratropium** per nebulizer connected in line to mask circuit			
*Hold mask firmly on patient's face with O_2 running			
*Stay in constant communication with pt; provide reassurance (*keep reassuring them!*) Attempt mask application for 10 min before conceding C-PAP failure Consider need for midazolam in **2 mg increments** every 30-60 sec **IVP** (0.2 mg/kg IN) **up to 10 mg IVP/IN/IM** if very anxious. May repeat to 20 mg if BP > 90. If pt needs frequent coaching, consider need for 3rd rescuer enroute.			
*Secure head straps to mask and gradually tighten			
*Reassess pt for their impression of comfort, dyspnea/WOB & BP q. 3-5 min after CPAP applied; reassess mental status			
*If HF: Give NTG every 3-5 min when pt is reassessed if SBP remains > 90			
*If SpO_2 remains < 92%: ↑ FiO_2 to 95% if mask is discretely adjustable If WOB remains labored & BP OK: adjust PEEP up to 10 cm in increments			
On-going care/monitoring			
*Reassess RR/depth & lung sounds, SpO_2 , capnography q. 3-5 min after C-PAP applied			
*Reassess VS q. 3-5 min – remove if SBP falls to < 90 mmHg			
*Continuously monitor patient for signs indicating need to D/C C-PAP &/or intubate. If DAI intubation needed, explain why and note time of intubation.			
Document: indications for CPAP, O_2 sat, capnography number & waveform, VS, lung sounds before & after CPAP; PEEP levels, FiO_2, pt response/adverse reactions, tolerance			

Contraindications

- ☐ **Altered mental status**; aspiration risk; inability to clear secretions; questionable ability to protect airway
- ☐ **Need for immediate airway control** (intubation), need for assist/control ventilation with BVM, facial burns. Intubation shall be considered if there is evidence of imminent cardiopulmonary arrest, decreased level of consciousness, severe hypotension, near-apnea, and/or copious frothy sputum.
- ☐ Unstable respiratory drive; **ventilatory failure**
- ☐ Severe hemodynamic or ECG instability (**BP ≤ 90** mmHg)
- ☐ Gastric distention; impaired swallowing, persistent vomiting, active upper GI bleeding; possible esophageal rupture
- ☐ Compromise of thoracic organs (penetrating chest trauma)
- ☐ Facial anomalies that would complicate C-PAP mask seal, epistaxis
- ☐ Uncooperative patient pr those unable to tolerate mask due to extreme anxiety, claustrophobia, or pain
- ☐ Pregnant
- ☐ Pneumothorax

Hazards/complications

- ☐ Requires patient cooperation to tolerate tight fitting mask
- ☐ *Pulmonary pressures that are too high can cause a decrease in blood volume through the lungs resulting in a decrease in cardiac output (↓**BP**).
- ☐ *High airway pressures can over distend alveoli resulting in barotraumas resulting in **pneumothorax**.
- ☐ Over distention of the lungs can reduce the ability of the lungs to move easily (decreases compliance)
- ☐ Positive pressure may increase secretions or dry upper airways
- ☐ Ventilation/perfusion mismatch
- ☐ Impedance of pulmonary blood flow, CO_2 retention and with an ↑ WOB
- ☐ Gastric distention (rare with C-PAP < 30 cm H_2O); use caution in aerophagia sensitive patients i.e., gastric bypass/stapling, upper GI surgery
- ☐ Aspiration with very high gas flow and gastric distention
- ☐ Facial skin necrosis at the site of mask contact if long-term use
- ☐ Increased ICP: if a possible cause of ↑ ICP is present; may need to be watched carefully

Criteria to discontinue C-PAP in the field

- ☐ Inability to tolerate the mask due to discomfort or pain
- ☐ *Need for tracheal intubation to manage secretions or protect the airway
- ☐ *Hemodynamic instability - hypotension
- ☐ ECG instability or clinically significant ventricular dysrhythmias

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

PULSE OXIMETRY

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult presents with shortness of breath. Prepare the equipment and apply a pulse oximeter monitor.

Equipment needed: ECG monitor or free standing SpO_2 monitor; peripheral and central sensors

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Verbalize indications for the procedure: *To non-invasively monitor O_2 saturation in pts who are at risk for hypoxemia			
Prepare the patient Explain procedure to patient and what it is meant to measure.			
Prepare equipment *Select appropriate sensor for pt size, age, & condition (peripheral vs. central)			
Perform procedure *Choose appropriate sensor site: clean, well perfused, comfortable, age-appropriate ☐ Newborn - right upper extremity (wrist or medial aspect of palm) ☐ Infants - toe or lateral aspect mid foot ☐ Pediatrics - toe or finger ☐ Adults - fingers, toes, ear lobes, or bridge of nose			
*Remove metallic/black nail polish. Clean site if contaminated w/ blood/dirt.			
*Apply sensor so optical components are aligned. Attach sensor cable to monitor.			
*Turn unit on			
*Observe for pulse bar to begin sensing and fluctuating up and down or waveform/ number to appear.			
*Correlate palpated to sensed pulse. HR on ECG monitor should correlate to HR on the oximeter & the palpable peripheral pulse. If there is a discrepancy or pulse deficit check the monitor and the patient.			
*Interpret reading in light of pt's age; complaint & PMH. State expected readings.			
If hypoxic: Apply appropriate O_2 delivery device and FiO_2			
*Trend pulse ox reading after oxygen delivery			
*Give one example when a pulse ox reading may be unreliable ☐ Cold/hypoperfused extremities ☐ Motion ☐ Edema ☐ Light ☐ Nail polish ☐ Venous pulsations ☐ Dyshemoglobins like CO, anemia ☐ ↓ BP			
Set/check the appropriate alarms			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

CAPNOGRAPHY

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* State uses for digital waveform capnography ☐ Confirm position of ETT ☐ Differentiate between asthma/COPD and heart failure ☐ Determine severity of asthma attack ☐ Recognition of respiratory depression / hypoventilation ☐ Recognition of hyperventilation; monitor hyperventilation for TBI pts ☐ Recognition of need for additional post-ETI sedation ☐ Predict chance for successful CPR resuscitation ☐ Recognition of ROSC ☐ Determine adequacy of perfusion			
Procedure for spontaneously breathing pt			
☐ Gather equipment ☐ Mainstream: capnography mask, sensor, and cable ☐ Micro/side-stream: Nasal cannula (available with or without oxygen delivery capability)			
*Attach capnography sensor/tubing to monitoring device (usually ECG monitor)			
*Place nasal cannula or capnography mask on patient			
Procedure for pt receiving assisted ventilation			
☐ Gather equipment ☐ Mainstream: capnography sensor, and cable ☐ Micro/side-stream sensor			
*Attach capnography sensor/tubing to monitoring device (usually ECG monitor)			
*Place adapter on face-mask, ETT, or King LT			
***Observe $EtCO_2$ value & waveform**			
*State normal reading: 35-45 mmHg, rectangular shape			
*Provide treatment based on history & capnography findings			
*Print copy of tracing & write patient's name on tracing			
*Document capnography value & waveform shape on PCR			
Attach capnography tracing to original copy of PCR (left at hospital)			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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Evaluator

DIANA-5/14

NWC EMSS Skill Performance Record

APPLICATION OF ECG ELECTRODES

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is complaining of chest pain. You are asked to assemble the equipment, apply electrodes to the patient's chest and monitor the ECG.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare patient Explain procedure to patient. Ask if they have any questions.			
Remove clothing from the patient's chest. Maintain pt. modesty whenever possible.			
*Prep skin where electrodes are to be placed, by wiping with an alcohol pad and rubbing briskly with a dry towel or gauze (to minimize artifact) * In men, may be necessary to shave chest hair for electrode placement. As an alternative can "part & spread" chest hair to allow for skin prep and electrode placement.			
Prepare equipment * Attach lead wires to the electrodes before applying them to the patient			
* Remove the protective liner on the electrodes slowly, exposing the adhesive outer circle and the gel core. Make sure gel is moist and in the middle of the electrode.			
Apply electrodes * Apply electrodes without gaps or wrinkles to appropriate locations for RA, LA, RL and LL. Avoid placing electrodes over sites in fatty areas or over major muscles, large breasts, or bony prominences.			
* Press each electrode to the patient's skin without gaps or folds for good contact. Apply pressure firmly but gently all around the adhesive rings.			
* Turn on the ECG monitor and assess quality of the tracing. Select appropriate monitoring lead and adjust gain if necessary.			
Can appropriately trouble shoot abnormalities in ECG signal ☐ Loose lead ☐ 60 cycle interference ☐ Patient movement ☐ Low amplitude tracing ☐ Artifact			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

12- LEAD ECG

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is complaining of chest pain. You are asked to assemble the equipment, apply electrodes to the patient and obtain a 12 L ECG.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* **Identify indications for 12-L ECG** ☐ Chest pain or discomfort nose to navel; front and back ☐ SOB (especially exertional dyspnea) ☐ Syncope or near syncope ☐ Palpitations ☐ Unexplained N / V ☐ Feeling of impending doom ☐ Diaphoresis unexplained by ambient temperature ☐ General weakness ☐ Suspected DKA ☐ Risk factors: MI/HF, age, cholesterol high, diabetes, HTN, smoking ☐ ECG rhythm: ectopy, identify pacer, QRS width determination (VT vs. SVT)			
***Timing of 12 L - Verbalize**: "Preferably, 12-L should be acquired where pt is found, with 1st set of VS & prior to NTG (NTG can change tracing and is contraindicated in pts w/ inferior/RVMI)"			
Explain procedure to pt			
To minimize artifact, electrodes for 12-L ECGs should be fresh and stored in airtight package to preserve moisture of electrode gel			
Prepare the patient/electrode placement			
☐ *Prep skin where electrodes are to be placed, by wiping with alcohol and rubbing briskly with a dry towel or gauze (to minimize artifact) ☐ *Place limb leads on limbs (white - RA, black - LA, green - RL, red - LL). For accurate 12-L interpretation, limb leads should be place on limbs (not torso).			
☐ Turn on ECG monitor and observe ECG rhythm ☐ * Rhythm should usually be determined from Lead II strip (not 12-L interpretation)			
* Position pt lying supine, w/ pillow under head for comfort * If pt unable to lie supine (e.g., acute dyspnea), document directly on 12-L tracing "pt sitting up" as position can affect interpretation			
* Preserve patient modesty as much as possible by removing unnecessary people from area and covering patient with towel/blanket.			
* Identify landmarks for chest leads & prep skin (as described above) * In men, may be necessary to shave chest hair for electrode placement; as an alternative can "part & spread" chest hair to allow for skin prep and electrode placement			
☐ Apply V1 in 4th ICS just to right of sternum ☐ Apply V2 in 4th ICS just to left of sternum			
* In women, ask pt to hold left breast up with left hand while applying chest electrodes. (Preserves pt modesty while allowing EMT/PM to use both hands to remove electrode backing and apply electrode. If pt unable to do this, use back of hand to lift breast tissue out of way.			
* Apply V4 electrode 5th ICS, midclavicular line (avoid common error of too low placement) In women, this electrode should be placed on chest wall, immediately under breast tissue			
* Apply V3 electrode half-way between V2 and V4 electrodes			
* Apply V5 electrode in 5th ICS, horizontal with V4 electrode, in anterior axillary line			
* Apply V6 electrode in 5th ICS, horizontal with V4 & V5 electrodes in mid-axillary line (avoid common error of too anterior placement of this electrode)			
* Attach 12-L cable to main electrode cable (attaching cable prior to this may cause device to beep signaling "leads off")			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Set age & gender of patient on 12-L device (age/gender will affect interpretation)			
* Make sure pt's arms and legs are fully supported & relaxed			
* Ask pt to hold still while device acquires ECG, takes ~10-15 sec (generally NOT recommended to instruct pt to hold breath as this often causes pt to take a deep breath tensing chest muscles causing artifact)			
* Push "acquire" button on device			
* Once device states "acquisition complete," "analyzing data" can instruct pt "OK to move"			
* After printing of 12-L, assure at least one clear, without artifact, P-QRS-T in each lead.			
* If artifact present, remove & discard affected electrode, re-prep skin, apply new electrode, and acquire new tracing			
* If 12-L interpretation states "Acute MI Suspected," notify hospital that you have a "*Cardiac Alert - STEMI patient*" ASAP (while on-scene, prior to transport) so preparation of cardiac cath lab can be made - prior to pt's arrival			
* Interpret 12-L by looking for: ST elevation with or without pathologic Q waves, left bundle branch block (LBBB), ST depression, hyperacute or inverted T waves.			
Identifies ECG criteria for diagnosis of STEMI (MILIS) – any of these in the presence of chest pain or anginal equivalent ☐ New of presumably new Q waves (at least 30 ms wide & 0.20 mV deep) in at least two leads from any of the following (a) leads II, III, aVF; (b) leads V1 through V6; or (c) leads I and aVL; ☐ New or presumably new ST-T segment elevation or depression (~0.10 mV MEASURED 0.02 s after the J point in two contiguous leads of the previously mentioned lead combination); or ☐ A complete left bundle branch block in the appropriate clinical setting (Hurst's, The Heart 11th Ed, p. 1283)			
* Verbalize: "*12-L ECG can NOT be used to rule-out MI, as ⅓ of pts with acute MI will have "normal ECG" initially as it takes time for changes to occur and not all heart locations are seen on 12-L ECG*"			
* Verbalize: "*Age-undetermined infarction generally means an old, not acute, MI*."			
*When contacting hospital, read 12-L interpretative statement verbatim; do not summarize.			
* Write name of patient on 12-L tracing			
* Upon arrival at hospital, especially if abnormal 12-L - hand tracing directly to MD (preferably), or RN while giving report; do not leave 12-L lying on a counter			
* Document 12-L interpretative statement in comments section of PCR; this can be facilitated by either printing 2 copies of the 12-L or making a photocopy immediately upon arrival in ED. Do not keep sole copy of prehospital 12-L with you while completing PCR.			
* Document time 12-L acquired in section of PCR where ECG rhythm (e.g., NSR) is documented. Chose most applicable of 3 categories: "Normal ECG," "Abnormal ECG," or "Acute MI suspected"			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

DIANA-5/14

NWC EMSS Skill Performance Record

TRANSCUTANEOUS PACING

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

An adult presents with chest pain following a syncopal episode. The patient weak and is c/o lightheadedness and feels like they may faint again.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient * Confirm the need for pacing: bradycardia with hypoperfusion unresponsive to atropine and dopamine per SOP			
Initiate Initial Medical Care			
* Explain procedure to patient if conscious and oriented. Warn that procedure may be uncomfortable, muscles will twitch, and medication is available.			
* Remove all clothing from patient's chest; preserve modesty whenever possible			
* Skin prep: Remove all nitro patches, briskly wipe skin with a dry towel or gauze			
Prepare equipment ☐ Do NOT use electrodes if they have been removed from the foil package for more than 24 hours. ✓ electrodes for expiration date. ☐ Connect pace/defib cable to pace/defib electrodes by aligning arrows on connectors and pressing firmly. ☐ Slowly peel back protective liner on electrodes beginning with cable connection end. ☐ Inspect electrodes to make sure gel is moist, undamaged, and in the middle of the electrode. Do not use pads that are dried out or damaged as this may cause electrical arcing and patient skin burns. ☐ Avoid spilling any fluids on the adapters, cables, connectors, or electrodes. ☐ Do not clean the electrodes or their permanently attached electrode cable with alcohol Note: One electrode set can be used for up to 50 shocks at any energy setting. They can withstand a continuous pacing current for 12 hrs and can remain on pt for 24 hours.			
* **Apply pads** either anterior-posterior (preferred) or anterior-lateral ☐ **Anterior-posterior**: Place negative electrode on left anterior chest halfway between xiphoid process and left nipple line (See drawing next page). ☐ Place positive electrode on left posterior chest below scapula, lateral to spine. ☐ **Anterior-lateral**: Place the anterior electrode (black electrode) without wrinkles or gaps on the patient's right upper torso, lateral to the sternum and below the clavicle. ☐ Place the lateral (♥) red electrode without wrinkles or gaps under and lateral to the patient's left nipple in the midaxillary line, with the center of the electrode in the midaxillary line. ☐ Avoid placing pads over bony prominences (sternum/scapula) or breasts. ☐ Smooth electrode center and edges onto patient's chest to eliminate air pockets between gel surface and skin. Firmly press all adhesive edges to skin.			
* Select leads I, II, or III. Cannot pace if lead select switch is on paddles.			
* Connect limb lead ECG electrodes to the patient cable and apply to patient. Allow at least 2-3 cm between monitoring and pacing electrodes to prevent current arcing.			
Prepare atropine, fentanyl, and midazolam for use if needed			
Perform procedure * Turn the monitor on			
* Confirm the native rhythm; adjust gain so R waves can be sensed. Should see a "•" on each R wave. If no dot markers appear, adjust ECG size or select another lead.			
* Turn pacing button on. Set rate at 60 BPM. May adjust rate to 70 BPM based on clinical response.			
* Confirm presence of pacing spikes at set rate.			
* Push start/stop button			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
☐ Device turns on at 0 mA. * If pt is awake w/ pulse: Slowly increase in 5 mA increments until evidence of **electrical capture** (pacer spike followed by a wide QRS). Can troubleshoot failure to capture. ☐ Assess femoral pulse for **mechanical capture**. Halt at lowest mA at which 1:1 mechanical capture takes place. ☐ If pt unconscious: Rapidly turn up in 20 mA increments until evidence of mechanical capture is present.			
* Continue upward adjustment of mA until mechanical capture or 200 mA			
* Assess for response to the procedure (VS in right arm, mental status, SpO_2, pain).			
If no mechanical capture at 200 mA, push stop button and reposition electrodes, check for good skin contact. Push start and slowly increases mA again.			
Evaluate patient - If successful: Assess need for sedation & pain mgt: If SBP ≥ 90 (MAP≥ 65): ☐ **Sedation: MIDAZOLAM 2 mg** increments slow IVP q. **2 min** (0.2 mg/kg IN*)* **up to 10 mg IVP/IN** titrated to pt response. If IV unable and IN contraindicated: IM dose 5-10 mg (0.1-0.2 mg/kg) max 10 mg single dose. All routes: may repeat to total of 20 mg prn if SBP ≥ 90 (MAP ≥ 65) unless contraindicated. ↓ **total dose to 0.1 mg/kg** if elderly, debilitated, chronic diseases (HF/COPD); and/or on opiates or CNS depressants. ☐ **If pain**: **FENTANYL 1 mcg/kg** (max single dose 100 mcg) IVP/IN/IM/IO. May repeat once in 5 min: 0.5 mcg/kg (max dose 50 mcg). Max dose per SOP: 150 mcg (1.5 mcg/kg). **Elderly** (>65) or **debilitated**: **0.5 mcg/kg** (**max single dose 50 mcg)** IVP/IN/IM/IO. **Additional doses require OLMC:** 0.5 mcg/kg q. 5 min up to a total of 3 mcg/kg (300 mcg) if indicated & available.fentanyl 1 mcg/kg per SOP ☐ If considerable muscle twitching: readjust lateral pad away from pectoral muscle ☐ Complete IMC and prepare for transport.			
If unsuccessful and pulse present: *Continue dopamine per SOP			
Continue to reassess patient for pulses & hemodynamic response			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments: _____

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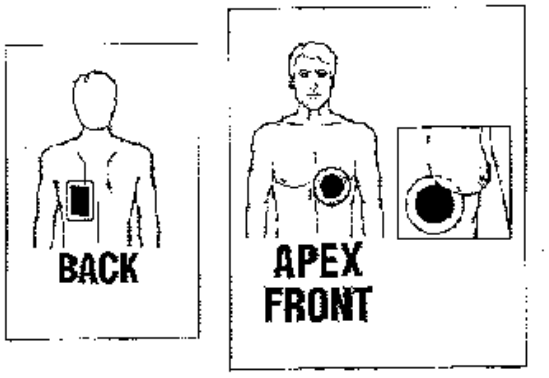
Evaluator

Notes:

Muscle twitching does not mean that the pacemaker is producing good cardiac output.
Effective capture should improve hemodynamic status.
Troubleshooting failure to capture: ✓ pads for good skin contact; correct placement; correct lead selection; snug wire connections

CJM: 5/14



NWC EMSS Skill Performance Record

SYNCHRONIZED CARDIOVERSION

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient * Confirm the need for cardioversion, i.e., unstable SVT or unstable VT with pulse			
Initiate Initial Medical Care; apply SpO_2 monitor			
Explain procedure to pt if conscious. Warn that procedure may be uncomfortable and medication is available.			
* Remove all clothing and NTG patches from chest; briskly wipe skin w/ dry towel or gauze			
Prepare equipment ✓ electrodes for expiration date; connect pace/defib cable to pace/defib electrodes			
* Peel back the protective liner on the electrodes slowly, beginning with the cable connection end. Make sure gel is moist and in the middle of the electrode.			
* Place the anterior electrode (black electrode) without gaps or wrinkles on the patient's right upper torso, lateral to the sternum and below the clavicle			
* Place the lateral (♥) red electrode under and lateral to the patient's left nipple in the midaxillary line, with the center of the electrode in the midaxillary line if possible			
* Smooth electrode center and edges onto the patient's chest to eliminate air pockets between the gel surface and the skin. Firmly press all adhesive edges to the skin			
* Select paddles mode			
* If responsive & SBP ≥ 90 (MAP≥ 65): **MIDAZOLAM 5 mg IVP/**IN. May repeat X 1 up to **10 mg** if needed **and** SBP ≥ 90 (MAP≥ 65). If condition deteriorating, omit sedation.			
Perform procedure * Confirm rhythm. Turn synchronizer on & adjust gain so R waves are sensed. Note marker on R wave.			
* Charge to monitor-specific joules - (SVT, A-flutter 50 J)			
* Clear patient: Look around 360°; assure no contact with pt and announce all clear			
* Depress discharge button and keep depressed until the discharge occurs			
* Assess patient for response to the procedure (ECG, pulse, mental status, pain)			
If successful: If pt in pain: fentanyl prn; complete IMC; treat post-cardioversion rhythm per SOP; transport			
If unsuccessful and pulse present: * Attempt again at monitor-specific joules - see below. Attempt appropriate drug therapy; transport.			
If unsuccessful and pulse absent: CPR - treat per VF SOP			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Evaluator

Defibrillator energy recommendations for VT			
Manufacturer	Waveform	Adult Synch J	Adult Defib J
LifePak 12 & 15	NA	100-150-200-300-360	200-300-360
MRL		100-150-200-300-360	200-300-360
Philips SMART™	BTE	100-150-200	150
Welch-Allyn	BTE	100-150-200-300-360	200-300-360
Zoll all series	RB	70 or 75-120-150-200	120-150-200
BTE = Biphasic Truncated Exponential, RB = Rectilinear Biphasic			
Monophasic		100-200-300-360	200-300-360 J

NWC EMSS Skill Performance Record

DEFIBRILLATION

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient * Confirm apnea and pulselessness or unstable TdP			
* Initiate CPR for 2 min if pulseless arrest unwitnessed by EMS; shock ASAP if witnessed			
Remove all clothing from the patient's chest Disconnect Lifevest batteries; remove vest if present; DO NOT disconnect VAD batteries			
If pulseless pt has an LVAD; ✓ SpO_2 . If perfusing: NO CPR and DO NOT DEFIBRILLATE (even if VF). If questionable: Call VAD Center to consult			
Remove all nitro patches, briskly wipe skin with a dry towel or gauze			
Prepare equipment ☐ ✓ electrodes for expiration date ☐ Connect defib cable to pace/defib electrodes.			
* Peel back the protective liner on the electrodes slowly, beginning with the cable connection end. Make sure gel is moist and in the middle of the electrode.			
* Place the anterior electrode (black electrode) without gaps or wrinkles on the patient's right upper torso, lateral to the sternum and below the clavicle.			
* Place the lateral (♥) red electrode under and lateral to the patient's left nipple in the midaxillary line, with the center of the electrode in the midaxillary line if possible.			
* Smooth electrode center and edges onto the patient's chest to eliminate air pockets between the gel surface and the skin. Firmly press all adhesive edges to the skin.			
* Select paddles mode			
*** After 2 minutes of CPR, ✓ rhythm (PVT/VF) & change compressors**			
Perform procedure * While continuing chest compressions, adjust J setting to device-specific joule setting			
* Charge the defibrillator and listen to ramping tone			
* Stop CPR; Look around 360°; Clear patient; announce all clear.			
* Depress current discharge button. Without checking ECG or pulse, resume chest compressions for 2 mins. Limit time from last compression to shock delivery & resumption of compressions to ≤10 sec.			
***After 2 minutes of CPR, ✓ rhythm (PVT/VF) & change compressors** Defib again at monitor-specific J & immediately resume chest compressions as above.			
***After 2 minutes of CPR, ✓ rhythm (PVT/VF) & change compressors** Defib again at monitor-specific J & immediately resume chest compressions as above.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Defibrillator energy recommendations		
Manufacturer	Waveform	Adult Defib J
LifePak 12 & 15	NA	200-300-360
MRL		200-300-360
Philips SMART™	BTE	150
Welch-Allyn	BTE	200-300-360
Zoll all series	RB	120-150-200
Monophasic		200-300-360

Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

CARDIAC ARREST MANAGEMENT - VF

Name #1 (leader):	Date:
Name #2:	1st attempt: ☐ Pass ☐ Team repeat
Name #3:	2nd attempt: #1: ☐ Pass ☐ Repeat
Name #4:	#2: ☐ Pass ☐ Repeat
Name #5	#3: ☐ Pass ☐ Repeat
Name #6	#4: ☐ Pass ☐ Repeat
	#5: ☐ Pass ☐ Repeat
	#6: ☐ Pass ☐ Repeat

Instructions to the students: This patient was found on the floor by a family member who called 911. Assess the patient and provide care per SOPs.

Performance standard	Performs w/o coaching	Needs additional practice
BLS IMC – All care is organized around 2 minute cycles of CPR in C-A-B priority unless arrest is caused by hypoxic event – multiple BLS steps may be done simultaneously if personnel resources allow ☐ * Assess responsiveness (unresponsive)		
☐ *Open airway using manual maneuvers; assess for breathing/gasping ; suction prn		
☐ Palpate carotid pulse: if not definitely felt in <10 sec begin CPR with quality chest compressions (see notes) at least 100/min. in cycles of 30:2 for 2 min. ☐ Attach impedance threshold device to bag-mask ☐ Give 1 breath every 5 to 6 sec (10-12 breaths/min) ☐ Give O_2 when available		
☐ *Attach and use AED or cardiac monitor as soon as available; apply pads with chest compressions in progress ☐ Disconnect Lifevest batteries; remove vest if present; DO NOT disconnect VAD batteries ☐ Pause compressions < 10 sec; check rhythm (VF); change compressor ☐ *Shockable? Defibrillate at monitor-specific J setting (charge defibrillator w/ chest compressions in progress; shock after compression – not ventilation; minimize interruptions in chest compression before & after shock ☐ Immediately resume CPR starting w/ chest compressions after each shock. (2 min; 5 cycles of 30:2) ☐ NO rhythm check until after 2 min of CPR unless pt wakes or begins to move extremities		

	Rating		Rating
* After 2 min of CPR; pause compressions (<10 sec) ☐ *✓ rhythm (VF); change compressor ☐ *Resume compressions while defibrillator is charging as above. ☐ * If VF/PVT: Defibrillate at monitor-specific J		☐ Advanced airway ☐ Avoid hyperventilation: 15 L O_2/ BVM 1 breath every 6-8 sec (8-10/min) unless asthmatic (6-8 BPM); just enough volume for visible chest rise; asynchronous with chest compressions; do not pause compressions to ventilate.	
* Without checking ECG or pulse, immediately resume chest compressions for 2 min.		* Vascular access (IV/IO), NS TKO	
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while defibrillator is charging.		*Prepare vasopressin, epi, amiodarone	
☐ If VF/PVT: Defibrillate at monitor-specific J setting ☐ * Immediately resume chest compressions for 2 min.		Vasopressor q. 3-5 min during CPR - order of use optional ☐ Vasopressin 40 U IVP/IO (1 time only- may replace 1st or 2nd dose of epi) ☐ Epinephrine (1:10,000) 1 mg IVP/IO	
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while defibrillator is charging.		☐ Amiodarone 300 mg IVP/IO ☐ IF VP persists: May repeat Amiodarone 150 mg IV/IO 5 min after 1st dose	
☐ If VF/PVT: Defibrillate at monitor-specific J setting ☐ * Immediately resume chest compressions for 2 min.		Consider $NaHCO_3$ 1 mEq/kg IV/IO if arrest caused by bicarb-responsive acidosis (DKA/TCA or ASA OD, cocaine or diphenhydramine) or known hyperkalemia.	

☐ ***2 minutes after last defib; check rhythm:*** **(show strip of SR)**

**Identify the rhythm:*

☐ *✓pulse (present); BP; capnography for abrupt rise; SpO_2, repeat 12L, and baseline temp

VS: BP: 86/60; P 80; R: 18 and spontaneous; T 98.6 F. The pt remains unconscious. What is indicated now?

☐ *Remove ResQPod

☐ Titrate O_2 to minimum needed to achieve SpO_2 94% (avoid hyperventilation and hyperoxia) f

☐ If SBP < 90 (MAP < 65): Run IV line wide open while prepping **DOPAMINE** 5 mcg/kg/min IVP - Goal MAP 90-100

☐ Obtain12 L ECG ASAP after ROSC

☐ Assess glucose level

<u>If patient remains unresponsive w/ no contraindications: Initiate induced hypothermia</u>

☐ Record baseline temp (repeat at ED arrival using same device/method)

☐ Place cold packs on neck, axillae, palms of hands (6 cold packs)

☐ Start 2nd IV line: Infuse cold NS at 30 mL/kg (max 2 L) as rapidly as possible (< 30 min),
> 50 kg (110 lbs) = 2,000 mL; 35 - 50 kg = 1,500 mL; < 35 kg: calculate based on 30 mL/kg

☐ Use pressure infuser maintained at 300 mm Hg while enroute

☐ Transport only to hospitals with active cooling protocols. Target temp: 34°C (93.2° F).

☐ **If shivering** & SBP ≥ 90 (MAP ≥ 65): **MIDAZOLAM 2 mg** slow IVP/IO every 5 minutes prn to max 20 mg.

☐ Avoid hyperthermia & hyperglycemia

Defibrillator energy recommendations		
Manufacturer	Waveform	Adult Defib J
LifePak 12 & 15	NA	200-300-360
MRL		200-300-360
Philips SMART™	BTE	150
Welch-Allyn	BTE	200-300-360
Zoll all series	RB	120-150-200
Monophasic		200-300-360

Notes on good CPR:

☐ Push hard (at least 2") and fast (at least 100 w/ ResQPod); ensure full chest recoil; minimize interruptions in chest compressions (≤ 10 sec); hand location center of chest (lower ½ of sternum)

☐ Use continuous quantitative waveform capnography monitoring during CPR to guide therapy, especially effectiveness of chest compressions (Class IIa); if $pEtCO_2$ <10 mmHg, attempt to improve CPR quality; if pEtCO2 < 10 for 20 min, resuscitation is unlikely; abrupt & sustained rise seen just before clinical S&S of ROSC. pEtCO2 levels my decrease 1-2 min after epinephrine due to ↓ pulmonary blood flow.

☐ Continue CPR while defibrillator is charging and drugs are prepared & given.

☐ Interrupt chest compressions only for ventilations (until advanced airway placed), rhythm check & shock delivery. Attempt to limit to < 10 seconds

☐ Rotate person providing compressions every 2 minutes during ECG rhythm checks (should take < 5 sec)

☐ Pts should not be moved while CPR is progress unless in a dangerous environment or pt is in need of intervention not immediately available. CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found.

☐ Continue resuscitation efforts for 20 minutes before moving or seeking order to cease resuscitation.

Scoring: All starred (*) items must be answered/performed correctly in sequence and timing without critical error in order for the **TEAM of students** to pass this station. Any errors or omissions of these critical points will require a retest if the first attempt and failure of the station if the second attempt. Discuss with them where they need to improve and send to Chris Dunn.

Recommendation:

☐ Proficient: Efficient and accurate performance; no critical errors; no coaching needed

☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed

☐ Unsatisfactory: Did not perform in correct sequence, timing, and/or without critical error; recommend retest or failure (if second attempt) regardless of score

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

CARDIAC ARREST MANAGEMENT – Asystole/PEA

Name #1 (leader):	Date:
Name #2:	1st attempt: ☐ Pass ☐ Team repeat
Name #3:	2nd attempt: #1: ☐ Pass ☐ Repeat #2: ☐ Pass ☐ Repeat #3: ☐ Pass ☐ Repeat #4: ☐ Pass ☐ Repeat #5: ☐ Pass ☐ Repeat #6: ☐ Pass ☐ Repeat
Name #4:	
Name #5	
Name #6	

Instructions to the students: This patient appears to be about 70 years old and was found in bed by a family member who called 911. There are no long-term indications of death. Assess the patient and provide care per SOPs.

Instructions to the students: This patient appears to be about 70 years old and was found in bed by a family member who called 911. There are no long-term indications of death. Assess the patient and provide care per SOPs.

Performance standard	Performs w coaching	Needs practice
One team member seeks information about possible contributing factors: ☐ Hypovolemia ☐ Hypoxia ☐ Hypothermia ☐ Hypoglycemia ☐ Hyper/hypokalemia ☐ Hydrogen ion (acidosis) ☐ Thrombosis (coronary or pulmonary) ☐ Toxins ☐ Tension pneumo ☐ Tamponade cardiac ☐ Trauma		
BLS IMC – All care is organized around 2 minute cycles of CPR in C-A-B priority unless arrest is caused by hypoxic event – multiple BLS steps may be done simultaneously if personnel resources allow * Assess responsiveness (unresponsive)		
☐ *Open airway using manual maneuvers; assess for breathing/gasping ; suction prn ☐ Assess for ventilations up to 10 sec: If no breathing, not breathing normally (only gasping)		
☐ Palpate carotid pulse: if not definitely felt in <10 sec begin CPR with quality chest compressions (see notes) at least 100/min. in cycles of 30:2 for 2 min. ☐ Attach impedance threshold device to bag-mask ☐ Give 1 breath every 5 to 6 sec (10-12 breaths/min) ☐ Give O_2 when available		
☐ *Attach cardiac monitor as soon as available; apply pads with chest compressions in progress ☐ Disconnect Lifevest batteries; remove vest if present; DO NOT disconnect VAD batteries ☐ Pause compressions < 10 sec; check rhythm (IVR); change compressor ☐ Immediately resume CPR starting w/ chest compressions (2 min; 5 cycles of 30:2) ☐ NO rhythm check until after 2 min of CPR unless pt wakes or begins to move extremities		

* After 2 min of CPR; pause compressions (<10 sec) ☐ *✓ rhythm (IVR); change compressor ☐ Immediately resume CPR starting w/ chest compressions (2 min; 5 cycles of 30:2) NO rhythm check until after 2 min of CPR unless pt wakes or begins to move extremities	**Rating**	☐ Advanced airway ☐ Avoid hyperventilation: 15 L O_2/ BVM 1 breath every 6-8 sec (8-10/min) unless asthmatic (6-8 BPM); just enough volume for visible chest rise; asynchronous with chest compressions; do not pause compressions to ventilate.	**Rating**
* After 2 min of CPR; pause compressions for≤ 10 sec; check rhythm (IVR); change compressor.		* Secure vascular access (IV/IO), run NS TKO	**Rating**
*Immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		*Prepare vasopressin & epinephrine	
* After 2 min of CPR; pause compressions for≤ 10 sec; check rhythm (IVR) change compressor.		Order of use optional * Vasopressin 40 units IVP/IO (1 time only) or * Epinephrine 1:10,000 1 mg IVP/IO	
* If electrical activity: Check pulse (no pulse)		* Vasopressor q. 3-5 min during CPR	
*Immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		May consider $NaHCO_3$ 1 mEq/kg IV/IO if arrest caused by bicarb-responsive acidosis or known hyperkalemia	
☐ ***2 minutes after last rhythm check; assess rhythm:*** **(show strip of SR)**			

Performance standard	Performs w coaching	Needs practice
**Identify the rhythm:*		
☐ *✓pulse (present); BP; capnography for abrupt rise; SpO_2, repeat 12L, and baseline temp ***VS: BP: 86/60; P 80; R: 18 and spontaneous; T 98.6 F. The pt remains unconscious. What is indicated now?***		
☐ *Remove ResQPod		
☐ Titrate O_2 to minimum needed to achieve SpO_2 94% (avoid hyperventilation and hyperoxia) f		
☐ If SBP < 90 (MAP < 65): Run IV line wide open while prepping **DOPAMINE** 5 mcg/kg/min IVP - Goal MAP 90-100		
☐ Obtain12 L ECG ASAP after ROSC.		
☐ Assess glucose level.		
<u>If patient remains unresponsive w/ no contraindications: Initiate induced hypothermia</u>		
☐ Record baseline temp (repeat at ED arrival using same device/method)		
☐ Place cold packs on neck, axillae, palms of hands (6 cold packs)		
☐ Start 2nd IV line: Infuse cold NS at 30 mL/kg (max 2 L) as rapidly as possible (< 30 min), > 50 kg (110 lbs) = 2,000 mL; 35 - 50 kg = 1,500 mL; < 35 kg: calculate based on 30 mL/kg		
☐ Use pressure infuser maintained at 300 mm Hg while enroute		
☐ Transport only to hospitals with active cooling protocols. Target temp: 34°C (93.2° F).		
☐ **If shivering** & SBP ≥ 90 (MAP ≥ 65): **MIDAZOLAM 2 mg** slow IVP/IO every 5 minutes prn to max 20 mg.		
☐ Avoid hyperthermia & hyperglycemia		
TERMINATION OF RESUSCITATION If normothermic, intubated patient remains in persistent monitored asystole 20 minutes or longer despite the steps above, and no reversible causes are identified seek OLMC physician's approval to terminate resuscitation.		

Notes on good CPR:

- ☐ Push hard (at least 2") and fast (at least 100 w/ ResQPod); ensure full chest recoil; minimize interruptions in chest compressions (≤ 10 sec); hand location center of chest (lower ½ of sternum)
- ☐ Use continuous quantitative waveform capnography monitoring during CPR to guide therapy, especially effectiveness of chest compressions (Class IIa); if $pEtCO_2$ <10 mmHg, attempt to improve CPR quality; if pEtCO2 < 10 for 20 min, resuscitation is unlikely; abrupt & sustained rise seen just before clinical S&S of ROSC. pEtCO2 levels my decrease 1-2 min after epinephrine due to ↓ pulmonary blood flow.
- ☐ Continue CPR while defibrillator is charging and drugs are prepared & given.
- ☐ Interrupt chest compressions only for ventilations (until advanced airway placed), rhythm check & shock delivery. Attempt to limit to < 10 seconds
- ☐ Rotate person providing compressions every 2 minutes during ECG rhythm checks (should take < 5 sec)
- ☐ Pts should not be moved while CPR is progress unless in a dangerous environment or pt is in need of intervention not immediately available. CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found.
- ☐ Continue resuscitation efforts for 20 minutes before moving or seeking order to cease resuscitation.

Scoring: All starred (*) items must be answered/performed correctly in sequence and timing without critical error in order for the **TEAM of students** to pass this station. Any errors or omissions of these critical points will require a retest if the first attempt and failure of the station if the second attempt. Discuss with them where they need to improve and send to Chris Dunn.

Recommendation:

- ☐ Proficient: Efficient and accurate performance; no critical errors; no coaching needed
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Unsatisfactory: Did not perform in correct sequence, timing, and/or without critical error; recommend retest or failure (if second attempt) regardless of score

Comments:

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

ResQPOD® Impedance Threshold Device (ITD)

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* State purpose of ResQPOD® Impedance Threshold Device (ITD): Augment negative intrathoracic pressure (vacuum) between chest compressions causing ↑ preload, resulting in improved blood flow (BP) to heart & brain with CPR			
* Verify indication for ITD: Cardiac arrest w/ CPR			
*Confirm absence of contraindications ☐ Flail chest ☐ Pulse present			
Verbalize: Must be used with quality CPR (good compression rate & depth, release completely, minimize interruptions, no hyperventilation) for improved pt outcomes			
Prepare equipment			
Remove ITD from sealed package (single-use device)			
Remove adhesive tab from timing light switch (tab prevents inadvertent activation)			
Slide timing light switch slightly counterclockwise, to activate ventilation timing lights			
Put adhesive tab on other side of switch, to prevent accidentally turning switch off			
Procedure prior to placement of advanced airway			
Place ITD between bag-valve device & face mask			
Assure continuous tight face-mask seal using 2-person BVM technique during chest compressions for device to be effective (chest compressor squeezes BVM)			
Procedure after placement of advanced airway (ETT or King LT)			
Place ITD directly on ETT or King LT			
Place colormetric $EtCO_2$ detector between ITD and bag-valve device			
If using digital/waveform capnography: place sensor between ITD & bag-valve device			
Timing lights flash 10 times per minute, for 1 second, indicating desired rate & duration of ventilations with advanced airway			
When using microstream capnography: use either a colormetric $EtCO_2$ or adapter (_____) between BVM device and capnography sensor. Note: microstream capnography sensor will not fit into ITD without use of an adapter [or colormetric $EtCO_2$ detector].			
* When return of spontaneous circulation (ROSC) occurs, remove ITD			
Retain device as timing device for ventilations, or for use if cardiac arrest recurs			
If device fills with secretions, shake and ventilate secretions out of device			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

Mechanical Circulatory Support (MCS) using a Ventricular Assist Device

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Notes: Unit runs on electricity provided by a Power Base Unit (PBU) during stationary use or by rechargeable batteries worn during mobile use.
Because blood bypasses aortic valve, there is usually no pulse, especially with continuous flow pumps.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* **State purpose of MCS**: Assist a failing heart by taking blood out of LV, through the pump, & back into ascending aorta – reduces need for native heart to pump blood through aortic valve, reducing cardiac workload & O_2 demand.			
Response to a pt with a VAD ☐ **Call VAD Coordinator immediately** if known – phone number from pt or caregiver or one of the listed centers below if specific Coordinator unknown ☐ Get history/instructions, VAD parameters from family/caregiver ☐ Ask if pt is looking, feeling, or acting differently than their baseline			
Decision tree responsive patient ☐ Assess ABCs: If breathing is labored; O2 per SOP ☐ Assess circulation: May NOT have a pulse (NORMAL); check cap refill, color, temp, mental status ☐ Listen for VAD sounds LUQ (when working device makes a quiet whiling sound) ☐ Look and listen for alarms; pt & caregivers can help troubleshoot alarms			
Decision tree unresponsive patients ☐ Airway, breathing assessment/Rx per SOP ☐ Quick check for driveline or wire existing abdomen, batteries, cable, system controller ☐ Caution removing clothes, especially using trauma scissors – DON"T CUT CABLES OR WIRES ☐ Assess circulation: May NOT have a pulse (NORMAL); check cap refill, color, temp, mental status ☐ Listen for VAD sounds LUQ (when working device makes a quiet whiling sound) ☐ Look and listen for alarms; pt & caregivers can help troubleshoot alarms – see below ☐ Consider other causes of AMS: stroke, cardiogenic shock, respiratory arrest, hyper or hypoglycemia – Rx per SOP			
State common causes of VAD alarms **Pt not connected to power properly** ☐ Check all connections; fix loose connections ☐ ✓Driveline connection to System Controller ☐ ✓System Controller to battery clip ☐ ✓Batteries "engaged" in battery clips – NEVER DISCONNECT BOTH BATTERIES AT THE SAME TIME or pump will stop ☐ ✓System controller in cable connected to wall unit ☐ Have pt/caregiver show how to silence alarms, use a hand pump if applicable			
Patient condition exists where low or no flow (cardiac output) is present ☐ Do they appear to be in cardiogenic shock? Can be from electrical disruption to pump or pump malfunction (rare) ☐ If yes, start SOPs; contact VAD Coordinator – provide assessments and VAD parameters if able ☐ Transport to nearest VAD Center if possible; if no airway – transport to nearest hospital ☐ Avoid external chest compressions: Pose a risk due to location of outflow graft on aorta & inflow conduit in the LV apex. Dislodgement could lead to fatal hemorrhage. Contact VAD Coordinator for instructions re: CPR. Get instructions for hand pumping if applicable.			
ECG findings: ☐ VADs fix the plumbing -electrical conduction system should be intact; ECG should be unchanged – do NOT expect asystole and they may be conscious w/ V-fib ☐ Can have dysrhythmias but are better tolerated because pump continues to function despite irregular rhythm – Rx dysrhythmias with drugs per SOP			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Caveats on DEFIBRILLATION Majority of VAD pts can be shocked without disconnecting the percutaneous lead from the System Controller or stopping the pump prior to delivering the shock; but older units may need to be disconnected first and hand pumped before defib ☐ Contact VAD Coordinator BEFORE defibrillating ☐ Only shock if pt is unresponsive with poor perfusion/decreased circulation per cap refill (remember, no pulse is normal) and if you cannot contact VAD coordinator ☐ **Warning:** If VAD stops operating & blood is stagnant in pump & conduits for > a few min (depending on pt's anticoagulant status) there is a risk of stroke and/or thromboembolism if device is restarted. Retrograde flow may occur during pump stoppage.			
Transport to nearest VAD center if possible			
Bring all VAD equipment if possible: batteries, battery clips, power base, plugs, battery charger (pt cannot be out of power)			
Allow family member/caregiver to ride in ambulance if possible			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

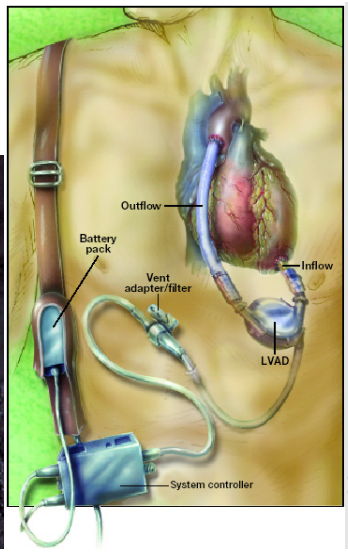
Recommendation: ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

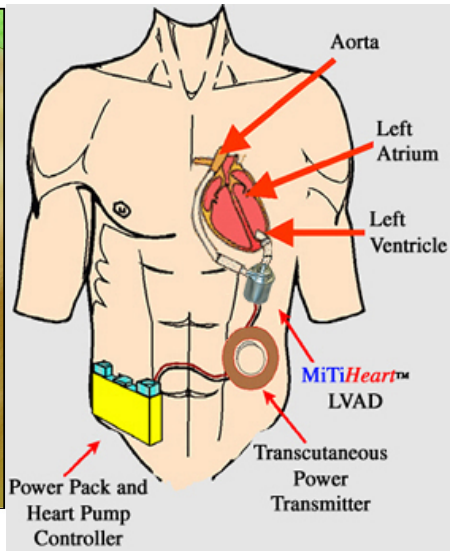
Evaluator

CJM: 5/14

Heartmate XVE & Heartmate II

Illinois Mechanical Circulatory Support Implant Centers	
Advocate Christ Medical Center - Oak Lawn	1-877-684-4327
Loyola University Medical Center - Maywood	1-708-216-8000
Northwestern Memorial Hospital - Chicago	1-312-695-9611
Rush University Medical Center - Chicago	1-312-656-6813
OSF Saint Francis Medical Center - Peoria	1-309-655-4101
University of Chicago Medical Center - Chicago	1-773-753-1880 id# 4823





NWC EMSS Skill Performance Record

INTRAVENOUS CATHETER INSERTION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is an adult in need of peripheral vascular access for a TKO line. Assemble the equipment, choose the correct size catheter from those available, and initiate an IV on the manikin or squad member.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare equipment ☐ Select appropriate IV solution (NS) ☐ Open the package and verify sterility of solution (all seals in place) ☐ * Check solution for clarity and expiration date			
Spike IV bag & prime IV tubing ☐ Remove infusion set from packaging, uncoil tubing, close clamp and remove spike protector ☐ Turn IV bag upright; remove plastic cover from port, maintain sterility of port ☐ Grasp IV set at drip chamber and squeeze ☐ * Insert spike until it punctures the port seal ☐ * Turn IV bag upright ☐ * Fill drip chamber ½ full and purge air from tubing. May temporarily remove end cap to facilitate this procedure, but is not necessary. Remove all large air bubbles from tubing. Hang bag on IV pole or have someone hold bag			
* Select appropriate size IV catheter (Adult: 18 or 20 for TKO; 14-16 for lg fluid boluses)			
* Prepare and open CHG/IPA skin prep, gauze pads, tape, skin protectant film, tourniquet, sharps container. Tear 3 or 4 pieces of ½" – 1" tape about 6-8" long.			
Prepare the patient Explain procedure to patient & gain consent from decisional adult			
Procedure * Observe strict Universal precautions & sterile technique of catheter insertion			
Site selection/preparation * Expose extremity to be cannulated. Inspect for visible veins.			
* Apply tourniquet 4"-8" proximal to selected IV site; palpate distal pulse			
* Lightly palpate veins and identify a suitable site. Avoid points of flexion if possible.			
* Prep selected site with CHG/IPA* from center outward in a circular motion. Allow to dry.			
Catheter insertion ☐ Remove protective cap from needle in a straight outward manner keeping catheter sterile. (Do not depress white activation button of Insyte® catheter) ☐ Rotate catheter hub 36O° while holding flashback chamber to loosen catheter from needle. Failure to do so may affect needle retraction. ☐ Inspect needle tip for any defects			
* Anchor vein with thumb distal to insertion site, stretching the skin near the vein			
* Hold catheter between thumb and index finger of dominant hand (like a pool cue). Insert needle, bevel up, through the skin & vein at a 15-30° angle. (Very sharp catheters enter veins with little or no popping sensation.)			
☐ Observe for blood return in flashback chamber ☐ If vein is missed, retract needle as described below, apply gauze dressing/Band-Aid and begin again with a new catheter at another site			
If vein successfully cannulated: Lower catheter angle to almost parallel to skin & advance needle/catheter unit 1/8th inch to ensure proper tip positioning in vein			
Catheter advancement: * Hold flash chamber/needle stationary and use index finger to advance catheter off the needle into the vein up to its hub. (Needle provides guidewire effect for catheter advancement. Some catheters have a push tab on the top of the colored hub for this step)			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Release tourniquet (Failure to release tourniquet before needle retraction may result in unwanted blood exposure)			
Needle retraction: ☐ Put gauze pad under hub of catheter. ☐ Apply digital pressure directly proximal to catheter tip w/ one fingertip and stabilize colored hub with another fingertip without contaminating needle insertion site ☐ Insyte catheter: Push activation button to retract needle into clear safety shield. If activation does not occur, press button a second time. If it still does not occur, withdraw needle & dispose of unshielded sharp immediately into a sharps container. ☐ Other catheters: Withdraw needle backward toward the catheter hub and shield needle into device ☐ Discard shielded needle unit immediately into an appropriate puncture resistant, leakproof sharps container			
Establish IV flow: ☐ * Remove protective cap on IV tubing; slide end of tubing onto the IV catheter hub. Release pressure to vein. ☐ * While continuing to hold the IV catheter, open clamp on IV tubing to start fluid flow, establish patency, adjust desired flow rate.			
Dressing/Stabilization: ☐ * Carefully peel lining from transparent dressing exposing the adhesive surface; center dressing over catheter site; apply protective film over dry skin without stretch or skin tension leaving the IV tubing connector to colored hub free. Slowly remove the frame while smoothing down the dressing from center to edges using firm pressure to enhance adhesion. ☐ * Secure IV tubing with adhesive strips or commercial dressing and arm board as needed			
* Document type of IV fluid, insertion site, catheter gauge, time started, and flow rate Label IV bag with number (#1, #2, etc.) & time started)			
* State 2 signs of infiltration ☐ IV does not flow ☐ Local swelling ☐ Site pain/burning			
* State method to determine patency: check retrograde flow			
* Properly discard all disposable components			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

* The Infectious Diseases Society of America and The Society for Healthcare Epidemiology of American guidelines recommend the use of a >0.5%CHG and 70% isopropyl alcohol product for skin antisepsis before vascular catheter insertion to prevent catheter-related infections. It is superior to povidone-iodine (without alcohol) solutions or plain alcohol. Skin antisepsis before vascular catheter insertion is one of the only currently approved indications for CHG use in the neonate.

When prepping skin, apply CHG/IPA with sufficient friction to ensure that the solution reaches into the invisible cracks and fissures in the skin. No evidence supports the use of the traditional concentric prepping technique, although this technique is widely employed (www.Medscape.com/viewarticle/726075 accessed 8/20/2010)

NWC EMSS Skill Performance Record

EXTERNAL JUGULAR VEIN ACCESS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An Unconscious adult is in need of immediate fluid resuscitation. Assemble the equipment, choose the correct size catheter from those available, and initiate catheterization of the external jugular vein.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare the equipment * Select the appropriate IV solution (NS)			
Open the package and verify sterility of solution (all seals in place)			
* Check solution for clarity and expiration date			
Remove infusion set from packaging, uncoil the tubing, close clamp and remove spike protector			
Turn bag upright; remove plastic cover from port, maintain sterility of port			
Grasp IV set at drip chamber and squeeze			
* Insert spike until it punctures the seal at the port			
* Turn the IV bag upright			
* Fill drip chamber ½ full and purge air from tubing. May temporarily remove end cap to facilitate this procedure, but is not necessary. Remove all large air bubbles from tubing. Hang bag on IV pole.			
* Select appropriate size IV catheter (14, 16 or 18 for fluid bolus)			
* Prepare and open CHG/IPA skin prep, gauze pads, tape, skin protectant film, sharps container. Tear 3 or 4 pieces of ¼ - ½" tape about 6-8" long.			
Prepare the patient * Place patient supine or in slight Trendelenburg position. Turn pt's head away from the vein			
Procedure * Put on gloves			
* Wipe selected site with CHG/IPA prep from center outward in a circular motion. Allow to dry.			
* Occlude the vein near the clavicle with digital pressure using non-dominate hand to promote venous distention			
* Remove IV catheter from packaging. Rotate catheter hub 36O° while holding flashback chamber to loosen catheter from needle.			
Remove protective cap from needle keeping catheter sterile			
Inspect needle tip for any defects			
*Hold catheter between thumb and index finger of dominant hand (like a pool cue). Bevel up; align needle parallel with vein with point aimed toward pt's torso.			
* Penetrate skin at a 35°-45° angle, enter vein at 10°-15° angle half way between angle of the jaw & clavicle. Point catheter toward medial 1/3 of the clavicle.			
* Observe for blood return in flashback chamber. Advance needle 1/8th inch.			
* Release the pressure on the vein and advance catheter to the hub. **Do not let air enter the catheter once it is in the vein.**			
Apply pressure over vein just proximal to the catheter tip			
* Withdraw needle completely and push button to retract needle into device. Properly dispose of used IV needle in sharps container.			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Remove protective cap on IV tubing and slide end of tubing onto the hub of the IV catheter. Release pressure to vein.			
* While continuing to hold the IV catheter, open clamp on IV tubing to establish patency, adjust IV flow rate.			
* Apply protective film over site. Secure IV with adhesive strip and tape or commercial dressing.			
* Note fluid, insertion site, catheter gauge, time started, and flow rate for documentation purposes. Label IV bag.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

NWC EMSS Lab Skill Performance Record

INTRAOSSEOUS ACCESS USING EZ IO

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalizes indications for IO infusions** ☐ EZ-IO® 25mm (≥40 kg); 15mm (3–39 kg); 45mm (≥40 kg w/ excessive tissue) ☐ Pts in extremis urgently needing fluids and/or medications, esp. if circulatory collapse; difficult, delayed, or impossible venous access; or conditions preventing venous access at other sites. ☐ States total # of attempts per site (1)			
***Verbalizes CONTRAINDICATIONS for IO infusions:** ☐ Fracture of the bone selected for IO infusion ☐ Excessive tissue at insertion site with absence of anatomical landmarks (*consider alternate sites*) ☐ Previous ortho procedures (*IO within 24–48 hrs, prosthesis – use alternate sites*) ☐ Infection at the site selected for insertion (*use alternate sites*)			
If pt conscious, advise of emergent need for procedure			
*** Select appropriate IO needle set; prepare and assemble equipment** ☐ EZ-IO driver ☐ CHG/IPA skin prep ☐ (2) 10 mL syringes ☐ EZ-IO needles: 25 mm; 45 mm; 15 mm ☐ IV NS & reg drip tubing ☐ Pressure infuser ☐ Tape; EZ stabilizer (opt) ☐ Lidocaine 2% (100 mg/5 mL) w/o preservative ☐ Extension set or EZ Connect tubing			
* BSI: gloves and eye protection			
* Attach pressure infuser to IVF bag; prime IV tubing; inflate pressure infuser to 300 mmHg			
☐ Inspect Needle Set packaging to ensure sterility ☐ *Fill syringe w/ at least 10 mL of NS – attach syringe to EZ-Connect ® extension tubing; prime tubing (tubing requires 1 mL; leave at least 9 mL NS in syringe). Leave syringe attached to EZ Connect tubing.			
Perform procedure			
* Position pt and palpate site(s) to identify appropriate anatomical landmarks and needle set suitability. Locate appropriate site (see p. 2).			
* Cleanse site using aseptic technique and CHG/IPA prep; allow to air dry thoroughly			
* Connect appropriate needle set to driver: (Open safety cap of needle, attach to driver, and momentarily power drill)			
* Stabilize site with non-dominant hand; remove needle cap – do not touch needle			
☐ *Hold driver w/ needle connected in your dominant hand; position needle tip over insertion site at a 90° angle to the bone surface. Activate driver by depressing trigger and gently pierce skin with needle until tip touches bone. ☐ Check that at least one black line is visible. If no black line is visible, pt may have excessive soft tissue over selected site and needle may not reach the medullary space. Consider alternative site for insertion or a longer needle. ☐ *Penetrate the bone cortex by squeezing driver's trigger and applying gentle, consistent, steady, downward pressure (allow the driver to do the work). Note: If driver seems to fail, lighten pressure on driver. If pt < 40 kg: do NOT push – gently guide to avoid penetrating through posterior bone If driver fails: Insert manually using gentle twisting motion			
*Release trigger and stop the insertion process when: ☐ Adults: Decreased resistance is felt and/or the hub is almost flush with the skin ☐ Peds: Decreased resistance indicates needle has entered the medullary space			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* While stabilizing catheter hub w/ hand, remove driver from needle set			
* Remove stylet from catheter by rotating counterclockwise. Place directly in sharps container. NEVER return used stylet to the EZ-IO kit.			
Secure site with EZ Stabilizer if available *Connect NS primed EZ Connect tubing to exposed Luer-lock catheter hub. Attempt to aspirate bone marrow (w/ syringe attached to primed connecting tubing). Prevent needle movement – do not attach syringe directly to IO catheter. If successful, do not remove more than 1 mL.			
Conscious pts (before NS flush): Replace NS syringe on connecting tubing w/ lidocaine syringe. Give LIDOCAINE 2% 1 mg/kg (max 50 mg) *slow* IO, unless contraindicated. Medications intended to remain in medullary space, such as a local anesthetic, must be given very slowly until the desired anesthetic effect is achieved.			
☐ *ALL pts: Using syringe, flush w/ at least 10 mL of NS. Observe for swelling around site. Verbalizes signs of correct placement (needle stable in place, needle flushes easily, no S/S of infiltration or increased leg circumference) ☐ If placement in doubt: leave needle in place w/ connecting tubing & syringe attached (for ED to evaluate placement) & attempt IO on alternate site, or IV			
☐ *Attach IV tubing to EZ connect tubing, and begin infusion using a pressurized infusion system. Frequently reassess pressure (300 mmHg) in pressure infuser device. Re-inflate as IVF is administered. ☐ *Calculate appropriate fluid challenge volume if indicated.			
Secure tubing to site with tape.			
Apply wristband to pt w date & time (reminds hospital to remove w/in 24 hrs).			
* Monitor IO site and pt condition. Verbalizes at least 1 complication of IO access.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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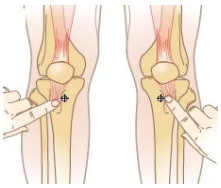
Evaluator

EZ-IO 25mm: (commonly for 40 kg and over)

- **Proximal Tibia** – Insertion site is ~2 cm below patella & ~2 cm (depending on anatomy) medial to tibial tuberosity.
- **Proximal Humerus** – Insertion site is located directly on the most prominent aspect of the greater tubercle. Slide thumb up the anterior shaft of the humerus until you feel the greater tubercle, this is the surgical neck. Approximately 1 cm (depending on pt anatomy) above the surgical neck is the insertion site. *Ensure pt's hand is resting on the abdomen and that the elbow is adducted (close to the body).*



EZ-IO 45mm: (recommended for proximal humerus, pts with excessive tissue over insertion site or when a black line not visible after penetration into the tissue)

- **Proximal Tibia** – See above.
- **Proximal Humerus** –See above**.**

EZ-IO 15mm: (commonly for 3-39 kg, consider tissue density over the landmark desired)

- **Proximal Tibia -** If NO tuberosity is present, insertion is located ~4 cm below patella and then medial along the flat aspect of the tibia. If the tuberosity IS present, the insertion site is ~2cm medial to the tibial tuberosity along the flat aspect of the tibia. Carefully feel for the "give" or "pop" indicating penetration into the medullary space.
- **Proximal Humerus – See above; plus** *The proximal humerus may be difficult or impossible to palpate in children < 5 years of age as the greater tubercle has not yet developed. In these cases the insertion will most likely be a shaft insertion.*

CJM 5/14

NWC EMSS Skill Performance Record

DRAWING UP MEDICATION FROM A GLASS AMPULE

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult is in need of a medication that comes packaged in a glass ampule. You are asked to give 0.5 mL of the drug. Assemble the equipment and draw up the appropriate dose from the ampule.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
* Apply appropriate PPE			
Prepare equipment/medication ☐ Medication ☐ Sharps container ☐ Syringe/needle ☐ Gauze pad			
*Inspect the medication packaging to confirm the drug name, integrity of the ampule; concentration, dose, and expiration date.			
* Inspect solution for clumping, frosting, precipitation, and change in clarity or color			
* Calculate appropriate amount of medication for administration			
* Select appropriate syringe and needle size for volume of fluid to be withdrawn and the route of administration			
* Remove pre-attached needle from the syringe and attach a filtered needle without contaminating either needle			
* Gently tap upper portion of ampule			
Place 4X4 over top of ampule, cover scored portion where the ampule should split apart			
Hold medication-filled bottom cylinder in non-dominant hand			
Grasp the ampule top with dominant hand and quickly snap the 2 sections apart. Use aseptic technique when exposing medication to the environment.			
* Place ampule top immediately into a sharps container			
Medication removal * Insert sterile filtered needle into the liquid medication			
* Withdraw appropriate amount of medication into the syringe. Remove syringe from ampule. Discard used ampule directly into a sharps container.			
* Hold syringe needle up and tap barrel to move air bubble to the top. Eject through needle.			
* Remove filtered needle and discard into a sharps container			
* Attach appropriate needle or IV adaptor for selected route of medication administration			
*Cross check: Reconfirm medication and appropriate dose prepared with another PM			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

CJM 5/14

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Evaluator

NWC EMSS Skill Performance Record

DRAWING UP MEDICATIONS FROM A VIAL

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in need of a medication that comes packaged in a glass vial. You are asked to give 1 mL of the drug. Assemble the equipment and draw up the appropriate dose from the vial.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
* Apply appropriate PPE			
Prepare the equipment/medication ☐ Medication vial ☐ CHG/IPA prep ☐ Sharps container ☐ Luer lock syringe ☐ Vent/needle			
* Inspect the medication packaging to confirm the drug name, integrity of the medication packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (all seals in place)			
* Inspect solution for clumping, frosting, precipitation, and change in clarity or color			
* Calculate appropriate amount of medication for administration			
* Select appropriate syringe for volume of fluid to be withdrawn			
* Remove plastic covering from the top of the vial without contaminating diaphragm. Use aseptic technique when exposing medication to the environment.			
Medication removal Fill syringe with air in an amount equal to the *mL*s that will be removed. Connect needle/vent to syringe.			
With vial upright, insert needle/vent into vial, but not into the liquid. Inject air into the vial. Note: If removing medication from a multi-dose vial and this is not the first dose being removed, cleanse vial stopper prior to inserting needle or vent.			
Invert vial			
* Withdraw appropriate volume/dose of medication into the syringe. Remove syringe from vial.			
Hold syringe up and tap barrel to move air bubble to the top. Eject air through needle or vent.			
*Cross check: Reconfirm medication and appropriate dose prepared with another PM			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

Mark I, DuoDote and/or Epi pen Autoinjector

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
* Apply appropriate PPE			
Prepare/assess patient Begin IMC/ITC			
*Confirm the need for Autoinjector use			
Confirm the absence of allergy or contraindications to the drug			
Explain drug actions and procedure to patient.			
Explain side effects of medication to patient			
Prepare equipment ☐ Medication ☐ Sharps container			
☐ *Select the appropriate medication, dose, and/or number of auto-injectors for the age/size of the patient and severity of distress ☐ Inspect the auto-injector(s) to confirm the name of the drug, integrity of the container; concentration, clarity & color of the medication, and expiration date			
ADMINISTRATION			
If time allows, prep skin. If urgent proceed w/o skin prep.			
Remove safety cap from injector(s)			
Place tip of auto injector against pt's thigh (Lateral portion, midway between waist and knee)			
Push injector firmly against thigh until it activates			
Hold injector in place until medication is injected			
Discard injector directly into a sharps container			
Record medication name, dose (including concentration), route and time given			
Assess response: Reassess VS, breath sounds, resp. distress, drooling, etc.			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

Comments _____

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Evaluator

CJM: 5/14

NWC EMSS Skill Performance Record

METERED DOSE INHALER (MDI)

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in need of Proventil given via MDI. You are asked to assemble the equipment, choose the correct medication from those available, and administer the appropriate dose using the MDI technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare/assess patient Initiate Initial Medical Care. (IV not necessary if mild distress)			
*Confirm need for Proventil (hx asthma, c/o SOB w/ wheezing; RA SpO_2 < 95%, peak flow readings in yellow zone)			
Confirm absence of allergy or contraindications to the drug			
Explain procedure to patient: parts of the MDI and how to coordinate breathing through the mouth with inhaling the medication			
Explain that they may feel a little jittery and pulse may increase			
Prepare equipment *Inspect MDI to confirm the name of the drug, integrity of the container; concentration of the medication, and expiration date			
Shake inhaler well			
Remove cap from mouthpiece. Check mouthpiece for FB; remove if present.			
Ensure that canister is fully and firmly inserted into plastic mouthpiece			
If using inhaler for the first time, or they have not used it for more than 7 days, "test spray" it 2 times into the air; avoid spraying into the eyes			
Apply a spacer, if available			
Administer medication Have patient exhale steadily and as comfortably as they can through their mouth			
Hold inhaler upright 1 – 2 inches in front of patient's mouth. If using a spacer, insert MDI into the open space and place mouthpiece in pt's mouth, instruct them to seal their lips tightly over mouthpiece.			
Have patient breathe in slowly through their mouth, and then press down on inhaler once.			
Have pt hold their breath for 10 sec to allow the medicine to reach deeply into the lungs			
Remove inhaler and instruct them to exhale slowly			
If order is for two puffs, wait 1-2 min & shake inhaler again before giving the 2nd puff			
Have patient rinse out mouth so no drug remains (Especially inhaled steroids)			
Record medication name, dose, route and time given			
Assess response to medication: Reassess VS, breath sounds, degree of distress			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

GIVING AEROSOL MEDICATIONS by HHN

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult with a history of asthma is short of breath with wheezing. You are asked to assemble the equipment, choose the correct medications from those available, and give the correct dose using a HHN.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare/assess patient Initiate Initial Medical Care. (IV not necessary if mild distress)			
*Confirm need for drug(s): Hx asthma/COPD, diffuse wheezing			
Confirm absence of allergy or contraindications to drug(s)			
Explain procedure to pt. Explain parts of the HHN; stress that they need to breathe through their mouth to inhale the nebulized medication.			
Explain that they may feel a little jittery and pulse may increase			
Prepare/assemble equipment ☐ Medications ☐ HHN unit ☐ O_2 source & tubing ☐ Nasal cannula			
* Inspect medication packaging to confirm the drug name, integrity of medication packaging; color, clarity, concentration, dose, and expiration date			
*Unscrew nebulizer lid to expose medication cup			
*Open medication by twisting off the top. Hold medication cup upright Without contaminating medication, pour desired dose into cup and attach nebulizer lid			
* Attach mouthpiece and O_2 reservoir tubing T piece to top of medication cup			
*Connect O_2 tubing to bottom of medication cup			
*Attach other end of the O_2 tubing to oxygen source and adjust O_2 flow to 6 L			
Watch for mist to come out of the nebulizer mouthpiece			
Administer medication (Universal precautions) *Instruct pt to hold mouthpiece firmly in their mouth and to breathe as deeply as they can through their mouth to inhale the mist			
Attach supplemental O_2 via NC at 6 L if pt is hypoxic			
Record medication name(s), dose(s), route and time given			
*Begin transport without waiting for a response (verbalizes)			
*Monitor pt throughout treatment; reassess breath sounds, SpO_2, $EtCO_2$; & VS			
Alternative technique mask using NRM *Remove bag from mask and attach medication cup to mask. Adjust O_2 flow at 6 L.			
Alternative technique: In-line via BVM: *Insert adaptors to connect medication cup in a T piece to the adaptor of a BVM and administer medication with ventilatory assist.			
If successful & wheezing resolves: Continue assessment and give O_2 as needed.			
***If unsuccessful and wheezing persists:** Repeat procedure while enroute			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

MUCOSAL ATOMIZER DEVICE (MAD)

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient Initiate Initial Medical Care. (IV not necessary if mild distress)			
*Confirm need for drug			
Confirm absence of allergy or contraindication to the drug if able.			
Explain drug actions, common side effects, and procedure to the patient (if conscious).			
* Inspect nostrils for problems that might inhibit absorption ☐ Trauma to nasal mucosa ☐ Epistaxis ☐ Damaged mucosa (chronic cocaine use) ☐ Severe hypotension or vasoconstriction ☐ If nasal secretions: suction or use alternate route			
Prepare equipment/medication * Select the appropriate medication ☐ naloxone 1 mg/1mL ☐ glucagon 1 mg/1 mL ☐ fentanyl 100 mcg/2 mL ☐ midazolam 10 mg/2 mL ☐ MAD device ☐ Syringe			
* Inspect medication packaging to confirm drug name, integrity of the medication packaging; concentration, dose, and expiration date. Inspect solution for clumping, frosting, precipitation, or change in clarity or color.			
* Calculate appropriate amount (dose/volume) of medication to administer			
Draw up appropriate dose using aseptic technique; expel air from syringe **Ideal IN volume for MAD = 0.25 - 0.3 mL** Use 1 mL leur-lock syringe If total volume > 0.4 mL: Divide amt between 2 syringes and give ½ dose each nostril (limit 1 mL per nostril) Remove needle and firmly attach MAD to syringe			
*Cross check: Reconfirm medication and appropriate dose prepared with another PM			
Procedure (Universal precautions) ☐ *Place tip of MAD 1.5 cm within the nostril; seat firmly to avoid leaks ☐ *Aim medial/inward (toward septum) & superior/upward Do NOT tell pt to inhale (pulls med into posterior pharynx) ☐ *Push syringe plunger briskly (important to atomize) (The nose may leak fluid so have a gauze pad or towel ready to catch secretions)			
Assess patient response to medication IN absorption not as fast as IV: may take 3-5 min for onset, 10-15 for peak effect If no effect from 1st IN dose, consider alternate route			
* Record medication name, concentration, dose, route, time administered; pt response			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM/DN 5/14

NWC EMSS Skill Performance Record

IV PUSH (IVP) MEDICATIONS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

***Instructions**: An adult is in need of a medication to be administered IV Push. You will be given the name of the drug and the dose to administer. You are asked to assemble the equipment, choose the correct medication from those available, and administer the appropriate dose using the IV Push technique.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ * Confirm need for drug ☐ * Confirm absence of allergy or contraindication to the drug if possible			
***** Explain drug actions, common side effects, and procedure to pt (if conscious)			
* Verify patent vascular access			
Prepare the equipment/medication * Select the appropriate medication			
* Inspect medication packaging to confirm drug name, integrity of the medication packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (all seals in place)			
* Inspect solution for clumping, frosting, precipitation, and change in clarity or color			
* Calculate appropriate amount of medication for administration			
* Prepare medication for administration (draw up into a syringe or engage preload cartridge with barrel of syringe)			
* Observe syringe for air bubbles, point syringe upward, and expel bubbles			
* Cross check: Reconfirm medication and dose prepared with another PM			
Procedure (Universal precautions) * Cleanse IV tubing injection port closest to IV catheter with CHG/IPA prep			
* Attach syringe to needless port			
* Close flow clamp or pinch tubing proximal to insertion port			
* Inject appropriate dose of drug at the prescribed rate			
* Open flow clamp and flush tubing with NS			
Readjust IV flow rate			
* If a one-time dose: detach syringe; discard appropriately			
* Document drug name, concentration, dose, route, and time of administration			
* Assess patient for response to medication			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

IV PIGGY-BACK (IVPB) MEDICATIONS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: *An adult is in need of a dopamine drip administered IV piggy-back at 5 mcg/kg/min. You are asked to assemble the equipment, choose the correct medication from those available, and administer the appropriate dose using the IVPB technique. The patient weighs 200 pounds.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ * Confirm need for the drug ☐ * Confirm absence of allergy or contraindication to the drug if possible			
***** Explain drug actions, common side effects, and procedure to the patient			
* Confirm patent vascular access			
Prepare the equipment/medication * Select the appropriate solution with premixed medication			
*Cross check: Reconfirm medication with another PM			
* Inspect the medication packaging to confirm the drug name, integrity of the medication packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (all seals in place)			
* Inspect solution for clumping, frosting, precipitation, change in clarity or color if poss.			
* Put on gloves			
Prepare medication for administration * Insert appropriate IV tubing into port of the IV bag containing the medication. Fill drip chamber ½ full.			
* Flush tubing with medication fluid without wasting fluid			
Observe tubing for air bubbles, expel			
* Attach an adaptor for a needless port			
Drug administration * Cleanse selected IV injection port on primary tubing with CHG/IPA prep			
* Secure to a needless port.			
* Close the flow clamp of the primary IV tubing above the medication injection port			
* Set the drip rate of the IVPB to deliver the desired dose of medication			
Document drug name, concentration, dose, route and time given			
* Assess patient response to medication			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

ORAL MEDICATION (PO) ADMINISTRATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: A patient is complaining of chest pain that started 15 minutes ago. You are asked to assemble the equipment, choose the correct medication, and to administer the appropriate dose of ASA using the PO technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs Additional Practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ * Confirm need for the drug ☐ * Confirm absence of allergy or contraindication to the drug			
***** Explain drug actions, common side effects, and procedure to the patient			
Prepare the equipment/medication * Select the appropriate medication			
* Inspect the container or packaging to confirm the name of the drug, integrity of the medication packaging/container; color and concentration of the medication, dose of the tablet, and expiration date.			
* Determine the amount of aspirin to be administered 4 (81mg) tablets			
* Put on gloves			
Drug administration If a multiple dose container; shake 4 tablets into the lid of the container; do not touch multiple tablets. If single dose packaging; open and prepare to administer.			
*Cross check: Reconfirm medication and dose prepared with another PM			
* Pour the tablets from the container lid into the patient's hand. Watch the patient place all of the tablets into their mouth. If patient needs assistance; place all 4 tablets into the patient's mouth.			
* Instruct the patient to chew and swallow the tablets			
* Paramedic may give a small amount of water to help wash down the medication. Confirm that the patient has swallowed all the medication.			
* Monitor patient's response to the medication (repeat vital signs)			
* Document drug, concentration, dose, route and time given and pt response			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

SUBLINGUAL (SL) MEDICATION ADMINISTRATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in need of a medication to be administered sublingually. You are asked to assemble the equipment, choose the correct medication, and to administer the appropriate dose using the SL technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*** Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ *Confirm need for the drug (Hx, PE, 12-lead ECG) ☐ *Confirm absence of allergy or contraindications to the drug			
Explain drug actions, common side effects, and procedure to the patient			
Prepare the equipment/medication * Select the appropriate medication			
* Inspect the container or packaging to confirm the name of the drug, integrity of the medication packaging/container; color and concentration of the medication, dose of the tablet, and expiration date.			
* Determine appropriate amount of medication for administration			
Drug administration (Universal precautions) * With gloved hand, take one tablet from the container or pour one tablet into the lid of the container.			
*Cross check: Reconfirm medication and dose prepared with another PM			
* Remove O_2 mask. Instruct pt to open mouth and lift tongue. Place tablet under the pt's tongue. Instruct pt to close their mouth.			
Advise patient not to swallow or chew the medication. If the patient's mouth is dry, may place a few drops of NS or water under the tongue.			
* Replace O_2 mask and monitor pt's response to the medication (repeat VS; reassess pain, degree of distress)			
* Document drug, concentration, dose, route and time administered and pt responses			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

SUBCUTANEOUS (Sub-Q) INJECTIONS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in need of epinephrine 1:1000 0.3 mg sub-q. Assemble the equipment, choose the correct medication from those available, and administer the appropriate dose using the sub-q technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ * Confirm need for the drug ☐ * Confirm absence of allergy or contraindication to the drug			
Explain drug actions, common side effects, and procedure to the patient			
Prepare equipment/medication ☐ Syringe 1 mL w 5/8" needle ☐ CHG/IPA prep ☐ Filtered needle ☐ Epinephrine 1:1000 ☐ Sharps container ☐ Adhesive strip ☐ Gauze pad			
* Select appropriate medication: Inspect the packaging to confirm drug name, integrity of packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (all seals in place)			
* Inspect solution for clumping, frosting, precipitation, and change in clarity or color			
* Calculate correct dose of medication			
* Put on filtered needle.			
* Prepare medication for administration (Draw up into the syringe from an ampule using a filtered needle/straw). Change to 5/8" needle.			
*Cross check: Reconfirm medication and dose prepared with another PM			
Drug administration (Universal precautions) * Select appropriate injection site on lateral middle third of patient's upper arm			
* Cleanse selected site with CHG/IPA prep			
* Pinch up flesh in selected area with index finger and thumb to create a skin surface at least 2" in which to deposit medication. Do not touch the cleansed site.			
* With dominant hand, grasp syringe between thumb and index finger (like a pool cue) and quickly insert needle bevel up at a 45° angle to the skin surface so needle tip remains in the sub-q space.			
* Slowly depress plunger to inject medication			
* Withdraw needle, place gauze pad over injection site, apply gentle pressure			
* Dispose of used needle, syringe, and ampule directly into a sharps container			
Apply adhesive strip over injection site if oozing or bleeding			
* Assess patient for response to medication			
* Document drug, concentration, dose, route, time given, & patient response			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

INTRAMUSCULAR (IM) INJECTIONS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult is in need of midazolam 5 mg IM for severe agitation. You are asked to assemble the equipment, choose the correct medication from those available, and to administer the appropriate dose using the IM technique.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ *Confirm need for the drug ☐ *Confirm absence of allergy or contraindication to the drug if possible			
Explain the drug action, possible side effects, and procedure to the patient			
Prepare the equipment/medication ☐ Syringe 3-5 mL w 1½ - 2½" needle ☐ CHG/IPA prep ☐ Medication ☐ Sharps container ☐ Adhesive strip ☐ Gauze pad			
*Select the appropriate medication			
* Select appropriate medication: Inspect packaging to confirm drug name, integrity of packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (all seals in place)			
* Inspect solution for clumping, frosting, precipitation, and change in clarity or color			
* Calculate correct dose of medication to give and draw up into syringe			
*Cross check: Reconfirm medication and dose prepared with another PM			
Drug administration (Universal precautions) *Preferred site: Vastus Lateralus muscle (adults and children). Alternate site: deltoid muscle two finger breadths below acromion process if other site inaccessible.			
*Cleanse selected site with CHG/IPA prep			
*Gently stretch the skin overlying the muscle; do not to touch the cleansed area			
*With dominant hand, grasp syringe like a dart and quickly insert needle bevel up at a 90° angle to the skin surface until it is firmly seated in muscle			
*Release skin, hold syringe and needle in place, and gently pull back on plunger to check for blood return			
*If no blood return: depress plunger and inject medication slowly			
If blood return: withdraw syringe and needle, apply pressure to site, discard syringe in a sharps container, and begin again			
*Withdraw needle, place gauze pad over injection site, and apply gentle pressure			
*Dispose of used needle and syringe directly into a sharps container			
Apply adhesive strip over injection site if oozing or bleeding			
*Assess patient for response to medication			
*Document drug, concentration, dose, route, time given & patient response			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
- ☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
- ☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

CJM 5/14

Evaluator

NWC EMSS Skill Performance Record

INTRARECTAL DIAZAPAM using Diastat® syringe

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: A child weighing 30 lbs presents with generalized seizure activity. The parents have Diastat available and are asking your assistance in providing diazepam via this route. You are asked to prepare and give diazepam using the Diastat syringe via the IR route.

Note: This is not the EMS System's preferred route for providing a benzodiazepine to abort tonic clonic seizure activity. In the absence of vascular access, midazolam IM is the preferred medication and route for PMs.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Verbalize the 6 rights of medication administration:** ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation			
Prepare the patient ☐ *Confirm need for the drug in child 2 years and older ☐ *Confirm absence of allergy or contraindication to the drug if possible			
Explain the drug action, possible side effects, and procedure to the pt/caregiver			
Prepare equipment/medication Diastat syringe (traditional) 2.5 mg or Diastat AcuDial system Note: When Diastat AcuDial is prescribed, the pharmacist "dials in" the correct amount of diazepam to deliver into a pre-filled delivery system and locks it into place. The locking mechanism ensures that the correct dose is given. Drug comes in a Twin Pack that contains 2 pre-filled delivery system with the patient's dose locked in, 2 packets of lubricating jelly, and administration and disposal instructions.			
* Select appropriate medication: Inspect packaging to confirm drug name, integrity of packaging; concentration, dose, and expiration date.			
* Open package and verify sterility of medication (seal pin is attached to cap)			
*Cross check: Reconfirm medication with another PM			
Push up with thumb and pull to remove cap from syringe. Remove seal pin with the cap; lubricate tip of syringe Ensure green ready band is visible on Diastat AcuDial			
Drug administration (Universal precautions) Position pt on side with upper leg/hip flexed, to allow better visualization of anus			
*Insert syringe tip into the rectum; syringe rim should be snug against rectal opening; slowly inject medication; count to three before removing syringe. Hold buttocks together for another count of 3 to minimize leakage of medication			
* **Reassess patient** ☐ Seizure activity should stop within one to three minutes ☐ Observe for signs of resp. depression (↓ rate/depth) and hypoxia. Assist ventilations prn. Slower absorption of IR Valium may make resp. depression and hypotension less likely to occur. ☐ Document drug, concentration, dose, route and time administered			

Scoring: All steps must be independently performed in sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the student to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Recommendation:
☐ Competent: Satisfactory entry-level performance without critical error; minimal coaching needed
☐ Did not perform in correct sequence, timing, and/or without critical error; recommend additional practice/repeat skill assessment.

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Evaluator

CJM 5/14

NWC EMSS Skill Performance Record

CAPILLARY GLUCOSE TESTING using PRECISION Xtra®

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult with type 1 diabetes is tremulous, light headed, tachycardic and diaphoretic. You are asked to assemble the equipment and obtain a blood glucose reading using the Precision Xtra monitoring system.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*** Prepare and assemble equipment** ☐ Precision Xtra monitor ☐ Lancing device ☐ Test strips ☐ CHG/IPA prep			
Perform procedure (Universal precautions) * Open a test strip packet by tearing at the notch on each side of the packet. Remove end of the packet so the contact bars of the test strip are showing.			
Grasp the contact bars and pull the test strip out of the packet. Save the test strip packet for disposal of the used test strip.			
Inspect the strip and discard if bent, scratched, wet, or damaged			
* Insert the contact bars of the test strip into the test port of the monitor			
* Advance test strip into the meter until it stops. Observe the monitor turn on. Recognize that the monitor will display the five digit lot number and then apply blood.			
Troubleshoot monitor if the calibration code does not appear before applying blood. Pull test strip out of the test port, press and release the button and reinsert the test strip.			
* Cleanse the side of the finger with a CHG/IPA prep. Allow to thoroughly air dry.			
☐ *Obtain a blood drop using an appropriately sized lancet and correct technique (side of finger) ☐ If the site did not dry thoroughly, wipe away first drop of blood and use 2nd drop for reading ☐ Do not squeeze fingertip to express a drop of blood ☐ * Dispose of lancet in a sharps container			
* Touch blood to target area of test strip. Hold finger on the target area while blood is drawn into the strip.			
Observe test start automatically when the sample is detected			
* Move finger away from the target area when the display shows --- (three dashes). Do **not** press the button.			
Verbalize that monitor will display --- -- - followed by a countdown from 5			
*Correctly read blood glucose reading after 5 seconds Below 20 = LO Above 500 = HI Above 300 will also flash Check Ketones			
Turn off the monitor by pressing and releasing the button			
Place test strip packet over used strip and remove it from monitor for proper disposal			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM: 7/10

NWC EMSS Skill Performance Record

DEXTROSE 10% (25 g / 250 mL)

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: *An unconscious adult is determined to be severely hypoglycemic. You are asked to assemble the equipment, and administer the appropriate dose of D10% (25 g / 250 mL) via IVPB. The patient weighs 150 pounds.*

Performance standard	Performs w precision	Needs additional practice
Equipment needed: ☐ IV start supplies (size-appropriate IV catheter ☐ 0.9% NS IV solution ☐ D10% (25g/250 mL) ☐ 2 sets IV tubing (15 drops = 1 mL) ☐ CHG/IPA prep		
Verbalize the 6 rights of medication administration: ☐ Right person ☐ Right dose ☐ Right route ☐ Right drug ☐ Right time ☐ Right documentation		
Verbalize the following: ☐ Drug action: Hypertonic monosaccharide; concentrated source of carbohydrate for IV infusion ☐ *Indication: Confirmed hypoglycemia ☐ *Side effects: hyperglycemia. The following are not as likely with D10 as D50: hyperosmolarity, hypervolemia, phlebitis, pulmonary edema, cerebral hemorrhage, cerebral ischemia		
Confirm RIGHT PATIENT (Drug is indicated) ☐ Confirm hypoglycemia (bG ≤ 70) or S&S hypoglycemia ☐ Confirm absence of allergy to the drug (hypersensitivity to corn products) ☐ Confirm absence of contraindications to the drug: glucose level is normal or high		
Prepare the patient Explain drug and procedure to the patient		
Start peripheral IV/IO line with age & size appropriate catheter per procedure. Hypertonic dextrose solutions (above 5% concentration) should be given slowly, preferably through a small bore needle into a large vein, to minimize venous irritation. Infuse 0.9 NS at TKO rate		
* Verify patency of primary IV line before giving Dextrose 10%. In peripheral vein, check for retrograde blood flow (should be blood return in tubing) when IV bag is lowered. IV and IO lines should run well with no swelling at the site.		
Prepare the equipment/medication **Confirm RIGHT DRUG**: D10% (25g/250mL) ☐ Open the package and verify sterility of medication (all seals in place) ☐ Check drug solution for color (discoloration), clarity (particulate matter), expiration date		
Prepare medication for administration (RIGHT ROUTE – Intravenous or IO) Concentrated dextrose solutions should not be administered via sub-q or IM routes ☐ Insert piercing pin from secondary set IV tubing (15 gtts/mL) into D10% IV bag. Suspend and squeeze drip chamber to fill ⅓ full. ☐ Open roller clamp & expel air (prime tubing without wasting fluid); close clamp ☐ Cleanse IV injection port closest to patient on primary IV tubing with CHG/IPA ☐ Using strict aseptic technique, attach the secondary set (D10% line) to the primary IV tubing at the port closest to the patient ☐ Close flow clamp of the primary IV tubing and open secondary tubing to D10% line to begin infusion		
Deliver RIGHT DOSE in RIGHT TIME Calculate appropriate dose of medication based on age, size, blood glucose (bG) level. The maximum rate at which dextrose can be infused without producing glycosuria is 0.5g/kg /hr. ☐ **Adult dose if bG is borderline 60-70 & no evidence of pulmonary edema:** Open IV WO for DEXTROSE 10% and infuse 12.5 Gm (125 mL or ½ of IV bag). Once dose administered, close IV clamp on D10% IV and open 0.9 NS clamp to TKO rate. ☐ **Adult dose if bG < 60 and no evidence of pulmonary edema:** Open IV WO for DEXTROSE 10% and infuse 25 Gm (entire 250 mL). Once dose administered, close IV clamp on D10% IV and open 0.9 NS clamp to TKO rate.		

Performance standard	Performs w precision	Needs additional practice
☐ **Children and Infants if bG is borderline 60-70 and symptomatic:** Give half (½) of the dose listed below. ☐ **Children and Infants (up to 50 kg or 110 lbs) dose if bG < 60:** Initial dose **0.5g/kg up to 25 g** (5mL/kg) For smaller children, draw up desired volume into a syringe and administer slow IV push. Can give additional 0.5 g/kg (5mL/kg) if pt remains hypoglycemic and symptomatic 5 minutes after initial medication dose. **If pt has HF or a history of HF and lungs are clear: standard** dose, but slow infusion rate to 50 mL increments followed by reassessment **If pt has HF and lungs have crackles or wheezes:** Call OLMC for orders		
Caution: administering too forcefully can result in loss of IV line and damage to surrounding tissues. Exercise care to insure that the IV catheter is well within the lumen of the vein and that extravasation of the medication does not occur. If IV infiltration with fluid extravasation does occur, immediately stop the infusion and inform OLMC.		
Reassess patient response 5 minutes after infusion: Mental status (GCS) and blood glucose level **If bG 70 or greater**: Ongoing assessment **If bG less than 70**: Repeat D10% in 5 Gm (50 mL) increments at 5 -10 minute intervals. Reassess bG and mental status every 5 minutes after each increment.		
RIGHT DOCUMENTATION Note presenting S&S of hypoglycemia; baseline bG level; lack of contraindications to drug; drug name, concentration, dose (in Gm), route, time given; patient response (repeat bG level and mental status); any side effects and/or complications.		

Scoring: All starred (*) items must be answered/performed correctly in order to demonstrate proficiency. Any errors or omissions of these items will require practice and re-evaluation.

Recommendation: ☐ Proficiency demonstrated; no critical errors.
☐ Not yet proficient OR one or more critical errors; recommend practice/repeat.

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Evaluator

Peds dosing DEXTROSE 10% (25 g/250 mL)
Dose: 0.5 g/kg (5 mL/kg)
(0.1 g/1 mL in solution)
Max initial dose: 25 g

Weight	Dose g = mL	Weight	Dose g = mL	Weight	Dose g = mL
6.6 lbs = 3 kg	1.5 g = 15 mL	41.8 lbs = 19 kg	9.5 g = 95 mL	77 lbs = 35 kg	17.5 g / 175 mL
8.8 lbs = 4 kg	2 g = 20 mL	44 lbs = 20 kg	10 g = 100 mL	79.2 lbs = 36 kg	18 g = 180 mL
11 lbs = 5 kg	2.5 g = 25 mL	46.2 lbs = 21 kg	10.5 g = 105 mL	81.4 lbs = 37 kg	18.5 g = 185 mL
13.2 lbs = 6 kg	3 g = 30 mL	48.4 lbs = 22 kg	11 g = 110 mL	83.6 lbs = 38 kg	19 g = 190 mL
15.4 lbs= 7 kg	3.5 g = 35 mL	50.6 lbs = 23 kg	11.5 g = 115 mL	85.8 lbs = 39 kg	19.5 g = 195 mL
17.6 lbs = 8 kg	4 g = 40 mL	52.8 lbs = 24 kg	12 g = 120 mL	88 lbs = 40 kg	20 g = 200 mL
19.8 lbs = 9 kg	4.5 g = 45 mL	55 lbs = 25 kg	12.5 g = 125 mL	90.2 lbs = 41 kg	20.5 g = 205 mL
22 lbs = 10 kg	5 g = 50 mL	57.2 lbs = 26 kg	13 g = 130 mL	92.4 lbs = 42 kg	21 g = 210 mL
24.2 lbs = 11 kg	5.5 g = 55 mL	59.4 lbs = 27 kg	13.5 g = 135 mL	94.6 lbs = 43 kg	21.5 g = 215 mL
26.4 lbs = 12 kg	6 g = 60 mL	61.6 lbs = 28 kg	14 g = 140 mL	96.8 lbs = 44 kg	22 g = 220 mL
28.6 lbs – 13 kg	6.5 g = 65 mL	63.8 lbs = 29 kg	14.5 g = 145 mL	99 lbs = 45 kg	22.5 g = 225 mL
30.8 lbs = 14 kg	7 g = 70 mL	66 lbs = 30 kg	15 g = 150 mL	101.2 lbs = 46 kg	23 g = 230 mL
33 lbs = 15 kg	7.5 g = 75 mL	68.2 lbs = 31 kg	15.5 g = 155 mL	103.4 lbs = 47 kg	23.5 g = 235 mL
35.2 lbs = 16 kg	8 g = 80 mL	70.4 lbs = 32 kg	16 g = 160 mL	105.6 lbs = 48 kg	24 g = 240 mL
37.4 lbs = 17 kg	8.5 g = 85 mL	72.6 lbs = 33 kg	16.5 g = 165 mL	107.8 lbs = 49 kg	24.5 g = 245 mL
39.6 lbs = 18 kg	9 g = 90 mL	74.8 lbs = 34 kg	17 g = 170 mL	110 lbs = 50 kg	25 g = 250 mL

CJM: 5/13

NWC EMSS Skill Performance Record

MONITORING a NASOGASTRIC TUBE

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult with a nasogastric tube must be transported. You are asked to prepare the patient for transport and explain the steps a paramedic should take to troubleshoot a non-draining tube.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*** State indications for an NG tube** ☐ Aspiration risk ☐ Need for gastric lavage ☐ Need for gastric decompression			
* Apply gloves			
State at least two **complications** of NG tubes ☐ Soft tissue trauma from poor technique ☐ Tube misplacement ☐ Tube obstruction			
Check to see if tube is draining. If no drainage: ☐ Use a 60-mL syringe; instill air into tube. Listen over the epigastric area for air movement into the stomach. ☐ Aspirate syringe to see if gastric contents can be withdrawn. ☐ If the tube is misplaced, contact OLMC to see if the tube can be removed. If not, leave tube in place and ensure nothing gets instilled into the tube.			
☐ Disconnect tube from suction machine if applicable ☐ Tape a glove securely around distal tube end to collect drainage			
Secure tube prior to transport: ☐ Ensure that tube is secure to nose or face ☐ Without tension on tube extending from nose or mouth, measure length to upper chest ☐ Place loop of tape around tube at that point creating a tape tab and pin through tape to shirt or gown to prevent kinking or dislodging during transport			
Allow distal end of tube to rest in pt's lap if sitting or below stomach if supine to allow for gravity drainage. Do not allow end of tube to touch floor.			
If patient is non-decisional/combative apply soft wrist restraints to protect tube			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM: 8/10

NWC EMSS Skill Performance Record

MONITORING an INDWELLING URINARY CATHETER

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult with a Foley catheter must be transported. You are asked to prepare the patient and explain the steps a paramedic should take to ensure safe transport with an indwelling urinary catheter in place.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*** State indications for an indwelling urinary catheter** ☐ Urinary retention or incontinence ☐ Epidural ☐ Surgical patient (drainage of urine) ☐ Clinical need/unstable/sacral or perineal wound ☐ Medications ☐ Strict output ☐ Comfort care			
* Apply gloves			
State at least two **complications** of indwelling urinary catheters ☐ Soft tissue trauma; bleeding ☐ Tube kinking, obstruction ☐ Infection (common) ☐ Abdominal pain ☐ May be pulled out accidentally: inflated balloon can cause trauma; impotence			
Assess for S&S of urinary tract infection ☐ Pain ☐ Change in urine color ☐ Abdomen/flank discomfort ☐ Temp > 38° C ☐ Clots/mucous in urine			
***Secure tube prior to transport:** ☐ Maintain closed system; don't clamp tubing ☐ Ensure that securing device or tape applied to upper thigh prevents tension on tubing and "in & out" movement of catheter from urethra (Photo 1) ☐ Ensure that tubing is never kinked or obstructed to prevent Autonomic Hyperreflexia or infection ☐ Secure drainage bag below level of bladder; don't allow bag to be carried higher than bladder ☐ Don't place bag between patient's legs on stretcher ☐ Do not allow drainage tube to loop around leg or fall below bag (no dangling or looping) ☐ Don't let bag lay on floor			
☐ Recommend drain urine out of tubing and collection bag pre transfer; document output (Photo 2) ☐ *Wash hands before & after emptying bag, change gloves - avoid touching spout to container			
If patient is non-decisional/combative apply soft wrist restraints to protect tube			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM 8/10

NWC EMSS Skill Performance Record

CONTACT LENS REMOVAL: HARD LENSES

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult has experienced ocular trauma but the globe appears intact. You are asked to remove the hard contact lenses.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Obtain rapid gross visual acuity** ☐ Can read name badge ☐ Sees shape/shadow/motion ☐ Can count fingers ☐ Sees light projection only ☐ NLP			
***Prepare and assemble equipment** ☐ Contact lens storage case or 2 containers w/ lids ☐ Suction cup - optional ☐ Sterile saline without preservatives ☐ Towel or 4X4s			
* Apply BSI (gloves)			
Prepare patient ☐ Remove external debris by gently touching adhesive tape against closed eyelids. ☐ Gently remove dirt, blood, or makeup from eyelids with 4X4s moistened with saline or cotton applicators. Do not dislodge clots. ☐ Place 2 mL. of sterile saline into each specimen cup and label containers L & Rt. If a lens case is used, place a few gtts of saline into each compartment. ☐ If eye appears dry, instill several drops of preservative-free sterile saline solution and wait a few minutes before removing the lens to help prevent corneal damage.			
Locate the lens in each eye: Can be seen moving on cornea when pt. blinks or by looking sideways across eye - shine a penlight across the eye.			
Critical steps: It is safer for the lens to be entirely on sclera (white) or cornea (color) then partially on each. So if unable to remove, slide to either position.			
Using one thumb, pull the pt's upper eyelid towards the lateral orbital rim (towards ear)			
With other thumb on lower lid, and index finger on upper lid gently move the lids towards each other to trap the lens edges and break the suction.			
Gently press eyelids together toward lens. Use slightly more pressure on lower lid when moving it toward bottom edge of lens.			
Pop or slide the lens out between the lids			
Remove the lens and place it in prepared container			
Remove and care for the opposite lens in the same manner			
Examine the eyes for redness or irritation			
Optional approach: Suction cup removal of hard lenses ☐ Wet the suction cup with a drop of saline ☐ Gently pull up the upper lid with index finger and pull lower lid down with thumb ☐ Press the suction cup gently to the center of the lens ☐ Pull the suction cup and lens away from the eye in a straight line ☐ Place the lens in the prepared container			
State one complication of the procedure: Trauma after touching cornea w/ suction cup or attempting to remove dry lenses			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Evaluator

NWC EMSS Skill Performance Record

CONTACT LENS REMOVAL: SOFT LENSES

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult has eye trauma but the globe appears intact. You are asked to remove the soft contact lenses.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*__Obtain rapid gross visual acuity__ ☐ Can read name badge ☐ Sees shape/shadow/motion ☐ Can count fingers ☐ Sees light projection only ☐ NLP			
__*Prepare and assemble equipment__ ☐ Contact lens storage case or 2 containers w/ lids ☐ Suction cup - optional ☐ Sterile saline without preservatives ☐ Towel or 4X4s			
* Apply BSI (gloves)			
__Prepare patient__ ☐ Remove external debris by gently touching adhesive tape against closed eyelids. ☐ Gently remove dirt, blood, or makeup from eyelids with 4X4s moistened with saline or cotton applicators. Do not dislodge clots. ☐ Place 2 mL. of sterile saline into each specimen cup and label containers L & Rt. If a lens case is used, place a few gtts of saline into each compartment. ☐ If eye appears dry, instill several drops of preservative-free sterile saline solution and wait a few minutes before removing the lens to help prevent corneal damage.			
Locate the lens in each eye: Can be seen moving on cornea when pt. blinks or by looking sideways across eye when shining a penlight across eye. They are less dangerous than hard lenses when left in place.			
Critical steps: It is safer for the lens to be entirely on sclera (white) or cornea (color) then partially on each. So if unable to remove, slide to either position.			
Raise upper eyelid with index finger and hold it against the upper orbital rim. Place thumb on lower lid and gently pull down.			
Have patient look up and slide the lens downward onto sclera (white of eye) with index finger of other hand			
Compresses or pinch lens gently between index finger and thumb			
Remove lens from eye and place in separate, clearly marked ("right" and "left") containers filled with sterile saline solution			
State one complication of the procedure: Trauma as a result of touching the cornea while attempting to remove the lenses.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM 2/10

NWC EMSS Skill Performance Record

EYE IRRIGATION

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An adult has experienced a chemical splash to their eyes. You are asked to assemble the equipment and perform eye irrigation.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*__Obtain rapid gross visual acuity__ ☐ Can read name badge ☐ Sees shape/shadow/motion ☐ Can count fingers ☐ Sees light projection only ☐ NLP			
☐ **Determine type of chemical if known:** acid, alkali or other ☐ Determine care provided prior to EMS arrival			
*** Prepare and assemble equipment** ☐ 1000 mL NS IV ☐ Gauze pads ☐ Towels ☐ Regular IV tubing ☐ Tetracaine gtts ☐ Bath basin			
* Apply BSI (gloves)			
Prepare patient – move as quickly as possible Obtain history for contact use; remove contact lenses if in place			
Explain procedure to patient if awake			
* Ask patient to look up, pull lower eyelid downward and instill 1-2 gtts of tetracaine in the conjunctival cul-de-sac. Ask patient to roll eyes back and forth if possible to distribute gtts.			
☐ Position patient on side with affected eye downward or turn head to side ☐ Place towel around neck; position bath basin to collect liquid			
Perform procedure * Apply dry gauze above and below eyelids * Ask patient to look upward and gently pull down lower lid			
* Irrigate, aim fluid from inner to outer canthus, avoid direct stream on cornea			
Remove any particulate matter with a moistened cotton applicator			
* Ask patient to look down and gently retract upper lid. Irrigate under upper lid.			
Continue irrigation enroute, repeating installation of tetracaine prn			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
☐ Excellent knowledge of material; no coaching needed.
☐ Satisfactory knowledge of material: minimal coaching needed.
☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments:_____

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Evaluator

CJM 7/10

NWC EMSS Skill Performance Record

EYE PRESSURE PATCH

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions*: An adult has sustained a possible corneal abrasion. You are asked to pressure patch the affected eye.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Obtain rapid gross visual acuity** ☐ Can read name badge ☐ Sees shape/shadow/motion ☐ Can count fingers ☐ Sees light projection only ☐ NLP			
* Inspect the eye for signs of perforation or penetration			
***Prepare and assemble equipment** ☐ Tetracaine eye drops ☐ Oval eye patches (2) or 4x4 gauze (2) for each eye to be patched ☐ Tape - at least three 9" lengths ☐ Towel or 4X4s			
*Apply BSI (gloves)			
State one contraindication to the procedure: ☐ Eye irritation as a result of infection ☐ Suspected open globe evidenced by hyphema, leak of aqueous or vitreous humor, tear-drop shaped pupil etc.			
Prepare patient ☐ *Instill several drops of tetracaine and wait a few sec before applying the patch ☐ Cleanse skin around eye to remove debris, drainage, or residual eye medications			
Critical steps: Ask patient to close eyes			
Determine the number of eye pads needed to fill the depth of patient's eye socket			
*Fold oval eye patch in half or 4x4 in quarters			
*Position folded patch or 4x4 against closed lid. Cover first patch with one or more flat eye patches angled across eye to fill socket.			
☐ *Tape snugly in place with parallel strips of tape extending from central forehead to lateral cheek on both sides of patch. ☐ Before securing tape to cheek, lift cheek up, apply tape, and then release cheek. ☐ Avoid placing tape over side of nose or nasolabial fold.			
***State one complication of the procedure:** ☐ Eye patches applied too tightly can result in eye damage ☐ Further trauma due to lid motion under a loose patch			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

NWC EMSS Skill Performance Record

PEDIATRIC MEASUREMENT using a LENGTH-BASED TAPE

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

***Instructions**:* A 3 y/o appears to be very ill. Apply the pediatric length based tape to determine what information is needed to care for the child.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Apply PPE			
Procedure			
* Place child in supine position			
* Place the end of the tape with the arrow (RED) at the top of the patient's head			
* Stretch tape down to the child's heel			
* Identify the color section on the tape			
Identify the information that can be obtained from a length based tape			
☐ *Approximate weight of the patient ☐ *Medication dosages ☐ *Airway management (ET size, suction catheter, oral/nasal airways) ☐ *Fluid bolus amount			
* Document patient's weight on patient care report			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM: 1/10

NWC EMSS Skill Performance Record

PEDIATRIC INTUBATION

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: *An infant presents with apnea from a non-traumatic cause. Prepare the equipment and intubate the patient.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* BSI: gloves, goggles, face mask			
Prepare the patient * Place head and neck in neutral alignment with folded towel under shoulder blades			
* Assess SpO_2 on room air if available			
Assess patient for difficult intubation; mobility of the mandible or foreign body			
* **Preoxygenate** for 3 min w/ 15 L O_2/peds BVM with OPA in place and partner performing Sellick's maneuver. (Must demonstrate good ventilation of manikin)			
* Apply ECG monitor (rhythm & pulse present)			
Prepare equipment * Prepare appropriate suction equipment (8-10 Fr and Yankauer tip); suction prn			
* Select correct size *uncuffed* ETT tube (verbalize size of 5th finger). Insert peds stylet and form tube.			
Lubricate ETT with water soluble gel (verbalizes)			
* Select correct size laryngoscope blade and handle using straight blade up to age 8			
* Engage blade on handle. Check light to be certain it is bright, tight, & white			
* Prepare peds $EtCO_2$ detector, tape, stethoscope, head blocks or towel roll			
*** Premedicate:** * Atropine 0.02 mg/kg rapid IVP			
Pass the tube * Have partner apply external laryngeal manipulation			
* Insert laryngoscope down midline of tongue, visualize epiglottis as inserting. Seat blade under epiglottis. Lift at a 45° to floor of mouth avoiding the upper gums/teeth.			
* Visualize glottic structures/cords; insert tube from R side of the mouth. If > 30 sec: ventilate X 30 sec; reposition, try new blade.			
* Pass ETT through cords until markings on distal tube are level with vocal cords			
*While holding ETT in place, remove laryngoscope blade and stylet			
* Attach peds $EtCO_2$ detector. Ventilate w/ 15 L O_2/peds BVM at age-appropriate rate; observe chest rise. Auscultate over epigastrium, both midaxillary lines and bilaterally over anterior chest.			
* If tube is incorrectly placed, adjust tube depth, re-ventilate. If still incorrectly placed, re-oxygenate 30 sec and attempt again.			
If tube placed correctly, insert OPA as a bite block			
*Note ETT depth (markings at exit point level with upper gum or lip)			
Secure tube in place onto non-mobile bone			
* Immobilize head and neck to prevent tube movement			
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Evaluator

12/10

NWC EMSS Skill Performance Record

PEDIATRIC IV INSERTION

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: A 4 y/o is in need of peripheral vascular access for a TKO line. You are asked to assemble the equipment, choose the correct size catheter from those available, and initiate an IV on the manikin.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare the equipment Select the appropriate IV solution ☐ 1000 mL NS(boluses) ☐ 250 mL NS (TKO)			
Open package and verify sterility of solution (all seals in place)			
* Check solution for clarity and expiration date			
Verbalize indications for ☐ IV fluid bolus ☐ TKO line			
* If giving a bolus, calculate child's wt. X 20 mL/kg.			
☐ Remove IV tubing from bag, uncoil tubing, close slide clamp ☐ Remove spike protector on tubing. ☐ Turn IV bag so ports are upright; remove cover from port, maintain sterility of port			
* Insert spike until it punctures the port seal; turn the IV bag upright;. If giving a bolus attach 3-way stopcock to end of tubing, attach other end of tubing to a J-loop making sure all tubing is flushed.			
* Select appropriate size IV catheter for size of child ☐ Neonates 24-26 g ☐ Infants 22-24 g ☐ Children 20-22 g			
☐ Skin prep pads (CHG/IPA) ☐ Gauze pads ☐ Tape ☐ Skin protectant film ☐ Tourniquet ☐ Sharps container ☐ Tear 3-4 pieces of ¼ - ½" tape about 4-6" long ☐ IV protector shield; arm board			
Prepare the patient Explain procedure to the patient and caregiver; provide reassurance			
Procedure * Put on gloves			
* Expose/immobilize the extremity to be cannulated			
* Place tourniquet proximal to selected IV site; ensure presence of a distal pulse			
* Lightly palpate veins and identify a suitable site			
* Wipe site with CHG/IPA from center outward in a circular motion. Allow to dry.			
* Remove IV catheter from packaging. Rotate catheter hub 36O° while holding flashback chamber to loosen catheter from needle.			
Take protective cap off of needle, keeping catheter sterile			
Inspect needle tip for any defects			
* Anchor vein with non-dominant thumb distal to insertion site stretching skin near vein			
* Hold catheter between thumb and index finger of dominant hand (like a pool cue). Insert needle, bevel up, through skin at a 35°- 45° angle, penetrate vein at 10°-15° angle.			
* Observe for blood return in flashback chamber			
Advance needle 1/8th inch			
* When needle is securely in vein, hold needle in place and use index finger to push off and advance catheter to hub			
* Put gauze pad under hub of needle and withdraw needle backward toward the catheter hub but do not pull the needle entirely out.			
* Apply light pressure over the vein just proximal to the catheter tip			
* Release tourniquet			
* Withdraw needle completely and push button to retract needle into device			

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Remove protective cap on IV tubing and slide end of tubing onto the hub of the IV catheter. Release pressure to vein.			
* While continuing to hold the IV catheter, open clamp on IV tubing to establish patency.			
* Secure IV with adhesive strip and tape or commercial dressing; IV protective shield. Secure limb to arm board if necessary for good flow.			
* Document fluid, site, catheter gauge, time started, and flow rate. Label IV bag.			
* State 2 signs of infiltration ☐ IV does not flow ☐ Local swelling ☐ Pain/burning			
* State method to determine patency: check retrograde flow			
* Properly dispose of used IV needle in sharps container			
* If giving an IV bolus attach 60 mL syringe to stopcock; open stopcock up to IV bag and withdraw amount needed for bolus. Turn stopcock to the child and slowly push fluids. Repeat until child has received correct amount of fluid.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM: IVPEDS 10/06; 1/10

NWC EMSS Skill Performance Record

CARDIAC ARREST MANAGEMENT - PEDIATRIC VF

Name #1	Date:
Name #2:	1st attempt: ☐ Pass ☐ Team repeat
Name #3:	2nd attempt: #1: ☐ Pass ☐ Repeat #2: ☐ Pass ☐ Repeat #3: ☐ Pass ☐ Repeat #4: ☐ Pass ☐ Repeat #5: ☐ Pass ☐ Repeat #6: ☐ Pass ☐ Repeat
Name #4:	
Name #5	
Name #6	

Instructions to the students: This child appears to be about 6 and was found in on the floor by a family member who called 911. Assess the patient and provide care per SOPs.

Performance standard			Performs w/o coaching	Needs additional practice
* Assess responsiveness (unresponsive)				
* Open airway using chin lift; assess for spontaneous ventilations: look, listen, feel for air movement for no more than 10 sec. (none present)				
Suction as necessary				
* Give 2 breaths 1 sec each w/ just enough volume to see chest rise				
* Assess for carotid pulse (5-10 sec) (none present)				
* Initiate good chest compressions (see notes) in 5 cycles of 30:2 for 2 min.				
* Apply defibrillator pads w/ chest compressions in progress.				
* Rapidly measure child with Broselow tape to determine approximate size/weight (<50 kg)				
* After 2 min of CPR; pause compressions ≤10 sec; ✓rhythm (VF). Change compressor.				
* Defibrillate at 2 J/kg (charge defibrillator w/ chest compressions in progress).				
* Without checking ECG or pulse, immediately resume CPR starting w/ chest compressions for 2 min.				
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while monitor is charging.	**Rating**	*While compressions paused for rhythm ✓: Intubate. Ventilate w/ 15 L O_2/BVM at 8-10 BPM. If unable to intubate, ventilate w/ OPA + BVM. After ET placed, do not pause compressions to ventilate.		**Rating**
*If shockable rhythm: Clear pt. Defibrillate at 4 J/kg		* Secure vascular access (IV/IO), NS TKO		
*Without checking ECG or pulse, immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		*Prepare epinephrine and amiodarone		
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while monitor is charging.		* Epinephrine 1:10,000 0.01 mg/kg (0.1 mL/kg) up to 1 mg IVP/IO. (See chart p. 90 SOP) Repeat every 3-5 min.		
* If shockable rhythm: Clear pt. Defibrillate at 4 J/kg		* Amiodarone 5 mg/kg (max single dose 300 mg) IVP/IO (See chart p. 90 SOP)		
*Without checking ECG or pulse, immediately resume CPR starting w/ chest compressions at 100/min for 2 min.				
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while monitor is charging.		Consider $NaHCO_3$ 1 mEq/kg IV/IO if arrest caused by bicarb -responsive acidosis (DKA/tricyclic antidepressant , ASA OD, cocaine or diphenhydramine) or known hyperkalemia.		
* If shockable rhythm: Clear pt. Defibrillate at 4 J/kg				
*Without checking ECG or pulse, immediately resume CPR starting w/ chest compressions at 100/min for 2 min.				
Return of spontaneous circulation (ROSC): Assess for post-arrest shock. Support ABCs; follow appropriate SOP to support BP w/ UNWARMED NS 10-20 mL/kg IVP and DOPAMINE at 2 to 20 mcg/kg/min as needed. Avoid hyperthermia & hyperglycemia.				

Notes on good CPR:

- ☐ Push hard (Approx. ⅓ to ½ depth of chest) and fast (100); over lower ½ of sternum (1-adolescent) or just below nipples (infant); ensure full chest recoil; minimize interruptions in chest compressions (≤ 10 sec)
- ☐ Continue CPR while defibrillator is charging and drugs are prepared & given.
- ☐ Interrupt chest compressions only for ventilations (until advanced airway placed), rhythm check & shock delivery.
- ☐ Rotate person providing compressions every 2 minutes during ECG rhythm checks
- ☐ Pts should not be moved while CPR is progress unless in a dangerous environment or pt is in need of intervention not immediately available. CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found.

Scoring: **All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require additional practice.**

Recommendation:

- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments:

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Evaluator

CJM: 7/10

NWC EMSS Skill Performance Record

CARDIAC ARREST MANAGEMENT - PEDIATRIC ASYSTOLE/PEA

Name #1 (leader):	Date:
Name #2:	1st attempt: ☐ Pass ☐ Team repeat
Name #3:	2nd attempt: #1: ☐ Pass ☐ Repeat #2: ☐ Pass ☐ Repeat #3: ☐ Pass ☐ Repeat #4: ☐ Pass ☐ Repeat #5: ☐ Pass ☐ Repeat #6: ☐ Pass ☐ Repeat
Name #4:	
Name #5	
Name #6	

Instructions to the students: This child appears to be about 2 years old and was found in bed by a family member who called 911. There are no long-term indications of death. Assess the patient and provide care per SOPs.

Performance standard	Performs w/o coaching	Needs additional practice
One team member seeks information about possible contributing factors: ☐ Hypovolemia ☐ Hypoxia ☐ Hypothermia ☐ Hypoglycemia ☐ Hyper/hypokalemia ☐ Hydrogen ion (acidosis) ☐ Thrombosis (coronary or pulmonary) ☐ Toxins ☐ Tension pneumo ☐ Tamponade cardiac ☐ Trauma		
* Assess responsiveness (unresponsive)		
* Open airway using chin lift; assess for ventilations: look, listen, feel for air movement (≤10 sec.) (none)		
Suction as necessary		
* Give 2 breaths 1 sec each w/ just enough volume to see chest rise		
* Assess for brachial/apical pulse (5-10 sec) (none present)		
* Initiate good chest compressions (see notes) (5 cycles of 30:2) for 2 min.		
* Apply (peds) defibrillator pads w/ chest compressions in progress.		
* Rapidly measure child with Broselow tape to determine approximate size/weight (<50 kg)		
* After 2 min of CPR; pause compressions (≤10 sec.); ✓ rhythm (Asystole - confirm in 2 leads). Change person doing compressions.		
*Immediately resume CPR starting w/ chest compressions at 100/min. in cycles of 30:2 for 2 min.		

	Rating		Rating
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (IVR); change compressor. *If electrical activity: ✓ pulse (no pulse)		*While compressions paused for rhythm ✓: Intubate. Ventilate w/ 15 L O_2/BVM at 8-10 BPM. If unable to intubate, ventilate w/ OPA + BVM. After ET placed, do not pause compressions to ventilate.	
*Immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		* Secure vascular access (IV/IO), NS TKO	
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (IVR); change compressor. * If electrical activity: ✓ pulse (no pulse)		*Prepare epinephrine	
*Immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		* Epinephrine 1:10,000 0.01 mg/kg (0.1 mL/kg) up to 1 mg IVP/IO. (See chart p. 90 SOP) Repeat every 3-5 min. as long as CPR needed	
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (IVR); change compressor. * If electrical activity: ✓ pulse (no pulse)		Assess temp & glucose as time allows	
*Immediately resume CPR starting w/ chest compressions at 100/min for 2 min.		Consider $NaHCO_3$ 1 mEq/kg IV/IO if arrest caused by bicarb -responsive acidosis (DKA/tricyclic antidepressant , ASA OD, cocaine or diphenhydramine) or known hyperkalemia.	
Return of spontaneous circulation (ROSC): Assess for post-arrest shock. Support ABCs; follow appropriate SOP to support BP w/ UNWARMED NS 10-20 mL/kg IVP and DOPAMINE at 2 to 20 mcg/kg/min as needed. Avoid hyperthermia & hyperglycemia.			

Notes on good CPR:

- ☐ Push hard (Approx. ⅓ to ½ depth of chest) and fast (100); over lower ½ of sternum (1-adolescent) or just below nipples (infant); ensure full chest recoil; minimize interruptions in chest compressions (≤ 10 sec)
- ☐ Continue CPR while defibrillator is charging and drugs are prepared & given.
- ☐ Interrupt chest compressions only for ventilations (until advanced airway placed), rhythm check & shock delivery.
- ☐ Rotate person providing compressions every 2 minutes during ECG rhythm checks
- ☐ Pts should not be moved while CPR is progress unless in a dangerous environment or pt is in need of intervention not immediately available. CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found.

Scoring: **All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require additional practice.**

Recommendation:

- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments:

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Evaluator

CJM: 1/10

NWC EMSS Skill Performance Record

REMOVAL of CHILD from CAR SEAT for SPINE MOTION RESTRICTION

Name #1:	1st attempt: ☐ Pass ☐ Team repeat
Name #2	2nd attempt: #1: [ ] Pass [ ] Repeat
Date	#2: [ ] Pass [ ] Repeat

Instructions: *A child presents with possible spine trauma following an MVC. Prepare the equipment and remove the child from the car seat and place them in spine motion restriction on a peds spine board.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Equipment needed ☐ Backboard of appropriate size ☐ Peds cervical collar ☐ Towel rolls and/or appropriate size ☐ Min. 2 rescuers ☐ Straps for backboard ☐ Heavy-duty scissors			
Prepare the patient * Apply manual c-spine motion control while keeping child as calm as possible; limit head and neck motion.			
Remove car seat padding from sides of the pt's head and neck if possible. If padding cannot be removed push into the seat as best as possible.			
To remove or loosen the harness: ☐ Unbuckle 5 point harness & remove from limbs. If seat has a removable clip or bar type device at the back for the harness system; remove so harness can be slipped out of the shoulder slots. If this is difficult, cut the straps with heavy-duty scissors. ☐ To loosen harness, check for tightening/loosening tabs at bottom of seat. Infant carriers may have a tightening clip on back of seat. If manipulating the straps causes movement of the pt or is difficult, cut the straps.			
Place car seat at foot of the backboard. Tip seat backwards onto the board (child's torso flat; legs upward). The child should look as if a chair was tipped over and he or she is laying flat in the chair, with the back of the chair on the board (photo 1).			
☐ 1st rescuer positions self at child's head. Slide hands along each side of child's head until the hands are behind the child's shoulders. Support head and neck laterally with rescuer's arms (photo 2). ☐ 2nd rescuer controls child's body.			
The rescuer at head performs a 3 count. At count of 3, the child is slid upward out of the car seat onto the board and immobilized per usual procedure (photo 3)			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator



NWC EMSS Skill Performance Record

DRESSING & BANDAGING

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Apply PPE (gloves)			
Determine location of the wound and expose injured area (cut away clothing as appropriate, preserving evidence as necessary)			
Inspect wound for size, type, depth, nature (arterial/venous), amount and type of bleeding, debris, & foreign bodies. Remove loose debris or F/B.			
Remove all jewelry from the injured area and distally			
Select appropriate size dressing			
Open dressing using sterile technique and place over the wound site. Apply direct pressure with hand over the dressing.			
Secure dressing with a bandage, using roller gauze, wrapping distally to proximally. If a limb, leave fingertips or toes exposed to check distal neurovascular status. Secure the bandage with tape.			
Assess pain and consider need for pain medication; apply cold pack to reduce swelling.			
Note the rate at which a dressing becomes saturated with blood and apply additional pressure or consider need for more aggressive hemorrhage control			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments_____

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Evaluator

10/06

NWC EMSS Skill Performance Record

HEMORRHAGE CONTROL

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
* Apply PPE			
Assess pt for nature of bleeding: ☐ Type ☐ Source ☐ Amount ☐ Rate			
Apply direct digital pressure over a single layer sterile dressing placed over wound unless contraindicated (deep open skull wound)			
Bleeding persists: ☐ Cover entire bleeding surface; including deep areas of wound with QuikClot dressing ☐ Apply direct digital pressure over dressing ☐ If blood soaks through 1st layer, apply a 2nd ☐ Once bleeding stops, apply a pressure bandage (roller gauze or ACE wrap) to hold dressing in place. ☐ Do not remove blood-soaked bandages from wound, may cause more bleeding			
Severe extremity bleeding Verbalize need for a tourniquet ☐ * Mangled extremity; amputation ☐ * Arterial bleed ☐ * Hemostatic dressing ineffective in hemostasis			
Prepare equipment and explain procedure to patient.			
Procedure for CAT® tourniquet Route band around extremity and pass free-running end through inside slit of the buckle			
Pass band back through the outside slit of the buckle. This uses the Friction Adaptor Buckle which will lock band in place.			
Pull the band tight and securely fasten the band back on itself			
*Twist the Windlass Rod™ until bright red bleeding has stopped			
*Lock the rod With the clip: Bleeding should be controlled			
*Secure rod with the strap			
*Reassess extremity to insure bleeding has stopped. Continue reassessment enroute.			
Assess need for pain management: If hemodynamically stable – fentanyl per SOP			
Documentation (verbalize) ☐ MOI: Blunt, penetrating ☐ Site of tourniquet application: arm, leg; R or L ☐ Measures used prior to tourniquet application ☐ Time tourniquet applied &/or removed (if applicable) ☐ Who applied and/or removed tourniquet ☐ Success of hemorrhage control ☐ Total tourniquet time in minutes ☐ Whether pt required pain meds d/t tourniquet pain ☐ Tourniquet-related complications if known: ischemia damage, compartment syndrome			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments_____

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Evaluator

NWC EMSS Skill Performance Record
Decompression of Tension Pneumothorax

NEEDLE THORACOSTOMY

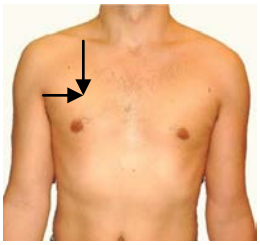
Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Instructions: An adult is experiencing severe shortness of breath following chest trauma and you suspect a tension pneumothorax. You are asked to assemble the equipment and perform needle pleural decompression.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications for procedure/S&S of a tension pneumothorax ☐ ***Unilateral absence of breath snds** ☐ ***SBP < 90** ☐ Severe dyspnea ☐ JVD ☐ Asymmetric chest expansion ☐ Pleuritic chest pain ☐ Hyperresonance to percussion on affected side			
State contraindications for procedure ☐ **SBP > 90** ☐Simple pneumothorax			
***Prepare and assemble equipment** ☐ 10 g; 3" needle ☐ 10 mL syringe ☐ CHG/IPA prep			
Attach 10 mL syringe to end of IV catheter			
*Observe Universal precautions (gloves & face protection); maintain aseptic technique			
Prepare patient: Explain procedure to patient if awake			
Perform procedure *Identify landmarks: 2nd-3rd intercostal space in midclavicular line on affected side			
Cleanse skin with CHG/IPA prep			
*Insert needle at a 90° angle to chest wall over superior border of 3rd or 4th rib			
*Listen for "pop" as needle penetrates pleural space; observe plunger move in syringe			
Assess radial pulses and ventilatory status for improvement			
*Advance catheter over needle into chest up to hub; remove needle – prevent catheter kinking			
*Immediately place needle in a sharps container			
Reassess pt to determine need for a second needle placement			
Verbalizes at least 2 **complications** associated w/ this procedure ☐ Hemothorax: Inadvertent puncture of costal vessels ☐ Pneumothorax if not pre-existing ☐ Sub-q emphysema ☐ Prolonged pain from injury to intercostal nerves			
Transport pt to a Level I trauma center if ground transport time ≤ 30 min			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
☐ Excellent knowledge of material; no coaching needed.
☐ Satisfactory knowledge of material: minimal coaching needed.
☐ Could not perform some points even with coaching; recommend practice/repeat.



Comments_____

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Evaluator
8/10

NWC EMSS Skill Performance Record

APPLICATION of a rigid C-COLLAR

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

NOTE: Never apply traction to neck or spine

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
*Assesses need for spine motion restriction: Positive MOI and/or + PE findings; unreliable patients with + or uncertain MOI			
*RESCUER #1 provides manual splinting of head/neck as found (in neutral alignment if possible)			
*Assess/open/maintain airway, ventilations & gas exchange			
Select and prepare equipment *Rescuer #2: Use fingers to measure key dimension for proper collar sizing (imaginary line from top of shoulder where collar will sit to bottom plane of chin)			
*Rescuer #2: Apply key dimension to the collar by aligning fingers with the bottom edge of the plastic neck band. Select sizing window closest to the height of the stacked fingers. Adjust chin piece until the markers are visible in both windows of the chosen size collar. Press tab locks on both sides of collar to secure.			
Rescuer #2: Pre-form collar by flexing end w/o strap inward to triangular trach hole			
Collar application ***PT SITTING:** Rescuer #2: Apply collar by sliding chin support up the chest wall until collar is placed under the chin. Pt's chin should at least cover the central fastener.			
*Rescuer #2: Secure collar by using the trach hole as an anchor point. Gently pull posterior portion around back of neck and secure Velcro tab.			
*Position pt on long spine board without moving spine.			
***PT SUPINE:** Rescuer #2: Slide back of collar under the neck. Position chin piece and fasten Velcro as above.			
*Lift onto long board with a scoop stretcher; position in center of board.			
Both positions: ☐ Heavy or bulky clothing takes up extra space beneath the collar. If this clothing is removed, the patient should be resized for an appropriately fitting collar ☐ *Pad occiput to keep head and neck in neutral alignment; apply lateral immobilizers.			
*Secure pt to long board with straps across shoulders, hips, knees			
Verbalize the following: The collar should not ☐ impede mouth opening or airway clearance. ☐ obstruct airway passages or breathing. ☐ be loose as to allow the chin to sink below the collar chin piece.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM: 2/10

NWC EMSS Skill Performance Record

STANDING BACKBOARD TECHNIQUE

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

An adult is found walking around a vehicle with major metal deformity following a high speed MVC. The patient is dazed and admits to some neck pain. You are asked to apply spine motion restriction using the standing backboard technique.

NOTE: Never apply traction to neck or spine

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications for procedure: Pt found standing and requires spine motion restriction.			
Assess pain, motor, sensory, & circulatory integrity prior to pt movement or splinting			
Need at least 3 rescuers ☐ *Rescuer 1: Apply manual splinting of head & neck standing behind or in front of the pt. Instruct patient to remain still; explain procedure to pt ☐ *Rescuer 2: Apply appropriately sized c-collar per procedure.			
*Rescuer 3: Bring long spine board in from side & position directly behind pt; align properly. Check board position from in front of pt. Place padding behind occiput to fill gap between head and board. Rescuer 1 Keep board pressed against pt with hip and leg.			
*Rescuers 2 & 3: Stand facing patient at each side ☐ Each inserts hand nearest pt under the pt's arm and grasps the handle hold on the board *above* the armpit ☐ Grasp pt's elbows with their other hand to provide additional stabilization ☐ Each rescuer puts foot closest to board against the base at the ground and steps forward with other foot to keep board from sliding			
☐ Under direction of rescuer at the head: slowly lower board part way to ground, stopping about halfway down ☐ *Rescuer 1 must move hands without losing stabilization as the board is lowered			
☐ *Lower board fully to ground ☐ *Rescuer 1 must go to a kneeling position to avoid moving head out of alignment			
☐ Move pt to proper position on the board ☐ *Apply lateral head immobilizers and secure pt to board per procedure			
Assess & document pain & SMV in all extremities after procedure			
State possible complications ☐ Movement of a pt founding standing with a spine injury could cause an unstable injury to worsen or a stable injury to become unstable ☐ Permanent paralysis, persistent pain or death can result			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM 7/10

NWC EMSS Skill Performance Record

KENDRICK EXTRICATION (Vest-Type) DEVICE (KED)

Name #1:	1st attempt:	☐ Pass	☐ Team repeat
Name #2	2nd attempt:	#1: ☐ Pass	☐ Repeat
Date		#2: ☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Assesses pain, SMV in all extremities & need for extrication and spine motion restriction			
*__Verbalize at least 2 contraindications__ to use of KED or vest-type device: ☐ Unstable pt. or scene w/ possible spine injury. (use rapid extrication) ☐ A vest-type device could cause hypoventilation in a pt w/ dyspnea ☐ Reliable pt. w/ uncertain or neg MOI w/ normal neuro exam			
*Rescuer #1 Apply manual stabilization to head and neck *Rescuer #2 Correctly size and apply c-collar			
Rescuer #2 Prepare KED for insertion behind patient			
*Rescuer #2: Slip body portion of KED behind pt. w/ smooth side towards pt's back. Straighten KED so pt. is centered in device and head support is behind head.			
Move leg straps down from stored position			
*Bring chest flaps around pt. Fasten middle strap first. (*MBLHT)			
Position firmly under armpits by using lift handles on side of unit			
*Fasten bottom chest strap next			
*Bring leg straps under buttocks; cross over to opposite side and secure into device unless contraindicated. Pad groin as needed.			
*Adjust head pad to fill gap between head and head support			
*Bring head flap forward and secure with straps over forehead and under chin piece of c-collar			
Release manual stabilization			
*Secure top chest strap last Check all straps for snugness before moving patient			
☐ *Place foot end of long spine board next to pt's buttocks, perpendicular to pt. Pivot pt. parallel to the board ☐ *Lift pt slightly onto board and position supine maintaining axial alignment. Keep knees bent during position change.			
Once supine, disengage leg straps and lower legs to board; may loosen chest straps to ensure adequate ventilations			
*Secure pt & KED to the long board with straps			
Reassess spine pain, SMV in all extremities			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments: _____

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Evaluator

* MBLHT (My baby looks hot tonight helps recall the order of strap application: middle, bottom, legs, head, top)

CJM: 8/10

NWC EMSS Skill Performance Record

HELMET REMOVAL

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

NOTE: Never apply traction to neck or spine

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
☐ *Rescuer#1: Kneel at pt's head, apply manual stabilization by palming each side of helmet & curling fingertips over helmet's lower edge so thumbs are on pt's mandible and index fingers are on the occipital ridges. ☐ *Rescuer #2: Position at pt's side near shoulder			
☐ *Perform primary assessment while patient supine w/ helmet in place ☐ *Remove chin strap or face shield if more direct access required for airway assessment ☐ *If airway/ventilations adequate; immobilize w/ helmet (pads) in place using tape and blanket roll and padding as necessary to maintain axial alignment			
State indications for procedure: ☐ *Helmet fails to hold head securely (loose-fitting) ☐ *Helmet/face shield prevent airway control even after removal of face shield ☐ Helmet has a face shield that cannot be removed within a reasonable period of time ☐ Helmet prevents proper immobilization for transport			
State contraindications for procedure: Untrained personnel unless obvious airway impairment evident & failure to remove helmet would compromise patient			
If pt awake, explain the procedure. Instruct pt not to attempt to help or to move. (Assess & document SMV status prior to procedure).			
If helmet has snap-out ear protectors, pry them loose with a tongue blade and remove. If helmet has an inflatable pad, DO NOT decompress air bladder until after the next step.			
*Rescuer #2: Place one hand on mandible: thumb on one side and the long and index fingers on the other. Place other hand under base of occiput under the helmet and maintain axial alignment.			
If helmet has an inflatable air bladder, deflate bladder with an air pump needle while the Rescuer #2 continues to hold C-spine motion restriction. Detach any other removable padding to make helmet easier to remove.			
*If no inflatable air bladder: Rescuer #1 should reach inside helmet & spread sides away from pt's head and ears while gently pulling and tilting helmet upward slightly, clearing pt's nose. As helmet comes over the occiput, it may be necessary to tilt the helmet FORWARD slightly about 30° following curvature of pt's head. Remove helmet by carefully pulling it in a straight line.			
*Rescuer #2: Maintain in-line stabilization throughout the process to prevent c-spine motion. Slide hand under neck upwards as helmet is removed to provide occipital support and prevent head from falling back once helmet is removed.			
After removal, apply padding under head to maintain neutral position. Apply a c-collar and lateral immobilization and secure pt. to long board with straps.			
Assess pain and SMV in all extremities after procedure.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require a repeat.

Recommendation: ☐ Excellent knowledge of material; no coaching needed.
☐ Satisfactory knowledge of material: minimal coaching needed.
☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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_____Evaluator

CJM 7/12

NWC EMSS Skill Performance Record

LOGROLL onto a LONG SPINE BOARD

Name #1:	Date:
Name #2:	1st attempt: ☐ Pass ☐ Team repeat
Name #3:	2nd attempt: #1: ☐ Pass ☐ Repeat #2: ☐ Pass ☐ Repeat #3: ☐ Pass ☐ Repeat #4: ☐ Pass ☐ Repeat
Name #4:	

NOTE: Never apply traction to neck or spine

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
***Prepare patient**: Position pt. supine. Rescuer 1 holds patient's head in axial alignment WITHOUT any traction on neck or spine and instructs pt not to move.			
* Rescuer 2 correctly applies appropriate size C-collar			
* Rescuers 3&4 assemble equipment: Long spine board, lateral head immobilizer, straps or spider, towels or padding			
Rescuers position themselves at head & same side of patient: ☐ *Rescuer 1 holds pt's head ☐ *Rescuer 2 kneels at pt's shoulders ☐ *Rescuer 3 kneels at pt's buttocks & hips			
Rescuers reach across patient and grasp: *Rescuer 2 - Patient's farther shoulder and hips *Rescuer 3 – Patient's waist and thigh (cross hands & arms)			
Perform procedure ***Rescuer 1 stabilizes head & neck. Gives command to roll pt on 3. Counts 1, 2, 3.			
*On signal, pt is rolled as a unit onto their side with head supported & turned with body			
*Rescuer 4 slides board parallel to back of body, tilted up at a 45° angle until it is snug to body with pivot point on floor			
*On signal from Rescuer 1 lower pt as a unit on board until board is flat on floor – keeping head slightly elevated in axial alignment if no occipital padding yet			
***Centering patient on board:** If pt is not centered on board, Rescuers maintain their position and on signal from Rescuer 1 move pt slightly downwards on board towards midline			
*On signal from Rescuer 1 all rescuers move pt slightly upwards on board towards midline so pt is centered on board. (Maintains axial alignment of spine and eliminates sideways motion)			
***Securing patient to board**: Rescuer 2 slides occipital pad under patient's head to fill gap between board and back of head			
Reassess position of c-collar. Secure lateral head immobilizers with straps or Velcro.			
Secure straps over patient's forehead and chin piece of cervical collar to board			
Secure pt to board with straps across shoulders/chest, thighs and below knees or use a spider strap			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments: _____

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Evaluator

CJM 7/10

NWC EMSS Skill Performance Record

SLING and SWATHE

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Apply PPE (gloves)			
Expose injured area (cut away clothing as appropriate, preserving evidence as necessary)			
Assess need for splint: pain, deformity, motor deficit, paresthesia, pallor, and/or pulselessness of injured shoulder, clavicle, or arm. Compare injured to uninjured side.			
Remove all jewelry & clothing from injured areas and distal extremity			
Cover all open wounds w/ sterile dressings			
Consider need for morphine and benzodiazepine prior to splinting			
Apply gentle support and stabilization to the fracture/dislocation site while applying sling			
Place padding between arm and chest in axillary area			
Fold forearm of injured side across chest, with hand slightly elevated toward opposite shoulder			
Place **triangular bandage** under and over arm with point at elbow and two ends tied around the neck. Knot should be to the side of the neck.			
Envelope wrist and most of hand in the sling. Hand and wrist should not be able to drop out of sling. Keep fingers exposed to check neurovascular status. Keep hand and wrist slightly elevated.			
Pin or tie point end of a triangular bandage to form a cup for the elbow			
Alternative approach: Apply commercially available sling by inserting forearm into the sleeve and securing the strap (at the elbow) behind the shoulder and forward around the opposite side of the neck to attach to the hand portion of the sling. The sling straps should not hang forward in front of the neck on both sides.			
Reassess motor, sensory, and circulatory integrity of injured extremity after splinting to compare injured to uninjured sides			
Wrap a wide cravat or roller gauze around injured arm and body as a swathe to pull shoulder back and secure injured arm to body			
Transport in a sitting position			
Apply cold pack to reduce swelling			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

NWC EMSS Skill Performance Record

RIGID SPLINTS

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State purpose of splinting ☐ Reduce pain ☐ Stabilize injury; provide substitute support ☐ Facilitate transfer and transport ☐ Prevent/minimize skin laceration; motion of broken bone ends; damage to muscle, nerves; restriction of distal blood flow; excessive bleeding			
Prepare/assess patient Explain procedure to pt			
*Completely expose the injured area (limb)			
*Assess need for splint and distal motor & neurovascular function prior to moving injured area: pain, position, paralysis or motor deficit, paresthesia, pallor, pulselessness, pressure. Compare injured to uninjured side.			
*Remove jewelry on affected limb. Secure w/ pt belongings. If unable to remove a ring with soap/lubricant, cold or string, consider a ring cutter.			
*Offer pain/antispasmodic meds before splinting if not contraindicated			
☐ *If angulated long bone fx with SMV impairment: apply gentle traction to both bone ends and attempt to realign. Constant firm pressure; NO jerky movements ☐ If resistance encountered or pt c/o severe pain – STOP. Splint in position of deformity ☐ Splint joint injury as found			
*Cover all open wounds w/ sterile dressings			
Prepare equipment: *Select a splint that immobilizes one joint above and one joint below a suspected fx.			
Pad splint or wrap limb distally to proximately with Webril if available. Overlap each layer by ½ the width. Smooth out creases. Apply extra padding to fill voids and over bony prominences. Omit step if using prepadded splint.			
Perform procedure – Generalized approach – adapt to device ☐ *Manually support site & minimize movement until splint is applied & secured ☐ *Apply splint per manufacturer's recommendations w/ minimal mvmt. of limb ☐ Splint knees straight unless injured or angulated ☐ If forearm injury, have pt hold (flex fingers over) a bandage wrap. Flex elbow to 90° if possible. Extend wrist to 20°; abduct thumb and flex finger joints to 70°.			
*Secure by fastening Velcro straps or w/ bandage or ACE wrap. Do not tape circumferentially (allow pressure relief).			
*Reassess distal motor & neurovascular integrity after splinting. Instruct pt to alert you if they experience numbness, color change, increasing pressure or pain.			
☐ *If possible; elevate injured extremity above level of heart ☐ Apply cold pack over injury site unless contraindicated			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

8/10

NWC EMSS Skill Performance Record

TRACTION SPLINTS

Name #1:	1st attempt: ☐ Pass ☐ Team repeat
Name #2:	2nd attempt: #1: ☐ Pass ☐ Repeat
Date:	#2: ☐ Pass ☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient Assess need for traction splint: Midthigh femur fracture & no need for immediate transport			
Verbalize at least 3 **contraindications** ☐ Partial amputation ☐ *Hip, pelvis injury ☐ *Knee or lower leg injury ☐ *Exposed bone ends			
State at least two **purposes** of traction splinting ☐ *Elongate muscle and decrease bleeding ☐ *Reduce pain ☐ Reduce or overcome muscle spasm ☐ Better alignment of bone ends prevents further nerve, vascular & tissue damage			
Remove shoe & sock if easily accomplished and expose leg; remove toe rings			
Compare and note motion, sensation and circulation in both feet			
Offer pain/antispasmodic medications if not contraindicated			
Prepare equipment: May use unipolar device (Sager or Faretec) or bipolar device (Hare or Donway style); scoop stretcher or long spine board ☐ Place splint beside pt's uninjured leg; adjust to 8-10" longer than uninjured leg; lock splint length ☐ Adjust proximal and distal support straps			
Perform procedure – Generalized approach – know your device ☐ Manually stabilize site above & below fx so minimal to no motion occurs ☐ Apply ankle hitch under heel, crossing side straps over instep OR apply ankle strap			
☐ Hare: Elevate leg slightly, apply manual traction by pulling on ankle hitch straps (not rings); exert slow, steady pull in axial alignment. Use enough force to align limb to fit into splint; do not attempt to align fragments anatomically. ☐ If pain is severe, stop and immobilize as found with rigid splint or spine board. ☐ Single post: No elevation or manual traction			
☐ Hare: Once manual traction applied; 2nd RESCUER: Slide splint under the leg from the foot upward until the padded ring rests against pt's. ischial tuberosity ☐ Pad the groin area if necessary and secure the ischial strap ☐ Fold down foot stand until it locks into place			
Connect ankle strap to end of splint and turn ratchet until manual traction is replaced by mechanical traction. Traction is sufficient when injured leg is as long as uninjured leg or pt feels relief.			
☐ Ensure that foot remains midline; not inverted or everted ☐ Verbalize action if pulse disappears after application of splint (inform OLMC; await orders)			
Secure proximal and distal support straps leaving injured area and knee open			
☐ Reassess motor, sensory and circulatory integrity of both feet ☐ Warn pt to tell you if they experience weakness or numbness, ↑ pressure, or pain			
Place pt on a long spine board, scoop stretcher, or vacuum mattress for transport			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM: 8/10

NWC EMSS Skill Performance Record

VACUUM SPLINTS

Name #1:	1st attempt:	☐ Pass	☐ Team repeat
Name #2:	2nd attempt:	#1: ☐ Pass	☐ Repeat
Date:		#2: ☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient Assess need for splint: Swollen, painful or deformed extremity or possible spine injury			
Advantage of vacuum splints: Angulated fractures can be splinted as found as opposed to fitting them into a preformed splint			
Inform patient about the procedure			
*Expose injured area; remove all clothing, jewelry and secure w/ pt belongings Remove any sharp or bulky items that may injure pt or damage the splint			
*Compare and note motion, sensation and circulation proximal & distal to injury			
*Cover open wounds with sterile dressings			
Offer pain/antispasmodic medications if not contraindicated			
Prepare equipment: Select appropriate size splint			
*Lay splint out flat, with all straps open and inner surface that will touch patient's skin (face up). May need to pad splint if using on frail skin.			
*Check integrity of splint: rigidity will be compromised due to a leak or tear in splint or if valve is damaged or open			
Perform procedure – Generalized approach – know your device *Gently elevate and support area of injury as splint is placed beneath, then around injured limb, or use a scoop stretcher to place pt into a body mattress splint (maintain spine alignment)			
Wrap splint around sides of limb, or lift edges of mattress to conform around contour of pt, starting at the head; secure with straps (chest, hips, legs)			
*Attach vacuum pump to splint and evacuate air until the splint feels firm and solid Splint should be rigid, conforming to the shape of the limb or body			
Close off vacuum valve and disconnect pump			
Ensure that splint does not shrink too much and become too tight when air is removed Readjust straps as necessary			
*Reassess pain; motor, sensory and circulatory integrity distal to the injury			
May place pt on a long spine board, scoop stretcher for transport if indicated (vacuum mattress may take place of spine board)			
Monitor for cautions: ☐ Loss of vacuum will soften the splint and cause loss of immobilization ☐ Vacuum splints can make motor, sensory and neurovascular checks difficult			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM: 8/10

NWC EMSS Skill Performance Record

APPLICATION of a PELVIC SPLINT

Name #1:	1st attempt:	☐ Pass	☐ Team repeat
Name #2:	2nd attempt:	#1: ☐ Pass	☐ Repeat
Date:		#2: ☐ Pass	☐ Repeat

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient Assess hemodynamic stability and need for splint: possible pelvic fracture ☐ Blood at urinary meatus ☐ Scrotal swelling/hematoma			
Verbalize no contraindications in emergent setting except open fracture			
Inform patient about the procedure			
Compare and note motion, sensation and circulation distal to injury			
Provide pain medication if not contraindicated			
Prepare equipment:			
Select appropriate size splint			
Perform procedure – Generalized approach – know your device Gently slide sheet or pelvic splint under patient from the feet up to the level of the greater trochanters without rocking the patient			
Draw ends of the sheet or pelvic splint together and create circumferential tension to stabilize the pelvis; ensure that splint is not too tight			
Secure feet together			
Reassess motor, sensory and circulatory integrity distal to the injury			
Use scoop stretcher or vacuum body mattress to place pt on stretcher			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

CJM: 8/10

NWC EMSS Skill Performance Record

PNEUMATIC ANTI-SHOCK GARMENT (PASG)

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: You are asked to verify the need and to correctly apply the PASG.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Prepare/assess patient Assess baseline VS; Verbalize indications for PASG: ☐ Fractured pelvis or femur ☐ Intra-abdominal bleeding (AAA, ruptured ectopic pregnancy)			
Verbalize two contraindications: ☐ Abdominal evisceration (legs only) ☐ Penetrating injury above the diaphragm ☐ 2nd/3rd trimester of pregnancy (legs only) ☐ Impaled object in abdomen ☐ Cardiogenic shock ☐ (Absolute) Pulmonary edema/HF			
Quickly examine lower torso and extremities for sharp objects and signs of injury. Remove materials such as broken glass that could injure patient or damage garment.			
Prepare equipment Unfold garment; check to make sure all parts are present & functional; and place next to pt			
Perform procedure Explain procedure to the patient			
Unfold garment with the inside facing up			
Position under a supine patient by having 2 rescuers slide the garment upwards from the feet up to the buttocks. Lift the pelvis slightly and slide garment so the top is at the lower border of the patient's rib cage.			
Snugly wrap and apply Velcro fasteners around the left leg, right leg, and lastly the abdominal section without wrinkles or gaps			
Open valves and attach inflation tubing and foot pump			
Inflate leg compartments one at a time then the abdominal compartment according to the manufacturer's instructions using the foot pump or compressed air source.			
Continue inflation until the SBP reaches 90, garment pop-off valve is activated or Velcro pulls.			
Monitor vital signs (BP) at least every 5 minutes			
Close all valves after sufficient inflation			
If asked to remove trousers: Deflate abdominal compartment slowly while monitoring BP. If BP drops 5 mmHg or more, stop deflation. If BP < 90, provide IVF in 200 mL boluses. Once BP stabilizes, continue to deflate legs as patient tolerates. Reinflate if there is a sudden deterioration in VS.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments_____

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Evaluator

CJM 2/10

NWC EMSS Skill Performance Record

SCOOP STRETCHER

Name:	1st attempt: ☐ Pass ☐ Repeat
Date:	2nd attempt: ☐ Pass ☐ Repeat

NOTE: Never apply traction to neck or spine

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
State indications: Supine pt requires movement to the stretcher when log-rolling onto a long spine board is not advised or contraindicated (impaled objects to posterior body, possible SCI; hip fx)			
State contraindication: Pt size exceeds capacity of device			
Prepare scoop stretcher ☐ Adjust stretcher to length of pt; turn lock pegs where the stretcher narrows to open sliding mechanism ☐ Pull the bottom of stretcher out to desired length ☐ Lock back into place by turning lock pegs in opposite direction (will hear a distinct click when it locks in place)			
* Open mechanism at top and bottom of stretcher to separate into right & left halves			
Prepare the patient Explain process to patient			
☐ Position pt supine unless contraindicated (impaled object on posterior of body ☐ Hold axial alignment and apply C-collar if indicated			
Fold patient's arms across chest			
Procedure * Slide one stretcher half beneath pt on each side, taking care not to pinch skin or clothing. Use a gentle see-saw motion to get each side under pt.			
* Lock stretcher back together at head and foot			
☐ Properly position head support & lateral immobilization; pad as necessary ☐ Secure pt to scoop stretcher with straps over chest, pelvis & knees			
* Bring ambulance stretcher close to pt; put side rails down; lock wheels			
* Place a long board on ambulance stretcher if desired. Note: New model scoop stretchers may replace need for long spine boards on stretcher.			
* Lift scoop stretcher by end-carry method			
* Lower scoop stretcher gently onto backboard or directly onto stretcher			
* Secure patient to stretcher with straps per procedure			
* Reassess patient			

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments _____

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Evaluator

CJM: 8/10

NWC EMSS Skill Performance Record

START & JUMP START TRIAGE SYSTEMS

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: The paramedic shall use the START triage system to initially categorize patients for priority movement to the triage sector.

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
START PRIMARY TRIAGE			
Use appropriate BSI			
Ask pts who can to walk to move to a safe designated area. If can walk: Tag GREEN			
Respiratory status			
* Assesses respirations ☐ If no respirations: open airway ☐ If breathing does not resume: tag deceased and move on ☐ If breathing resumes with airway maneuver: Tag RED (immediate) ☐ If breathing present - check rate. If >30 Tag RED ☐ If rate <30 - check perfusion			
Perfusion			
*** Assess radial pulse** ☐ If pulse absent or cap refill > 2 sec: tag RED; control bleeding ☐ If radial pulse present or cap refill <2 sec: check mental status			
Mental status			
*If pt cannot follow simple commands tag RED			
If pt follows simple commands tag YELLOW (delayed)			
JUMP START TRIAGE SYSTEM			
Use appropriate BSI			
* If patients are able to walk: tag MINOR and send to secondary triage			
* If patients cannot walk assess for breathing ☐ If breathing: assess respiratory rate: If <15 or >45 tag RED ☐ If no breathing: open airway – breathing resumes tag RED ☐ If apneic - check for a pulse. If absent tag BLACK (Deceased) ☐ If pulse present - give 5 rescue breaths, if remains apneic tag BLACK (Deceased) ☐ If breathing resumes - tag RED (Immediate)			
* If respiratory rate is 15-30 per min. - check pulse ☐ if pulse absent - tag RED (Immediate) ☐ If pulse present assess AVPU ☐ If AVPU is inappropriate or unresponsive - tag RED (Immediate) ☐ If AVPU is appropriate - tag YELLOW (Delayed)			

Scoring: **All starred (*) items must be answered or performed correctly in order for the student to pass this station. Any errors or omissions of these items will require a retest.**

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments:_____

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Evaluator

NWC EMSS Skill Performance Record

RESTRAINTS

Date:	EMS Agency		
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education
Name:		☐ Pass	☐ Re-education

Instructions: Use this checklist in conjunction with Policy E-1, the NWC EMSS Procedure: Use of Restraints and the NWC EMSS SOPs. Each system EMT, Paramedic, and PHRN must have their competency measured using this checklist at least every two years. Randomly ask questions requiring a verbal response of all team members.

Performance standard	Yes	No
State 2 observations that should be made during the scene size-up if a pt appears agitated or violent ☐ Inspect for bottles, drugs, letter, notes, toxins ☐ Ask bystanders about recent behavioral changes ☐ Confer with law enforcement if applicable; determine the patient's condition prior to EMS arrival		
Verbalize that EMS personnel must perform a primary assessment		
****State at least 3 assessments that must be performed to determine decisional capacity*** ☐ Consciousness ☐ Speech ☐ Affect/mood ☐ Orientation ☐ Activity ☐ Thought processes ☐ Memory ☐ Perception		
List at least 3 elements that indicate a behavioral emergency with a possibility of violence: ☐ Combative ☐ Shouting ☐ Pacing Punching or kicking ☐ Apparent anger		
Define physical restraint (May paraphrase): Direct application of force to an individual without the person's permission to restrict freedom of movement.		
****Give 2 examples of patients on whom restraints might be needed*** ☐ DAI intubation ☐ Controlled access for medical procedures ☐ Anticipation of improved patient condition producing combativeness ☐ Cardiac arrest patient with ROSC attempting extubation ☐ Patient is combative/uncooperative and poses an imminent risk to self, others, or property ☐ Transport of non-decisional or suicidal patient against their will		
****State at least 3 medical or psychological causes of threatening behaviors.*** ☐ Hypoxia ☐ Neurologic disease (stroke, seizures, intracerebral bleed, dementia) ☐ Substance abuse/OD ☐ Metabolic disorders (hypoglycemia)		
State at least 2 general types of restraint: *May be human, material, mechanical devices, drugs or a combination* ☐ Verbal de-escalation ☐ Physical ☐ Chemical		
****State at least 1 example of a soft restraint*** ☐ Roller gauze ☐ Sheets/blankets ☐ Chest Posey		
****State at least one example of a hard restraint*** ☐ Velcro limb restraints ☐ Plastic ties ☐ Leather restraints		
State one example of a forensic restraint (Handcuffs)		
State who is responsible for a prisoner in handcuffs (Arresting law enforcement officer)		
State what an officer must give to EMS personnel if a prisoner is in handcuffs and they follow the ambulance in the police vehicle (Handcuff key)		
****Verbalize 2 approved positions for a prisoner being transported in handcuffs behind their back*** ☐ Seated ☐ On their side		
Verbalize two civil torts (wrongs) that prehospital providers can be accused of if restraints are incorrectly or inappropriately applied ☐ False imprisonment ☐ Assault/battery		

Performance standard	Yes	No
State a Federal allegation that may be brought due to improper restraint use ☐ Violation of civil rights under the Constitution		
Application of 4 point restraints		
State at least 5 general guidelines regarding application of restraints ☐ Use proper size for patient ☐ Use correct product to prevent patient injury ☐ Secure straps to spine board or stretcher part that moves w/ pt ☐ Secure straps out of patient's reach ☐ Use quick release ties for non-Velcro restraints ☐ Follow infection control guidelines for cleaning restraints ☐ Must be informed restraint *		
State at least 2 steps to prepare a patient for restraint application ☐ Remove all jewelry from areas to be restrained ☐ Expose area to assess limb SMV ☐ Provide as much privacy as possible		
State the minimum number of rescuers needed to apply restraints to a violent pt. (4-5)		
*Prepare equipment (2 wrist; 2 leg restraints)		
Plan the approach to the patient		
Demonstrate application of 4 point restraints with team members ***Take patient safely down to a prone position**		
*One person should control each limb by grasping clothing and large joints		
*Adjust patient to a supine or side-lying position as soon as EMS has control of patient's movements (on backboard preferred). **Auto-Repeat:** Patient left supine and hogtied		
*Restrain 1 arm at side and other above head; both legs to stretcher		
*Place stretcher straps over bony prominences, criss-crossed over chest, pelvis, legs **Auto-Repeat**: Straps cinched across neck, chest, abdomen or compromised airway/ventilations		
*Reassess SMVs in all 4 extremities		
****How often must VS, airway patency, and neurovascular status be reassessed while patient is restrained?*** At least every 15 minutes		
****Verbalize how to recognize improperly applied restraints and how to resolve the situation immediately.*** ☐ Patient can move or thrash about ☐ Release/reapply one limb at a time		
****State at least 3 signs of physical distress in individuals who are being held or restrained*** ☐ Shortness of breath ☐ Reduced/absent pulse distal to restraint ☐ Inability to speak ☐ Cool/pale limb distal to restraint ☐ Hypoxia ☐ Hyperthermia ☐ Pain due to restraint ☐ Cardiac dysrhythmia; unstable VS ☐ Soft tissue injury		
****Who must provide authorization for restraints either before or after their application?*** On-line medical control physician		
Under what circumstances are EMS personnel authorized to remove restraints once applied? Patient is reassessed to be fully decisional and cooperative and EMS personnel receive orders from on-line medical control to discontinue restraint.		
What steps may EMS personnel take if a patient is biting or spitting at them? Apply a c-collar and place a surgical or oxygen mask over the patient's face or use the TranZport hood		
Special populations		
Who must accompany a child in restraints? Responsible adult		
How can one compensate for an elderly adult's loss of sight or hearing? Reassuring physical contact		
What special accommodations must be made for hearing impaired persons whose primary mode of communication is sign language? Hands must be freed for brief periods unless freedom may result in physical harm		
****To whom must EMS personnel report a death of a patient while in handcuffs?*** EMS MD *Within what time frame?* 2 hours		

Performance standard	Yes	No
Chemical restraint (Paramedics/PHRNs) **Which agent is used to achieve sedation for combative patients?* midazolam IVP/IN **State the IN dose for adult patients* 0.2 mg/kg up to 10 mg **State the IV dose for adult patients* 2 mg increments up to10 mg		
State at least 3 continued risks to a patient who is struggling before or after restraint application that justifies the use of chemical restraint? ☐ Hypoxia ☐ Severe acidosis ☐ Hyperthermia ☐ Positional asphyxia ☐ Hyperkalemia ☐ Fatal dysrhythmia ☐ Aspiration ☐ Rhabdomyolysis ☐ Sudden cardiac arrest		
***Documentation:** *List at least 6 things that must be documented if a patient was placed into restraints:* ☐ Clinical justification for use ☐ Failure of non-physical methods of restraint ☐ Reasons for restraint were explained to patient (informed restraint) ☐ Restraint order: on-line medical control or SOP; physician's name who authorized restraint ☐ Rationale for type of intervention selected ☐ Type(s) of restraint used ☐ Reassessments every 15 minutes ☐ Care during transport ☐ Any injuries sustained by patient or rescuers ☐ A petition form is to be completed when EMS personnel or family members have first hand knowledge and reasonably suspect that a patient **is mentally ill** and because of their illness **would intentionally or unintentionally inflict serious physical harm upon themselves or others in the near future, is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future, or is unable to provide for his or her own basic physical needs so as to guard himself or herself from serious harm** and needs transport to a hospital for examination by a physician (Ill Mental Health Code).		

Scoring: All starred (*) items must be answered/performed correctly in order for the participant to complete this station successfully. Any errors or omissions of these items will require practice/repeat.

Recommendation:

☐ Excellent knowledge of material; no coaching needed.
☐ Satisfactory knowledge of material: minimal coaching needed.
☐ Could not perform some points even with coaching; recommend practice/repeat.

Comments_____

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Evaluator

CJM: 2/10

NWC EMSS Skill Performance Record

POST-TASER EMS PROCEDURE

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions**:** *An adult has been subdued by law enforcement personnel using a taser. Please examine the patient and verbalize any treatment that you should provide.*

Performance standard	Performs w/o coaching	Performs w/ coaching	Needs additional practice
Scene size up Confer with police; determine pt's condition before, during & after taser discharge			
Perform a primary assessment ☐ SpO_2 monitor ☐ ECG monitoring for potential cardiac dysrhythmias ☐ If pt is reporting symptoms that could be cardiac in nature, is elderly, or has a history of cardiac or drug use, do a 12 L ECG			
Perform a rapid secondary assessment. Tased individuals can have injury or illness that occurs before they are tased and/or injury when they are tased and fall			
Assess for excited delirium: ☐ State of agitation, excitability, paranoia, aggression ☐ Great strength ☐ Numbness to pain ☐ Violent behavior			
☐ Assess baseline vital signs ***"What should a paramedic be looking for?"*** ☐ Hyperthermia ☐ Volume depletion ☐ Tachycardia (hypersympathetic state) ☐ Metabolic acidosis			
Determine SAMPLE history: date of last tetanus prophylaxis cardiac history; ingestion of mind altering stimulant (PCP, cocaine)			
ITC: Supportive care ☐ Apply/maintain restraints if needed ☐ Sedate w/ benzodiazepine prn ☐ IV fluids to correct volume depletion if present			
Identify location of probes: DO NOT remove if in face, neck, groin, spinal column			
Removal of probe: If not contraindicated, probes may be removed. Place one hand over area where probe is embedded; stretch skin around puncture site. Place other hand firmly around probe.			
In one movement, pull probe straight out from the puncture site. Apply direct pressure over wound with a sterile 4X4. Repeat with additional probes.			
Handle as a sharp & dispose of removed probes in a designated sharps container. Check with local law enforcement to see if they require that probes be kept as evidence.			
Cleanse puncture sites and bandage as appropriate			
If patient has not had tetanus immunization in the last 5 yrs, advise to acquire it			
Transport for further evaluation			
If pt is decisional and refuses treatment and/or transport, advise to seek medical attention immediately if they experience any abnormal S or S. Provide disclosure of risk and obtain signature on refusal form. Contact OLMC from point of patient contact.			

Scoring: All starred (*) items must be answered/performed correctly in order for the student to complete this station. Any errors or omissions of these items will require practice/repeat.

Recommendation:
- ☐ Excellent knowledge of material; no coaching needed.
- ☐ Satisfactory knowledge of material: minimal coaching needed.
- ☐ Could not perform some points even with coaching; recommend practice/repeat.

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Evaluator

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