NORTHWEST
COMMUNITY
EMERGENCY
MEDICAL
SERVICES
SYSTEM

PROCEDURE MANUAL

2016

NWC EMSS PROCEDURE MANUAL December 2016

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, intervene as needed, and call your findings in to the hospital.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
SCENE SIZE UP		
* Determine scene safety; control & correct hazards; remove pt/crew from unsafe environment ASAP		
If a potential crime scene, make efforts to preserve possible evidence		
* Determine nature of illness; scan environment for clues; DNR/POLST orders		
Universal blood/body secretion & sharps precautions; use appropriate PPE prn		
Determine number of patients & triage if necessary. Determine need for additional assistance and request additional help if necessary, Weigh risk of waiting for resources against benefit of rapid transport to definitive care. Consider if medium or large scale MPI declaration is needed.		
PRIMARY ASSESSMENT/RESUSCITATION (IMC) Time assessment began:		
Introduce self to patient; ask patient name; begin to establish rapport with patient/significant others		
Form general impression: age, gender, general appearance, position, purposeful movements		
*Determine **Level of consciousness** using AVPU or GCS		
Determine chief complaint S&S		
Determine if immediate life threat exists and resuscitate as found		
If unconscious, apneic or gasping, & pulseless START QUALITY CPR		
AIRWAY: Assess for impairment: Snoring, gurgling, stridor, silence; consider possible spine injury		
Intervention: ☐ Open/maintain using position, suction, and appropriate adjuncts ☐ If Obstructed: Go to AIRWAY OBSTRUCTION SOP ☐ Loosen tight clothing; vomiting and seizure precautions as indicated		
Breathing/gas exchange/adequacy of ventilations. Assess/intervene as needed ☐ *Assess for spontaneous ventilations; general rate (normal, fast or slow) ☐ *Assess depth; effort/WOB; accessory muscle use ☐ Assess position, adequacy of air movement, symmetry of chest expansion, retractions ☐ Lung sounds if in ventilatory distress ☐ ***Assess gas exchange;** apply SpO_2 monitor; assess for hypoxia, cardiorespiratory or neurological compromise. Note before & after O_2 if able. Note signs of hypoxia ☐ *Assess $ETCO_2$ number& waveform if possible ventilatory, perfusion, metabolic compromise		
***Correct hypoxia/**assure adequate ventilations: Target SpO_2: 94%-98% (92% COPD) unless hyperoxia contraind. ☐ **O_2 1-6 L/NC**: Adequate rate/depth; minimal distress; SpO_2 92%-94% (88%-91% COPD) ☐ **O_2 12-15 L/NRM:** Adequate rate/depth: mod/severe distress; SpO_2 < 92%; (<88% COPD) ☐ **O_2 15 L/ BVM:** Apnea and/or shallow/inadequate rate/depth with moderate/severe distress; unstable. Adults: 1 breath every 6 sec (10 breaths/minute) (Asthma: 6-8 BPM) ☐ **CPAP:** Per appropriate SOP *Hyperoxia contraindicated: Uncomplicated Acute MI; post-cardiac arrest; acute exacerbations COPD; stroke; newborn resuscitation. Give O_2 only if evidence of hypoxia; titrate to dose that relieves hypoxemia w/o causing hyperoxia: SpO_2 94% (92% COPD)		
CIRCULATION / PERFUSION / ECG: ☐ *Central and peripheral pulses for presence, general rate/quality/regularity ☐ **Perfusion**: Mental status (central); skin: color, temperature, moisture; turgor (peripheral) ☐ Identify type, volume, & source(s) of bleeding; verbalize sequencing of external hemorrhage control ☐ Assess jugular veins for distension ☐ *Verbalize need for **ECG:** (rhythm/12 L) based on chief complaint or PMH: pain/discomfort nose to navel, SOB/HF, weak/tired/ fatigued, dizziness/syncope, c/o nausea, indigestion, palpitations/dysrhythmia, diaphoresis, etc.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ Treat rate/rhythm/pump/volume/volume distribution disorders per appropriate SOP ☐ **Vascular access:** actual/potential volume replacement and/or IV meds prior to hospital arrival **0.9% NS** – Catheter size, access site, & infusion rate based on pt size, hemodynamic status; SOP or OLMC. Do not delay transport of time-sensitive pts to establish elective vascular access on scene ☐ **Indications for IO**: Pts in extremis urgently needing fluids and/or medications (circulatory collapse; difficult, delayed, or impossible venous access; or conditions preventing venous access at other sites). If conscious: infuse Lidocaine 2% 1 mg/kg (max 50 mg) IO before NS flush unless contraindicated ☐ If peripheral IV unsuccessful / not advised, may use central venous access devices already placed based on OLMC		
Disability if altered mental status ☐ *Assess glucose level (verbalizes) ☐ *Assess pupils for size, shape, equality, reactivity to light (direct & consensual) ☐ *Assess Glasgow Coma Score (using chart in SOP) ☐ Evaluate gross motor and sensory function in all extremities; if acute stroke suspected go to Stroke SOP		
Exposure/environment ☐ Discretely undress patient to inspect appropriate body areas; protect patient modesty ☐ Maintain body warmth		
*Identify time-sensitive (priority transport) patients/makes appropriate transport decision Goal: 10 min or less		
SECONDARY ASSESSMENT		
Vital signs ☐ *BP (MAP); obtain 1st manually, trend pulse pressure; orthostatic changes prn ☐ *Pulse: rate, quality, rhythmicity ☐ *Resp: rate, pattern, depth ☐ Temp if high or low based on skin		
History of present illness ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/radiation ☐ *Time (last seen normal) ☐ Clarifying questions of associated signs and symptoms as related to OPQRST		
SAMPLE history ☐ *Allergies (meds, environment, foods), ☐ *Medications (prescription/over-the-counter – bring containers to hospital if possible) ☐ *Past pertinent history: medic-alert jewelry; advance directives; medical devices/implants ☐ *Last oral intake/LMP ☐ *Events leading to present illness In pts with **syncope, seizure, AMS, cardiac arrest, or acute stroke**, consider bringing witness to hospital or obtain **call back phone number** ☐ *Date of birth; approx. weight		
PHYSICAL EXAM (Review of Systems) – must touch the patient		
Head/eyes, ear, nose throat (HEENT) ☐ *Inspect head, eyes, ears, nose, throat ☐ Palpate: skull, orbits, nasal and facial bones		
Neck ☐ *Inspect: jugular veins, edema ☐ Palpate: position of trachea; cervical spines		
Chest: Pulmonary/Cardiovascular ☐ *Inspect: Symmetry, contour/shape; AP/lateral diameter; chest wall mvmnt, deformity, retractions ☐ *Palpate ☐ *Auscultate breath sounds; heart sounds if applicable		
Abdomen/pelvis/genitalia/reproductive organs - in correct order ☐ *Inspect (contour, symmetry, discoloration; pain; changes in function (verbalizes) ☐ Auscultate bowel sounds ☐ *Palpate (light) for point tenderness, guarding, rigidity; ✓ rebound tenderness if S&S peritonitis		
Musculoskeletal assessment: Lower extremities ☐ Inspect symmetry, edema, skin changes, discoloration ☐ *Palpate: pulses, warmth, pain; pitting edema ☐ Sensory/Motor/Vascular status of each limb		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Upper extremities ☐ Inspect symmetry, edema, skin changes, discoloration ☐ *Palpate: pulses, warmth, pain; pitting edema ☐ Sensory/Motor/Vascular status of each limb		
Back ☐ Inspect ☐ Palpate		
Neurologic ***Mental status**: affect, behavior, cognition (verbalizes); memory/orientation; GCS **Cranial nerves** (Select) ☐ *Visual acuity ☐ EOMs ☐ Hearing ☐ *Pupil size, shape, equality ☐ Facial sensation ☐ Gag ☐ *Pupil reactivity to light ☐ Facial movement/symmetry/eyelid closing ☐ Stick out tongue **Cerebellar exam**: Assess for ataxia ☐ **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 pt slide heel of one foot rapidly up and down shin of opposite leg ☐ If possible stroke: Prehospital **Stroke Screen**:		
Skin: Integumentary assessment (integrated above) color (variation), moisture, temp, texture, turgor, lesions/breakdown; hair distribution; nails (clubbing)		
Psychological/social assessment		
*State **paramedic impression**:		
Verbalize treatment plan and appropriate interventions		
Transport decision re-evaluated		
On-going assessment enroute		
Repeat primary & secondary assessments		
Evaluate responses to treatments		
Reassess VS/pt. responses. Every transported pt. should have at least 2 sets of VS. ☐ **Stable**: At least q. 15 min & after each drug/cardiorespiratory intervention; last set should be taken shortly before arrival at receiving facility ☐ **Unstable**: More frequent reassessments; continue to reassess all abnormal VS & physical findings		
Actual time to complete assessment in 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(s) (list): ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/radiation ☐ *Time		
Associated complaints:		
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 ☐ Temp prn ☐ *Pulse: rate , quality ☐ SpO_2 ☐ Capnography		
*Physical examination findings; include pertinent positives and negatives		
Treatments initiated prior to hospital contact (IMC) and patient response to treatment		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
ETA		
Critical Criteria - Check if occurred during an attempt ☐ Failure to initiate or call for transport of the patient within 15 minute time limit ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to determine scene safety before approaching patient ☐ Failure to voice and ultimately provide appropriate oxygen therapy ☐ Failure to assess/provide adequate ventilation ☐ Failure to find or appropriately manage problems associated with airway, breathing, hemorrhage or shock [hypoperfusion] ☐ Failure to differentiate pt's need for immediate transport vs assessment & treatment at scene ☐ Does Secondary assessment before assessing and treating threats to airway, breathing,& circulation ☐ Failure to determine the patient's primary problem ☐ Uses or orders a dangerous or inappropriate intervention ☐ Failure to provide for spinal protection when indicated ☐ Exhibits unacceptable affect with patient or other personnel		

Factually document below your rationale for checking any of the above critical criteria.

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

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Preceptor (PRINT NAME - signature

WC EMSS Skill Performance Record

TRAUMA ASSESSMENT

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

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
SCENE SIZE UP		
* Determine scene safety; control & correct hazards; remove pt/crew from unsafe environment ASAP		
If a potential crime scene, make efforts to preserve possible evidence		
* Determine nature of illness; scan environment for clues; DNR/POLST orders		
Universal blood/body secretion & sharps precautions; use appropriate PPE prn		
Determine number of patients & triage if necessary. Determine need for additional assistance and request additional help if necessary, Weigh risk of waiting for resources against benefit of rapid transport to definitive care. Consider if medium or large scale MPI declaration is needed.		
PRIMARY ASSESSMENT/RESUSCITATION (IMC) Time assessment began:		
*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 ☐ **Assess for immediate life threats**: tension pneumo; open pneumo; flail chest ☐ *Verbalize appropriate resuscitative intervention for life-threat ☐ Ensures adequate ventilations ☐ *Initiate appropriate O_2 therapy based on SpO_2 and level of distress ☐ -Manages any injury which may compromise breathing/ventilation		
Circulatory status; assess for impairment (C-A-B-C-D-E approach if sign external bleeding) ☐ *Assess for and control major bleeding if present ☐ *Central and peripheral pulses for presence, general rate/quality/rhythmicity ☐ *CPR if indicated (rapid transport decision for patient in traumatic arrest) ☐ *Skin (verbalizes color, temperature, moisture, turgor) ☐ Assess neck veins for distension ☐ ***Assess for immediate life threats**: Cardiac tamponade; blunt cardiac injury; shock ☐ *Verbalize appropriate resuscitative intervention for life-threat ☐ *Verbalize need for ECG monitor if pulse absent/irregular ☐ * Initiate appropriate vascular access and (warm) IV fluids for condition		
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		
☐ **Pain mgt** if SBP ≥ 90 (MAP≥ 65): **FENTANYL** standard dose per IMC ☐ **Nausea**: **ONDANSETRON** standard dose per IMC		
Exposure/environment ☐ Discretely undress patient to inspect appropriate body areas; protect patient modesty ☐ Maintain body warmth		
*Identify time-sensitive priority patients/make transport decision to appropriate hospital		
SECONDARY ASSESSMENT		
Vital signs		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ *BP (MAP); obtain 1st manually, trend pulse pressure; orthostatic changes prn ☐ *Pulse: rate, quality, rhythmicity ☐*Resp: rate, pattern, depth ☐ Temp based on skin		
History of present illness/trauma ☐ Onset ☐ *Quality ☐ *Severity ☐ *Provocation/palliation ☐ *Region/Radiation ☐ *Time ☐ Associated complaints		
***SAMPLE history** from patient/family/bystanders ☐ Allergies ☐ Past medical hx ☐ *Events leading to injury/MOI ☐ Medications ☐ Last meal/LMP ☐ Age ☐ Approx wt.		
PHYSICAL EXAM (Review of Systems) – must touch the patient		
Head/eyes, ear, nose throat (HEENT) ☐ Inspect: DCAP-BLS, drainage from eyes, nose, mouth (open/close jaw)/malocclusion, face, scalp, ears ☐ *Palpate: skull, orbits, nasal and facial bones		
Neck: May temporarily remove anterior c-collar to assess neck ☐ *Inspect: DCAP, BLS; jugular veins; sub-q emphysema ☐ *Palpate: position of trachea; C-spines, carotid pulses		
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 injury/peritonitis by quadrant: contour, visible pulsations, pain referral sites, localized tenderness, guarding, rigidity; evidence of rebound tenderness ☐ **PELVIS/GU:** Inspect perineum for blood at urinary meatus/rectum ☐ Assesses for pelvic fractures if not done already; apply upside down KED		
Lower extremities ☐ *Inspect for position, false motion, skin color, and signs of injury ☐ *Palpate ☐ *Assesses SMV status of each limb		
Upper extremities ☐ Inspect for position, false motion, skin color, and signs of injury ☐ *Palpate ☐ *Assesses SMV status of each limb		
Posterior thorax/flank and buttocks ☐ *Inspect ☐ *Palpate (assess for muscle spasms)		
Neurologic ***Mental status**: affect, behavior, cognition (verbalizes); memory/orientation; GCS, RTS **Cranial nerves** (Select) ☐ *Visual acuity ☐ EOMs ☐ Hearing ☐ *Pupil size, shape, equality ☐ Facial sensation ☐ Gag ☐ *Pupil reactivity to light ☐ Facial movement/symmetry/eyelid closing ☐ Stick out tongue **Cerebellar exam**: Assess for ataxia ☐ **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 pt slide heel of one foot rapidly up and down shin of opposite leg.		
Skin: Integumentary assessment (integrated above) color (variation), moisture, temp, texture, turgor, lesions/burns; breakdown; hair distribution;		
*State paramedic impression:		
Verbalize treatment plan using appropriate SOP		
*Select appropriate receiving hospital based on trauma triage criteria		
Actual total time to complete assessment in minutes		
On-going assessment		
Repeat initial (primary) assessment		
Evaluate response to treatments		
Reassess VS/pt. responses. Every transported pt. should have at least 2 sets of VS. ☐ **Stable**: At least q. 15 min & after each drug/cardiorespiratory intervention; last set should be taken shortly before arrival at receiving facility ☐ **Unstable**: More frequent reassessments; continue to reassess all abnormal VS & physical findings		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
OLMC 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)		
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		
CRITICAL CRITERIA in addition to starred items ☐ Failure to initiate or call for transport of the patient within 10 minute time limit ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to determine scene safety ☐ Failure to assess for and provide spinal protection when indicated ☐ Failure to voice and ultimately provide high concentration of oxygen ☐ Failure to assess/provide adequate ventilation ☐ Failure to find or appropriately manage problems associated with airway, breathing, hemorrhage or shock [hypoperfusion] ☐ Failure to differentiate pt's need for immediate transport vs cont. assessment/treatment at scene ☐ Does secondary assessment before assessing/treating threats to airway, breathing, and circulation ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document your rationale for checking any of the above Critical Criteria items

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

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Preceptor (PRINT NAME - signature

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 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 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

Instructions: You are asked to open the airway of a patient who has snoring ventilations.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
HEAD-TILT, CHIN-LIFT MANEUVER		
*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: look, listen and feel 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		
JAW-THRUST MANEUVER		
☐ *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.		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 10/16

Station preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ *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 pt's lips. Verify 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)		
Critical Criteria: Check if occurred during an attempt Failure to take or verbalize appropriate body substance isolation precautions Performs any improper technique resulting in the potential for patient harm Exhibits unacceptable affect with patient or other personnel	 ☐ ☐ ☐	 ☐ ☐ ☐

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 10/16

Station preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
State indications: upper airway impairment; need for 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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Rating: (Select 1)

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 10/16

Station preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
State indications for procedure: Secretions in mouth, nose or pharynx		
* Universal plus droplet precautions (gloves/face shield)		
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.		
Without applying suction ☐ Insert suction catheter no deeper than pharynx. ☐ If Yankauer tip, insert w/ convex side along roof of mouth.		
* Apply suction using a gentle twisting motion while limiting suction application to 10 sec on an adult and 5 sec in a child		
Refrain from jabbing catheter up and down while applying suction		
* Reoxygenate patient with O_2 15 L/NRM or BVM		
Verbalize: Flush the suction catheter 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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Station preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Universal plus droplet precautions (gloves/face shield)		
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: ☐ Suction kit, suction catheter; suction source ☐ 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).		
* Using sterile technique, open suction kit and catheter packaging. Apply one sterile glove on dominant hand. Using sterile hand, lift catheter from packaging and wrap catheter around sterile hand. Maintain sterility of the catheter.		
* Using non-dominant hand, connect catheter to suction tubing.		
* Turn power on to high		
Perform procedure * Without applying suction, insert catheter into ETT. 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 in adult and 5 sec in child.		
* 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Continue manual attempts while preparing for direct laryngoscopy. Verbalize appropriate indications for performing this skill		
*Universal precautions: gloves, face shield		
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 management 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 alternate airway ☐ *Unable to insert King or ventilate effectively: Cricothyrotomy		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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Station preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Takes or verbalizes BSI precautions: gloves, goggles, facemask		
Prepare patient ☐ Open the airway manually ☐ *Elevate tongue, insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate for 3 min w/ O_2 12-15 L/BVM with O_2 reservoir; at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; overbite		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Laryngoscopes & blades (curved and straight; multiple sizes) ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Bougie; 10 mL syringe; water-soluble lubricant ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT)		
☐ **Prepare Bougie** (disposable, flexible; ET tube introducer; 15 Fr, 60-70 cm, with curved tip). Remove Bougie from package; note markings and orientation of upturned coude tip. If needed, straighten bougie and curve distal end (~1" from tip) at 35-40° angle ☐ **Verbalize indications for Bougie:** All ETI attempts if either the epiglottis or posterior cartilages are seen ☐ **Verbalize contraindications for Bougie**: Inability to visualize either epiglottis or posterior cartilages		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
* Assemble laryngoscope; ensure it is operational; check light source (tight, bright & white)		
Pass tube: * (Allow no more than 30 sec of apnea)		
☐ Maintain O_2 6 L/NC during procedure ☐ Assistant or examiner stops ventilating pt; withdraws OPA (NPA remains) ☐ Have partner apply lip retraction, external laryngeal pressure ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, (SpO_2 if perfusing rhythm) q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ 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 ☐ *Seat blade. Lift at a 45° to floor of mouth avoiding the upper gums/teeth. Look to visualize epiglottis, posterior cartilages, and/or vocal cords		
Bougie assisted procedure *Grip Bougie like pencil with curved tip facing upward in dominant hand (laryngoscope in non-dominant hand). Caution: Minor rotation of bougie can change orientation and location of tip, prevent placement and confirming clicking sensation		
***Visualization & insertion** ☐ Insert gently in midline under epiglottis and/or above posterior cartilage; avoid forceful insertion – can cause tracheal trauma/perforation		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Confirmation of bougie placement into trachea** ☐ Advance until resistance (hold up) is felt (25-40 cm at teeth) due to distal airway narrowing ☐ Clicking/vibration sensation felt (60-95% of cases) when bougie tip rubs against anterior tracheal rings (tip must be oriented anteriorly) ☐ If inserted into esophagus, no clicking/vibration is felt and tip easily advances well beyond 40 cm		
***Insertion of ET tube** ☐ Intubator maintains view with laryngoscope in place and firm hold onto bougie; maintain bougie at 25 cm at teeth. Keep laryngoscope in place to allow ETT to pass under tongue. ☐ Assistant places ETT with lubricated tip over top of bougie and advances ETT until it reaches intubator's fingers ☐ As ETT reaches intubator's fingers, assistant takes over hold onto bougie while intubator continues to advance the ETT toward glottic opening ☐ Alternate approach: Insert bougie through ETT and extend bougie tip ~8-10" beyond distal end of ETT prior to inserting ☐ Counterclockwise rotation of ETT facilitates insertion through vocal cords into trachea		
***If > 30 sec: of apnea**; remove laryngoscope and bougie, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position, blade, or PM and attempt again. May go straight to King LT if unable to visualize anything.		
* Once ETT is inserted to proper depth (3X tube ID at teeth), firmly hold ETT in place and carefully remove blade from mouth and bougie from ETT		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 ventilate as needed at 10 BPM unless asthma/COPD (6-8 BPM)– observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2. ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If in esophagus: remove ETT, reoxygenate 30 sec; repeat from insertion of blade with new tube ☐ *If ETT cannot be placed successfully (2 attempts) or nothing can be visualized; attempt extraglottic airway.		
If tube placed correctly ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ * Insert OPA; align ETT with side of mouth; secure ETT with commercial tube holder; apply lateral head immobilization.		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change If intubated & deteriorates, consider**: D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
Post-intubation sedation: If pt remains unconscious but begins to bite 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 ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ **Over sedation**		
***Critical Criteria: Check if occurred during an attempt (automatic fail)** ☐ Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully intubate within 2 attempts without immediately providing alternate airway ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Uses teeth as a fulcrum ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

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Rating: (Select 1)

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

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Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Gloves, goggles, facemask		
* Takes or verbalizes BSI precautions: gloves, goggles, facemask		
Prepare patient ☐ Open the airway manually using spine precautions ☐ *Insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/BVM with O_2 reservoir; at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; overbite		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Laryngoscopes & blades (curved and straight; multiple sizes) ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Bougie; 10 mL syringe; water-soluble lubricant ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT)		
☐ **Prepare Bougie** (disposable, flexible; ET tube introducer; 15 Fr, 60-70 cm, with curved tip). Remove Bougie from package; note markings and orientation of upturned coude tip. If needed, straighten bougie and curve distal end (~1" from tip) at 35-40° angle ☐ **Verbalize indications for Bougie:** All ETI attempts if either the epiglottis or posterior cartilages are seen ☐ **Verbalize contraindications for Bougie**: Inability to visualize either epiglottis or posterior cartilages		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
* Assemble laryngoscope; ensure it is operational; check light source (tight, bright & white)		
Pass tube: * (Allow no more than 30 sec of apnea)		
☐ Maintain O_2 6 L/NC during procedure ☐ Assistant stops ventilating pt; withdraws OPA (NPA remains) and opens front of c-collar ☐ *Intubator positions self at head of pt and straddles pt head between their legs or kneels with pt head between their knees ☐ 2nd person positions self to side of patient and provides neck stabilization by placing their thumbs on pt maxillae & circling fingers around side of head and neck ☐ If another assistant available: Have them apply lip retraction, external laryngeal pressure ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, (SpO_2 if perfusing rhythm) q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ Intubator: 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 ☐ *Seat blade. Lean back while extending arm and lift blade ☐ Look to visualize epiglottis, posterior cartilages, and/or vocal cords		
Bougie assisted procedure		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*Grip Bougie like pencil with curved tip facing upward in dominant hand (laryngoscope in non-dominant hand). Caution: Minor rotation of bougie can change orientation and location of tip, prevent placement and confirming clicking sensation		
***Visualization & insertion** ☐ Insert gently in midline under epiglottis and/or above posterior cartilage; avoid forceful insertion – can cause tracheal trauma/perforation ***Confirmation of bougie placement into trachea** ☐ Advance until resistance (hold up) is felt (25-40 cm at teeth) due to distal airway narrowing ☐ Clicking/vibration sensation felt (60-95% of cases) when bougie tip rubs against anterior tracheal rings (tip must be oriented anteriorly) ☐ If inserted into esophagus, no clicking/vibration is felt and tip easily advances well beyond 40 cm		
***Insertion of ET tube** ☐ Intubator maintains view with laryngoscope in place and firm hold onto bougie; maintain bougie at 25 cm at teeth. Keep laryngoscope in place to allow ETT to pass under tongue. ☐ Assistant places ETT with lubricated tip over top of bougie and advances ETT until it reaches intubator's fingers ☐ As ETT reaches intubator's fingers, assistant takes over hold onto bougie while intubator continues to advance the ETT toward glottic opening ☐ Alternate approach: Insert bougie through ETT and extend bougie tip ~8-10" beyond distal end of ETT prior to inserting ☐ Counterclockwise rotation of ETT facilitates insertion through vocal cords into trachea		
*** If > 30 sec: of apnea**; remove laryngoscope & bougie, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position, blade, or PM. May go straight to King LT if unable to visualize anything.		
* Once ETT is inserted to proper depth (3X tube ID at teeth), firmly hold ETT in place and carefully remove blade from mouth and bougie from ETT		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 ventilate as needed at 10 BPM unless asthma/COPD (6-8 BPM)– observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2. ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If in esophagus: remove ETT, reoxygenate 30 sec; repeat from insertion of blade with new tube ☐ *If ETT cannot be placed successfully (2 attempts) or nothing can be visualized; attempt extraglottic airway.		
If tube placed correctly ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ *Insert OPA; align ETT with side of mouth; secure ETT with commercial tube holder; reattach anterior c-collar; apply lateral head immobilization.		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change If intubated & deteriorates, consider**: D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
Post-intubation sedation: If pt remains unconscious but begins to bite 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 ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ **Over sedation**		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
***Critical Criteria: Check if occurred during an attempt (automatic fail)** ☐ Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully intubate within 2 attempts without immediately providing alternate airway ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Uses teeth as a fulcrum ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

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Preceptor (PRINT NAME - signature

NWC EMSS Skill Performance Record

DRUG-ASSISTED INTUBATION w/ Bougie

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

Instructions: An awake adult with an intact gag reflex (non-traumatic cause) is in 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 with bougie.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize at least 2 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.		
* Takes or verbalizes BSI precautions: gloves, goggles, facemask		
Prepare patient ☐ Open the airway manually if needed ☐ *Insert BLS adjuncts: NPA or OPA unless contraindicated if bag-mask ventilations needed		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/NRM or BVM with O_2 reservoir at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Assess for signs suggesting a difficult intubation: neck/mandible immobility, oral trauma, loose teeth; F/B; inability to open mouth, Mallampati view III or IV, short thyromental distance; overbite		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Laryngoscopes & blades (curved and straight; multiple sizes) ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Bougie; 10 mL syringe; water-soluble lubricant ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT) ☐ Premedication (benzocaine spray, fentanyl) and sedative (etomidate or if asthma/child: ketamine)		
☐ **Prepare Bougie** (disposable, flexible; ET tube introducer; 15 Fr, 60-70 cm, with curved tip). Remove Bougie from package; note markings and orientation of upturned coude tip. If needed, straighten bougie and curve distal end (~1" from tip) at 35-40° angle ☐ **Verbalize indications for Bougie:** All ETI attempts if either the epiglottis or posterior cartilages are seen ☐ **Verbalize contraindications for Bougie**: Inability to visualize either epiglottis or posterior cartilages		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside top of ETT package; draw tube through lubricant when removing		
* Assemble laryngoscope; ensure it is operational; check light source (tight, bright & white)		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Premedicate if applicable ☐ ***Benzocaine spray** to posterior pharynx 1-2 sec spray, 30 sec apart X 2 (if + gag) ☐ Fentanyl per SOP for pain		
Sedate: ☐ *__Etomidate__ 0.5 mg/kg IVP (max 40 mg) OR ☐ ***Ketamine** (asthma attack or child) 2 mg/kg slow IVP (over one min) or 4 mg/kg IM Allow for clinical response before intubating (if possible)		
Pass tube: * (**Allow no more than 30 sec of apnea**)		
☐ Maintain O2 6 L/NC during procedure ☐ Assistant or examiner stops ventilating pt; withdraws OPA (NPA remains) ☐ Have partner apply lip retraction, external laryngeal pressure ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, (SpO_2 if perfusing rhythm) q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ 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 ☐ *Seat blade. Lift at a 45° to floor of mouth avoiding the upper gums/teeth. Look to visualize epiglottis, posterior cartilages, and/or vocal cords		
Bougie assisted procedure *Grip Bougie like pencil with curved tip facing upward in dominant hand (laryngoscope in non-dominant hand). Caution: Minor rotation of bougie can change orientation and location of tip, prevent placement and confirming clicking sensation		
***Visualization & insertion** ☐ Insert gently in midline under epiglottis and/or above posterior cartilage; avoid forceful insertion – can cause tracheal trauma/perforation ***Confirmation of bougie placement into trachea** ☐ Advance until resistance (hold up) is felt (25-40 cm at teeth) due to distal airway narrowing ☐ Clicking/vibration sensation felt (60-95% of cases) when bougie tip rubs against anterior tracheal rings (tip must be oriented anteriorly) ☐ If inserted into esophagus, no clicking/vibration is felt and tip easily advances well beyond 40 cm		
***Insertion of ET tube** ☐ Intubator maintains view with laryngoscope in place and firm hold onto bougie; maintain bougie at 25 cm at teeth. Keep laryngoscope in place to allow ETT to pass under tongue. ☐ Assistant places ETT with lubricated tip over top of bougie and advances ETT until it reaches intubator's fingers ☐ As ETT reaches intubator's fingers, assistant takes over hold onto bougie while intubator continues to advance the ETT toward glottic opening ☐ Alternate approach: Insert bougie through ETT and extend bougie tip ~8-10" beyond distal end of ETT prior to inserting ☐ Counterclockwise rotation of ETT facilitates insertion through vocal cords into trachea		
* If > 30 sec: of apnea; remove laryngoscope and bougie, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position, blade, or PM. May go straight to King LT if unable to visualize anything.		
* Once ETT is inserted to proper depth (3X tube ID at teeth), firmly hold ETT in place and carefully remove blade from mouth and bougie from ETT		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 ventilate as needed at 10 BPM unless asthma/COPD (6-8 BPM)– observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2. ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If in esophagus: remove ETT, reoxygenate 30 sec; repeat from insertion of blade with new tube ☐ *If ETT cannot be placed successfully (2 attempts) or nothing can be visualized; attempt extraglottic airway.		
If tube placed correctly ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ * Insert OPA; align ETT with side of mouth; secure ETT with commercial tube holder; apply lateral head immobilization.		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change If intubated & deteriorates, consider**: D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
Post-intubation sedation: If pt remains unconscious but begins to bite 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 ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ **Over sedation**		
***Critical Criteria: Check if occurred during an attempt (automatic fail)** ☐ Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully intubate within 2 attempts without immediately providing alternate airway ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Uses teeth as a fulcrum ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Please factually document below your rationale for checking any of the above critical criteria.

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Rating: (Select 1)

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Gloves, goggles, facemask		
Prepare the patient ☐ *Confirm unresponsiveness & no protective airway reflexes ☐ Consider c-spine injury – if yes, open airway with spine motion restriction; assess breathing ☐ *Insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/ BVM with O_2 reservoir at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Selects, checks, assembles equipment		
Have everything ready before placing fingers into mouth ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT)		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
Pass tube: * (Allow no more than 30 sec of apnea)		
☐ Maintain O_2 6 L/NC during procedure ☐ Assistant or examiner stops ventilating pt; withdraws OPA (NPA remains) ☐ Have partner apply lip retraction, external laryngeal pressure ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, (SpO_2 if perfusing rhythm) q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ Intubator: 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		
***If** > 30 sec: of apnea; remove fingers, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position or PM and attempt again. May go straight to King LT if unable to feel anything.		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 assist ventilations as needed at 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; Auscultate over epigastrium, both midaxillary lines and anterior chest X 2 ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. Continue to monitor continuously. ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
Troubleshooting		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat with new tube from insertion of fingers ☐ *If ETT cannot be placed successfully (2 attempts) attempt extraglottic airway		
* **If tube placed correctly** ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ * Insert OPA; align ETT with side of mouth; secure ETT with commercial tube holder; apply lateral head immobilization.		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **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 ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ Trauma to intubator's fingers		
Critical Criteria: Check if occurred during an attempt (automatic fail) ☐ Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at an appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully provide an airway and effective ventilations ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

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Rating: (Select 1)

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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		
* Takes or verbalizes BSI precautions: gloves, goggles, facemask		
Prepare patient Open the airway manually; insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/BVM with O_2 reservoir at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; overbite		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Laryngoscopes & blades (curved and straight; multiple sizes) ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Bougie;10 mL syringe; water-soluble lubricant ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT)		
☐ **Prepare Bougie** (disposable, flexible; ET tube introducer; 15 Fr, 60-70 cm, with curved tip). Remove Bougie from package; note markings and orientation of upturned coude tip. If needed, straighten bougie and curve distal end (~1" from tip) at 35-40° angle ☐ **Verbalize indications for Bougie:** All ETI attempts if either the epiglottis or posterior cartilages are seen ☐ **Verbalize contraindications for Bougie**: Inability to visualize either epiglottis or posterior cartilages		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
* Assemble laryngoscope; ensure it is operational; check light source (tight, bright & white)		
Pass the tube (Allow no more than 30 sec of apnea)		
☐ Maintain O_2 6 L/NC during procedure ☐ Assistant or examiner stops ventilating pt; withdraws OPA (NPA remains) ☐ Have partner apply lip retraction, external laryngeal pressure ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, (SpO_2 if perfusing rhythm) q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ Intubator: Position self in front of (facing) pt ☐ Withdraw tube from pkg through lubricant; hold in nondominant hand; do not contaminate ETT ☐ 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 bougie per usual procedure if able ☐ Pass ETT w/ L hand; pass cuff through cords w/in 30 sec.		
***** If > 30 sec: of apnea; remove laryngoscope and bougie, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position, blade, or PM. May go straight to King LT if unable to visualize anything.		
* Once ETT is inserted to proper depth (3X tube ID at teeth), firmly hold in place and carefully remove blade from mouth and bougie from ETT		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 assist ventilations as needed at 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; Auscultate over epigastrium, both midaxillary lines and anterior chest X 2 ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. Continue to monitor continuously.		
Troubleshooting ☐ *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 with new tube ☐ *If ETT cannot be placed successfully (2 attempts) attempt extraglottic airway		
* **If tube placed correctly** ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ *Insert OPA; align ETT with side of mouth; secure ETT with commercial tube holder; apply lateral head immobilization.		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **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 (R) ☐ Hypoxia, dysrhythmia		
Critical Criteria: Check if occurred during an attempt (automatic fail) ☐ Failure to initiate ventilations within 30 sec after applying gloves or interrupts ventilations for >30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully provide an airway and effective ventilations ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Uses teeth as a fulcrum ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

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Rating: (Select 1)

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CJM 12/16

Preceptor (PRINT NAME – signature

NWC EMSS Skill Performance Record

NASAL TRACHEAL 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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Gloves, goggles, facemask		
State indication for procedure: Spontaneously breathing pt who requires advanced airway where orotracheal intubation or use of an alternate airway is not advised		
***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 precautions; assess breathing ☐ Insert BLS adjunct: NPA unless contraindicated		
Explain each step as it is performed even if pt appears unconscious		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/ NMR or BVM with O_2 reservoir at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available.		
Selects, checks, assembles equipment		
Have everything ready before placing tube into the nose ☐ Prepare suction equipment (Yankauer and flexible catheters); turn on to ✓ unit; suction prn ☐ Select ETT (size of 5th finger); prepare one size larger and one smaller than anticipated size ☐ Capnography, commercial tube holder, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT) ☐ NO STYLET		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
Premedicate if applicable ☐ Benzocaine spray to posterior pharynx 1-2 sec spray, 30 sec apart X 2 (if + gag)		
Pass the tube ☐ Withdraw tube from pkg through lubricant; hold in dominant hand; do not contaminate ETT ☐ 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 pt 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:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 assist ventilations as needed at 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; Auscultate over epigastrium, both midaxillary lines and anterior chest X 2		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ Definitive confirmation: **monitor $ETCO_2$** number & waveform. Continue to monitor continuously.		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, reoxygenate 30 sec; repeat from insertion with new ETT ☐ *If ETT cannot be placed successfully (2 attempts) asses need for sedation and extraglottic airway		
* **If tube placed correctly** ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Secure ETT with tape		
If secretions in tube or gurgling sounds with exhalation: suction prn ☐ Select a flexible suction catheter ☐ Preoxygenate patient ☐ Mark maximum insertion length with thumb and forefinger ☐ Insert catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and applies suction while withdrawing catheter ☐ Ventilate/direct ventilation of patient (NO SALINE FLUSH)		
* **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 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully intubate within 3 attempts (2 attempts for NCH) ☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube ☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* 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 ☐ +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); 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 lube to beveled distal tip & posterior tube surface; avoid lube near anterior ventilatory openings.		
Confirming & securing equipment: EDD, capnography attached to BVM, tube holder, tape, head immobilizer, stethoscope (put around neck)		
Premedicate if applicable ☐ ***Benzocaine spray** to posterior pharynx 1-2 sec spray, 30 sec apart X 2 (if + gag) ☐ Fentanyl per SOP for pain		
Sedate: Allow for clinical response before intubating (if possible) ☐ ***Etomidate** 0.5 mg/kg IVP (max 40 mg) OR ☐ ***Ketamine** (preferred for asthma) 2 mg/kg slow IVP (over one min) or 4 mg/kg IM		
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 King 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).		
*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. Withdraw slightly and reinsert in midline.		
☐ ***INFLATE** cuffs with minimum inflation volume; do not overinflate (an overinflated cuff may put pressure on vascular structures in the neck): 3 (Yellow) 45-60 mL 4 (Red) 60-80 mL 5 (Purple) 70-90 mL ☐ *Keep pressure on plunger until syringe removed from valve; remove syringe from valve		
☐ Attach BVM with capnography sensor to KLTSD		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ *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 heard and ventilation easy/free flowing		
CONFIRM proper tube position (listed in order) ☐ *Auscultation bilateral breath sounds over midaxillary lines & anterior chest ☐ *$ETCO_2$ 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.		
***Preceptor ask,** "How would you know if you are delivering appropriate volumes with each ventilation?" (Chest rise, good breath sounds to periphery bilaterally; good capnography number and waveform; SpO2 if not in card arrest)*		
When good ventilations established, note depth markings at proximal end of airway aligned with 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, vomiting; prolonged BVM ventilations prior to King: insert **18 Fr Salem Sump NGT** into King gastric access port after confirming King placement ☐ **Measure insertion depth**: from nose→ear→xiphoid; lubricate NGT ☐ Insert into proximal lumen of King & gently advance to measured length; If resistance felt – abort procedure ☐ ***IF concern about proper placement** (NOT routine/required step)* o *Attach capnography using ETT adapter (should have no persistent ETCO2)* o *Inject 60mL air & auscultate over epigastrium* o *Insert end into cup of water & observe for bubbling* ☐ **Connect to suction**: Continuous @ 30-40 mmHg; Intermittent up to 120 mmHg PRN		
REASSESS: Ventilates patient at proper rate and volume. Frequently to detect displacement and complications (esp .after pt. movement or pt. status/condition changes ☐ $EtCO_2$ ☐ SpO_2 ☐ HR ☐ BP ☐ Lung sounds		
If protective reflexes return: Remove King in an area where suction equipment and the ability to rapidly intubate is present. Deflate both cuffs completely prior to removal		
Critical Criteria - Check if occurred during an attempt ☐ Failure to initiate ventilations within 30 sec after taking BSI precautions or interrupts ventilations for >30 sec at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentration [at least 85%] ☐ Failure to ventilate the patient at an appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to insertion of the supraglottic airway device ☐ Failure to insert the supraglottic airway device at a proper depth or location within 3 attempts ☐ Failure to inflate cuffs properly and immediately remove the syringe ☐ Failure to secure the strap (if present) prior to cuff inflation ☐ Failure to confirm that pt is being ventilated properly (correct lumen and proper insertion depth) by auscultation bilaterally over lungs and over epigastrium ☐ Insertion or use of any adjunct in a manner dangerous to the patient ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.
☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.
☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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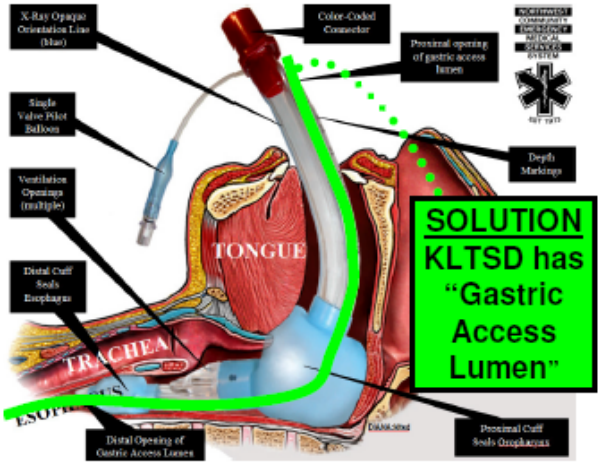
Preceptor (PRINT NAME - signature

King LTSD & Gastric Tubes

Problem

King LTSD

- Does not protect airway, from secretions, as well as ETT
- Pts should be preoxygenated prior to advanced airway, which often requires BVM use
- BVM ventilation may result in gastric distention……
- 18 fr soft suction catheter is too short to reach the stomach



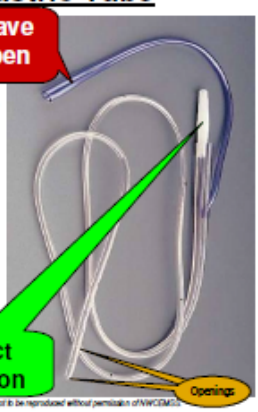
Salem-Sump® Gastric Tube

Dual Lumen Gastric Tube

1. Secondary lumen (blue pigtail, smaller) vents large lumen

   Open to atmosphere; allows air to be drawn in, which equalizes vacuum in the stomach and prevents suction openings from damaging stomach wall

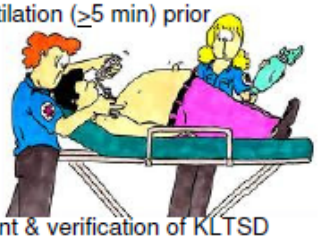
2. Drainage lumen (larger): to suction stomach contents



Gastric Tube & KLTSD

Indications - when KLTSD in place

- Vomiting
- Gastric distention
- Prolonged BVM ventilation (>5 min) prior



Contraindications

Same as KLTSD

NOTE

Insert **AFTER** placement & verification of KLTSD

Procedure

1. **Measure for insertion depth** (Nose → Ear → Xyphoid)
2. **Lubricate**

3. **Insert into proximal lumen & gently advance**
   - If resistance felt – abort procedure
4. ***IF concern about proper placement*** *(NOT routine/required step)*
   - *Attach capnography using ETT adapter (should have no persistent $ETCO_2$)*
   - *Inject 60mL air & auscultate over epigastrium*
   - *Insert end into cup of water & observe for bubbling*
5. **Connect to suction**
   - Continuous @ 30-40 mmHg
   - Intermittent up to 120 mmHg PRN

Gastric Tube & KLTSD

How far to insert tube?

Measure from:

- tip of **Nose**
- around **Ear**
- down to **Xyphoid**

Measuring distance from nostril to tip of earlobe.

Measuring distance from earlobe to tip of xiphoid process.

DIANA:ce-kltsd-ngt-oct-12

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Gloves, goggles, facemask		
***Verbalize the indications for the procedure:** ☐ Cannot intubate ☐ Cannot insert a King or alternate airway ☐ Cannot ventilate w/ BVM or other means to maintain SpO2 > 90%		
* **Verbalize contraindications for procedure:** ☐ Children < 8; need OLMC order for ages 8-12 ☐ Pts with known bleeding disorders and/or anticoagulant therapy ☐ Inability to identify landmarks; laryngeal fx or trauma causing distortion or obliteration of landmarks		
Prepare the patient Position supine; head in neutral position with padding under shoulders to extend neck slightly 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 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		
Attempt manual maneuvers for opening upper airway; direct visualization with laryngoscope; may or may not attempt advanced airways based on patient situation		
***Concurrently: Prepare equipment – Have everything ready before beginning procedure** ☐ #11 scalpel ☐ Chlorhexidine/IPA prep ☐ Clamp/spreader ☐ Stethoscope ☐ Tracheal hook (opt) ☐ ETT 5.0-7.0 ☐ Gauze pads 4X4 ☐ Full BSI ☐ Tube holder ☐ 10 mL syringe ☐ Bougie ☐ Water-soluble lubricant ☐ Capnography ☐ BVM; O_2 source ☐ SpO_2 and ECG monitors ☐ Suction equipment; turn on to ✓ unit ☐ Sharps container		
* 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 procedure ***Identify anatomical landmarks**: Palpate thyroid cartilage superiorly & cricoid cartilage inferiorly w/ thumb & middle finger. Locate cricothyroid membrane with index finger. If Rt handed, work from Rt side. If Lt handed, work from pt's left side.		
Consider need for FENTANYL; surgical procedures are painful, even if apparently unresponsive		
Prep skin with Chlorhexidine/IPA		
*While stabilizing trachea with non-dominant hand, make a ½ to 1" mid-line vertical incision just through skin over membrane. Partner to control bleeding with gauze pads. Suction site prn.		
* Remove scalpel; feel through incision with index finger; locate cricothyroid membrane		
* Make a horizontal stabbing incision through the membrane; width of the space. Never direct blade upward; cords just above membrane & easily damaged. Expect secretions/blood to spray out if patient breathes. Suction prn.		
* Before removing scalpel, insert forceps or spreader on either side of blade. Withdraw scalpel; open & close forceps to separate cartilages & dilate opening. Place scalpel into sharps container.		
☐ With forceps in place, insert 5th finger through incision ☐ Confirm tracheal penetration with finger ☐ ***Insert Bougie** into incision next to forceps; advance caudally until you meet resistance ☐ Apply tracheal hook to anterior ring of cricoid cartilage (opt) to stabilize distal segment		
* Insert ETT over Bougie; advance until cuff is fully in trachea; advance about 1".		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Once catheter is advanced, remove tracheal hook and/or Bougie.		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 assist ventilations as needed at 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; Auscultate over epigastrium, both midaxillary lines and anterior chest X 2 ☐ Definitive confirmation: **monitor $ETCO_2$** number & waveform. Continue to monitor continuously.		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If incorrectly placed: remove ETT, attempt to reoxygenate 30 sec; assess to determine error and take corrective action.		
* **If tube placed correctly** ☐ *If no gastric sounds & breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe ☐ Secure ETT with commercial tube holder; immobilize head. May place 4X4 around tube to help absorb bleeding; do NOT cut gauze; fibers may enter trachea		
* **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		
Document: Indication for procedure, size ETT placed, how correct placement was confirmed; ongoing assessment findings; any complications, your interventions, and the patient's response.		
Critical Criteria - Check if occurred during an attempt ☐ Failure to attempt ventilations within 30 sec after taking BSI precautions or interrupts ventilations for >30 sec any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentration [at least 85%] ☐ Failure to attempt to pre-oxygenate patient prior to beginning procedure ☐ Contaminates equipment or site without appropriately correcting situation ☐ Failure to insert airway device into trachea at a proper depth or location within 2 attempts ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage or in a manner dangerous to pt ☐ Failure to dispose blood-contaminated sharps immediately in proper container at point of use ☐ Failure to inflate ETT cuff properly and immediately remove the syringe ☐ Failure to secure the airway adequately ☐ Failure to confirm that patient is being ventilated properly (rate & volume) by auscultation bilaterally over lungs, over epigastrium, and confirming with capnography ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Fctually document below your rationale for checking any of the above critical criteria.

_____

_____

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.
☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.
☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

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Preceptor (PRINT NAME - signature

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 & extreme hypoxia. Prepare equipment and perform a needle cricothyrotomy.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Gloves, goggles, facemask		
Verbalize indications for the procedure: ☐ Cannot intubate ☐ Cannot insert a King or alternate airway ☐ Cannot ventilate w/ BVM or other means to maintain SpO2 > 90%		
* **List two disadvantages of the procedure – least effective lower airway** ☐ Does not allow for good elimination of CO_2 ☐ It is invasive ☐ Requires constant monitoring ☐ Does not protect airway from aspiration ☐ Does not allow for elimination of CO_2; so accumulates rapidly ☐ Ineffective tidal volume; especially if upper airways open at all ☐ Provides temporary relief (30-40 minutes) ☐ No suctioning of secretions		
Contraindications ☐ Inability to identify the anatomical landmarks necessary to perform the procedure. ☐ Controversy in very small children; false placement easy, excessive bleeding real risk		
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		
Attempt manual maneuvers for opening upper airway; direct visualization with laryngoscope; may or may not attempt advanced airways based on patient situation		
***Concurrently: Prepare equipment – Have everything ready before beginning procedure** ☐ 10 g needle ☐ 20 mL syringe ☐ Stethoscope ☐ BSI ☐ 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		
***Identify anatomical landmarks**: Palpate thyroid cartilage superiorly & cricoid cartilage inferiorly w/ thumb & middle finger. Locate cricothyroid membrane with index finger. If Rt handed, work from Rt side. If Lt handed, work from pt's left side.		
Prep skin with Chlorhexidine/IPA as per an IV or IO		
*Insert needle through the membrane at a 90° angle to the skin through the midline of the membrane using firm downward pressure until a "popping" sensation is felt		
* When resistance abruptly ceases, stop advancing needle; aspirate air into syringe like an EDD to confirm tracheal placement. Should aspirate easily without resistance.		
* Angle needle tip downward (towards chest) and posteriorly at a 20-45° angle		
☐ *Hold needle stationary, advance ONLY 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 (with ETT adaptor attached) to hub of catheter.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
Apply capnography sensor to ETT adapter. Ventilate slowly /peds BVM at 10/BPM. Allow 4 sec exhalation for each 1 sec inhalation. Confirm exhaled CO_2. ▪ If upper airways are open: For each 1 second of inspiration allow 4 seconds for exhalation to prevent barotrauma. ▪ If the upper airways are entirely obstructed: Allow 8 seconds of exhalation for each 1 second of inhalation. ▪ May need to compress chest to assist exhalation		
☐ *Auscultate epigastrium, both midaxillary lines & anterior chest X 2 ☐ *Assess quantitative waveform capnography to confirm exhaled CO_2. ☐ If incorrectly placed: assess to determine error and take corrective action ☐ *If correctly placed, control bleeding prn & 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. **CO_2 accumulation can be dangerous in head injured patient.** Patients can be adequately oxygenated for 30 to 40 minutes using this technique. Because of inadequate exhalation, CO2 accumulates and limits the long-term use of this approach, especially in head-injured patients (ATLS). High flow O_2 (>15 L/min) may actually dislodge a foreign body in the airway, however, significant barotrauma may occur including pulmonary rupture with tension pneumothorax if exhalation is poor. Low flow rates (5 to 7 L/min) should be used when total glottic obstruction is present (ATLS).		
Complications ☐ High pressure during ventilation and air entrapment may produce pneumothorax ☐ Hemorrhage at the insertion site. ☐ Thyroid gland & esophagus can be perforated if needle is inserted inappropriately and/or advanced too far ☐ Subcutaneous emphysema		
Critical Criteria - Check if occurred during an attempt ☐ Failure to attempt ventilations within 30 seconds after taking BSI precautions or interrupts ventilations for >30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentration [at least 85%] ☐ Failure to attempt to pre-oxygenate patient prior to beginning procedure ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Failure to insert the airway device into the trachea at a proper depth or location within 2 attempts ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage or in a manner dangerous to the patient ☐ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Failure to secure the airway adequately ☐ Failure to confirm that patient is being ventilated properly (proper insertion depth, rate and volume) by auscultation bilaterally over lungs and over epigastrium ☐ Failure to manage the patient as a competent paramedic ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ 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		

Comments: _____

_____

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Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Verbalize two examples of patients who require a NC ☐ Nose breathing patient with mild hypoxia who needs minimum FiO_2 ☐ Patient claustrophobic when using an O_2 face mask ☐ To provide extra O_2 during albuterol/ipratropium neb Rx by HHN ☐ To provide continuous oxygenation during intubation attempts ☐ Facial anomaly prevents adequate seal with an O_2 mask ☐ Patients who are vomiting		
* Apply BSI (gloves)		
*** Prepare equipment:** Open adult NC; unwind tubing to prevent kinks; connect to oxygen source.		
* Adjust oxygen flow rate based on patient need and SpO_2 (1-6 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)		

Comments: _____

_____

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ Determine the need for supplemental oxygen. Verbalize two examples of patients who require a NRM ☐ Spontaneously breathing pt. with moderate to severe hypoxia (SpO_2 < 92%); good ventilatory effort ☐ Prior to DAI in spontaneously breathing patient with good ventilatory effort ☐ Apneic oxygenation during early phases of cardiac arrest management ☐ Carbon monoxide or other toxic inhalation injuries ☐ May be used to deliver nebulized medication by removing reservoir bag and inserting nebulizer acorn		
***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 mask and is 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 at 12-15 L/minute so bag remains partially inflated during peak inspiration (never < 2/3rd full. and completely refills prior to next inspiration)		
Verbalize steps if reservoir bag collapses on inhalation. (Increase L flow)		
Verbalize complication if O_2 source is removed (pt receives inadequate O_2)		

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Apply BSI		
***Verbalize an indication for using a BVM** ☐ Patient with inadequate ventilations/oxygenation		
Identify the correct size mask & bag to ventilate patient: 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** Can verbalize 2 causes of inadequate mask seal: Beards: apply KY jelly; large tongue & jaw; lack of teeth; protruding teeth; facial burns; trauma; facial dressings		
2 person technique: Have 1st rescuer hold mask on face with both hands. Have 2nd person compress bag.		
☐ With other hand, squeeze bag w/ just enough volume to see chest rise (400-600 mL) ☐ Ventilate over 1 sec at 10 BPM (every 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 pt passively exhale and bag refill from O_2 source & reservoir		
Feel for lung compliance w/ each squeeze of the bag		
☐ **Can't ventilate:** Reposition head & jaw, suspect & Rx F/B obstruction; consider other causes (tension pneumo) ☐ **Ventilates but no chest rise**: ✓ mask seal, open pneumo (?), ✓ airway misplacement (esophagus)		

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NWC EMSS Skill Performance Record

CONTINOUS-POSITIVE AIRWAY PRESSURE (CPAP)

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

Instructions: An adult presents with severe dyspnea & ↑ work of breathing. Assess for indications & contraindications; apply C-PAP if indicated.
Equipment needed: Airway manikin or simulated patient; C-PAP mask, O_2 tank; BSI, drug bag

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Assess for indications: Must be 18 yrs of age; alert w/ intact airway & ventilatory drive (Patients you may expect to intubate if untreated) ☐ *Cardiogenic pulmonary edema w/ hemodynamic stability ☐ COPD/asthma w/ severe distress ☐ Submersion incident ☐ Flail chest without evidence of pneumothorax ☐ Elderly patients with if O_2 via NC or NRM is ineffective ☐ Extremely obese patient with hypoxia/hypercarbia ☐ Patients with DNR/POLST orders w/ severe resp distress declining intubation ☐ Post-extubation rescue for acute respiratory failure		
Assess for contraindications: ☐ Younger than 18 years of age ☐ **AMS**; 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** ☐ Hypotension ***SBP ≤ 90 & DBP < 60** or ECG instability ☐ Gastric distention; impaired swallowing, persistent vomiting, active upper GI bleeding; possible esophageal rupture ☐ Compromise of thoracic organs (penetrating chest trauma, pneumothorax) ☐ Uncooperative pt or those unable to tolerate mask due to extreme anxiety, claustrophobia, or pain ☐ Recent upper airway or esophageal surgery ☐ Possible increased ICP: Evidenced by decreased LOC; HTN; abnormal pupils ☐ Facial abnormalities/trauma that would complicate mask seal (facial burns) and result in a significant air leak, epistaxis		
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 patient *Position stretcher at 45° or higher unless contraindicated		
*Inform pt what you are doing; explain purpose/benefits of CPAP and what it will feel like		
Begin treatment of condition per SOP (Integrate vascular access and appropriate medications (unless contraindicated) per SOP while prepping mask. ☐ *If HF: **NTG 0.4 mg SL** ☐ *If severe asthma: **Epinephrine** (1mg/1mL) 0.3 mg IM ☐ *If severe COPD: **Albuterol/ipratropium** per nebulizer connected in line to mask circuit		
Prepare intubation equipment		
Prepare C-PAP equipment Open package FlowSafe CPAP mask package; securely connect mask to valve/tubing		
Attach CPAP O_2 tubing to regulator/flow-meter. Begin O_2 flow @ 15 L; Slowly ↑ O_2 to desired SpO2/ PEEP (start at 5 cm PEEP -do not exceed 10 cm PEEP) FlowSafe O_2 L flow = PEEP (cm H2O) 10 L = ~1.5 - 2 cm PEEP 20 L =~6-7 cm PEEP 15 L =~3-4 cm PEEP 25 L =~8.5-10 cm PEEP		
Mask application Undo 1-2 quick release clip(s); Hold mask firmly on pt's face w/ O_2 running or allow them to hold mask to face without straps. Allow pt time to adjust to mask. Reassure pt; stay in constant communication with them.		
Tighten head straps using Velcro tabs; adjust forehead pad flat on forehead		
Nasal/oral capnography cannula should be used under CPAP mask		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
May connect nebulizer between CPAP valve & mask; Begin O2 flow to neb before connecting to CPAP unit		
Reassess after three minutes ☐ Patient tolerance, comfort, mental status ☐ Respiratory rate/depth; feeling of distress, use of accessory muscles, ability to talk ☐ Lung sounds; SpO2; capnography ☐ BP (✓ for hypotension); P; ECG rhythm ☐ Gastric distention or vomiting		
***** If SBP < 90 (MAP < 65): Titrate PEEP down to 5 cm; remove C-PAP if hypotension persists		
*If SpO_2 remains < 92% and/or WOB remains labored & BP OK: adjust PEEP up to 10 cm in increments		
Attempt mask application for 10 min before conceding C-PAP failure If SBP ≥ 90 (MAP ≥ 65) and pt very anxious**:** 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 pt needs frequent coaching, consider need for 3rd rescuer enroute.		
*Secure head straps to mask and gradually tighten		
CPAP Complications: ☐ *High pulmonary pressures can cause a decrease in preload to Rt heart (blood volume through the lungs) resulting in a decrease in cardiac output (↓**BP**) and possible V/Q mismatch. ☐ *High airway pressures can over distend alveoli resulting in barotrauma resulting in pneumothorax ☐ Over distention of lungs can reduce their ability to move easily (decreases compliance) ☐ Positive pressure may increase secretions or dry upper airways; difficulty clearing respiratory secretions ☐ Gastric distension/vomiting; rare with PEEP levels < 15 cm H2O. Use caution in aerophagia sensitive patients (following gastric stapling or upper GI surgery) ☐ Aspiration with very high gas flow and gastric distention ☐ Increased ICP: if a possible cause of ↑ ICP is present; may need to be watched carefully ☐ Eye irritation ☐ Sinus congestion: pain ☐ Requires patient cooperation to tolerate tight fitting mask ☐ Facial skin necrosis at the site of mask contact if long-term use		
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 after PEEP at 5 cm ☐ *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.		
Criteria to DC CPAP in field ☐ Inability to tolerate the mask due to discomfort, pain, or claustrophobia ☐ Need for ETI to manage secretions, protect the airway, or ventilate patient ☐ Hemodynamic instability: SBP < 90 mm Hg at lowest levels of PEEP ☐ ECG instability with evidence of clinically significant ventricular dysrhythmias		
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		
Critical Criteria - Check if occurred during an attempt ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide appropriate oxygen therapy ☐ Failure to assess/provide adequate ventilation ☐ Failure to find or appropriately manage problems assoc w/ airway, breathing, or hypoperfusion ☐ Performs a dangerous or inappropriate intervention ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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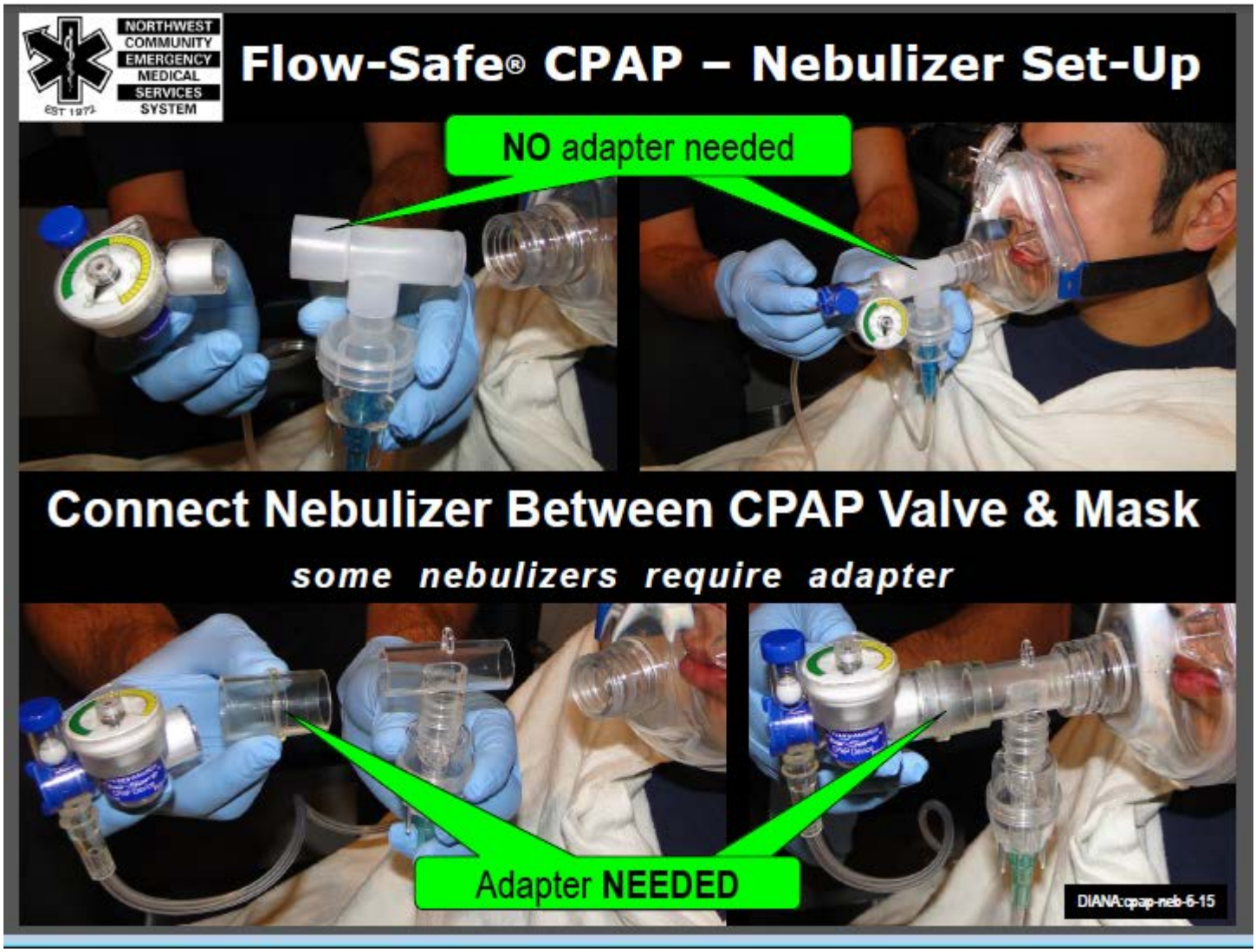
NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1973
Flow-Safe® CPAP – Nebulizer Set-Up
NO adapter needed
Connect Nebulizer Between CPAP Valve & Mask
some nebulizers require adapter
Adapter NEEDED
DIANA:cpap-neb-6-15

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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 or turn sensor to lateral to lateral aspect of finger. 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 & 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.		
Explain why an SpO2 < 90% is dangerous to pt: (RBCs have impaired ability to carry oxygen)		
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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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NWC EMSS Skill Performance Record

CAPNOGRAPHY

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

An elderly patient presents with AMS (GCS 13); a fever of 102° F, BP of 88/60; RR of 24 and crackles in the right middle and lower lobes. You need to determine if they are in septic shock. Prepare equipment and monitor their $ETCO_2$.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* **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		
☐ 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		
*Place adapter on face-mask, ETT, or King LT		
*State normal reading: 35-45 mmHg, rectangular shape		
☐ State expected reading if patient in shock w/ poor perfusion (< 31) ☐ State expected reading if patient is hyperventilating (<35) ☐ State expected reading if patient has RR of 4/minute (> 45) ☐ State expected change in waveform if pt has bronchoconstriction (sharkfin) ☐ State expected reading with ROSC after cardiac arrest (high 65+) ☐ State expected reading if pt has a large pulmonary embolism: Short (15), square waveform		
*Provide treatment based on history & capnography findings		
*Print copy of tracing & write patient's name on tracing		
*Document capnography value & waveform shape on PCR (comments section)		
Attach capnography tracing to original copy of PCR (left at hospital)		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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 clip 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 limb lead electrodes without gaps or wrinkles to appropriate locations (limbs, NOT chest) 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.		
Appropriately trouble shoot abnormalities in ECG signal ☐ Loose lead ☐ 60 cycle interference ☐ Patient movement ☐ Low amplitude tracing ☐ Artifact		
Critical Criteria - Check if occurred during an attempt ☐ Failure to differentiate pt's need for immediate transport vs assessment and Rx at the scene ☐ Failure to determine the patient's primary problem ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

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

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* 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 BBB 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"		

Factually document below your rationale for checking any of the above critical criteria.

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Prepare/assess patient * Confirm the need for pacing: bradycardia with hypoperfusion unresponsive to atropine and/or norepinephrine or drugs are contraindicated		
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 pacing 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 fentanyl and midazolam for use if needed		
Perform procedure: Varies by monitor manufacturer * 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.(Some monitors preset at rate of 70)		
* Confirm presence of pacing spikes at set rate		
* Push start/stop button		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ 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). 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, femoral pulse; 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. ☐ If considerable muscle twitching: readjust lateral pad away from pectoral muscle ☐ Complete IMC and prepare for transport.		
If no mechanical capture and pulse present: *Continue norepinephrine per SOP		
Continue to reassess patient for pulses & hemodynamic response		
Critical Criteria - Check if occurred during an attempt ☐ Failure to differentiate patient's need for immediate transportation versus continued assessment and treatment at the scene ☐ Failure to determine the patient's primary problem ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

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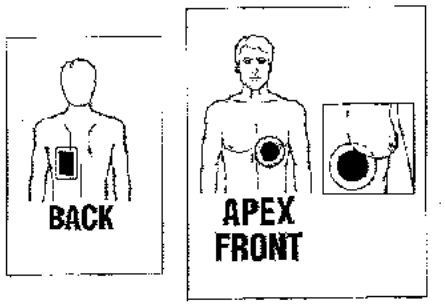
Notes:

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



NWC EMSS Skill Performance Record

SYNCHRONIZED CARDIOVERSION

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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: *Repeat at monitor-specific joules. Attempt appropriate drug therapy; transport.		
If unsuccessful and pulse absent: CPR - treat per VF SOP		
Critical Criteria - Check if occurred during an attempt ☐ Failure to differentiate pt's need for immediate transport vs assessment & Rx at the scene ☐ Failure to determine the patient's primary problem ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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NWC EMSS Skill Performance Record

DEFIBRILLATION

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Prepare/assess patient * Determine unresponsiveness; open airway (manually); assess for breathing/gasping; suction prn; simultaneously		
Assess pulse: If not definitively felt in <10 sec - Begin quality CPR with compressions per SOP p. 89		
☐ Remove all clothing from the patient's chest ☐ Remove all nitro patches, briskly wipe skin with a dry towel or gauze ☐ 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 Coordinator for instructions.		
As quickly as possible: 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.		
* With compressions continuing: Place anterior electrode (black) 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 patient's left nipple in the midaxillary line, with 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		
*** ✓ rhythm:** Pause compressions just long enough to determine if rhythm is shockable (< 5 sec) (PVT/VF)		
Perform procedure * Immediately resume compressions. Charge monitor to device-specific joule setting; listen to ramping tone		
*Compressor verbally counts down to the pause in compressions to shock: 5-4-3-2-1; briefly pause CPR (< 5 sec); look around 360°; clear patient		
☐ *Depress current discharge button(after last compression -not a ventilation) ☐ *Without checking ECG or pulse, change compressors and resume chest compressions for 2 mins. Limit time from last compression to shock delivery & resumption of compressions to ≤5 sec. ☐ NO rhythm/pulse check until after 2 min of CPR unless pt wakes or begins to move extremities		
***If persistent/refractory VF**: change pad location to A-P. If 2 monitors available: consider dual sequential defibrillation at device-specific joule settings		
Critical Criteria - Check if occurred during an attempt ☐ Failure to determine the patient's need for rapid defibrillation ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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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.

- Use "Pit crew" or "Team" approach to cardiac arrest management per local policy/procedure.
- Do not move while CPR is in progress unless in a dangerous environment/adverse climate or pt. is in need of intervention not immediately available (trauma). CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found. Continue resuscitation for at least 30 minutes (non-trauma) before moving.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Begin **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 steps may be done simultaneously** if personnel resources allow		
Determine unresponsiveness; open airway (manually); assess for breathing/gasping; suction prn; **Simultaneously:**		
☐ Assess pulse: If not definitively felt in <10 sec - **Begin quality CPR with compressions** ☐ Use real-time CPR feedback device if available		
☐ Remove all clothing from the patient's chest ☐ Remove all nitro patches, briskly wipe skin with a dry towel or gauze ☐ Disconnect Lifevest batteries; remove vest if present; DO NOT disconnect VAD batteries ☐ If pulseless pt has an LVAD; ✓ SpO2 . If perfusing: NO CPR and DO NOT DEFIBRILLATE (even if VF). If questionable: Call VAD Coordinator for instructions.		
As quickly as possible: 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. ☐ *With compressions continuing: Place anterior electrode without gaps or wrinkles on the patient's right upper torso, lateral to the sternum and below the clavicle. ☐ *Place the lateral electrode under and lateral to patient's left nipple in the midaxillary line, with 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		
*** ✓ rhythm:** Pause compressions just long enough to determine if rhythm is shockable (< 5 sec) (PVT/VF)		
* Shockable? Immediately resume compressions. Charge monitor to device-specific joule setting; listen to ramping tone		
*Compressor verbally counts down to the pause in compressions to shock: 5-4-3-2-1; briefly pause CPR (< 5 sec); look around 360°; clear patient		
☐ *Depress current discharge button(after last compression -not a ventilation) ☐ *Without checking ECG or pulse, change compressors and resume chest compressions for 2 mins. Limit time from last compression to shock delivery & resumption of compressions to ≤5 sec. ☐ NO rhythm/pulse check until after 2 min of CPR unless pt wakes or begins to move extremities		
Airway/ventilations: ☐ **Witnessed arrest; shockable rhythm**: Delayed PPV; 3 cycles (200) compressions before ventilating; O_2/NRM ☐ Unwitnessed arrest: BLS airways; ventilate with BVM; CPR at 30:2 ratio (5 cycles = 2 min); give 15 L O_2 when available ☐ Attach impedance threshold device (RQP/ITD) to mask/advanced airway and capnography sensor to bag		

* After 2 min of CPR; pause compressions (<5 sec) ☐ *✓ rhythm (VF); change compressor ☐ * If VF/PVT *Resume compressions while defibrillator is charging. ☐ Compressor verbally counts down to pause in compressions; stop CPR < 5 sec; clear patient: Defibrillate at monitor-specific J	**Rating**	ALS interventions with no interruption to CPR ☐ Establish vascular access (IV/IO): NS TKO ☐ When IV/IO available, give meds during CPR:	**Rating**
* Without checking ECG or pulse, immediately resume chest compressions for 2 min.		**EPINEPHRINE** (1mg/10mL) **1 mg IV/IO** Repeat every 3-5 min as long as CPR continues.	
* After 2 min of CPR; pause compressions (<5 sec); ☐ *✓ rhythm (VF); change compressor ☐ *If VF/PVT: Resume compressions while defibrillator is charging. ☐ Compressor verbally counts down to pause in compressions; stop CPR < 5 sec; clear patient: Defibrillate at monitor-specific J		☐ **AMIODARONE 300 mg IVP/IO** ☐ After 5 min: **AMIODARONE 150 mg IVP/IO**	
* Without checking ECG or pulse, immediately resume chest compressions for 2 min..		☐ Advanced airway prn: 10 BPM ☐ After adv airway: no compression pause for breaths	
* **If persistent/refractory VF**: change pad location to A-P and defibrillate per procedure. Continue pattern as long as pulseless state persists.		☐ As time allows: ✓Hs & Ts (Rx appropriately) ☐ If possible opioid OD: NALOXONE 1 mg; repeat q. 30 sec up to 4 mg.	
If 2 monitors available: consider dual sequential defibrillation at device-specific joule settings		**SODIUM BICARB 1 mEq/kg IVP/IO:** If arrest caused by a bicarb-responsive acidosis (DKA/TCA/ ASA OD, cocaine, diphenhydramine) or known hyperkalemia.	

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

**Identify the rhythm:*_____

☐ *✓pulse (present); VS; capnography (70); SpO_2 (90%);
VS: BP: 86/60; P 80; R: 18 and spontaneous; T 98.6 F. The pt remains unconscious. What is indicated now?
☐ *Support ABCs; **remove ResQPod**
☐ Assist ventilations / Do not hyperventilate even if ↑ $ETCO_2$; titrate O_2 to SpO_2 94% (avoid hyperventilation and hyperoxia)
☐ Start 2nd IV if needed
☐ If SBP < 90 (MAP < 65): IV WO while prepping **NOREPINEPHRINE 8 mcg/min** (2 mL/min IVPB), adjust upwards in 2 mcg/min (0.5 mL/min) increments prn (Max 20 mcg/min). Retake BP q. 2 min until desired BP reached, then every 5 min. Maintenance: 2 to 4 mcg/min (0.5 mL to 1 mL/min) OR (Dose: 0.03 mg IVP with caution)
Keep fingers on pulse & watch SpO_2 pleth on monitor for 5 min to detect PEA; Goal: MAP 90-100
☐ Obtain12 L ECG ASAP (call alert if STEMI)
☐ Assess glucose level (Rx hypoglycemia)

If patient remains unresponsive to verbal commands w/ no contraindications: ☐ Chemical cold packs (CCP) to cheeks, palms, soles of feet; if additional CCP available, apply to neck, lateral chest, groin, axillae, temples, and/or behind knees. ☐ Avoid hyperthermia & hyperglycemia	**Rating**	**Rating**
Critical Criteria - Check if occurred during an attempt ☐ Failure to determine the patient's need for rapid defibrillation ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Notes on good CPR:

Rate: 100-120/min (100-110 when using RQP) avoid rate >120 (use audible prompt for correct rate)
Depth: 2" – 2.4" (5-6 cm); ensure full chest recoil; minimize interruptions in chest compressions (≤ 5 sec); hand location center of chest (lower ½ of sternum). Interrupt chest compressions only for ventilations (until adv airway placed), rhythm ✓ & shock delivery; limit to < 5 sec

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Rating: (Select 1) for team

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.
☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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Preceptor (PRINT NAME – signature

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.

- Use "Pit crew" or "Team" approach to cardiac arrest management per local policy/procedure.
- Do not move while CPR is in progress unless in a dangerous environment/adverse climate or pt. is in need of intervention not immediately available (trauma). CPR is better and has fewer interruptions when resuscitation is conducted where the pt. is found. Continue resuscitation for at least 30 minutes (non-trauma) before moving.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
One team member seeks information about possible contributing factors: ☐ Hypoxia (ventilate/O_2) ☐ Hypothermia (core rewarm) ☐Toxins (opiate? Naloxone; TCA? $NaHCO_3$) ☐ Hypovolemia (IVF) ☐ Hypo/hyperkalemia ($NaHCO_3$) ☐ Tamponade, cardiac (IVF) ☐ Thrombosis ☐ H ion (acidosis; $NaHCO_3$) ☐ Hypoglycemia (✓glucose) ☐ Tension pneumo (✓ lung snds; pleural decompression)		
Begin **BLS IMC** – All care is organized around 2 min cycles of CPR in C-A-B priority unless arrest is caused by hypoxic event – multiple steps may be done simultaneously if personnel resources allow		
Determine unresponsiveness; open airway (manually); assess for breathing/gasping; suction prn; **simultaneously:**		
☐ Assess pulse: If not definitively felt in <10 sec - **Begin quality CPR with compressions** ☐ Use real-time CPR feedback device if available		
☐ Remove all clothing from the patient's chest ☐ Remove all nitro patches, briskly wipe skin with a dry towel or gauze ☐ Disconnect Lifevest batteries; remove vest if present; DO NOT disconnect VAD batteries ☐ If pulseless pt has an LVAD; ✓ SpO2 . If perfusing: NO CPR and DO NOT DEFIBRILLATE (even if VF). If questionable: Call VAD Coordinator for instructions.		
As quickly as possible: 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. ☐ *With compressions continuing: Place anterior electrode without gaps or wrinkles on the patient's right upper torso, lateral to the sternum and below the clavicle. ☐ *Place the lateral electrode under and lateral to patient's left nipple in the midaxillary line, with 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		
***✓ rhythm:** Pause compressions just long enough to determine if rhythm is shockable (< 5 sec) (PVT/VF)		
***Not Shockable?** Resume compressions; no rhythm/pulse check until after 2 min of CPR unless pt. wakes or begins to move extremities (see below)		
Airway/ventilations: ☐ Witnessed arrest; shockable rhythm: Delayed PPV; 3 cycles (200) compressions before ventilating; O_2/NRM ☐ Unwitnessed arrest: BLS airways; ventilate with BVM; CPR at 30:2 ratio (5 cycles = 2 min); give 15 L O_2 when available ☐ Attach impedance threshold device (RQP/ITD) to mask/advanced airway and capnography sensor to bag		

* After 2 min of CPR; pause compressions (<5 sec) ☐ *✓ rhythm (VF); change compressor ☐ * Non-shockable	**Rating**	ALS interventions with no interruption to CPR ☐ Establish vascular access (IV/IO): NS TKO ☐ When IV/IO available, give meds during CPR	**Rating**

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary			**Attempt 1 rating**	**Attempt 2 rating**
* Without checking ECG or pulse, immediately resume chest compressions for 2 min.		**EPINEPHRINE** (1mg/10mL) **1 mg IV/IO** Repeat every 3-5 min as long as CPR continues.		**Rating**
*After 2 min of CPR; pause compressions (<5 sec); ☐ *✓ rhythm (VF); change compressor ☐ *Non-shockable		☐ Advanced airway prn: 10 BPM ☐ After adv airway: no compression pause for breaths		
* Without checking ECG or pulse, immediately resume chest compressions for 2 min.		☐ As time allows: ✓Hs & Ts (Rx appropriately) ☐ If possible opioid OD: NALOXONE 1 mg; repeat q. 30 sec up to 4 mg.		
Repeat pattern as long as CPR continues		**SODIUM BICARB 1 mEq/kg IVP/IO:** If arrest caused by a bicarb-responsive acidosis (DKA/TCA/ ASA OD, cocaine, diphenhydramine) or known hyperkalemia.		
☐ ***2 minutes after last defib; check rhythm:*** **(show strip of SR)** **Identify the rhythm:*_____ ☐ *✓pulse (present); VS; capnography (70); SpO_2 (90%); ***VS: BP: 86/60; P 80; R: 18 and spontaneous; T 98.6 F. The pt remains unconscious. What is indicated now?*** ☐ *Support ABCs; **remove ResQPod** ☐ Assist ventilations / Do not hyperventilate even if ↑ $ETCO_2$; titrate O_2 to SpO_2 94% (avoid hyperventilation and hyperoxia) ☐ Start 2nd IV if needed ☐ If SBP < 90 (MAP < 65): IV WO while prepping **NOREPINEPHRINE 8 mcg/min** (2 mL/min IVPB), adjust upwards in 2 mcg/min (0.5 mL/min) increments prn (Max 20 mcg/min). Retake BP q. 2 min until desired BP reached, then every 5 min. Maintenance: 2 to 4 mcg/min (0.5 mL to 1 mL/min) OR (Dose: 0.03 mg IVP with caution) Keep fingers on pulse & watch SpO_2 pleth on monitor for 5 min to detect PEA; Goal: MAP 90-100 ☐ Obtain12 L ECG ASAP (call alert if STEMI) ☐ Assess glucose level (Rx hypoglycemia)				
If patient remains unresponsive to verbal commands w/ no contraindications: ☐ Chemical cold packs (CCP) to cheeks, palms, soles of feet; if additional CCP available, apply to neck, lateral chest, groin, axillae, temples, and/or behind knees. ☐ Avoid hyperthermia & hyperglycemia			**Rating**	**Rating**
VERBALIZES criteria for TERMINATION OF RESUSCITATION: If normothermic pt. remains in persistent monitored asystole or no shock advised rhythm for 30 minutes or longer despite steps above, and if $ETCO_2$ remains ≤ 10 for 20 min & no reversible causes of arrest are identified, seek OLMC physician's approval to terminate resuscitation.				
Critical Criteria - Check if occurred during an attempt ☐ Failure to determine the patient's need for rapid defibrillation ☐ Performs any improper technique resulting in potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention				

Notes on good CPR:

Rate: 100-120/min (100-110 when using RQP) avoid rate >120 (use audible prompt for correct rate)
Depth: 2" – 2.4" (5-6 cm); ensure full chest recoil; minimize interruptions in chest compressions (≤ 5 sec); hand location center of chest (lower ½ of sternum). Interrupt chest compressions only for ventilations (until adv airway placed), rhythm ✓ & shock delivery; limit to < 5 sec

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Rating: (Select 1) for team

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NWC EMSS Skill Performance Record

ResQPOD® Impedance Threshold Device (ITD)

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* State purpose of ResQPOD® Impedance Threshold Device (ITD): The ResQPOD lowers intrathoracic pressure during the recoil phase of CPR by selectively restricting unnecessary airflow into the chest. This vacuum increases preload, lowers intracranial pressure (ICP), and improves blood flow to the brain and vital organs.		
* Verify indication for ITD: Cardiac arrest w/ CPR; age >12		
*Confirm absence of contraindications ☐ Flail chest ☐ Pulse present ☐ Children < 18: The ResQPOD should be effective in patients of all ages, however it has only been tested clinically in adults ages 18 years and above. Animal studies in a pediatric model of cardiac arrest, have demonstrated that the ResQPOD effectively enhances circulation in 10 kg piglets in cardiac arrest. It is the ultimate decision of the prescribing physician to determine in what ages of patients the ResQPOD should be used.		
Verbalize: Must be used with quality CPR (good compression rate & depth, release completely, minimize interruptions, no hyperventilation) for improved pt outcomes		
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 Timing lights flash 10 times per minute, for 1 second, indicating desired rate & duration of ventilations with advanced airway		
Put adhesive tab on other side of switch, to prevent accidentally turning switch off		
Place ITD directly on ETT or King LT between bag-valve device & face mask Note: microstream capnography sensor will not fit into ITD without use of an adapter [or colormetric $EtCO_2$ detector].		
Assure continuous tight face-mask seal using 2-person BVM technique during chest compressions for device to be effective (chest compressor squeezes BVM)		
If using digital/waveform capnography: place sensor between ITD & bag-valve device		
* 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		

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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 may be no pulse, especially with continuous flow pumps.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* **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. Patients will be on anticoagulation medications – get list of all meds Patients will often have pacemakers and/or Internal Cardioverter Devices (ICDs). ☐ Ask if pt is looking, feeling, or acting differently than their baseline		
Decision tree responsive patient ☐ Assess ABCs: SpO_2 waveforms may be flat; without amplitude despite accurate readings ☐ If breathing labored; O_2 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 if possible: 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. CHEST COMPRESSIONS ARE ALLOWED if patient is unconscious and non-breathing.		
ECG findings: ☐ VADs fix the plumbing - electrical conduction system should be intact; Do NOT expect asystole; pt may be conscious w/ V-fib ☐ ECG waveforms may have a lot of artifact due to the device. ☐ Can have dysrhythmias but are better tolerated because pump continues to function despite irregular rhythm – Rx dysrhythmias with drugs per SOP		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
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 ☐ Do not defibrillate over the pump; defibrillate at nipple line or above. Anterior-posterior pad placement preferred. ☐ Warning: If VAD stops operating & blood is stagnant in pump & conduits for > a few min (depending on pt's anticoagulated state) there is 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		
Notes: NO MRIs - CT Scans are ok; avoid water submersion; avoid contact with strong magnets or magnetic fields		

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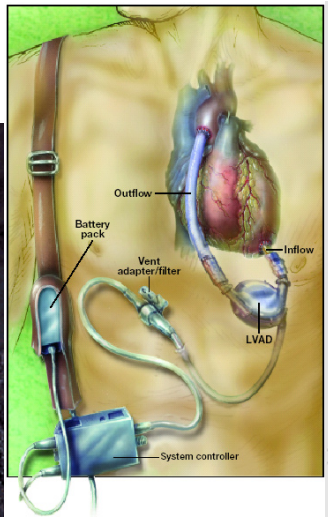
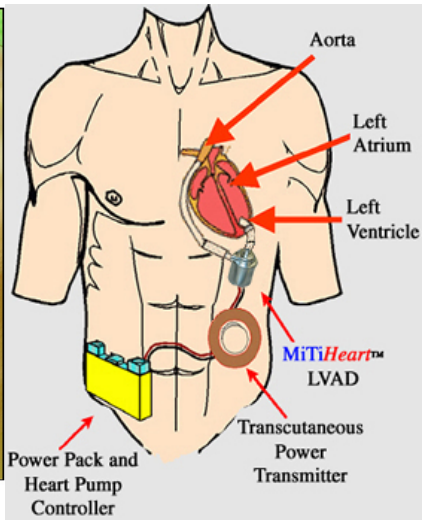
Heartmate XVE & Heartmate II

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Prepare equipment ☐ Select appropriate IV solution (NS) ☐ *Select appropriate IV solution (NS) and examine covering for leakage or other damage. Open outer bag at the precut slit at either end. Take care not to cut or puncture the inner IV bag. ☐ *Verify sterility of solution (all seals in place). Check solution for leaks, cloudiness, contaminates, precipitation, and expiration date.		
Spike IV bag & prime IV tubing ☐ Remove infusion set from package; uncoil tubing; close clamp, remove spike protector without contaminating spike or the needle adaptor. ☐ Turn IV bag upside down with IV & medication ports facing up; remove cover from IV port, maintain sterility of port ☐ *Insert tubing spike into IV port with a pushing and twisting motion until it punctures seal. ☐ *Invert bag. Grasp IV set at drip chamber and squeeze. Fill drip chamber ⅓ to ½ full or to the fill line. ☐ *Open clamps and/or flow regulator to flush (prime) line with NS. May temporarily remove end cap to facilitate procedure, but not necessary. Remove all large air bubbles from tubing. (Empty IV tubing contains ~30 mL of air. This could cause a lethal air embolus if all infused into the patient.) ☐ Reclamp tubing shut. Recap end if removed to flush tubing. ☐ Hang IV or have someone hold bag. Place capped tubing end close to where line will be started for easy access.		
* 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, skin protectant film, venous 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; ask re: their best veins		
Procedure * Observe strict Universal precautions & aseptic technique during catheter insertion		
Site selection/preparation * Expose extremity to be cannulated. Inspect and palpate for best veins		
* Apply venous tourniquet 4"-8" proximal to selected IV site; palpate distal pulse. Never leave in place for more than two minutes as changes occur in slowed venous blood.		
* Lightly palpate veins with index finger and identify a suitable site. If it rolls or feels hard and rope-like, select another vein. Avoid points of flexion if possible. If vein easily palpable but not sufficiently dilated: ☐ Tap gently over vein with your finger. **Do not slap** - will collapse the vein. ☐ Place extremity in a dependent position ☐ Have patient open and close fist several times		
* Prep site with CHG/IPA*. Dry 30 sec. Do not contaminate by touching after cleaned.		
Catheter insertion ☐ Remove protective cap from needle in a straight outward manner keeping catheter sterile. (Do not depress white activation button of Insyte® catheter) ☐ If using InSyte catheter: Rotate catheter hub 36O° to loosen catheter from needle. Failure to do so may affect needle retraction. NEVER slide catheter end over needle to break seal. ☐ Inspect needle tip for defects		
* Anchor vein with thumb distal to insertion site, stretching the skin near the vein. Do not place your thumb directly over vein or blood flow will be occluded and veins will flatten. If using a hand vein, slightly flex patient's wrist.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Hold catheter between thumb and index finger of dominant hand (like a pool cue). Insert needle, bevel up (in relation to the patient's skin surface) through skin & vein at a 15-30° angle. (Very sharp catheters enter veins with little or no popping sensation.) Take care not to enter too fast or too deeply as needle can pass through back-side of vein.		
☐ 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 1/8th inch to ensure proper tip positioning in vein ☐ If unable to enter vein, withdraw needle & catheter slightly, use caution not to withdraw needle tip out of skin. Re-attempt to advance into vein. If vein is missed or needle is pulled entirely out of skin, retract needle, apply gauze/Band-Aid and begin again with new catheter at another site. Limited to 2 attempts unless OLMC authorizes additional tries.		
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)		
* **Release tourniquet** (Failure to release before needle retraction may result in 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 ☐ **Protectiv™ IV catheter** (Criticon) o Glide the protective guard over the needle o Listen for the "click" that confirms needle is safely locked in place o Remove encased, locked needle from the catheter hub ☐ **Insyte Saf-T-Cath** (Becton Dickinson) o Do not fully retract needle until catheter is fully inserted into vein. o Avoid premature activation of retraction button. Push button to retract needle into clear safety shield. If activation does not occur, press button again. If activation still does not occur, withdraw needle & place immediately into sharps container. ☐ Discard shielded needle unit immediately into sharps container		
Connect IV tubing to catheter and establish IV flow: ☐ *Remove protective cap on IV tubing; slide end of tubing onto IV catheter hub; release pressure to vein ☐ Use of J loop preferred between IV catheter and IV tubing ☐ *While continuing to hold the IV catheter, open clamp on IV tubing to start fluid flow to establish patency, adjust desired flow rate.		
Dressing/Stabilization: ☐ Clean up blood at site with a gauze pad. ☐ Peel lining from transparent dressing exposing adhesive surface; center dressing over catheter site; apply protective film over dry skin without stretch or skin tension, leave IV tubing connector to colored hub free. Slowly remove the frame while smoothing dressing from center to edges using firm pressure to enhance adhesion. ☐ Secure IV tubing with adhesive strips or commercial dressing as needed. Do not tape over IV connection sites. Do not conceal hub-tubing connection.		
* Document IV fluid, insertion site, # of attempts as successful or unsuccessful, catheter gauge, time started, flow rate and amount infused. Label IV bag.		
*State 2 signs of infiltration ☐ IV does not flow ☐ Local swelling ☐ Site pain/burning		
* State method to determine patency: check retrograde flow * State method to troubleshoot poorly running line (see options below)		
* Properly discard all disposable components		
State 3 complications of an IV (see below)		
Actual time for each attempt from start to finish		
☐ Check if patent IV was not established within 2 minutes		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IV within 2 minute time limit ☐ Failure to take or verbalize appropriate body substance isolation precautions prior to performing venipuncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage, catheter shear, or air embolism ☐ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

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Rating: (Select 1)

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_____
Preceptor (PRINT NAME - signature

If IV does not flow - consider the following causes:

☐ Tourniquet still on and in place
☐ Flow clamp closed
☐ Height of IV bag too low
☐ Needle not patent (clot formation)
☐ Tip of catheter is abutted against a valve or vein wall
☐ Tubing kinked or pinched
☐ Completely filled drip chamber
☐ Air vent not patent

Complications

☐ Catheter shear and potential plastic embolism
☐ Thrombophlebitis (redness and pain)
☐ Extravasation (leakage of fluid/infiltration)
☐ Bruising/ecchymosis at the puncture site
☐ Infection, both localized and systemic
☐ Volume overload

Trouble-shooting a malfunctioning IV

☐ Pull the catheter back between 1/8" and ¼"
☐ Lower the IV bag below the patient to check for blood return
☐ Raise the IV bag to see if line will flow better with greater "drop"
☐ Inspect the IV site for S&S of infiltration
☐ Move the limb or immobilize on arm board to stabilize a positional line
☐ Check all flow clamps to ensure that they are open
☐ Inspect tubing to make sure that nothing has pinched or kinked the line
☐ Make sure the tourniquet has been removed

* 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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Prepare the equipment ☐ *Select appropriate IV solution (NS) and examine covering for leakage or other damage. Open outer bag at the precut slit at either end. Take care not to cut or puncture the inner IV bag. ☐ *Verify sterility of solution (all seals in place). Check solution for leaks, cloudiness, contaminates, precipitation, 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/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 * Observe strict Universal precautions & aseptic technique during catheter insertion		
* Wipe selected site with CHG/IPA prep. Allow to dry for 30 sec.		
* 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.		
* Advance catheter to the hub. **Do not let air enter the catheter once it is in the vein.**		
Needle retraction: ☐ Put gauze pad under hub of catheter; stabilize colored hub with a fingertip without contaminating needle insertion site ☐ Withdraw needle ☐ **Protectiv™ IV catheter** (Criticon) o Glide the protective guard over the needle o Listen for the "click" that confirms needle is safely locked in place o Remove encased, locked needle from the catheter hub ☐ **Insyte Saf-T-Cath** (Becton Dickinson) o Do not fully retract needle until catheter is fully inserted into vein. o Avoid premature activation of retraction button.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
Push button to retract needle into clear safety shield. If activation does not occur, press button again. If activation still does not occur, withdraw needle & place immediately into sharps container. ☐ Discard shielded needle unit immediately into sharps container		
* Remove protective cap on IV tubing and slide end of tubing onto the hub of the IV catheter. Use of J loop preferred between IV catheter and IV tubing.		
* While continuing to hold the IV catheter, open clamp on IV tubing to establish patency, adjust IV flow rate.		
Dressing/Stabilization: ☐ Clean up blood at site with a gauze pad. ☐ Peel lining from transparent dressing exposing adhesive surface; center dressing over catheter site; apply protective film over dry skin without stretch or skin tension, leave IV tubing connector to colored hub free. Slowly remove the frame while smoothing dressing from center to edges using firm pressure to enhance adhesion. ☐ Secure IV tubing with adhesive strips or commercial dressing as needed. Do not tape over IV connection sites. Do not conceal hub-tubing connection.		
* Document IV fluid, insertion site, # of attempts as successful or unsuccessful, catheter gauge, time started, flow rate and amount infused. Label IV bag.		
* State method to determine patency: check retrograde flow * State method to troubleshoot poorly running line (see options below)		
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IV within 2 minute time limit ☐ Failure to take or verbalize appropriate BSI precautions prior to performing venipuncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage, catheter shear, or air embolism ☐ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

If IV does not flow - consider the following causes:	**Complications**
☐ Flow clamp closed ☐ Height of IV bag too low ☐ Needle not patent (clot formation) ☐ Tip of catheter is abutted against a valve or vein wall ☐ Tubing kinked or pinched ☐ Completely filled drip chamber ☐ Air vent not patent	☐ Catheter shear and potential plastic embolism ☐ Thrombophlebitis (redness and pain) ☐ Extravasation (leakage of fluid/infiltration) ☐ Bruising/ecchymosis at the puncture site ☐ Infection, both localized and systemic ☐ Volume overload

Trouble-shooting a malfunctioning IV

☐ Pull the catheter back between 1/8" and ¼"
☐ Lower the IV bag below the patient to check for blood return
☐ Raise the IV bag to see if line will flow better with greater "drop"
☐ Inspect the IV site for S&S of infiltration
☐ Check all flow clamps to ensure that they are open
☐ Inspect tubing to make sure that nothing has pinched or kinked the line
☐ Make sure the tourniquet has been removed

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Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.
☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

NWC EMSS Lab Skill Performance Record

INTRAOSSEOUS ACCESS USING EZ IO

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

A patient presents unconscious in cardiac arrest. You are asked to assemble the equipment and achieve venous access via the IO route using an EZ-IO driver.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalizes indications for IO infusions** ☐ Unstable pt urgently needing IV fluids or critical life-saving meds, esp. if circulatory collapse; difficult, delayed, or impossible venous access; or conditions preventing venous access at other sites. May be used prior to IV attempt in cardiac arrest (medical/trauma). ☐ Not intended for prophylactic use. Always consider benefit vs. risk ☐ States total # of attempts per site (1)		
***Verbalizes CONTRAINDICATIONS for IO infusions:** ☐ Fracture of the bone selected for IO infusion ☐ Infection at the site selected for insertion (*use alternate sites*) ☐ Previous ortho procedure (joint replacement, *IO within 48 hrs, prosthesis – use alternate site*) ☐ Re-existing medical condition (tumor near site, severe peripheral vascular disease (PVD) ☐ Inability to locate landmarks (Morbid obesity, tissue edema) (*consider alternate sites*)		
Prepare patient: If pt conscious, advise of emergent need for procedure		
*** Select appropriate IO needle set; prepare and assemble equipment** ☐ EZ-IO driver ☐ IV NS & reg drip tubing ☐ Pressure infuser bag ☐ (2) 10 mL syringes w/ NS to prime connect tubing & flush IO ☐ Conscious pt: Lidocaine 2% (100 mg/5 mL) w/o preservative ☐ Extension set or EZ Connect tubing ☐ Skin prep: Chlorhexidine (CHG 2%)/(IPA 70%) ☐ EZ-IO® needle sets: o Bariatric or humeral insertion : Yellow (45 mm) o 40 kg or greater: Blue (25 mm) o 3-30 kg: Pink (15 mm) consider for peds ☐ Tape; EZ stabilizer **Flow rate:** Due to anatomy of IO space, flow rates slower than per IV cath. A 10mL NS rapid bolus/flush w/ syringe, improves flow rates. Attach a pressure infuser device around bag of IVF.		
* BSI: Universal precautions: 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 syringes w/ at least 10 mL of NS (if not prefilled) – 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.		
* **LOCATE INSERTION SITE:** Position pt and palpate site(s) to identify appropriate anatomical landmarks and needed needle size. Preferred: proximal medial tibia; alternate: proximal humerus.		
* Cleanse site using aseptic technique and CHG/IPA prep; allow to air dry 30 sec.		
* Prepare EZ-IO driver and needle set: Open cap of needle, attach to driver, and momentarily power drill. Remove safety cap from needle – do not touch needle		
* Stabilize extremity with non-dominant hand;		
☐ *With other hand, hold driver w/ needle connected. Rest needle on skin/bone directly over insertion site at a 90° angle to the bone surface. Activate driver by depressing trigger on handgrip and gently pierce skin with needle until tip touches bone. ☐ Check that at least one black line on the needle is visible after piercing skin and touching bone surface. 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. ☐ *Activate driver and penetrate the bone cortex – **ALLOW DRIVER AND NEEDLE to DO WORK**; maintain gentle steady, consistent, pressure on driver.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ **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**		
Once decreased resistance is felt or needle flange touches skin (whichever is first) release trigger and stop insertion process		
* While stabilizing catheter hub w/ hand, remove driver from needle set		
* Remove stylet from catheter by rotating counterclockwise (while stabilizing hub with hand). Place directly in sharps container. NEVER return used stylet to the EZ-IO kit.		
*Connect NS primed EZ Connect tubing to exposed Luer-lock catheter hub and 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): Remove NS syringe on connecting tubing and replace w/ lidocaine syringe. Give **LIDOCAINE 2% 1 mg/kg (max 50 mg**)(2.5 mL) ***slow* IO BEFORE NS FLUSH**, 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. ☐ Confirm placement: Needle firm in bone and able to infuse w/o extravasation (Do NOT rock needle in bone) ☐ Inability to aspirate blood is NOT a reliable indicator of non-placement ☐ 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. Frequently reassess pressure (300 mmHg) in infuser device. Re-inflate as IVF is administered. ☐ *Calculate appropriate fluid challenge volume if indicated.		
☐ Secure site with EZ Stabilizer if available ☐ Secure tubing to extremity 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.		
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IO line within 6 minute time limit ☐ Failure to take or verbalize appropriate BSI precautions prior to performing IO puncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for air embolism ☐ Failure to assure correct needle placement [must aspirate or watch closely for early signs of infiltration] ☐ Failure to successfully establish IO infusion within 2 attempts during 6 minute time limit ☐ Performs IO puncture in an unacceptable manner [improper site, incorrect needle angle, holds leg in palm and performs IO puncture directly above hand, etc.] ☐ Failure to properly dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Failure to manage the patient as a competent EMT ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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Rating: (Select 1)

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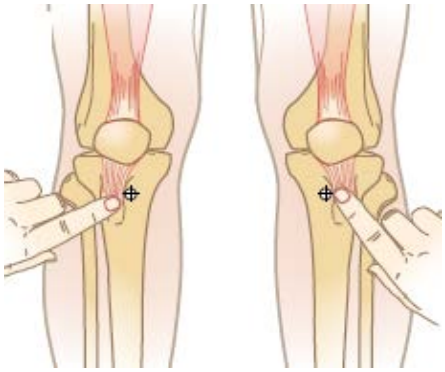
EZ-IO 25mm: (commonly for 40 kg and over)	• Proximal Tibia – Insertion site is ~2 cm below patella & ~2 cm (depending on anatomy) medial to tibial tuberosity. • Proximal Humerus – Insertion site is located directly on the most prominent aspect of the greater tubercle. Slide thumb up the anterior shaft 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 patient'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.*



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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT:** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ Documentation		
* Apply appropriate PPE		
Prepare equipment/medication ☐ Medication ☐ Sharps container ☐ Syringe/ filtered needle or straw ☐ Gauze pad		
*Inspect medication packaging to confirm 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 approp syringe & needle size for volume of fluid to be withdrawn & route of administration ☐ *Remove pre-attached needle from syringe& 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 or straw into liquid medication (may invert ampule – keep tip within liquid to be withdrawn; avoid pulling air into syringe with 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 = to the *mL*s that will be removed. (Some sources omit this step). 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.		
* Withdraw appropriate volume/dose of medication into the syringe. (May invert vial) 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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, side effects, and procedure 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.		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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Preceptor (PRINT NAME - signature

CJM: 12/16

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 in yellow zone)		
Confirm absence of allergy or contraindications to the drug		
Explain procedure to pt: parts of MDI and how to coordinate breathing through mouth with inhaling 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		

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Rating: (Select 1)

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CJM 12/16

Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 packaging to confirm the drug name, integrity of packaging; color, clarity, concentration, dose, & 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 O_2 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; breathe deeply as they can through their mouth to inhale mist		
Attach supplemental O_2 via NC at 6 L if pt is hypoxic (need 2nd O2 source)		
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 or CPAP mask *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 correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.
☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.
☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

NWC EMSS Skill Performance Record

MUCOSAL ATOMIZER DEVICE (MAD)

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 total amt between 2 syringes; 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 correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

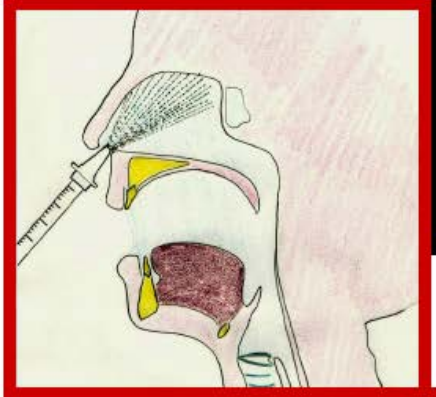
NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972

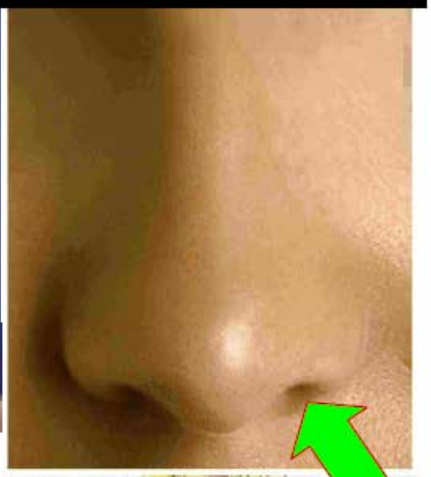
CLINICAL PRACTICE ALERT

MAD – IN Administration

- **Fentanyl**
- **Glucagon**
- **Naloxone**
- **Midazolam** (10mg/2mL concentration only)

- If nasal secretions: suction or use alternate route
- **Ideal IN volume for MAD = 0.25 - 0.3 mL**
- If total volume ≥ 0.4 mL: Divide amt between 2 syringes and give ½ dose each nostril (to increase surface area)
- **Use smallest syringe (1 mL leur-lock ideal)**
- **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)
- 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





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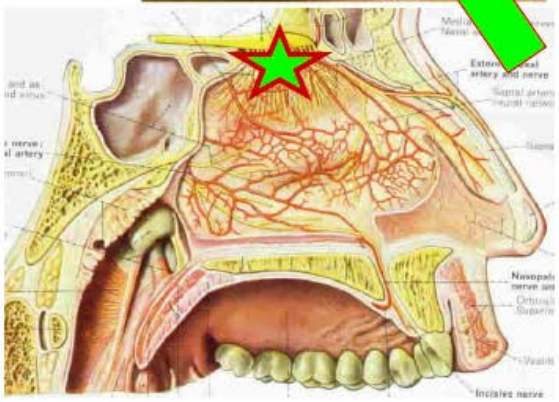

NWC EMSS Skill Performance Record

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 drug and dose to administer. You are asked to assemble the equipment, and give the appropriate dose using the IV Push technique.*

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 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 appropriate amount of medication for administration ☐ Prepare medication 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 ☐ * Observe strict Universal precautions & aseptic technique during drug delivery ☐ * 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 and readjust IV flow rate ☐ * If a one-time dose: detach syringe; discard appropriately		
* Assess patient for response to medication; repeat VS		
* Document drug name, concentration, dose, route, time given, PM & pt response		
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IV within 2 minute time limit ☐ Failure to take or verbalize appropriate BSI precautions prior to performing venipuncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage, catheter shear, or air embolism ☐ Failure to verbalize disposal of blood-contaminated sharps immediately in proper container at point of use ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME – signature

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 vasopressor. You are asked to assemble the equipment, choose the correct medication from those available, and administer the appropriate dose using the IVPB technique.*

Performance standard 2 Step omitted (or leave blank) 3 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 ☐ *Observe strict Universal precautions & aseptic technique during drug prep & delivery ☐ Select the appropriate medication and IV solution. ☐ *Cross check: Reconfirm medication with another PM ☐ *Inspect medication packaging; confirm drug name, integrity; concentration, dose, & expiration date. ☐ *Open IV outer bag and verify sterility of medication (all seals in place) ☐ * Inspect solution for clumping, frosting, precipitation, change in clarity or color if poss.		
Prepare medication for administration *Add norepinephrine 4 mg/4 mL to 1,000 mL D5W or NS. Label bag. * 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 ☐ 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; repeat VS		
* Document drug name, concentration, dose, route, time given, PM who initiated IVPB & pt response		
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IV within 2 minute time limit ☐ Failure to take or verbalize appropriate body substance isolation precautions prior to performing venipuncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage, catheter shear, or air embolism ☐ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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Rating: (Select 1)

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CJM 12/16

Preceptor (PRINT NAME – signature

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 choose the correct medication, and to administer the appropriate dose of ASA using the PO technique.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ Documentation		
Prepare the patient ☐ * Confirm need for the drug ☐ * Confirm absence of allergy or contraindication to the drug ☐ If possible place patient in an upright or sitting position		
***** 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, PM and pt response		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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CJM 12/16

Preceptor (PRINT NAME - signature

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 choose the correct medication and to administer the appropriate dose using the SL technique.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*** Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 to confirm name of the drug, integrity of the 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 container or pour one tablet into lid of the container.		
*Cross check: Reconfirm medication and dose prepared with another PM		
* Temporarily remove O_2 mask if applicable. Instruct pt to open mouth and lift tongue. Place tablet under the pt's tongue. Instruct pt to close their mouth and allow the tablet to dissolve.		
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.		
* Monitor pt's response to the medication (repeat VS; reassess pain, degree of distress)		
* Document drug, concentration, dose, route and time administered, PM and pt responses		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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Rating: (Select 1)

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CJM 12/16

Preceptor (PRINT NAME – signature

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 1mg/1mL 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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ 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 mg/1 mL ☐ Sharps container ☐ Adhesive strip ☐ Gauze pad		
☐ Select the appropriate medication ☐ Inspect packaging to confirm drug name, integrity of packaging; concentration, dose, & 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 dose and draw up into syringe ☐ *Prepare medication: Draw into syringe from an ampule using filtered needle/straw) ☐ Observe syringe for air bubbles, point syringe upward, expel bubbles; 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 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ Documentation		
Prepare patient ☐ *Confirm need for the drug ☐* Confirm absence of allergy or contraindication to the drug ☐ Explain the drug action, possible side effects, and procedure to the patient		
Prepare equipment/medication ☐ Syringe 1-3 mL w 21-22 g; 1½ - 2½" needle ☐ CHG/IPA prep ☐ Medication ☐ Sharps container ☐ Adhesive strip ☐ Gauze pad		
☐ *Select the appropriate medication ☐ Inspect packaging to confirm drug name, integrity of packaging; concentration, dose, & 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 dose and draw up into syringe from a vial ☐ Observe syringe for air bubbles, point syringe upward, and expel bubbles ☐ **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; allow to dry for 30 seconds ☐ *Gently stretch skin overlying muscle; do not to touch 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/needle, apply pressure to site, discard syringe in a sharps container, 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***Verbalize the 6 rights of medication administration: RIGHT** ☐ Person ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ Documentation		
Prepare the patient ☐ *Confirm need for the drug ☐* Confirm absence of allergy or contraindication to the drug ☐ Explain the drug action, possible side effects, and procedure to the patient/caregiver		
Prepare equipment/medication Diastat syringe (traditional) 2.5 mg or Diastat AcuDial system. When Diastat AcuDial is prescribed, 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, 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, & PM		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Failure to dispose/verbalize disposal of sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel		

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*** Prepare and assemble equipment** ☐ Precision Xtra monitor ☐ Lancet (no lancing device) ☐ Test strips ☐ CHG/IPA prep		
* Apply gloves		
Perform procedure * Open a test strip; tear at notch on each side of packet so contact bars of test strip are showing.		
Grasp contact bars and pull test strip out of packet. Save test strip packet for disposal of used strip.		
Inspect strip and discard if bent, scratched, wet, or damaged		
* Insert contact bars of test strip into the monitor test port		
* Advance test strip until it stops. Observe monitor turn on. Recognize that monitor will display five digit lot number and then apply blood.		
Troubleshoot monitor if 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 side of patient's finger with a CHG/IPA prep. Allow to dry completely.		
☐ *Obtain a blood drop using a lancet and correct technique (side of finger, not pad) ☐ *Did not squeeze or milk finger past most distal knuckle ☐ *Dispose of lancet in a sharps container		
If skin did not dry thoroughly, wipe away first drop of blood and use second drop to run test. *Touch blood to target area of test strip. Hold finger on target area while blood is drawn into the strip.		
Observe test start automatically when blood sample is detected		
* Move finger away from target area when display shows three dashes. Do **not** press meter button.		
Verbalize that monitor will display --- -- - followed by a countdown from 5		
*Correctly read glucose reading after 5 secs <20 = LO >500 = HI; > 300 will flash Check Ketones		
Turn off monitor off by pressing and releasing the button		
Place test strip packet over used strip and remove from monitor for proper disposal		
Critical Criteria - Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions prior to performing skin puncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for incorrect test result/patient harm ☐ Failure to dispose/verbalize disposal of blood-contaminated sharp immediately in proper container ☐ Exhibits unacceptable affect with patient or other personnel		

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CJM 12/16

Preceptor (PRINT NAME – signature

NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972

CLINICAL PRACTICE ALERT

ALL pts w/ DIABETES - with ANY hypoglycemia S&S

If 1st blood glucose level NOT low, REPEAT test

REPEAT

DIANA:cpa-diabetes-glucose-6-15

Mild Hypoglycemia **Early adrenergic** Pallor Diaphoresis Shakiness Hunger Anxiety Irritability Headache Dizziness	Feeling of shakiness, trembling Perspiration Blurred vision Dizziness Difficulty concentrating Feeling nervous or anxious Feeling of weakness Numbness or tingling around mouth and lips Fatigue Headache Sudden hunger Nausea Rapid heart rate, palpitations
Moderate Hypoglycemia	Irritability Agitation Confusion Lack of coordination Difficulty speaking or slurred speech **STROKE s&s**
Severe Hypoglycemia	Confusion Fainting/loss of consciousness Seizures Inability to swallow

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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 ☐ Drug ☐ Dose ☐ Route ☐ Time ☐ Documentation		
Verbalize the following: ☐ Drug action: Concentrated source of carbohydrate for IV infusion ☐ *Indication: Confirmed hypoglycemia ☐ *Side effects: hyperglycemia. Less likely with D10% than with 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. 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 equipment/medication: Confirm RIGHT DRUG: D10% (25g/250mL) ☐ Open D10% outer wrap 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 – IV or IO) Concentrated dextrose solutions should not be administered via sub-q or IM routes ☐ Insert piercing pin from secondary set IV macrodrip tubing into D10% IV bag. Suspend and squeeze drip chamber to fill ⅓ full; 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 secondary set (D10% line) to primary IV tubing at port closest to the patient ☐ Close flow clamp of primary IV tubing; 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. 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. **If S&S of hypoglycemia fully reverse** and pt becomes decisional after a partial dose, reassess bG. If >70; clamp off D10% and open 0.9 NS TKO ☐ **Children and Infants if bG is borderline 60-70 and symptomatic:** Give half (½) of the dose listed below.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ **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. Give additional 0.5 g/kg (5mL/kg) if pt remains hypoglycemic &symptomatic 5 min after initial medication dose. ☐ **<u>If pt has HF or a history of HF and lungs are clear:</u> standard** dose, but slow infusion rate to 50 mL increments followed by reassessment ☐ **<u>If pt has HF and lungs have crackles or wheezes:</u>** Call OLMC for orders		
Verbalize 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.		

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CJM 12/16

Preceptor (PRINT NAME - signature

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

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*** State indications for an NG tube** ☐ Aspiration risk ☐ Need for gastric lavage ☐ Need for gastric decompression		
* Universal precautions		
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		

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Rating: (Select 1)

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☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*** 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		
* Universal precautions		
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		

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CJM 12/16

Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*__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 – Apply BSI__ ☐ Contact lens storage case or 2 containers w/ lids ☐ Suction cup - optional ☐ Sterile saline without preservatives ☐ Towel or 4X4s		
__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		

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Rating: (Select 1)

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CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*__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 pt 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.		

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r CJM 12/16

Preceptor (PRINT NAME - signature

NWC EMSS Skill Performance Record

INSTALLATION OF TETRACAINE EYE DROPS

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

Instructions: An adult is experiencing severe eye pain after falling asleep wearing their contact lenses. You are asked to assemble the equipment and perform installation of tetracaine eye drops for possible corneal abrasions.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
*__Obtain rapid gross visual acuity__ ☐ Can read name badge ☐ Sees shape/shadow/motion ☐ Can count fingers ☐ Sees light projection only ☐ NLP		
☐ Determine care provided prior to EMS arrival		
Prepare the patient ☐ *Confirm need for the drug ☐ *Confirm absence of allergy or contraindication to the drug		
Explain the drug action, possible side effects, and procedure to the patient		
* Select appropriate medication: Inspect packaging to confirm drug name, integrity of packaging; concentration, dose, and expiration date		
* Inspect solution for precipitation and change in clarity or color		
* Open package after verifying sterility of medication		
Perform procedure: * Universal precautions * Instruct patient to look up		
* Gently pull lower eyelid downward		
☐ *Without touching medication container to eye, instill 1 gtt tetracaine into conjunctival cul-de-sac ☐ * Do not place drops directly onto the cornea		
Release lower eyelid and allow pt to close eyes normally to distribute gtts Provide patient with tissue to absorb excess drops		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

Factually document below your rationale for checking any of the above critical criteria.

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CJM 12/16

Preceptor (PRINT NAME – signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***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		
* Universal precautions		
Prepare patient – move as quickly as possible Obtain history for contact use; remove contact lenses if in place		
Explain procedure to patient if awake		
* Instill tetracaine drops per procedure.		
☐ 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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
***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		
Critical Criteria: Check if occurred during an attempt ☐ Failure to take or verbalize appropriate body substance isolation precautions ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in the potential for patient harm ☐ Exhibits unacceptable affect with patient or other personnel		

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

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CJM 12/16

Preceptor (PRINT NAME - signature

NWC EMSS Skill Performance Record

PEDIATRIC MEASUREMENT using a LENGTH-BASED TAPE

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

Instructions: A child appears to be very ill. Accurately use the Broselow pediatric length based tape to determine the size/weight of various pediatric manikins and identify the information to be gained from the tape relative to catheter sizes, fluid volumes to infuse, drug doses, etc.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Apply PPE		
* 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		
☐ *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 steps must be independently performed in correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

NWC EMSS Skill Performance Record

PEDIATRIC INTUBATION

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

Notes from 2016 SOP:

CHILDREN < 12 years of age shall have airways secured using BLS adjuncts & interventions

If unable to secure airway with BLS interventions: May make 1 attempt at advanced airway per OLMC only

ADOLESCENTS > 12 yrs: Manage airways per adult SOPs

Possible indications for advanced airway in children

- Persistent airway impairment, ventilatory failure (apnea, RR <10 or >40; shallow/labored effort; $SpO_2 \leq 92$; increased WOB (retractions, nasal flaring, grunting) → fatigue
- Inability to ventilate/oxygenate adequately after insertion of OP/NP airway and/or via BVM
- Need for ↑ inspiratory or positive end expiratory pressures to maintain gas exchange or sedation to control ventilations.

Contraindications/restrictions for DAI: Coma with absent airway reflexes or known hypersensitivity/allergy to drugs

Instructions: *An unconscious child presents from a submersion incident with an impaired airway but protective airway reflexes intact with a carotid pulse present. No c-spine injury is suspected. Prepare the equipment and intubate patient.*

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* BSI: Universal and droplet precaution; May perform ONLY with **OLMC ORDER**		
Prepare patient ☐ Position appropriately with pad under occiput or torso depending on age and size ☐ Open the airway manually ☐ *Insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate**/ventilate **for 3 min** w/ O_2 12-15 L/BVM with O_2 reservoir every 3 to 5 sec.. (Must demonstrate good ventilation of manikin); squeeze bag over 1 sec with sufficient volume to see chest rise – avoid high pressure & gastric distention. Ventilate with room air until O_2 source available. Attach $ETCO_2$ sensor between bag and mask		
Assess for signs suggesting a difficult intubation: neck/mandible immobility, oral trauma, loose teeth; F/B; inability to open mouth, Mallampati view III or IV, short thyromental distance; overbite		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Check suction source; attach rigid tip (Yankauer/tonsillar); prepare advanced airway and cricothyrotomy equipment ☐ Select ET based on child's size, not age - Measure w/ Broselow tape up to 35 kg - See table. Cuffed ETT ID (mm) = 3.5 + (age/4) or size of 5th finger Prepare tubes one size larger and one size smaller than the one estimated ☐ Laryngoscopes & blades (curved and straight; multiple sizes) ☐ Peds stylette; 10 mL syringe; water-soluble lubricant ☐ Commercial tube holder or tape, head blocks or tape, stethoscope ☐ Have alternate airway selected, prepped, & in sight (King LT) or needle cric ☐ Premedication (benzocaine spray) and sedative (ketamine)		
☐ Insert peds stylet so distal tip is proximal to end of tube and form tube. ☐ Check ETT cuff integrity while in package if applicable; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant on inside of the top of the ETT package		
* Assemble laryngoscope; ensure it is operational; check light source (tight, bright & white)		
* Apply ECG monitor (perfusing rhythm & pulse present)		
*** Premedicate: Gag reflex present:** *Benzocaine 1-2 second spray, 30 seconds apart X 2 to posterior pharynx		
Sedate: KETAMINE 2 mg/kg slow IVP (over 1 min) or 4 mg/kg IN/IM (calculate dose based on size of child. See chart SOPs p. 101) Allow for clinical response before DAI (if possible).		
Pass tube: * (Allow no more than 30 sec of apnea)		
☐ Maintain O_2 6 L/NC during procedure		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ Assistant or examiner withdraws OPA/NPA remains ☐ Have partner apply lip retraction, external laryngeal pressure; in-line stabilization if indicated ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, SpO_2 q. 5 min. during procedure and time elapsed ☐ Interrupt DAI if HR < 60 or SpO_2 < 94%: 1 breath q. 3-5 sec w/ O_2 15 L/BVM until condition improves. Consider need for atropine if pt remains bradycardic.		
START TIMING tube placement after last breath_____ ☐ Withdraw tube from pkg through lubricant; hold in dominant hand; do not contaminate ETT ☐ 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 ☐ *Visualize epiglottis as inserting. Seat blade. 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: Align distal tube markings with vocal cords; Note marking on proximal tube end at teeth/gums. Depth of insertion= ETT diameter X 3. If > 2 yrs: (Age in yrs / 2) + 12		
*While holding ETT in place, remove laryngoscope blade and stylet		
* Attach peds $EtCO_2$ sensor to ETT. 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. **Time of first breath:**		
* If tube is in stomach: Withdraw, re-oxygenate 30 seconds and attempt again with new tube If placed in trachea, but breath sound unequal: adjust tube depth, re-ventilate.		
If tube placed correctly ☐ O_2 15 L/BVM ventilate every 3 to 5 seconds just to see chest rise ☐ Inflate cuff if present (avoid overinflation); note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT) ☐ Secure ETT with commercial device or tape. Reassess $ETCO_2$ & lung sounds. Apply lateral head immobilization. ☐ **Post-intubation sedation** if SBP > 70 + 2 X age or ≥ 90 if 10 -12 yrs: MIDAZOLAM 0.1 mg/kg slow IVP (0.2 mg/kg IN/IM) (max single dose 5 mg). May repeat to total of 10 mg based on size and BP. ☐ Continue to monitor $ETCO_2$ or capnography to confirm tracheal placement.		
If intubation unsuccessful and good air exchange w/ peds BVM: Continue ventilations/BVM.		
If unable to intubate or adequately ventilate with BVM: Consider need for alternate airway		
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change If intubated & deteriorates, consider**: D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
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		
Critical Criteria: Check if occurred during an attempt (automatic fail) ☐ Failure to initiate ventilations within 30 sec after applying gloves or interrupts ventilations for >30 sec at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at an age & size appropriate rate ☐ Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible] ☐ Failure to pre-oxygenate patient prior to intubation and suctioning ☐ Failure to successfully ventilate and oxygenate effectively ☐ Failure to disconnect syringe **immediately** after inflating cuff if present ☐ Uses teeth or gums as a fulcrum ☐ Failure to assure proper tube placement by $ETCO_2$ and auscultation of chest bilaterally and over the epigastrium ☐ Stylette extends beyond end of ET tube ☐ Inserts any adjunct in a manner dangerous to the patient ☐ Suctions patient excessively or does not suction the patient when needed ☐ Failure to manage the patient as a competent paramedic		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		
Evaluator initials for each attempt		

Age averages	0-12 mos	1-2 yrs	3-4 yrs	5 yrs	6-7 yrs	8-11 yrs
Wt. in kg	3-9 kg	10-13 kg	14-16 kg	16-20 kg	18-25	24-32 kg
Blade size	0-1 str	1 str	2 str	2 str	2 str or curved	2 str or c
Tracheal tube	3.5-4.0 No cuff	4.0 No cuff	4.5 No cuff	5.0 No cuff	5.5 May be cuffed	6.0 Cuffed
Distance to upper lip	7-10.5	11-12	12.5-13.5	14-15	15.5-16.5	17-18

Factually document your rationale for checking any of the above critical items below.

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_____

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Rating: (Select 1)

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Preceptor (Print name / signature)

CJM 12/16

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Verbalize indications for IV: ☐ Fluid & elect replacement ☐ Drug administration Most urgently needed for: hypovolemia, hemorrhage, or prolonged cardiac dysfunction with acidosis		
Prepare patient and caregiver Use age-appropriate techniques to prepare the child. Inform them about procedure in terms they can understand (what they will experience and feel). Explain procedure to caregiver; provide reassurance.		
Prepare equipment ☐ *Select appropriate IV solution (NS) ☐ 1000 mL NS or ☐ 250 mL NS and examine covering for leakage or other damage. Open outer bag at the precut slit at either end. Take care not to cut or puncture the inner IV bag. ☐ *Verify sterility of solution (all seals in place). Check solution for leaks, clarity, cloudiness, contaminates, precipitation, and expiration date.		
Spike IV bag & prime IV tubing ☐ Remove infusion set from package; uncoil tubing; close clamp, remove spike protector without contaminating spike or the needle adaptor. ☐ Turn IV bag upside down with IV & medication ports facing up; remove cover from IV port, maintain sterility of port ☐ *Insert tubing spike into IV port with a pushing and twisting motion until it punctures seal. ☐ *Invert bag. Grasp IV set at drip chamber and squeeze. Fill drip chamber ⅓ to ½ full or to the fill line. ☐ *Open clamps and/or flow regulator to flush (prime) line with NS. May temporarily remove end cap to facilitate procedure, but not necessary. Remove all large air bubbles from tubing. (Empty IV tubing contains ~30 mL of air. This could cause a lethal air embolus if all infused into the patient.) ☐ Reclamp tubing shut. Recap end if removed to flush tubing. ☐ Hang IV or have someone hold bag. Place capped tubing end close to where line will be started for easy access.		
* Select appropriate **IV catheter**. Type of venipuncture device will depend on the child's age, activity level, purpose of IV, available veins, and site selected. Largest gauge catheter with the shortest length is preferred to allow rapid fluid infusion when volume resuscitation is necessary. ☐ Neonates 24-26 g ☐ Infants 22-24 g ☐ Children 20-22 g ☐Adolescents needing fluids 16-18.g		
☐ Skin prep pads (CHG/IPA) ☐ Gauze pads ☐ Tape ☐ 50-60mL syringe. 3-way stopcock ☐ Skin protectant film ☐ Tourniquet ☐ Sharps container ☐ Tear 3-4 pieces of ¼ - ½" tape about 4-6" long ☐ IV protector shield; arm board		
Procedure * Observe strict Universal precautions & aseptic technique during catheter insertion		
Site selection/preparation Select vein that is pliable, appears long enough to accommodate catheter length without traversing a joint, and large enough to allow blood flow around the catheter. Commonly selected vessels: metacarpals on dorsum of hand, accessory cephalic, cephalic, and antecubitals (often visible or palpable in children when other veins won't dilate, as in shock or severe dehydration). During CPR: use IO. Avoid veins in the inner wrist or arm -small and uncomfortable to access. Avoid sites with circumferential burns, infection, or marked edema; extremity with a suspected fracture. ☐ Expose extremity to be cannulated. Inspect for suitable site. ☐ Place small roll of gauze behind elbow to aid in hyperextension for antecubital site. ☐ May need to papoose child with sheet to protect their safety during procedure.		
* Apply venous tourniquet 4" proximal to selected IV site; palpate distal pulse. Never leave in place for more than two minutes as changes occur in slowed venous blood.		
* Lightly palpate veins with index finger. If it rolls or feels hard and rope-like, select another vein. Avoid points of flexion if possible. If vein easily palpable but not sufficiently dilated:		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
☐ Tap gently over vein with your finger. **Do not slap** - will collapse the vein. ☐ Place extremity in a dependent position ☐ Have patient open and close fist several times		
* Prep site with CHG/IPA*. Dry 30 sec. Do not contaminate by touching after cleaned.		
Catheter insertion ☐ Remove protective cap from needle in a straight outward manner keeping catheter sterile. (Do not depress white activation button of Insyte® catheter) ☐ If using InSyte catheter: Rotate catheter hub 36O° to loosen catheter from needle. Failure to do so may affect needle retraction. NEVER slide catheter end over needle to break seal. ☐ Inspect needle tip for defects		
* Anchor vein with thumb distal to insertion site, stretching the skin near the vein. Do not place your thumb directly over vein or blood flow will be occluded and veins will flatten. If using a hand vein, slightly flex patient's wrist.		
* Hold catheter between thumb and index finger of dominant hand (like a pool cue). Insert needle, bevel up (in relation to the patient's skin surface) through skin & vein at a 15-30° angle. (Very sharp catheters enter veins with little or no popping sensation.) Take care not to enter too fast or too deeply as needle can pass through back-side of vein.		
☐ 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 1/8th inch to ensure proper tip positioning in vein ☐ If unable to enter vein, withdraw needle & catheter slightly, use caution not to withdraw needle tip out of skin. Re-attempt to advance into vein. If vein is missed or needle is pulled entirely out of skin, retract needle, apply gauze/Band-Aid and begin again with new catheter at another site. Limited to 2 attempts unless OLMC authorizes additional tries.		
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)		
* **Release tourniquet** (Failure to release before needle retraction may result in 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 ☐ **Protectiv^{TM} IV catheter** (Criticon) o Glide the protective guard over the needle o Listen for the "click" that confirms needle is safely locked in place o Remove encased, locked needle from the catheter hub ☐ **Insyte Saf-T-Cath** (Becton Dickinson) o Do not fully retract needle until catheter is fully inserted into vein. o Avoid premature activation of retraction button. Push button to retract needle into clear safety shield. If activation does not occur, press button again. If activation still does not occur, withdraw needle & place immediately into sharps container. ☐ Discard shielded needle unit immediately into sharps container		
Connect IV tubing to catheter and establish IV flow: ☐ *Remove protective cap on IV tubing; slide end of tubing onto IV catheter hub; release pressure to vein ☐ Use of J loop preferred between IV catheter and IV tubing ☐ *While continuing to hold the IV catheter, open clamp on IV tubing to start fluid flow to establish patency, adjust desired flow rate. Note: When using a roller or screw clamp for flow regulation, rate must be monitored closely as vein spasm, vein pressure changes, pt movement, bent or kinked tubing, and gravity drop height may cause flow rate to vary markedly. * If giving an IV bolus, calculate child's wt. X 20 mL/kg. Attach 60 mL syringe to stopcock; open stopcock to IV bag and withdraw appropriate amount. Turn stopcock to child and slowly push fluids. Repeat until correct amount given (over 5 min) while preserving the integrity of IV. If IVF is given too fast or too slowly, child may experience phlebitis, infiltration, circulatory overload, or insufficient resuscitation.		
Dressing/Stabilization: ☐ Clean up blood at site with a gauze pad.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	Attempt 1 rating	Attempt 2 rating
☐ Peel lining from transparent dressing exposing adhesive surface; center dressing over catheter site; apply protective film over dry skin without stretch or skin tension, leave IV tubing connector to colored hub free. Slowly remove the frame while smoothing dressing from center to edges using firm pressure to enhance adhesion. ☐ Secure IV tubing with adhesive strips or commercial dressing as needed. Do not tape over IV connection sites. Do not conceal hub-tubing connection. ☐ **Protect the site**: Immobilize limb on an arm board. Position board so fingers curve over the end rather than being fully outstretched on a flat plane. Cover/protect site with a paper or Styrofoam cup sliced in half or a commercially available product secured over IV insertion area.		
* **Document** IV fluid, insertion site, # of attempts as successful or unsuccessful, catheter gauge, time started, flow rate and amount infused. Label IV bag.		
*State 2 signs of infiltration (D/C line) ☐ IV does not flow ☐ Local swelling ☐ Site pain/burning		
* State method to determine patency: check retrograde flow * State method to troubleshoot poorly running line (See adult IV access procedure)		
* Properly discard all disposable components; Sharps directly into sharps container		
State 3 complications of an IV (See adult IV access procedure)		
Note actual time for each attempt from start to finish:		
☐ *Check if patent IV was not established within 2 minutes		
Monitor and document response to initial fluid bolus: improvement in capillary refill, mental status, skin color and temperature of the extremities, ↓ HR, and elevation of an initially low BP.		
Critical Criteria - Check if occurred during an attempt ☐ Failure to establish a patent and properly adjusted IV within 2 minute time limit ☐ Failure to take or verbalize appropriate body substance isolation precautions prior to performing venipuncture ☐ Contaminates equipment or site without appropriately correcting the situation ☐ Performs any improper technique resulting in potential for uncontrolled hemorrhage, catheter shear, or air embolism ☐ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use ☐ Exhibits unacceptable affect with patient or other personnel ☐ Uses or orders a dangerous or inappropriate intervention		

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Factually document your rationale for checking any of the above critical items below.

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_____

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

Rating: (Select 1)

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☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

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Preceptor (Print name / signature)

CJM: IVPEDS 10/06; 1/10; 5/14; 12/16

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
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 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.		

	Rating		Rating
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (VF); change compressor. Resume compressions while monitor is charging.		*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.	
*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) & capnography; change compressor. Resume compressions while monitor is charging.		* Epinephrine 1mg/10mL 0.01 mg/kg (0.1 mL/kg) up to 1 mg IVP/IO. (See chart in appendix 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. 93 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) & capnography; 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 NOREPINEPHRINE as needed. Avoid hyperthermia & hyperglycemia.			

Notes on good CPR:

- ☐ Push hard (Approx. ⅓ to ½ depth of chest) and fast (100-120); 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 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: 2/15

There are 6,400 cardiac arrests annually in children under 18 y/o (1.6%,18/day)

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.				
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (IVR); change compressor. *If electrical activity: ✓ pulse (no pulse)	**Rating**	*Ventilate w/ 15 L O_2/BVM at 10 BPM. Consider need to place advanced airway. After Advanced airway placed, do not pause compressions to ventilate.		**Rating**
*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) & capnography; 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 mg/10mL 0.01 mg/kg (0.1 mL/kg) up to 1 mg IVP/IO. (See chart SOP) Repeat every 3-5 min. as long as CPR needed		
* After 2 min of CPR; pause compressions (<10 sec); ✓ rhythm (IVR) & capnography; 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 NOREPINEPHRINE 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 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: 2/15

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
Equipment needed ☐ Backboard/scoop stretcher of appropriate size ☐ Peds cervical collar ☐ Towel rolls and/or appropriate size ☐ Min. 2 rescuers ☐ Straps for board/scoop ☐ 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/scoop stretcher. Tip seat backwards onto the device (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/scoop and immobilized per usual procedure (photo 3)		

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.

2/15

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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 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

5/14

NWC EMSS Skill Performance Record

HEMORRHAGE CONTROL –Tourniquet Use

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

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Apply PPE		
Assess pt for nature of bleeding: ☐ Type ☐ Source ☐ Amount ☐ Rate		
Apply direct digital pressure using palm of hand over a single layer sterile dressing placed over wound unless contraindicated (deep open skull wound)		
Bleeding persists: (Direct pressure ineffective or impractical; wound not amenable to tourniquet) ☐ Cover entire bleeding surface; including deep areas of wound with QuikClot dressing ☐ Apply direct pressure over dressing ☐ If blood soaks through 1st layer, apply a 2nd ☐ Once bleeding stops, apply pressure bandage (roller gauze/ 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 ☐ * Direct pressure ineffective or impractical; 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 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.

2/15

Evaluator

NWC EMSS Skill Performance Record
Decompression of Tension Pneumothorax

NEEDLE THORACOSTOMY

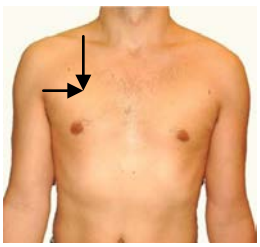
Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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 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
12/16

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 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

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 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

* 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 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 7/12

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 per hemorrhage control SOP			
Consider need for fentanyl 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 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

2/15

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; hemostasis per ITC SOP			
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 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 _____

5/14 _____ Evaluator

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 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

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 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

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 (KED)			
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			
Place padding between legs, 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 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: 2/15

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: Pt requires selective spine precautions and/or movement to the stretcher			
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 shoulders, chest, pelvis & knees			
* Bring ambulance stretcher close to pt; put side rails down; lock wheels			
* Note: Scoop stretchers replace need for long spine boards for most pts. See System memo #349.			
* Lift scoop stretcher by end-carry method			
* Lower scoop stretcher gently onto stretcher			
* Secure patient to stretcher with straps per procedure			
* Reassess patient			

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: 2/15

NWC EMSS Skill Performance Record

START & JUMP START PRIMARYTRIAGE

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 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:_____

5/14 **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 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: 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 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
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 ☐ 12 l ECG if: S&S that could be cardiac in nature, is elderly, history of CVD or drug use		
Secondary assessment. VS; ☐ Hyperthermia ☐ Volume depletion ☐ Tachycardia ☐ Metabolic acidosis		
Determine SAMPLE history: date of last tetanus prophylaxis cardiac history; ingestion of mind altering stimulant (PCP, cocaine). Tased individuals can have injury or illness that occurs before they are tased and/or injury when they are tased and fall		
ITC: Supportive care ☐ Apply/maintain restraints if needed ☐ IV NS to correct volume depletion if present		
Severe anxiety and SBP ≥ 90 (MAP≥ 65): MIDAZOLAM 2 mg increments slow IVP q. 2 min (0.2 mg/kg IN) up to 10 mg titrated to response. If IV unable/IN contraindicated: IM 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. If hypovolemic, elderly, debilitated, chronic dx (HF/COPD); and/or on opiates or CNS depressants: ↓ total dose to 0.1 mg/kg.		
Assess for **excited delirium:** State of agitation, excitability, paranoia, aggression ☐ Great strength ☐ Numbness to pain ☐ Violent behavior		
Rx excited delirium/ violent, severe agitation: KETAMINE 2 mg/kg slow IVP (over 1 min) or 4 mg/kg IN/IM. May repeat at ½ dose after 10 min up to Max of 4 mg/kg (500 mg). Use w/ caution in pts with schizophrenia, psychosis, or bipolar mania		
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.		
If probe becomes disengaged, 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 steps must be independently performed in correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 12/16

Preceptor (PRINT NAME - signature

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