

2016 CPR / Resuscitation Skills

EMERGENCY MEDICAL SERVICES

SKILL CHECKLIST

Cardiac Arrest

NAME

PRINT NAME

EMS #

DATE

Objective: Given a multi-person company, BLS/ALS equipment and manikin: demonstrate assessment and treatment for Cardiac Arrest as outlined in current **Standing Orders for the Treatment of Cardiac Arrest**. *Consider including ALS in this drill.

PPE / SAFETY (must demonstrate)

- Gloves Eye Protection Respiratory Protection (as needed) AED Safety

(CAB APPROACH) COMPRESSION PERSON(S)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Confirm: uncon./unresp. | <input type="checkbox"/> Pulse Check (no more than 10 sec.) | <input type="checkbox"/> Verbally counts compressions | <input type="checkbox"/> Airway/Breathing |
| <input type="checkbox"/> Remove patient to open area
<input type="checkbox"/> Remove clothing to start
<input type="checkbox"/> Immediately begins chest compressions with rate of at least 100 per minute
<input type="checkbox"/> Completes 30 compressions of CPR before first analysis
<input type="checkbox"/> Resume CC immediately after Analysis / Shock | | <input type="checkbox"/> Pulse Check (only after 2nd No Shock)
<input type="checkbox"/> Switches w/o pause every 2 minutes
<input type="checkbox"/> Proper hand placement
<input type="checkbox"/> Compress chest at least 2 inches
<input type="checkbox"/> Allow complete recoil between compressions | |

DEFIB TECHNICIAN

*****ANALYZE AS SOON AS AED APPLIED*** (minimum of 30 compressions)**

Shock Advised

- Shock** – (no pulse check)
 2 Minutes of CPR
 Analyze @ 2 mins. (post-shock)
 Changes compressor

No Shock Advised

- 2 mins. of CPR**
 Changes compressor
 Pulse Check < 10 sec. (**only after 2nd No Shock**)
 2 Minutes of CPR

- ***FEMORAL PULSE CHECK WITH CPR*****

VENTILATION PERSON

- Give 2 breaths/30 comp. (**unsecured airway**) **AND** About 1 second/breath (**achieves chest rise**)
 Give 1 breath/10 comp (**secured airway**) **AND** About 1 second/breath (**achieves chest rise**)

TIME KEEPER

- Tracks** 2min. intervals **Announces** time at **1:45** **Eliminates ALL** unnecessary interruptions

CRITICAL FAIL CRITERIA

All elements are CRITICAL FAIL CRITERIA

PASS

YES

NO

PRINT EVALUATOR NAME

EVALUATOR SIGNATURE

EMS #

BLS 2016 – BAG-VALVE-MASK VENTILATION OF AN APNEIC PATIENT EMERGENCY MEDICAL SERVICES			SKILLS CHECKLIST FOR RECERTIFICATION		
NAME	PRINT STUDENT'S NAME	ID #		DATE	
Objective: Given a partner the EMT will demonstrate his/her competency in dealing with proper assessment and the treatment of the Apneic patient as outlined in EMT Patient Care Guidelines and State.					
SCENE SIZE-UP (must verbalize)					
<input type="checkbox"/> Safety Precautions (BSI) <input type="checkbox"/> Scene Safety		<input type="checkbox"/> Reports "At Patient's Side"	<input type="checkbox"/> MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources
INITIAL ASSESSMENT (must verbalize)					
<input type="checkbox"/> Mental Status <input type="checkbox"/> C-Spine <input type="checkbox"/> Bleeding		<input type="checkbox"/> ABC's <input type="checkbox"/> Skin Signs <input type="checkbox"/> Chief complaint	<input type="checkbox"/> Obvious Trauma <input type="checkbox"/> Body Position	<input type="checkbox"/> SICK <input type="checkbox"/> NOT SICK	
PLAN (TREATMENT)					
<input type="checkbox"/> Opens airway properly <input type="checkbox"/> Opens airway manually properly <input type="checkbox"/> Appropriately measures oropharyngeal airway <input type="checkbox"/> Inserts oropharyngeal airway <input type="checkbox"/> Appropriate seal with mask			<input type="checkbox"/> Ventilates the patient immediately using a BVM device either attached or unattached to oxygen so long as first ventilation is delivered within 30 seconds <input type="checkbox"/> Ventilates the patient adequately <input type="checkbox"/> Proper volume to make the chest rise <input type="checkbox"/> Proper rate of 10-12/minute		
CRITICAL FAIL					
<input type="checkbox"/> Failure to take or verbalize appropriate standard precautions <input type="checkbox"/> Failure to check responsiveness and breathing for at least 5 seconds but no more than 10 seconds <input type="checkbox"/> Failure to open airway manually/properly <input type="checkbox"/> Failure to appropriately measure oropharyngeal airway <input type="checkbox"/> Failure to properly insert oropharyngeal airway			<input type="checkbox"/> Failure to initiate ventilations within 30 seconds <input type="checkbox"/> Failure to verbalize or attach BVM to high flow oxygen (15L/minute) <input type="checkbox"/> Failure to ventilate the patient adequately to make the chest rise (maximum 2 errors/minute permissible) <input type="checkbox"/> Failure to ventilate at the proper rate of 10-12/minute		
COMMUNICATION AND DOCUMENTATION			MEETS STANDARDS (RECERT)		
<input type="checkbox"/> Delivers timely and effective short report (if indicated) <input type="checkbox"/> Completes SOAP narrative portion of incident response form			<input type="checkbox"/> YES <input type="checkbox"/> NO 2nd ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO		
EVALUATOR SIGN YOUR NAME		ID	IF NO EXPLAIN		

BLS 2016 – NASOPHARYNGEAL AIRWAY
EMERGENCY MEDICAL SERVICES

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS 2016 – Nasopharyngeal Airway Student Name _____ Meets Standards Yes / No _____ Date: _____ Written Score _____ (online / other)

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE	
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Objective: Given a partner the EMT will demonstrate his/her competency with proper insertion of a Nasopharyngeal Airway

SCENE SIZE-UP (must verbalize)

<input type="checkbox"/> Safety Precautions (BSI)	<input type="checkbox"/> Reports "At Patient's Side"	<input type="checkbox"/> MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources
<input type="checkbox"/> Scene Safety				

INITIAL ASSESSMENT (must verbalize)

<input type="checkbox"/> Mental Status	<input type="checkbox"/> ABC's	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK
<input type="checkbox"/> C-Spine	<input type="checkbox"/> Skin Signs	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Chief complaint		

PLAN (TREATMENT)

<input type="checkbox"/> Takes or verbalizes appropriate standard precautions	<input type="checkbox"/> Fully inserts the airway with the bevel facing toward the septum
<input type="checkbox"/> Measures and selects appropriate size airway	<input type="checkbox"/> Demonstrates a patent airway by ventilating patient
<input type="checkbox"/> Verbalizes lubrication of the nasal airway	

CRITICAL FAIL

<input type="checkbox"/> Failure to take or verbalize appropriate and standard precautions	<input type="checkbox"/> Failure to demonstrate a patent airway by ventilating the patient
<input type="checkbox"/> Failure to measure and select appropriate size airway	<input type="checkbox"/> Uses or orders a dangerous or inappropriate intervention
<input type="checkbox"/> Failure to verbalize lubrication of the nasal airway	<input type="checkbox"/> Failure to manage the patient as a competent EMT
<input type="checkbox"/> Failure to fully insert airway with the bevel facing toward the septum	<input type="checkbox"/> Exhibits unacceptable affect with patient or other personnel

COMMUNICATION AND DOCUMENTATION

MEETS STANDARDS (RECERT)

<input type="checkbox"/> Delivers timely and effective short report (if indicated)	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Completes SOAP narrative portion of incident response form	<u>2nd</u> ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO

EVALUATOR SIGN YOUR NAME

ID

IF NO EXPLAIN

BLS 2016 – OROPHARYNGEAL AIRWAY
EMERGENCY MEDICAL SERVICES

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS 2016 – Oropharyngeal Airway Student Name _____ Meets Standards Yes / No _____ Date: _____ Written Score _____ (online / other)

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE	
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Objective: Given a partner the EMT will demonstrate his/her competency with proper insertion of a Oropharyngeal Airway

SCENE SIZE-UP (must verbalize)

<input type="checkbox"/> Safety Precautions (BSI)	<input type="checkbox"/> Reports "At Patient's Side"	<input type="checkbox"/> MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources
<input type="checkbox"/> Scene Safety				

INITIAL ASSESSMENT (must verbalize)

<input type="checkbox"/> Mental Status	<input type="checkbox"/> ABC's	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK
<input type="checkbox"/> C-Spine	<input type="checkbox"/> Skin Signs	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Chief complaint		

PLAN (TREATMENT)

<input type="checkbox"/> Takes or verbalizes appropriate standard precautions	<input type="checkbox"/> Properly inserts the airway
<input type="checkbox"/> Measures and selects appropriate size airway	<input type="checkbox"/> Demonstrates a patent airway by ventilating patient

CRITICAL FAIL

<input type="checkbox"/> Failure to take or verbalize appropriate and standard precautions	<input type="checkbox"/> Failure to demonstrate a patent airway by ventilating the patient
<input type="checkbox"/> Failure to measure and select appropriate size airway	<input type="checkbox"/> Uses or orders a dangerous or inappropriate intervention
	<input type="checkbox"/> Failure to manage the patient as a competent EMT
	<input type="checkbox"/> Exhibits unacceptable affect with patient or other personnel

COMMUNICATION AND DOCUMENTATION

<input type="checkbox"/> Delivers timely and effective short report (if indicated)
<input type="checkbox"/> Completes SOAP narrative portion of incident response form

MEETS STANDARDS (RECERT)

<input type="checkbox"/> YES	<input type="checkbox"/> NO
2nd ATTEMPT	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

EVALUATOR SIGN YOUR NAME

ID

IF NO EXPLAIN

BLS-2016 – Pediatric Respiratory Emergencies
EMERGENCY MEDICAL SERVICES

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS 2016 – Pediatric Respiratory Emergencies

NAME <small>PRINT STUDENT'S NAME</small>	ID #	DATE
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Objective: Given a partner the EMT will demonstrate his/her competency in dealing with proper assessment and the treatment of the pediatric patient in respiratory distress. As outlined in BLS-2016-Pediatric Respiratory Emergencies and EMT Patient Care Guidelines.

SCENE SIZE-UP (must verbalize)

<input type="checkbox"/> Safety Precautions (BSI)	<input type="checkbox"/> Scene Safety	<input type="checkbox"/> MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources
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INITIAL ASSESSMENT (must verbalize)

<input type="checkbox"/> Mental Status	<input type="checkbox"/> ABC's	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK
<input type="checkbox"/> P.A.T.	<input type="checkbox"/> Skin Signs	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK

SUBJECTIVE (FOCUSED HISTORY)

<input type="checkbox"/> Establishes rapport with patient	<input type="checkbox"/> Chief Complaint
<input type="checkbox"/> Permission To Treat	<input type="checkbox"/> Medications
<input type="checkbox"/> SAMPLE/OPQRST	<input type="checkbox"/> Medical Hx

OBJECTIVE (PHYSICAL EXAM)

<input type="checkbox"/> Baseline Vital Signs (With Temp)	<input type="checkbox"/> HEENT	<input type="checkbox"/> Productive Cough
<input type="checkbox"/> Medical Exam/Trauma Exam	<input type="checkbox"/> Lung Sounds	<input type="checkbox"/> Body Position
<input type="checkbox"/> LOC	<input type="checkbox"/> Duration of SOB	<input type="checkbox"/> 2 nd Exam

ASSESSMENT (IMPRESSION)

<input type="checkbox"/> Must Verbalize Impression	<input type="checkbox"/> ALS If Indicated: Why _____
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PLAN (TREATMENT)

<input type="checkbox"/> Immediate Life Threats	<input type="checkbox"/> Suction Airway (if indicated)
<input type="checkbox"/> Proper Oxygen Therapy	<input type="checkbox"/> Manual Ventilation
<input type="checkbox"/> Pulse Ox/Glucometry	<input type="checkbox"/> Assist Patient With Inhaler
<input type="checkbox"/> Positioning Patient	<input type="checkbox"/> Consider EpiPen
<input type="checkbox"/> Consider IOS	<input type="checkbox"/> Ongoing Assessment

CRITICAL FAIL

<input type="checkbox"/> Safety Precautions (BSI)/Scene Safety	<input type="checkbox"/> Administer O2 Appropriate Rate And Delivery
<input type="checkbox"/> Appropriately provide/manage airway, breathing, bleeding control, treatment of shock	<input type="checkbox"/> Need For ALS

COMMUNICATION

<input type="checkbox"/> Delivers timely and effective short report (if indicated)
<input type="checkbox"/> Completes SOAP narrative portion of incident response form

MEETS STANDARDS (RECERT)

<input type="checkbox"/> YES <input type="checkbox"/> NO
2nd ATTEMPT
<input type="checkbox"/> YES <input type="checkbox"/> NO

EVALUATOR SIGN YOUR NAME	ID #	IF NO EXPLAIN
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Student Name _____

Meets Standards Yes / No _____

Date: _____

Written Score _____

TIME →						
Blood Pressure						
Pulse Rate						
Respiratory Rate						
Consciousness						
ECG Rhythm						
Oxygen						
Meds						
(Pulse Oximetry)						
(Glucometry)						

Medications taken by patient at home

Allergies

Chief Complaint

Narrative

BLS 2016 – SPINAL IMMOBILIZATION (SEATED PATIENT) EMERGENCY MEDICAL SERVICES			SKILLS CHECKLIST FOR RECERTIFICATION		
NAME	PRINT STUDENT'S NAME	ID #		DATE	
Objective: Given a partner the EMT will demonstrate his/her competency in proper immobilization of a seated patient who requires spinal immobilization.					
SCENE SIZE-UP (must verbalize)					
<input type="checkbox"/> Safety Precautions (BSI)	<input type="checkbox"/> Reports "At Patient's Side"	<input type="checkbox"/> MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources	
<input type="checkbox"/> Scene Safety					
INITIAL ASSESSMENT (must verbalize)					
<input type="checkbox"/> Mental Status	<input type="checkbox"/> ABC's	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK		
<input type="checkbox"/> C-Spine	<input type="checkbox"/> Skin Signs	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK		
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Chief complaint				
PLAN (TREATMENT)					
<input type="checkbox"/> Directs assistant to place/maintain head in the neutral, in-line position <input type="checkbox"/> Directs assistant to maintain manual stabilization of the head <input type="checkbox"/> Assesses motor, sensory, and circulatory functions in each extremity <input type="checkbox"/> Applies appropriately sized cervical collar <input type="checkbox"/> Positions the immobilization device behind the patient without compromising the integrity of the spine			<input type="checkbox"/> Properly secures the device to the patient's torso <input type="checkbox"/> Evaluates torso fixation and adjusts as necessary <input type="checkbox"/> Evaluates and pads behind the patient's head as necessary <input type="checkbox"/> Secures the patient's head to the device <input type="checkbox"/> Verbalizes moving the patient to a long backboard <input type="checkbox"/> Reassesses motor, sensory, and circulatory functions in each extremity		
CRITICAL FAIL					
<input type="checkbox"/> Failure to take or verbalize appropriate standard precautions <input type="checkbox"/> Failure to direct assistant to place/maintain head in the neutral, in-line position <input type="checkbox"/> Failure to direct assistant to maintain manual stabilization of the head <input type="checkbox"/> Failure to initially assess motor, sensory, and circulatory functions in each extremity <input type="checkbox"/> Failure to apply appropriately sized cervical collar before ordering release of manual stabilization <input type="checkbox"/> Manipulated/moved or allowed the patient to move excessively, causing compromise of the spine			<input type="checkbox"/> Head immobilized to the device before the device was sufficiently secured to torso <input type="checkbox"/> Failure to immobilize the patient's torso to the immobilization device <input type="checkbox"/> Failure to immobilize the patient's head to the immobilization device <input type="checkbox"/> Torso fixation inhibits chest rise, resulting in respiratory compromise <input type="checkbox"/> Failure to reassess motor, sensory, and circulatory functions		
COMMUNICATION AND DOCUMENTATION			MEETS STANDARDS (RECERT)		
<input type="checkbox"/> Delivers timely and effective short report (if indicated) <input type="checkbox"/> Completes SOAP narrative portion of incident response form			<input type="checkbox"/> YES <input type="checkbox"/> NO 2nd ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO		
EVALUATOR SIGN YOUR NAME		ID	IF NO EXPLAIN		

BLS 2016 – SPINAL IMMOBILIZATION (SUPINE PATIENT)
EMERGENCY MEDICAL SERVICES

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS 2016 – Spinal Immobilization (Supine Patient) Student Name _____ Meets Standards Yes / No _____ Date: _____ Written Score _____ (online / other)

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE	
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Objective: Given a partner the EMT will demonstrate his/her competency in proper immobilization of a supine patient who requires spinal immobilization.

SCENE SIZE-UP (must verbalize)

- | | | | | |
|---|--|----------------------------------|---|---|
| <input type="checkbox"/> Safety Precautions (BSI) | <input type="checkbox"/> Reports "At Patient's Side" | <input type="checkbox"/> MOI/NOI | <input type="checkbox"/> Number of Patients | <input type="checkbox"/> Additional Resources |
| <input type="checkbox"/> Scene Safety | | | | |

INITIAL ASSESSMENT (must verbalize)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> ABC's | <input type="checkbox"/> Obvious Trauma | <input type="checkbox"/> SICK |
| <input type="checkbox"/> C-Spine | <input type="checkbox"/> Skin Signs | <input type="checkbox"/> Body Position | <input type="checkbox"/> NOT SICK |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Chief complaint | | |

PLAN (TREATMENT)

- | | |
|--|--|
| <input type="checkbox"/> Directs assistant to place/maintain head in the neutral, in-line position
<input type="checkbox"/> Directs assistant to maintain manual stabilization of the head
<input type="checkbox"/> Assesses motor, sensory, and circulatory functions in each extremity
<input type="checkbox"/> Applies appropriately sized cervical collar
<input type="checkbox"/> Positions the immobilization device appropriately
<input type="checkbox"/> Directs movement of the patient onto immobilization device without compromising the integrity of the spine
<input type="checkbox"/> Applies padding to voids between the torso and the device as necessary | <input type="checkbox"/> Immobilizes the patient's torso to the immobilization device
<input type="checkbox"/> Evaluates and pads behind the patient's head as necessary
<input type="checkbox"/> Immobilizes the patient's head to the immobilization device
<input type="checkbox"/> Secures the patient's legs to the immobilization device
<input type="checkbox"/> Secures the patient's arms to the immobilization device or body
<input type="checkbox"/> Reassesses motor, sensory, and circulatory functions in each extremity |
|--|--|

CRITICAL FAIL

- | | |
|---|--|
| <input type="checkbox"/> Failure to take or verbalize appropriate standard precautions
<input type="checkbox"/> Failure to direct assistant to place/maintain head in the neutral, in-line position
<input type="checkbox"/> Failure to direct assistant to maintain manual stabilization of the head
<input type="checkbox"/> Failure to initially assess motor, sensory, and circulatory functions in each extremity
<input type="checkbox"/> Failure to apply appropriately sized cervical collar before ordering release of manual stabilization
<input type="checkbox"/> Manipulate/moved or allowed the patient to move excessively, causing compromise of the spine | <input type="checkbox"/> Head immobilized to the device before the torso was sufficiently secured to the immobilization device
<input type="checkbox"/> Failure to immobilize the patient's torso to the immobilization device
<input type="checkbox"/> Failure to immobilize the patient's head to the immobilization device
<input type="checkbox"/> Failure to secure the patient's legs to the immobilization device
<input type="checkbox"/> Failure to reassess motor, sensory, and circulatory function |
|---|--|

COMMUNICATION AND DOCUMENTATION

- Delivers timely and effective **short report** (if indicated)
- Completes SOAP narrative portion of incident response form

MEETS STANDARDS (RECERT)

- YES NO
2nd ATTEMPT
 YES NO

EVALUATOR SIGN YOUR NAME

ID

IF NO EXPLAIN

BLS-2016-Abdominal Pain

EMERGENCY MEDICAL SERVICES (11/10 MH)

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS-2016-Abdominal Pain

Student Name

Recert Yes No Date

Written Score

NAME <small>PRINT STUDENT'S NAME</small>	ID #	DATE
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Objective: Given a partner, appropriate equipment and a patient with abdominal pain, demonstrate appropriate assessment and treatment as outlined in BLS-2016-Abdominal Pain and EMT Patient Care Guidelines.

SCENE SIZE-UP (must verbalize)

- BSI Scene Safety Determines NOI/MOI Number of Patients Additional Resources

INITIAL ASSESSMENT (must verbalize)

- | | | | | | |
|--|----------------------------------|------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Airway | <input type="checkbox"/> Breathing | <input type="checkbox"/> Circulation | <input type="checkbox"/> Body Position | <input type="checkbox"/> SICK |
| <input type="checkbox"/> Chief complaint | <input type="checkbox"/> C-spine | | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Obvious Trauma | <input type="checkbox"/> NOT SICK |

SUBJECTIVE (FOCUSED HISTORY)

- Establishes rapport with patient (reassures and calms) and obtains **consent to treat** (implied/actual)
- Determines patient's **chief complaint**
- Follows **SAMPLE** and **OPQRST** investigation (if possible)
- Obtains names/dosages of current **medications** (if possible)

OBJECTIVE (PHYSICAL EXAM)

- Records and documents **baseline vital signs**
- Performs **medical / trauma exam** – considers possible ectopic pregnancy (age-appropriate female)
- Performs a **proper abdominal exam** (supine, legs flexed)
- Obtains second set of vital signs and compares to baseline

ASSESSMENT (IMPRESSION)

- Verbalizes **impression**
- Determines if **ALS is needed** — states rationale _____

PLAN (TREATMENT)

GENERAL CARE (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Reports " At Patient's Side " | <input type="checkbox"/> Initiates steps to prevent heat loss |
| <input type="checkbox"/> Indicates need for ALS and/or immediate transport (SICK) | <input type="checkbox"/> Monitors patient vital signs |
| <input type="checkbox"/> Performs postural vital signs exam – (if indicated) (documents data) | <input type="checkbox"/> Considers index of suspicion |
| <input type="checkbox"/> Administers appropriate rate and delivery of oxygen (as indicated) | <input type="checkbox"/> Performs glucometry/oximetry |
| <input type="checkbox"/> Properly positions patient | <input type="checkbox"/> Performs pt. reassessment |
| | <input type="checkbox"/> Documents: Pt. LAS (follow-up care if needed) |
| | <input type="checkbox"/> _____ (additional) |

CRITICAL (FAIL) CRITERIA**DID NOT...**

- Take/verbalize **BSI**
- Appropriately provide/manage airway, breathing, bleeding control, treatment of shock
- Administer appropriate rate and delivery of **oxygen**
- Indicate need for **ALS and/or immediate transport** (SICK)

COMMUNICATION AND DOCUMENTATION**MEETS STANDARDS (RECERT)**

- Delivers timely and effective **short report** (if indicated)
- Completes SOAP narrative portion of incident response form

- YES NO
- 2nd ATTEMPT**
- YES NO

EVALUATOR SIGN YOUR NAME

ID #

IF NO EXPLAIN

BLS-2016 – Burns EMERGENCY MEDICAL SERVICES (12/15 JN)			SKILLS CHECKLIST FOR RECERTIFICATION					
NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE				
Objective: Given a partner, appropriate equipment and a patient with a burn injury, demonstrate appropriate assessment and treatment as outlined in BLS-2016-Burns and EMT Patient Care Guidelines.								
SCENE SIZE-UP (must verbalize)								
<input type="checkbox"/> BSI	<input type="checkbox"/> Scene Safety	<input type="checkbox"/> Determines MOI/NOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources				
INITIAL ASSESSMENT (must verbalize)								
<input type="checkbox"/> Mental Status	<input type="checkbox"/> Airway	<input type="checkbox"/> Breathing	<input type="checkbox"/> Circulation	<input type="checkbox"/> Obvious Trauma	<input type="checkbox"/> SICK			
<input type="checkbox"/> Chief complaint	<input type="checkbox"/> C-spine		<input type="checkbox"/> Bleeding	<input type="checkbox"/> Body Position	<input type="checkbox"/> NOT SICK			
SUBJECTIVE (FOCUSED HISTORY)								
<input type="checkbox"/> Establishes rapport with patient (reassures and calms) and obtains consent to treat (implied/actual) <input type="checkbox"/> Determines patient's chief complaint and follows SAMPLE and OPQRST investigation <input type="checkbox"/> Determines mechanism of injury (MOI) as soon as possible – and acts accordingly <input type="checkbox"/> Obtains names/dosages of current medications (maintains high IOS for pt. on anticoagulants)								
OBJECTIVE (PHYSICAL EXAM)								
<input type="checkbox"/> Records and documents baseline vital signs - listens to lung sounds and compares sides <input type="checkbox"/> Performs appropriate trauma exam — exposes/checks for bleeding/injuries (documents CMS distal to injury) <input type="checkbox"/> Obtains second set of vital signs and compares to baseline								
ASSESSMENT (IMPRESSION)								
<input type="checkbox"/> Verbalizes impression <input type="checkbox"/> Determines if ALS is needed — states rationale _____								
PLAN (TREATMENT)								
GENERAL CARE (<i>Check all that apply</i>) <input type="checkbox"/> Reports “ At Patient’s Side ” <input type="checkbox"/> Indicates need for ALS and/or immediate transport (SICK) <input type="checkbox"/> Administers appropriate rate and delivery of oxygen (as indicated) <input type="checkbox"/> Properly positions patient <input type="checkbox"/> Considers the use of tourniquet (as an alternate method for bleeding control)			<input type="checkbox"/> Monitors patient's vital signs <input type="checkbox"/> Maintains High IOS for MOI <input type="checkbox"/> Performs oximetry/glucometry <input type="checkbox"/> Assesses type, treatment and destination for a burn patient <input type="checkbox"/> Correctly identifies BSA and severity of burn <input type="checkbox"/> Initiates steps to prevent heat loss <input type="checkbox"/> Performs pt. reassessment			CRITICAL (FAIL) CRITERIA DID NOT... <input type="checkbox"/> Take/verbalize BSI <input type="checkbox"/> Appropriately provide/manage airway, breathing, bleeding control, treatment of shock <input type="checkbox"/> Administer appropriate rate and delivery of oxygen <input type="checkbox"/> Indicate need for ALS and/or immediate transport (SICK)		
COMMUNICATION AND DOCUMENTATION			MEETS STANDARDS (RECERT)					
<input type="checkbox"/> Delivers timely and effective short report (if indicated) <input type="checkbox"/> Completes SOAP narrative portion of incident response form			<input type="checkbox"/> YES <input type="checkbox"/> NO 2nd ATTEMPT <input type="checkbox"/> YES <input type="checkbox"/> NO					
EVALUATOR SIGN YOUR NAME		ID #	IF NO EXPLAIN					

BLS-2016 – Burns

Student Name

Recent Yes No

Date

Written Score

BLS-2016-Glasgow Coma Scale (GCS)

EMERGENCY MEDICAL SERVICES (11/10 MH)

SKILLS CHECKLIST FOR RECERTIFICATION

BLS-2016-Glasgow Coma Scale (GCS)

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE
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Objective: Given a partner, appropriate equipment and a patient with altered mental status, demonstrate appropriate assessment and treatment as outlined in BLS-2016-Glasgow Coma Scale (GCS) and EMT Patient Care Guidelines.

SCENE SIZE-UP (must verbalize)

- BSI
 Scene Safety
 Determines NOI/MOI
 Number of Patients
 Additional Resources

INITIAL ASSESSMENT (must verbalize)

- | | | | | | |
|--|----------------------------------|------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Airway | <input type="checkbox"/> Breathing | <input type="checkbox"/> Circulation | <input type="checkbox"/> Body Position | <input type="checkbox"/> SICK |
| <input type="checkbox"/> Chief complaint | <input type="checkbox"/> C-spine | | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Obvious Trauma | <input type="checkbox"/> NOT SICK |

SUBJECTIVE (FOCUSED HISTORY)

- Establishes rapport with patient (reassures and calms) and obtains **consent to treat** (implied/actual)
- Determines patient's **chief complaint** and follows **SAMPLE** and **OPQRST** investigation
- Determines **time of onset** of signs or symptoms (On scene time **<15mins for Stroke** patients)
- Obtains names/dosages of current **medications**

OBJECTIVE (PHYSICAL EXAM)

- Records and documents **baseline vital signs** (looks for **Medical Alert** bracelets, anklets, necklaces)
- Performs appropriate **medical/trauma exam** — exposes/checks for bleeding and/or injuries
- Checks for **neurologic deficits** using GCS (Demonstrates use of **noxious stimulus** in unresponsive pt.)
- Applies GCS score based on assessment Eye Response, Best Verbal Response, Best Motor Response

ASSESSMENT (IMPRESSION)

- Demonstrates use of the **"FAST" Exam** for potential stroke patients
- Determines if **ALS is needed** — states rationale _____

PLAN (TREATMENT)

GENERAL CARE (Check all that apply)

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Reports "At Patient's Side" <input type="checkbox"/> Indicates need for ALS and/or immediate transport (SICK) <input type="checkbox"/> Administers appropriate rate and delivery of oxygen (as indicated) <input type="checkbox"/> Properly positions patient <input type="checkbox"/> Monitors patient's vital signs <input type="checkbox"/> Considers IOS | <ul style="list-style-type: none"> <input type="checkbox"/> Performs glucometry (documentation required) <input type="checkbox"/> Performs pulse oximetry <input type="checkbox"/> Performs & documents GCS Assessment <ul style="list-style-type: none"> <input type="checkbox"/> Eyes <input type="checkbox"/> Verbal <input type="checkbox"/> Motor <input type="checkbox"/> Performs pt. reassessment |
|--|--|

CRITICAL (FAIL) CRITERIA DID NOT...

- Take/verbalize **BSI**
- Appropriately provide/manage airway, breathing, bleeding control, treatment of shock
- Indicate need for **ALS and/or immediate transport** (SICK)
- Properly perform & document GCS assessment

COMMUNICATION AND DOCUMENTATION

- Delivers timely and effective **short report** (if indicated)
- Completes SOAP narrative portion of incident response form

MEETS STANDARDS (RECERT)

- YES NO
2nd ATTEMPT
 YES NO

EVALUATOR SIGN YOUR NAME

ID #

IF NO EXPLAIN

Student Name _____

Recert Yes No Date _____

Written Score _____

BLS-2016-SICK/NOT SICK
EMERGENCY MEDICAL SERVICES (11/10 MH)

CHECKLIST
FOR RECERTIFICATION

BLS-2016-SICK/NOT SICK

NAME <small>PRINT STUDENT'S NAME</small>	ID #	DATE
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Objective: Given dispatch and scene information and/or a visual picture, EMS providers will discuss and demonstrate appropriate assessment, treatment and interaction in at least three SICK/NOT SICK scenarios for *Adult and/or Pediatric* patients. They will apply the guidelines outlined in BLS-2016-SICK/NOT SICK and EMT Patient Care Protocols or other appropriate guidelines as determined by local Medical Control.

Roundtable Exercise

- This exercise for CBT/OTEP 165 **SICK/NOT SICK** course was completed in a roundtable discussion panel format.

The above individual met standards regarding specific knowledge of:

- 6 elements of the "clinical picture" and:
 - Nature of illness (NOI) - medical
 - Mechanism of injury (MOI) - trauma

The above individual:

- Formulated **three probable scenarios** based on dispatch and discussed with partner(s) (en route to scene)
**** Developed a treatment plan for each of the "probable scenarios"**
- Assessed whether patient was **SICK** or **NOT SICK** within 1 minute
- Contacted **ALS if needed** - stating rationale _____
- Continued to evaluate patient and changed patient's category as appropriate

This exercise was a practical application of SICK/NOT SICK for:

ADULT:

- Medical patient(s)
- Trauma patient(s)

PEDIATRIC:

- Medical patient(s)
- Trauma patient(s)

This exercise/review evaluation fulfills the practical requirements for this course.

Student Name _____

Recert Yes No

Date _____

Written Score _____

COMMUNICATION AND DOCUMENTATION	MEETS STANDARDS (RECERT)
<input type="checkbox"/> Delivers timely and effective short report (if indicated)	<input type="checkbox"/> YES <input type="checkbox"/> NO
	2nd ATTEMPT
	<input type="checkbox"/> YES <input type="checkbox"/> NO
EVALUATOR SIGNATURE _____ ID # _____	IF NO EXPLAIN _____