

BLS-2017-Altered Mental States
EMERGENCY MEDICAL SERVICES (11/10 MH)

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS-2017-Altered Mental States

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE
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Objective: Given a partner, appropriate equipment and an altered mental status, demonstrate appropriate assessment and treatment as outlined in BLS-2017-Altered Mental States 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 AVPU (Demonstrates use of **noxious stimulus** in unresponsive pt.)
- Demonstrates proper assessment of pupils

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"/> Initiates "Code CVA" ("On-scene" time<15 mins) <input type="checkbox"/> Appropriate use of the: "EMS Sepsis Triangle" <input type="checkbox"/> Contacts receiving hospital <input type="checkbox"/> Performs pt. reassessment |
|--|--|

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

- 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

TIME →						
Blood Pressure						
Pulse Rate						
Respiratory Rate						
Consciousness						
ECG Rhythm						
Oxygen						
Meds						
(Pulse Oximetry- SpO2)						
(Glucometry)						

Medications taken by patient at home

Allergies

Chief Complaint

Narrative

BLS-2017- Neurological Emergencies
EMERGENCY MEDICAL SERVICES (11/16 JN)

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS-2017- Neurological Emergencies Student Name

Recert Yes No Date

Written Score

online / other

NAME <small>PRINT STUDENT'S NAME</small>	ID #	DATE
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Objective: Given a partner, proper equipment and a patient with s/s of a neurological emergency, demonstrate appropriate assessment and treatment as outlined in CBT 2017 Neurological Emergencies 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"/> 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)

- 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 complaint, signs or symptoms (*appreciates the need for rapid transport*)
- Obtains names/dosages of current **medications**

OBJECTIVE (PHYSICAL EXAM)

- Records and documents **baseline vital signs**
- Performs appropriate **medical / trauma exam** — exposes/checks for bleeding and/or injuries
- Performs the **FAST Exam** and obtains **LAMS Score**
- Obtains second set of vital signs and compares to baseline

ASSESSMENT (IMPRESSION)

- Verbalizes **impression** (i.e. – Acute CVA)
- Determines if **ALS is needed** — states rationale _____

PLAN (TREATMENT)

<p>GENERAL CARE (<i>Check all that apply</i>)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indicates need for ALS and/or immediate transport (SICK) <input type="checkbox"/> Reports APS to Dispatch <input type="checkbox"/> Administers appropriate rate and delivery of oxygen (<i>as indicated</i>) <input type="checkbox"/> Considers 95% SpO2 for decision <input type="checkbox"/> Properly positions patient <input type="checkbox"/> Performs FAST Exam (<i>interprets</i>) 	<ul style="list-style-type: none"> <input type="checkbox"/> Obtains LAMS Score <input type="checkbox"/> Considers Index of Suspicion <input type="checkbox"/> Glucometry (<i>required for suspected CVA</i>) <input type="checkbox"/> Oximetry <input type="checkbox"/> Initiates "Code CVA" <input type="checkbox"/> "On-scene" time <15 min (<i>when possible</i>) <input type="checkbox"/> Performs pt. reassessment <input type="checkbox"/> Early notification to ED 	<p>CRITICAL (FAIL) CRITERIA</p> <p>DID NOT...</p> <ul style="list-style-type: none"> <input type="checkbox"/> Take/verbalize BSI <input type="checkbox"/> Appropriately provide/manage airway, breathing, bleeding control, treatment of shock <input type="checkbox"/> Properly administers oxygen <input type="checkbox"/> Indicate need for ALS and/or immediate transport (SICK)
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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-2017-Cultural Awareness

EMERGENCY MEDICAL SERVICES (12/16 RB)

SKILLS CHECKLIST

FOR RECERTIFICATION

BLS-2017-Cultural Awareness

Student Name _____

Recent Yes No Date _____

Written Score _____

NAME

PRINT STUDENT'S NAME

ID #

DATE

Objective: With a partner or a group, discuss some of the key concepts of cultural awareness as they were presented in the BLS-2017-Cultural Awareness course

DISCUSSION QUESTIONS

- What are some culturally based barriers to treatment that you've encountered on previous calls?
- How does your culture influence you on calls? (Focused both on the EMT/Medic culture and their personal culture)
- What are some techniques you've used to deal with barriers to treatment in the past? What worked well? What didn't work well? Why do you think they either worked or didn't work?
- What are some ways that you can leverage each other's cultural backgrounds to help deal with barriers to treatment in the future?
- If you had to pick one "Take away" to try and incorporate into your day to day practices, what would it be? How do you see that having a positive impact on calls?

EVALUATOR SIGN YOUR NAME

ID #

BLS-2017-High Performance Trauma Management EMERGENCY MEDICAL SERVICES (8/13 JN)			SKILLS CHECKLIST FOR RECERTIFICATION		
NAME	ID #	DATE			
PRINT STUDENT'S NAME					
Objective: Given a partner, appropriate equipment and a trauma patient, demonstrate appropriate assessment, treatment and management of that patient as outlined in BLS-2017-High Performance Trauma Management.					
SCENE SIZE-UP (must verbalize)					
<input type="checkbox"/> BSI	<input type="checkbox"/> Scene Safety	<input type="checkbox"/> Determines NOI/MOI	<input type="checkbox"/> Number of Patients	<input type="checkbox"/> Additional Resources	
INITIAL ASSESSMENT (must verbalize)					
<input type="checkbox"/> Appearance	<input type="checkbox"/> Airway	<input type="checkbox"/> Work of 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 as appropriate <input type="checkbox"/> Obtains names/dosages of current medications and were any taken					
OBJECTIVE (PHYSICAL EXAM)					
<input type="checkbox"/> Records and documents baseline vital signs <input type="checkbox"/> Performs appropriate medical / trauma exam – exposes/checks for bleeding and/or injuries <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"/> Performs rapid trauma exam <input type="checkbox"/> Identifies and treats life threatening bleeding using pressure dressing and/or tourniquet <input type="checkbox"/> Administers appropriate rate and delivery of oxygen (as indicated)		<input type="checkbox"/> Performs rapid spinal immobilization <input type="checkbox"/> Prepares patient for ALS transport <input type="checkbox"/> Monitors patient vital signs <input type="checkbox"/> Considers index of suspicion <input type="checkbox"/> Performs ongoing assessment <input type="checkbox"/> Performs pulse oximetry <input type="checkbox"/> Performs glucometry (if trained) <input type="checkbox"/> _____(additional) <input type="checkbox"/> _____(additional)		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-2017-High Performance Trauma Management Student Name Recert Yes No Date Written Score

TIME →						
Blood Pressure						
Pulse Rate						
Respiratory Rate						
Consciousness						
ECG Rhythm						
Oxygen						
Meds						
(Pulse Oximetry- SpO2)						
(Glucometry)						

Medications taken by patient at home

Allergies

Chief Complaint

Narrative

NAME	<small>PRINT STUDENT'S NAME</small>	ID #		DATE	
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Objective: With a partner or a group, discuss some of the key concepts of mental health as they were presented in BLS-2017-Mental Health.

DISCUSSION QUESTIONS

- What has been your personal experience with mental health issues? Have you had friends, family or co-workers who have experienced a mental health condition?
- What steps are you currently taking to maintain balance in your own life? What are some opportunities you have to improve?
- Describe a time when you were working with someone who was in trouble due to stress or a mental health concern? What were some of the signs and symptoms that you saw? How did you approach the situation? Describe what you might do differently the next time based on your new knowledge and experience.
- How do you access your agency's Employee Assistance Program and what other resources are available to you through your agency?

Student Name _____

Recert Yes No

Date _____

Written Score _____

EVALUATOR SIGN YOUR NAME	ID #	
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BLS-2017 – OB/GYN Emergencies
EMERGENCY MEDICAL SERVICES

SKILLS CHECKLIST
FOR RECERTIFICATION

BLS 2017 – OB/GYN Emergencies

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 dealing with proper assessment and the treatment of the obstetrical patient. As outlined in BLS-2017-OB/GYN 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 Injury	<input type="checkbox"/> SICK
<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	<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"/> Lung Sounds	<input type="checkbox"/> CMS/Swelling
<input type="checkbox"/> Medical Exam	<input type="checkbox"/> Para/Grava	<input type="checkbox"/> Crowning
<input type="checkbox"/> Trauma Exam	<input type="checkbox"/> Neck Veins	<input type="checkbox"/> Assessment Of Mother
<input type="checkbox"/> Skin Signs	<input type="checkbox"/> DCAP/BTLS	<input type="checkbox"/> Assessment Of Baby
<input type="checkbox"/> HEENT		

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"/> Proper Bleeding Control
<input type="checkbox"/> Proper Oxygen Therapy	<input type="checkbox"/> Prepare For Birth
<input type="checkbox"/> Pulse Ox/Glucometry	<input type="checkbox"/> Hemorrhage
<input type="checkbox"/> Positioning Patient	<input type="checkbox"/> Prevent Heat Loss (Mom And Baby)
<input type="checkbox"/> Consider IOS	<input type="checkbox"/> Ongoing Assessment
<input type="checkbox"/> Transportation Decision	<input type="checkbox"/> Reports "At patient's side"

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 AND DOCUMENTATION

<input type="checkbox"/> Written 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

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
