MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES COMMISSION

TECHNICAL ADVISORY COMMITTEE MEETING SUMMARY

DATE:	July 1, 2014 10:00 a.m.
LOCATION:	Noblesville Fire Department, Station 77 15251 Olio Road Noblesville, IN 46060
PRESENT:	Leon Bell, Chairman, ALS Training Institute Elizabeth Weinstein, EMS for Children Michael McNutt, BLS Training Program Director Faril Ward, EMS Chief of Operating Officer Jaren Kilian, Jessica Lawley, ALS Training Program Director Sherry Fetters, Vice Chairman, EMS Chief Executive Officer Sara Brown, EMS Medical Director Michael Gamble, Emergency Department Director Tina Butt, First Responder Training Director
NOT PRESENT:	Charles Ford, EMS Chief Executive Officer Edward Bartkus, EMS Medical Director
OTHERS PRESENT:	John Zartman, EMS Commissioner, Terri Hamilton EMS Commissioner, EMS State Director Michael Garvey, IDHS Staff, other IDHS Staff.

Indiana
A State that Works

A) Meeting called to order at 10:27 a.m. by Chairman Leon Bell.
B) Quorum present
C) Adoption of minutes:
Minutes are not completed there will be two sets of minutes for the September meeting.
D) Announcements:
   a. Chairman Bell gave a brief summary of the last EMS Commission meeting including that the Commission accepted the following recommendations from the TAC:
      i. The 72 hours for the AEMT continuing education
      ii. The AEMT provider organization recommendation was tabled until the next meeting.
      iii. Section 2 of the Primary Instructor manual was approved
      iv. Staff is working on the motion for the TAC and the Commission to use teleconference for attendance of the meetings.
      v. Briefly discussed the special group that met and revised Section 1, 3 and 4 from the Primary Instructor manual.
   b. Introductions of Kraig Kenny from Putman Co and the Education Working Group, Tina's son Erin Butt, and Kaitlin Grubbs IDHS intern.
   c. Reviewed the remaining TAC meeting date of November 18th.
E) Old business
   a. Discussion and review of the TAC recommendations for EVOC and fiscal impact.
      i. A sub- group to look at the EVOC and provider drug screens and alcohol screens was appointed. The group will be Mrs. Sherry Fetters, Mr. Faril Ward, and Mr. Chuck Ford
      ii. A sub-group to look at the Training Institution survey was appointed. The group will be Mr. Leon Bell, Mr. Michael McNutt and Ms. Tina Butt.
F) PI manuel
   a. Commissioner Terri Hamilton reported out on the special group that met and worked on the PI manual sections 1, 3, and 4. Commissioner Hamilton stated she would like to see the list of names in the document that are listed for recognition be removed. Discussion followed.

A motion was made by Mr. Faril Ward to redact the individual names for recognition from the document. The motion was seconded by Mr. Michael McNutt. The motion passed.

Mr. McNutt asked who will keep the hyper links in the document up to date. The training staff will be responsible. Discussion regarding the need for web addresses to be added under the hyper links.

A motion was made by Vice Chairwoman Sherry Fetters to add the web addresses under the hyper links in the document. The motion was seconded by Mr. McNutt.

The question was asked who would make sure that the manual is kept up to date as Commission rules change or processes change. After some discussion it was decided that a section needed to be added to the document outlining the process of how the document will be kept up to date.

A motion was made by Vice Chairwoman Fetters to add the following section to the PI manual:

Every year in December the EMS commission will assign a sub group to meet, review and make recommendations for modification of the Training Resource Manual. This subgroup will be made up of 2 members of the TAC, 2 agency staff members, 2 members of the EMS Education Community and a representative of the EMS Commission. The following timeline will govern the process:

Timeline:

- **By the Dec EMS Commission Meeting- EMS Subcommittee Assigned**
- **Feb15- Recommendations to the TAC**
- **By the May TAC Meeting- Final Recommendations to EMS Commission**
- **By the June EMS Commission Meeting- Recommendations Reviewed from the TAC**

July 1- Implementation of Changes to Training Resource Manual

The motion was seconded by Faril Ward. The motion passed unanimously. The above motion is the final motion. Changes were made to refine the motion after the original motion was made. Vice Chairman Fetters accepted the changes that were made to the original motion and Mr. Ward accepted the changes as well before the vote was taken to pass the motion.

b. Discussion over section 1 of the PI manual took place. Revisions and corrections were made by the TAC members (see attachment #1).

A motion was made by Dr. Weinstein to accept section 1 with the changes and revisions. The motion was seconded by Vice Chairwoman Fetters. The motion passed unanimously.

c. Discussion over section 3 of the PI manual took place. Revisions and corrections were by the TAC members (see attachment #2). The decision was made to remove the scenarios from the manual for security and the integrity of the scenarios.

A motion was made by Vice Chairwoman Fetters to accept section 3 with the changes and revisions and the removal of the scenarios from section 3. The motion was seconded by Dr. Weinstein. The motion passed unanimously.

A motion was made by Vice Chairwoman Fetters to strike section H under the psychomotor exam. The motion was seconded by Mr. Ward. The motion passed unanimously.

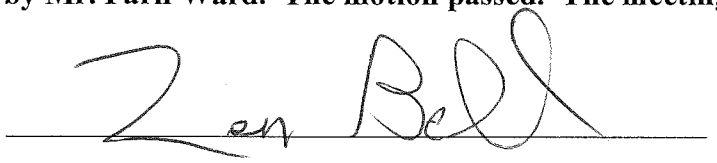
Chairman Bell reviewed the following things that are ready to take to the Commission for approval:

1. Remind the Commission to implement the PI recommendations that were approved by the Commission.
2. Ask permission to create a Primary Instructor Evaluation Form and Course Evaluation Form.
3. Ask the Commission to look at the TAC membership to get vacant positions filled and help with members with inconsistent attendance.

Chairman Bell asked for the following to be placed on the TAC agenda for the next meeting:

1. Chairman Bell asked that everyone bring the best practices of course evaluation forms to the September meeting.
2. Sub-groups bring back recommendations for EVOC, back ground checks, and drug tests.
3.

A motion was made by Ms. Elizabeth Weinstein to adjourn the meeting. The motion was seconded by Mr. Faril Ward. The motion passed. The meeting was adjourned at 1:01pm.

Approved 

Leon Bell, Chairman

Attachment #1

Training Reference Manual Section 1

Vision Statement

The Indiana Department of Homeland Security EMS Branch under the State Fire Marshal Office, the Indiana EMS Commission, and the instructors of the State of Indiana are committed to providing a training format that will ensure our EMS professionals have access to adequate and uniform training standard from all EMS training institutions. This training standard should meet the established guidelines set forth by the EMS Commission of the State of Indiana. The training that Indiana adopts for EMS should allow our responders to maintain both Indiana and National EMS certifications where possible. This training manual should be the key resource on how Indiana conducts EMS training and testing.

Mission Statement

This EMS Training Resource Manual is a work product adopted by the Indiana EMS Commission and the policies of the Indiana Department of Homeland Security EMS Branch under the State Fire Marshal Office. Our mission is to create a manual that can be accessible to State of Indiana staff and our EMS community.

Acknowledgement

The Indiana EMS Commission and the Indiana Department of Homeland Security would like to recognize the individuals of the Indiana EMS Community who contributed countless hours towards the creation of this document. Without their dedication and expertise, this creation of this guide would not have been possible.

I. Training Institutions

EMS Training Guidance (for Instructors and Training Institutions)

This section is designed for Training Institutions and Primary Instructors who are applying to become training institutions, applying for Indiana certified EMS training courses, and for the remittance of course information. The following directions will assist you in the timely and efficient submission of all information necessary to become a training institution and to open and close a certified EMS training course. These guidelines follow the rules outlined in Title 836, processes as approved by the EMS Commission, as well as Indiana Department of Homeland Security (IDHS) policy. The links in this manual will be updated as legislation and forms are revised.

A. Becoming a Indiana Certified Training Institution

836 Emergency Rules
(http://www.in.gov/legislative/iac/20120711-IR-836120393ERA.xml.pdf)

836 IAC Article 4. Training and Certification
(http://www.in.gov/legislative/iac/iac_title?iact=836&iaca=4)

Points to Remember

1. "836 IAC 4-2-1 (c) Each Indiana emergency medical services training institution of emergency medical technician programs shall be:

   A post secondary institution as defined in IC 20-12-71-8

   A private technical, vocational, or trade school as defined in IC 20-12-62-3

   A high school as defined in IC 20-18-2-7;

   A provider organization as defined in IC 16-31; or

   An appropriately accredited hospital licensed under IC 16-21;"

   AND

"that has adequate resources and dedication to educational endeavors. Educational institutions shall be appropriately accredited by a regional accrediting association for higher education or have state licensure that assures comparable educational standards."

2. "836 IAC 4-2-1 (d) Such an institution shall submit an application to the agency at least ninety (90) days prior to the date for which certification is requested in a manner prescribed by the agency."

Training Institution application
(https://forms.in.gov/Download.aspx?id=9396)

Certification

"836 IAC 4-2-1 (e) Certification as an emergency medical services training institution is valid for a period of two (2) years from the date of certification."

"836 IAC 4-2-1 (f) Certified emergency medical services training institutions shall be certified according to the institution's intent and ability to teach various levels of emergency medical services curricula."

> The EMS Commission currently approved courses for basic life support training institution is defined as an institution that presents one (1) or more of the following training courses:
> (a) Emergency Medical Responder
> (b) Emergency Medical Technician
>
> The EMS Commission currently approved courses for an advanced life support training institution is defined as an institution that presents one (1) or more of the following training courses and may include one (1) or more of the basic life support training courses listed above:
> (a) Advanced Emergency Medical Technician
> (b) Paramedic.

"836 IAC 4-2-1 (g) A certified training institution shall submit an application for recertification to the agency at least sixty (60) days prior to the date of certification expiration. The application for recertification shall indicate compliance with the requirements currently in effect at the time of the application for renewal."

"836 IAC 4-2-1 (h) Certified advanced life support training institutions conducting paramedic training programs on or after July 1, 2008, shall show written proof of national accreditation of the program."

B. 836 IAC 4-2-2 Institution Responsibilities

836 Emergency Rules
(http://www.in.gov/legislative/iac/20120711-IR-836120393ERA.xml.pdf)

836 IAC 4-2-2 is the responsibility of each training institution.

Points to Remember:

- Evaluation on each course is required
- Evaluation on each affiliated instructor is required annually
- Classrooms must have adequate space and equipment
- Make available twelve (12) hours over a two (2) year period of continuing education.
- Must keep all records for seven (7) years

C. *836 IAC 4-2-3 Educational Staff Requirements and Responsibilities*

836 Emergency Rules
(http://www.in.gov/legislative/iac/20120711-IR-836120393ERA.xml.pdf)

836 IAC 4-2-3 is the responsibility of each training institution.

Remember:

- A Program Director must be an Indiana Primary Instructor
- A Program Director must be at the highest level of certification that is being presented by the training institution.
- Medical Directors are responsible for the competency of the course graduates
- Medical Directors must approve all affiliated instructors and the courses that are administered
- During psychomotor testing instructional staff must be certified or licensed to at least the level of skill being tested
- Program Director is responsible for coordinating and evaluating all didactic, clinical, psychomotor, and field internship components

D. *Curriculum*

The following documents provide the minimum requirements for each type of EMS Course. These courses are:

- EMR
- EMT
- AEMT (ALS Training Institutions)
- Paramedic (CoAEMSP Accredited Training Institutions)

EMS Course Requirements
(http://www.in.gov/dhs/files/EMS_Course_Requirements_9-18-13.pdf)

Indiana EMS Commission Levels of EMS Personnel Certification Quick Reference
(http://www.in.gov/dhs/files/IN_EMS_lvls_EMS_Personnel_Cert061713.pdf)

Indiana Skill Levels and Scope of Practice
(http://www.in.gov/dhs/files/Indiana_EMS_Skills_Side_by_Side_Comparison_8-27-13.pdf)

Indiana EMS Course Standards

The following documents are the **minimum course times and standards for each EMS course.** All courses must comply with the minimum standards for course approval. Pre-requisite and co-requisite material can be applied towards the section time standards, but you must indicate that in your syllabi. Any questions regarding course creation can be sent to certcourseapps@dhs.in.gov.

- EMR Minimum Course Hours *(http://www.in.gov/dhs/files/EMR_Hours.pdf)*
- EMT Minimum Course Hours *(http://www.in.gov/dhs/files/EMT_Hours.pdf)*
- AEMT Minimum Course Hours *(http://www.in.gov/dhs/files/AEMT_Hours_9-18-13.pdf)*
- Paramedic Minimum Course Hours *(http://www.in.gov/dhs/files/Paramedic_Hours.pdf)*

National Education Standards and Instructional Guidelines

The following are links to the National Educational Standards and Instructional Guidelines. Please utilize these documents as guides to creating your syllabi. All sections of the instructional guidelines must be addressed in your course, according to the Indiana EMS Commission, as well as any Indiana specific curricula which can be found in the minimum course hour documents above.

- National EMS Education Standards *(http://www.ems.gov/pdf/811077a.pdf)*
- Emergency Medical Responder Instructional Guidelines *(http://www.ems.gov/pdf/811077b.pdf)*
- Emergency Medical Technician Instructional Guidelines *(http://www.ems.gov/pdf/811077c.pdf)*
- Advanced Emergency Medical Technician Instructional Guidelines *(http://www.ems.gov/pdf/811077d.pdf)*
- Paramedic Instructional Guidelines *(http://www.ems.gov/pdf/811077e.pdf)*

E. 836 IAC 4-2-4 Institution Reporting Requirements

"836 IAC 4-2-4 Each Training Institution shall submit any staff changes within thirty (30) days to the agency that includes the following information:

(1) Name, address, and telephone number of the training institution official.
(2) List of affiliated educational staff, including name, certification level, and certification number.
(3) Changes in the training institutions standards and criteria."

"836 IAC 4-2-4 Each Training Institution will provide a final report on each course to the agency within fifteen (15) days following the completion of the course. These reports will be submitted in a manner prescribed by the agency."

- The final report on each course is defined by the agency as the Report of Training.

Report of Training
(https://forms.in.gov/Download.aspx?id=7147)

The Report of Training must be submitted for BLS courses prior to students taking State certification written exam.

Candidates will not be allowed to take the State Cognitive until the completed Report of Training is submitted to the agency and processed. Training Institutions are no longer allowed to authorize candidates to take the Indiana Cognitive Exams by signing the authorization letter.

F. *Agency Policies*

Submitting a Course

- All course requests must be submitted 30 days prior to the course start date.
- Collect and organize all necessary information
    - Course syllabus (including dates, times, and locations of course)
    - Course check list
        - For EMR, EMT, AEMT, and Paramedic, the hourly requirements must be identified on the syllabus that meet or exceed the hourly requirements outlined on the checklist.

EMR Course Checklist
(https://forms.in.gov/Download.aspx?id=9343)
EMT Course Checklist
(https://forms.in.gov/Download.aspx?id=9387)
AEMT Course Checklist
(https://forms.in.gov/Download.aspx?id=10129)
Paramedic Course Checklist
(https://forms.in.gov/Download.aspx?id=10131)

        - You must, in narrative form, outline how you will fulfill the Indiana required curriculum as well as how you will fulfill/verify the psychomotor requirements.

- Fill out the EMS Training Course and Psychomotor Exam Reservation form.
    - These two components are now on one form.
    - Please make sure that you fill out the form in its entirety or it will be sent back.

Course Application
(https://forms.in.gov/Download.aspx?id=9755)

- If you are holding a psychomotor exam, please use the form listed below to make a reservation.
    - This form is to be used for the EMR and EMT psychomotor examination reservation.

Psychomotor Exam Reservation
(https://forms.in.gov/Download.aspx?id=9753)

- E-mail the course syllabus, check list, attachments, and Course/Reservation form to:

certcourseapps@dhs.in.gov

- Please title the subject line of any e-mail with the reason for the correspondence.
- Once we receive and review your application, you will be notified via e-mail of your approval or whether we need more information.
- Once a completed course request (including all necessary attachments) is received, you will receive your course confirmation.
- Carry out the course once approval is granted.

Candidate Remediation

- If you have a student who needs to be remediated for either failing the State Cognitive Exam or the State Psychomotor Exam:
- Complete remediation according to the mandatory hours for the State Cognitive Exam (see remediation form for hourly requirements) or the needed skill(s) for the State Psychomotor Exam.

Cognitive Remediation Form
(http://www.in.gov/dhs/files/54414.pdf)

EMT Psychomotor Remediation Form
(https://forms.in.gov/Download.aspx?id=9382)

EMR Remediation Form
(https://forms.in.gov/Download.aspx?id=9344)

- All remediation must be completed by a **Primary Instructor**

Cognitive Exam Remediation Required Hours
EMR 6 Hours
EMT 24 Hours
AEMT 24 Hours

- Fill out the remediation form in its entirety including necessary signatures

- Submit the remediation form by any of the following manners:

    - US Mail, Federal Express, or UPS (**Highly recommend sending via Certified mail with delivery confirmation**)
    - Email to certCourseApps@dhs.in.gov
    - Fax to 317-233-0497
- Candidate will be mailed a letter allowing retest

Processing Information

- Once testing is entirely completed and submitted to the state (both Cognitive and Psychomotor testing), it may take up to 4 weeks to become certified.
- If a candidate has ever been charged or convicted of a crime as an adult other than a minor traffic violation:
    - they must report this to the agency on the appropriate form.
    - their application will be reviewed on a case by case basis.
    - the candidate will receive communication from the agency regarding their certification status.
- Fail letters are the only letters that will be issued to candidates regarding testing results.

EMS Commission Approved 8/20/2014

- The agency will NOT give test results out over the phone
- The agency can verify whether or not a candidate is missing any requirements for certification

- When a candidate is awarded certification they will receive their initial certification by US mail.

G. Agency Forms and Tools

For All Courses

Course Application *(https://forms.in.gov/Download.aspx?id=9755)*
Report of Training *(https://forms.in.gov/Download.aspx?id=7147)*
Psychomotor Exam Reservation *(https://forms.in.gov/Download.aspx?id=9753)*

For EMR Course

Course Checklist *(https://forms.in.gov/Download.aspx?id=9343)*
EMR Examination Report Form (Psychomotor Exam sheets)
(https://forms.in.gov/Download.aspx?id=9764)
Statement of Remediation
Cognitive *(http://www.in.gov/dhs/files/54414.pdf)*
Psychomotor *(https://forms.in.gov/Download.aspx?id=9344)*

For EMT Course

Course Checklist *(https://forms.in.gov/Download.aspx?id=9387)*
Psychomotor Examination Report Form (Skills Sheets)
(https://forms.in.gov/Download.aspx?id=9249)
Statement of Remediation
Cognitive *(http://www.in.gov/dhs/files/54414.pdf)*
Psychomotor *(https://forms.in.gov/Download.aspx?id=9382)*

For Advanced EMT Course

Course Checklist
(https://forms.in.gov/Download.aspx?id=10129)

For Paramedic Course

Course Checklist
(https://forms.in.gov/Download.aspx?id=10131)

H. Revision Process

Every year in December the EMS commission will assign a sub group to meet, review and make recommendations for modification of the Training Resource Manual. This subgroup will be made up of 2 members of the TAC, 2 agency staff members, 2 members of the EMS Education Community and a representative of the EMS Commission. The following timeline will govern the process:

Timeline:

- By the Dec EMS Commission Meeting- EMS Subcommittee Assigned
- Feb15- Recommendations to the TAC
- By the May TAC Meeting- Final Recommendations to EMS Commission
- By the June EMS Commission Meeting- Recommendations Reviewed from the TAC
- July 1- Implementation of Changes to Training Resource Manual

Attachment #2

Training Institution Psychomotor Examination Guidelines

This section of the manual will outline the requirements to become a State approved Training Institution, the requirements during an examination, and the ongoing requirements needed to maintain the status of a Training Institution.

All Training Institutions

FOREWORD

This section of the manual was adopted from the National Registry of Emergency Medical Technicians by the Emergency Medical Services Commission as a result of their continued awareness, and the need for standardized and uniform criteria for psychomotor examinations. The evolution of psychomotor examinations has been guided by many changes within emergency medical services in the United States. When EMT training began in the early 1970's, there were relatively few people with an in-depth knowledge of the spectrum of emergency medical care, limited types of equipment and one training standard. Since then, situations have changed and thus standardization is becoming more difficult to attain. Emergency medical care has evolved into a recognized body of knowledge and skill, multiple approaches for accomplishing a task have been advocated in peer journals and a variety of methods for the use of standard equipment have been suggested by equipment manufacturers. Because of this situation, there are currently multiple ways to perform a skill, conduct a psychomotor examination, and define competency. Therefore, because standardization has become more difficult in the assessment of psychomotor skills, the EMS Commission has adopted this document as a tool to assess psychomotor comp.

Completed in 2009, the National EMS Education Standards represents another step toward realizing the vision of the *1996 EMS Agenda for the Future*, as articulated in the *2000 EMS Education Agenda for the Future: A Systems Approach*. The *Standards* define the minimal entry-level educational competencies for each level of EMS personnel as identified in the *National EMS Scope of Practice Model*. Eventually, the *Standards* will replace the current DOT National Standard Curricula (NSC). The less rigid *Standards* format supports diverse implementation methods and more frequent content updates.

At NO time may local medical direction or training officials choose to alter the format or design of the examination or the Psychomotor Exam Sheets in order to meet local protocols or constraints.

If the examination is being given for the purpose of fulfilling National Registry entry requirements, candidates must be deemed competent in the mandatory stations and the random psychomotor station. The National Registry will continue to accept state-approved psychomotor examinations provided they meet or exceed the criteria presented by the National Registry. The format of the Indiana State EMR/EMT Psychomotor Examination meets all National Registry requirements.

The Indiana State Emergency Medical Services Commission and the National Registry is dedicated to the goal of establishing a standardized, valid psychomotor examination that can be utilized from state to state, across the nation. As we work toward this goal, we welcome your comments concerning this examination and its format. Please address all comments to the Indiana EMS Commission, Indiana Government Center-South room E-239, 302 W. Washington St., Indianapolis, Indiana 46204

Introduction

With the development of the National Scope of Practice and National Education Standards (NES), the National Registry of EMTs adopted updated psychomotor exam forms in 2012. Effective in 2013, the Indiana EMS Commission approved a compliant version of the National Registry of EMTs forms. These forms relate to psychomotor skills that an EMR/ EMT would likely utilize in day-to-day pre-hospital care as well as the criticality of the skill in relationship to public safety and patient care. The following eleven (11) psychomotor skills were identified as being the performance items that could be included in a psychomotor examination.

Patient Assessment Management - Trauma

Patient Assessment Management - Medical

Cardiac Arrest Management/AED

BLS Airway Management

Spinal Immobilization - Supine Patient

Spinal Immobilization - Seated Patient

Long Bone Injury Immobilization

Joint Injury Immobilization

Traction Splint Immobilization

Bleeding Control/Shock Management

Oxygen Preparation and Application

Ventilation and Airway Management of the Apneic Patient (E.M.R. Candidates)

These psychomotor skills reflect performance items that are directly related to the loss of life or limb. Therefore, the major focus of the examination is on airway, breathing, circulation and immobilization skills.

The EMS Commission identified the following criteria that must be met for a performance examination to be used statewide:

Each task on the Psychomotor Exam Sheets must be scored as a separate task.

All items critical to patient/limb outcome must be identified on the exam sheet.

Sequencing of tasks in some instances must be considered critical behavior.

Overall competency must be achieved as defined in this manual.

The Psychomotor Exam Sheets provided in this guide were developed to meet the above criteria.

> The Psychomotor Examination Skill Examination sheets shall be furnished by the agency or institution hosting the skill examination. The examination host shall furnish a sufficient quantity and required colors as noted below for initial tests and possible retests for each candidate.
>
> PSYCHOMOTOR SKILLS SHEETS
>
> The following are highly recommended colors for Skill Sheet copies. This is to expedite the processing of the psychomotor paperwork in an efficient and uniform manner.
>
> Trauma: shade of tan or off-white
> Medical: Shade of lavender or purple
> Cardiac Arrest/AED: Shade of pink or red
> BLS Airway Management: Shade of light blue
> Spinal Seated: Shade of light green
> Spinal Supine: Shade of light yellow
> Random Basic: White or gray copies of each random station

The National Registry of Emergency Medical Technician was sensitive to input received, requesting the National Registry to develop an administratively feasible and cost effective psychomotor examination. The EMT Psychomotor Examination Committee and the National Registry Board of Directors considered the following factors when developing and approving this Psychomotor Examination User's Guide:

Protection of the public is the primary responsibility of the National Registry of Emergency Medical Technicians and all certifying agencies.

The current NHTSA EMT training curriculum contains scheduled psychomotor skills laboratories.

The National Registry and many states have been using limited random psychomotor stations with success and have found that they reduce cost without reducing the quality of the examination.

Training programs are responsible for assuring competency of candidates seeking National Registration. Candidates deemed incompetent by the training program should not be permitted to take this Psychomotor Examination.

Outside verification by agencies or individuals not directly associated with the training program must be accomplished in order to assure protection of the public.

A totally random psychomotor examination is not acceptable and does fulfill all of the criteria listed above. When using this psychomotor examination for Indiana State Certification and National Registration.

Best Practice

The training program measures and documents the candidate's competency in all psychomotor skills included in the mandatory and random psychomotor stations. This must be accomplished prior to allowing a candidate to attempt the psychomotor examination used for certification.

Examination Stations

The EMR Psychomotor Examination consists of five (5) stations – Four (4) mandatory stations and one (1) random station. The EMT psychomotor examination consists of seven (7) stations -- Six (6) mandatory stations and one (1) random station. The mandatory and random stations consist of both skill based and scenario based testing. The random station is conducted so the candidate is totally unaware of the skill to be tested until he/she arrives at the station.

The candidate will be tested individually in each station and will be expected to direct the actions of any assistant who may be present in the station. The candidate should pass or fail the examination based solely on his/her actions and decisions.

The following is a list of the stations and their established time limits. The maximum time is determined by the number and difficulty of tasks to be completed:

EMR	Skill to be Tested	Maximum Time Limit	Number of Staff Needed
Station 1:	Patient Assessment Management - Trauma	10 minutes	Evaluator, Patient
Station 2:	Patient Assessment Management - Medical	10 minutes	Evaluator, Patient
Station 3:	Cardiac Arrest Management/AED	10 minutes	Evaluator, Assistant
Station 4:	Spinal Immobilization- Supine	10 minutes	Evaluator, Assistant, Patient
Station 5:	One Random Basic Skill listed below:		
	Long Bone Injury Immobilization	5 minutes	Evaluator, Patient
	Bleeding Control/Shock Management	10 minutes	Evaluator, Patient
	Ventilation and Airway Management of the Apneic Patient	5 minutes	Evaluator
	Oxygen Preparation and Application	5 minutes	Evaluator

EMT	Skill to be Tested	Maximum Time Limit	Number of Staff Needed
Station 1:	Patient Assessment Management - Trauma	10 minutes	Evaluator, Patient
Station 2:	Patient Assessment Management - Medical	10 minutes	Evaluator, Patient
Station 3:	Cardiac Arrest Management/AED	10 minutes	Evaluator, Assistant
Station 4:	BLS Airway Management	10 minutes	Evaluator
Station 5:	Spinal Immobilization- Supine	10 minutes	Evaluator, Assistant, Patient
Station 6:	Spinal Immobilization - Seated Patient	10 minutes	Evaluator, Assistant,

			Patient
Station 7:	One Random Basic Skill listed below:		
	Long Bone Injury Immobilization	5 minutes	Evaluator, Patient
	Joint Injury Immobilization	5 minutes	Evaluator, Patient
	Traction Splint Immobilization	10 minutes	Evaluator, Patient
	Bleeding Control/Shock Management	10 minutes	Evaluator, Patient (real or hard shell mannequin)
	Oxygen Preparation and Application	5 minutes	Evaluator

Random Skill Selection

The random psychomotor skill that is to be tested will be randomly chosen at the beginning of the psychomotor exam for all candidates.

If a candidate fails the random skills station, then the candidate will retest the same random skills station.

Best Practice

Cards with random skill stations can be drawn by evaluators.

Selection of an Examination Facility

All exams must be conducted by an IDHS approved Training Institution. It is important that the testing stations are set up in such a way to prevent candidates from seeing or hearing other stations. The facility should have a waiting area large enough to accommodate the number of candidates scheduled to attempt the examination. The waiting area should have chairs or benches, access to rest rooms and drinking sources as well as adequate storage space for examination supplies. Arrangements for meals and other breaks for staff members and candidates is an additional consideration. A secured room must be provided for the examinations coordinator or the state examination representative. This room should have a suitable work area to grade the examinations.

Community facilities with available space may include schools, office buildings, hospitals, fire stations and other structures which will meet the criteria described above.

Selection of the Examination Staff

One of the major considerations in the selection of examination staff members is their enthusiasm and interest in the examination. The examination procedure is demanding and time-consuming. Therefore, without full cooperation from the staff members, it will be difficult to conduct the repeated evaluations necessary for a large group of candidates.

Whenever possible, it is recommended to form a core group of regular examination personnel. This will help promote teamwork and consistency among the examination staff. It has been our experience that the more frequently a group works together, the more smoothly and effectively the examination runs; however, all examination personnel should be fully aware of their responsibilities as Psychomotor Station Examiners.

Psychomotor examiners should be recruited from the local EMS community. You should only consider individuals who are currently certified to the EMS level or above the skill level in which they are evaluating. Careful attention must be paid to avoid possible conflicts of interest, local political disputes or any pre-existing condition(s) which could bias the potential examiner towards a particular individual or group of individuals. **In no instance should the course primary instructor or lead instructor serve as a Psychomotor Station Examiner.** Casual members of the instructor staff may be utilized, if necessary, provided there is no evidence of bias and they do not evaluate any psychomotor skills for which they served as the instructor.

If a candidate has concerns with the objectivity of an evaluator, the candidate must notify the State Representative prior to being evaluated. The State Representative will address each notification on a case by case basis.

Every effort should be made to select examiners who are fair, consistent, objective, respectful, reliable and impartial in conduct and evaluation. Examiners should be selected based on their expertise in the skill to be evaluated.

Examiners must understand that there is more than one acceptable way to perform a skill and should not indicate a bias that precludes acceptable methods. All examiners should have experience working with EMT's, teaching or formal evaluation of pre-hospital care.

It is highly recommended that a **minimum** EMR examination should consist of five (5) psychomotor skill station examiners, four (4) programmed patients, and three (3) assistants. It is highly recommended that a **minimum** EMT examination staff should consist of seven (7) psychomotor skill station examiners, five (5) programmed patients, four (4) assistants to the ratio of fifteen (15) candidates.* There must be one (1) examination coordinator (preferably the course primary instructor).

It is recommended one individual is available for moulage purposes. The candidate ratio to testing stations is recommended to be 16-30 candidates should have a minimum of (14) stations, **minimum** (2) of each station.

Responsibilities of the Examination Staff

The psychomotor skills to be tested and the acceptable levels of performance should always be determined with physician medical director input. Physician medical director should be available by telephone, pager, or have a designated physician to serve in his/her absence.

The Examination Coordinator is responsible for the overall planning, implementation, equipment for the examination process. The State Examination Representative/ Examination Coordinator is responsible for the quality control and validation of the examination process according to the rules set forth by the Indiana Emergency Medical Services Commission. Specific duties include orientation of the candidates, the skill station examiners, grading of all report sheets, and reporting of examination results to the Indiana Emergency Medical Services Staff. **Examination results and all report forms must be submitted within five (5) working days from the date of the examination.**

Skill station examiners observe candidate performance and complete psychomotor exam sheets. With input from programmed patients, they also make an initial evaluation of a candidate's performance. In the interest of fairness and objectivity, instructors shall not examine their own candidates. Examiners must maintain a professional and impartial attitude at all times. This not only creates an environment of fairness to the candidate, it also assists in creating a more realistic atmosphere. Examiners may be selected from a fairly wide range of resources. For example, local physicians, nurses, paramedics, and experienced EMTs provide potential examination staffing.

Assistants should be knowledgeable in the skill that they are assisting. They are required to perform as trained EMS professionals would in an actual field situation. They should follow the direction of the EMR/EMT candidate and may not coach the candidate relative to the performance of any skill.

The programmed patient's performance is also extremely important. A lack of uniformity in performance by a programmed patient may cause a variance in the candidate's ability to identify and treat an injury correctly. In addition, an informed programmed patient frequently is able to evaluate certain aspects of a candidate's proficiency not readily observed by the examiner.

Attempts should be made to ensure that programmed patients are experienced EMS personnel and/or other allied health personnel. The advantages of this approach are that prior patient contact enables the

programmed patient to re-enact injuries more accurately and to evaluate appropriate or inappropriate behavior/technique by the candidate.

Moulage personnel are responsible for realistically simulating wounds. This realism has a great deal of influence on the candidate's actions during the examination. Virtually any type of wound can be realistically reproduced with moulage by using the right materials, common sense and a little practice.

Equipment

The supplies and equipment needed to prepare each of the examination stations are listed in this manual. Each examiner will need a watch and a supply of psychomotor exam sheets to score each candidate's performance.

Best Practice

The funds required to conduct an examination will vary. The exact cost will depend on the availability of volunteers to staff the examination and the degree of other community support such as donations of space and supplies. Equipment can usually be borrowed from local rescue agencies or hospitals. Equipment from a certified emergency vehicle shall not be removed for use in the examination process.

Orienting the Psychomotor Station Examiners as a Group

An important component of ensuring that the examination operates smoothly is orienting the Psychomotor Station Examiners to their role and responsibilities during the examination process. In order to ensure the consistent performance of examiners throughout the day, the examiners should be assembled as a group prior to the start of the examination and instructed in the procedures of the examination according to a standardized orientation script in this manual.

Orienting the Candidates as a Group

An important aspect of the examination is the initial meeting and orientation of the candidates. Once all candidates have been registered for the examination, they should be assembled as a group and instructed in the procedure of the examination according to a standard orientation script in this manual. During this

period, the candidates should be given clear and complete directions as to what is expected of them during the examination. However, special effort should be made to put the candidates at ease. It is during this period that questions regarding the examinations should be solicited and answered.

During this orientation session, candidates should also be instructed to leave the testing area immediately upon completion of their examination and to not discuss the examination with those candidates waiting to be tested.

Orienting the Individual

Following the group orientation, candidates will wait for directions to report to a specific testing area. Prior to entering these areas, the candidates are greeted by the examiner and read the "Instructions to the Candidate" as they appear at the end of each psychomotor exam essay provided by the Examination Coordinator. To assure consistency and fairness, these instructions should be read to each candidate exactly as written. Each candidate should then be questioned as to his/her understanding of the instruction and provided with clarification as required.

Caution must be used to avoid lengthy questions or attempts by the candidate to obtain answers to questions which have no bearing on the examination. Examiners should be courteous and professional in all conversations with candidates.

Minimum Required Equipment List

Patient Assessment/Management (Trauma)	
*Examination Gloves Pen light Blood pressure cuff Stethoscope Moulage	One (1) Evaluator One (1) Patient
Patient Assessment/Management (Medical)	
*Examination Gloves Pen light Blood pressure cuff Stethoscope Moulage	One (1) Evaluator One (1) Patient
Cardiac Arrest Management/AED	
*Examination Gloves CPR mannequin **Oxygen tank, regulator and flow meter Automated external defibrillator trainer	Bag-valve-mask device or pocket mask Simple airway adjunct (OPA/NPA) in multiple sizes
BLS Airway Management	
*Examination Gloves Oropharyngeal airways (various sizes) Handheld or powered suction unit with catheter tips Bag-valve-mask device	Oxygen tank, regulator and flow meter Oxygen connecting tubing Intubation mannequin (Must be anatomically accurate) Supraglottic / Non-visualized airway
Spinal Immobilization (Seated Patient)	
*Examination Gloves	Head immobilizer (commercial or improvised)

Short spine immobilization device (short board, KED, etc.) Cervical collars (various sizes or adjustable)	Padding (i.e. towels, cloths) Patient securing straps Roller gauze or cravats Tape
Spinal Immobilization (Supine Patient)	
*Examination Gloves Long spine immobilization device (i.e. long spine board) Cervical collars (various sizes or adjustable)	Head immobilizer (commercial or improvised) Padding (i.e. towels, cloths) Patient securing straps Roller gauze or cravats Tape
Random Station	
*Examination Gloves Filled oxygen tank, regulator and flow meter Oxygen connecting tubing Nasal cannula Non-rebreather mask with reservoir Artificial mannequin or limb for tourniquet application (hard shell)	Mannequin Traction Splint and associated equipment EMT only Sling and swathe Various splinting material (various sizes) Field dressings and bandage Suitable tourniquet dressings and torquing device or commercial device Blanket

*Exam gloves to be available for each station or in the staging area.

** Preferred item for testing station may be simulated if limited supply.

A. *Roles and Responsibilities of the Indiana Psychomotor Exam Coordinator*

Reservation requirements(if not part of course application)	
At least 30 days prior to the date of the psychomotor exam: Ensure Candidates have a PSID number. Complete and submit the Psychomotor Exam Reservation Form and Candidate Roster with PSID numbers.	
Room Set-up (Best Practice)	
EMT - For every set of stations (15 candidates)	EMR - For every set of stations (15 candidates)
1 for Patient Assessment Management- Trauma 1 for Patient Assessment Management- Medical 1 for Cardiac Arrest Management/ AED 1 for BLS Airway Management 1 for Spinal Immobilization – Supine Patient 1 for Spinal Immobilization – Seated Patient 1 for Random Basic Skill Station 1 for the candidates 1 for the evaluators 1 for the Psychomotor Exam Representative	1 for Patient Assessment Management - Trauma 1 for Patient Assessment Management - Medical 1 for Cardiac Arrest Management/AED 1 for Spinal Immobilization- Supine 1 for Random Basic Skill Station 1 for the candidates 1 for the evaluators 1 for the Psychomotor Exam Representative
Equipment/Supply requirements	
One set of equipment is recommended for every 15 candidates completing the full psychomotor exam. Refer to the corresponding section for the list of required equipment by station. Copy the Psychomotor Exam Sheets per the color code listed in the Training Manual and the Face Sheet with the "What You Need to Know" printed on the reverse side. Copy enough forms for every candidate to complete the station twice. Copy one set of station instructions for each station.	
Staffing recommendations	

EMT - For every set of stations	EMR - For every set of stations
7 Qualified Station Examiners 5 People as Patients 4 assistants 1 Person as moulage person 1 Person to monitor the staging area at all times and send candidates to the skill stations Refer to the Training Manual for the list of recommended staffing	5 Qualified Station Examiners 3 People as Patients 3 Assistants 1 Person as moulage person 1 Person to monitor the staging area at all times and send candidates to the skill stations Refer to the Training Manual for the list of recommended staffing

Best Practice

It is recommended to print a sheet of labels for each candidate (enough for the required amount of stations being tested) and give to candidates. Instruct candidates to give a label to each evaluator upon entering the skill station. If you do not use labels, make sure that each person legibly writes their name on the psychomotor exam sheets.

Candidate Preparation
Review the "What You Need to Know as an Indiana EMR / EMT Psychomotor Exam Candidate" document with the candidates. This document can be found in the Psychomotor Exam Packet. Instructors are encouraged to provide the Psychomotor Exam Packet to candidates at the beginning of the course and reference it throughout the course. Advise candidates to bring a state issued picture identification and black ink pen to the Psychomotor Exam.
Day of the Psychomotor Exam
All equipment/stations, evaluators and candidates should be ready to begin upon arrival of the Psychomotor Exam Representative.
Verify sufficient staffing, equipment and stations for the number of candidates testing.
Verify all equipment is working properly and that all required equipment is in each skill station.
Have evaluators sign in and document their PSID numbers or credentials for the Psychomotor Exam Representative. Evaluators must be currently qualified to evaluate the station they are assigned.
Ensure all candidates have their state issued picture identification ready for the Psychomotor Exam Representative.
Ensure that the Psychomotor Exam Representative room remains secured throughout the entire exam. This room is exclusively for the Representative, and **no one** should enter this room without explicit permission from the Representative
Verify that the candidate waiting area will always be monitored and that candidates are being sent to the stations in a timely manner.
Assist the Psychomotor Exam Representative in collecting completed evaluation forms per the direction of the Representative.
In collaboration with the Psychomotor Exam Representative, determine whether retests will be offered. The preference is to allow retests. However, you may choose to not offer retests if there are an excessive number of retests, if staffing has fallen too low, if time does not permit, or any situation has arisen that would make offering retests impractical.
If retests will be offered, assign new evaluators to the skill stations being retested and assist the Psychomotor Exam Representative in distributing station paperwork at the direction of the Representative.
Under the direction of the Psychomotor Exam Representative, bring candidates to obtain their exam results.

After the Psychomotor Exam
Review the completed Psychomotor Exam Quality Control Checklist with the Psychomotor Exam Representative.
Complete the Psychomotor Exam Representative evaluation when it is received from IDHS.

B. Evaluating the Candidate

Examiner's Role

It is stressed again that the examiners must be objective and fair in their scoring. An examiner may not evaluate any psychomotor skill for which he/she was the instructor. The primary instructor for the course as well as any core instructors may not function as a psychomotor skill evaluator for their candidates.

Using the Psychomotor Examination Sheets

The evaluation process consists of the examiner at each station observing the candidate's performance and recording it on a standardized Psychomotor Exam Sheet. The examiner's role becomes that of an observer and recorder of events. Psychomotor Exam Sheets have been developed for each of the testing stations. Additionally, essays explaining each psychomotor skill have been developed to assist the examiner with the appropriate use of the instrument. These essays are listed in the last section of the manual.

Except to start or stop a candidate's performance, to deliver necessary cues (e.g., "The patient's blood pressure is 100/40; pulse is 120 and thready.") or to ask for clarification, the examiner should not speak to the candidate during his/her performance. Similarly, the examiner should not react, either positively or negatively, to anything the candidate says or does.

Programmed Patient's Role

The programmed patient is responsible for an accurate and consistent portrayal as the victim in the scenario for the station. The programmed patient's comments concerning the candidate's performance can be noted on the reverse side of the performance exam sheet. These comments should be as brief and as objective as possible so they can be used in the final scoring of the candidate's performance when appropriate.

Determining a Final Grade

Scoring

As mentioned earlier, the psychomotor station examiners observe the candidate's performance and record the observations on the exam sheet. These exam sheets are collected, brought directly to the State Examination Representative, and graded by the Indiana State Examination Representative according to the pass/fail criteria provided by the testing agency.

It should be noted that there are two Critical Criteria that deal with the affective domain, which measures the candidate's attitudes, behaviors, and professional attributes. The best place for "constructive criticism" is in the classroom and clinical phases of education—not during the examination process. A failure of a Critical Criteria for an affective or behavior based performance issue should be reserved for an egregious behavior that is serious enough that it would result in harsh disciplinary action in most EMS systems. The affective performance based criteria are "Failure to manage the patient as a competent EMT" and "Exhibits unacceptable affect with patient or other personnel." While this document cannot identify all of the forms of behavior, some of the behaviors that would be unacceptable are listed below. Any failure of a Critical Criteria relating to affective domain should be based upon a clearly defined "offensive" observation by the evaluator and not just "unreasonable" behaviors.

The following list should be used as a guide. IT is not intended to be exclusive as potential Critical Criteria level of behaviors:

Fails to behave with INTEGRITY. Unacceptable would be any form of cheating during the testing process, lying during the testing process, or deliberate disrespectful/ insubordinate behavior towards the patient, assistants, or evaluator.

Lack of EMPATHY or failure to treat the simulated patient in a calm, compassionate manner. Unacceptable examples would be deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance. Inappropriately fitting clothing or grooming are examples.

Lack of COMMUNICATION that impedes patient evaluation or care. Examples would include failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of RESPECT for the patient or other assistants includes no deliberate demeaning terms or derogatory language.

In most cases, the pass/fail will be easily determined. If, however, the pass/fail determination of official criteria is not easily identified, the Examination Coordinator and the Indiana State Examination Representative should review the situation as a committee before coming to a final decision, and, if necessary, they should contact the Medical Director. The programmed patient's comments, the examiner's comments and the documentation on the exam sheets should all be considered when determining whether a critical criterion was met.

Once the individual exam sheets have been scored, the State Psychomotor Examination Representative should transcribe the individual station results onto the Psychomotor Examination Report Form. The

Indiana Psychomotor Examination Report Form is then used to determine and record the overall score of the Psychomotor Examination.

Reporting Examination Results to the Candidate

The State Psychomotor Examination Representative is responsible for reporting the unofficial psychomotor examination results to the individual candidate. A copy of the Indiana Psychomotor Examination Report Form could be used for this purpose. At no time should the station examiner notify the candidate of examination results. Notifying candidates of failing performances prior to completion of the entire Psychomotor Exam may have an adverse effect on their performance in subsequent stations.

The results of the Psychomotor Examination should be reported as a pass/fail of the station. At no time should the candidate be allowed to review the completed Psychomotor Exam sheets. Identifying errors is not only contrary to the principles of this type of examination, but it could result in the candidate "learning" the examination while still not being competent in the necessary skills.

All forms of the Indiana Psychomotor Examination must be submitted to the Indiana Emergency Medical Services Commission Staff (IDHS) for formal processing.

Assuring Standardization and Quality Control

To be reliable, a psychomotor examination must be conducted according to a uniform set of criteria. These control criteria must be rigidly applied to all aspects of the examination if impartial, objective, and standardized scoring is to be assured.

The State Psychomotor Examination Representative must validate the standardization and quality control of the examination process by completing the Quality Control Checklist provided with the Psychomotor Examination Packet (email).

Orientation Script

This script should be read before each examination session. The script is to be read by the State Psychomotor Examination Representative, who should maintain a friendly and professional attitude.

GENERAL INSTRUCTIONS TO THE CANDIDATES

Welcome to the Indiana EMR/EMT Psychomotor Examination. My name is ____. I will be serving as the Indiana Psychomotor Examination Representative today. By successfully completing this examination process and receiving subsequent certification, you will have proven to yourself and the medical community that you have achieved the level of competency assuring that the public receives quality pre-hospital care.

Please note: No personal electronic devices are permitted in the building. These must either be left in your vehicle or at home.

The station examiners utilized today are state certified and or licensed personnel and are observers and recorders of your expected appropriate actions. They record your performance in relationship to the criteria listed on the exam sheets approved by the National Registry of EMTs and the Indiana EMS Commission.

The station examiner will call you into the station when it is prepared for testing. **NO** candidate, at any time, is permitted to remain in the testing area while waiting for his/her next station. You must wait outside the testing area until the station is open and you are called. You are not permitted to take any books, pamphlets, brochures or other study material into the station. You are not permitted to make any copies or recordings of any station. When the examiner asks your name, please assist him/her in spelling your name so that your results may be recorded accurately, or provide him/her with the pre-printed sticker provided to you by staff. Do not use nicknames.

If you have concerns with the objectivity of an evaluator, you must notify me prior to being evaluated. I will address each notification on a case by case basis.

Please pay close attention to the instructions, as they correspond to dispatch information you might receive on a similar emergency call and give you valuable information on what will be expected of you during the station. The station examiner will offer to repeat the instructions and will ask you if the instructions were understood. Do not ask for additional information not contained within the instructions, as the station examiner is not permitted to give this information.

We have instructed the station examiners not to indicate to you in any way a judgment regarding your performance in the station. Do not interpret any of the examiners remarks or documentation practices as an indication of your overall performance. Please recognize the station examiner's attitude as professional and objective, and simply perform the skills to the best of your ability.

You will be given time at the beginning of the station to survey and select the equipment necessary for the appropriate management of the patient. Do not feel obligated to use all the equipment. If you brought any of your own equipment, I must inspect and approve it before you enter the station.

The station examiner does not know or play a role in the establishment of pass/fail criteria, but is merely an observer and recorder of your actions in the station. This is an examination experience, not a teaching or learning experience.

Each station has an overall time limit; the examiner will inform you of this during the reading of the instructions. When you reach the time limit, the station examiner will inform you to stop your performance. However, if you complete the station before the allotted time, inform the examiner that you are finished. You may be asked to remove equipment from the patient before leaving the station.

You are not permitted to discuss any details of any scenario with each other at any time. Please be courteous to the candidates who are testing by keeping all excess noise to a minimum. Be prompt in reporting to each station so that we may complete this examination within a reasonable time period.

Failure of less than the majority of stations (as noted on the skills cover sheet) may allow you to retest of those stations failed if offered by the examine coordinator and the candidate elects to retest Failure of the majority of stations constitutes complete failure of the entire psychomotor examination, requiring a retest of the entire psychomotor examination after remedial training. Failure of a same-day retest entitles you to a retest of those skills failed. **This retest must be accomplished at a different date and test site, with a different examiner.** Failure of the retest at the different site constitutes a complete failure of the psychomotor examination, and you will be required to retest the entire psychomotor examination after providing proof of remedial training to the Indiana Emergency Medical Services Commission. A candidate is allowed to test a single station a maximum of three (3) times before he/she must retest the entire psychomotor examination. Any retest of the entire psychomotor examination requires the candidate to document remedial training over all skills before re-attempting the examination. Failure to pass all stations by the end of two (2) full examination attempts constitutes a complete failure of the skills testing process. Therefore, you must complete a new EMR/EMT training program to be eligible for future testing for certification. NOTE: You have one (1) year from your EMR/EMT course completion date to successfully complete all phases of the psychomotor examination process.

The results of the psychomotor examination are reported as a pass/fail of the skill station. You will not receive a detailed critique of your performance on any skill. Please remember that today's examination is a formal verification process and was not designed to assist with teaching or learning. Identifying errors will be contrary to the principle of this type of examination, and could result in the candidate "learning" the examination while still not being competent in the necessary skill.

If you feel you have a complaint concerning the examination, a formal complaint procedure does exist. Complaints must be initiated with me before you learn of your results or leave this site. You may file a complaint for only two (2) reasons:

You feel you have been discriminated against. Any situation in which you feel an unfair evaluation of your abilities occurred may be considered discriminatory.

There was an equipment problem or malfunction in your station.

If you feel either of these two things occurred, you must contact me immediately to initiate the written complaint process. The Indiana Psychomotor Examination Representative, Examination Coordinator and, if warranted, the Medical Director will review your concerns.

I am here today to assure that a fair, objective, and impartial testing process occurs. If you have any concerns, notify me immediately to discuss them. I may be visiting stations throughout the examination to verify appropriate testing procedures.

Does anyone have any questions concerning the psychomotor examination at this time?

POINTS TO REMEMBER

Follow instructions from the staff.

During the examination, move only to areas directed by the staff.

Give your full legal name as you arrive at each station.

Listen carefully as the testing scenario is explained at each station.

Ask questions if the instructions are not clear.

During the examination, do not talk about the examination with anyone other than the station examiner, programmed patient and, when applicable, to the trained assistant.

Be aware of the time limit, but do not sacrifice quality performance for speed.

Equipment will be provided. Select and use only that which is necessary to care for your patient adequately.

Read roster and Check ID's

Programming the Patient

Patient programming involves two essential elements: acting and medical input as to the type of injury, type of pain, general reaction and what should and should not be accomplished by the EMR/ EMT candidate.

It is not necessary to have professional actors as programmed patients. Almost anyone with the proper motivation can do an excellent job. If the programmed patient really believes in the scenario, it will become believable to others; however, patients with a working knowledge of EMS are preferred and recommended.

Once the programmed patient has received the medical information on the type of injury or illness, he/she should concentrate on how he/she personally reacts to pain. The programmed patient should work with the medical personnel until he/she has fully developed the proper reactions and responses. Medical personnel should always use lay terms in programming the patient, and the patient should always respond in lay terms to any questions from the candidate. After the patient has been fully "programmed," it is essential that he/she stay in character, regardless of what goes on around him/her.

Input from the programmed patient with respect to the way candidates handle him/her is important in the scoring process. This should be strongly emphasized to the programmed patient.

Moulage

Moulage of simulated patients is important if the Training Institution is expecting candidates to identify wounds readily. The sample psychomotor examination only requires moulage in the Patient Assessment/Management stations. Although theatrical moulage is ideal, commercially available moulage kits are acceptable in alerting the candidate to the presence of injuries on the simulated patient.

Regardless of the quality of moulage, examiners must communicate with the candidate concerning information on wound presence and appearance. Candidates will need to distinguish between venous and arterial bleeding, paradoxical chest movement, obstruction of the airway and any other injury that a programmed patient cannot realistically simulate. If candidates complain about the quality of moulage, the Coordinator should objectively re-examine the quality of the moulage. If the quality of the moulage is deemed to be marginal and does not accurately represent the wound, the Coordinator should instruct the station examiner to alert candidates to the exact nature of the injury.

The station examiner should do this only after the candidate has assessed the area of the wound as would be done in an actual field situation.

PSYCHOMOTOR EXAM GUIDELINES-Trauma

Instructions to the Evaluator

This station is designed to test the candidate's ability to integrate patient assessment and intervention skills on a victim with multi-systems trauma. Since this is a scenario based station, it will require some dialogue between the examiner and the candidate. The candidate will be required to physically accomplish all assessment steps listed on the exam sheets. However, all interventions should be spoken instead of physically accomplished. Because of the limitations of moulage, you must establish a dialogue with the candidate throughout this station. If a candidate quickly inspects, assesses or palpates the patient in a manner in which you are uncertain of the areas or functions being assessed, you must immediately ask the candidate to explain his/her actions. For example, if the candidate stares at the patient's face, you must ask what he/she is assessing to precisely determine if he/she was checking the eyes, facial injuries or skin color. Any information pertaining to sight, sound, touch, smell, or an injury that cannot be realistically moulaged but would be immediately evident in a real patient encounter must be supplied by the examiner as soon as the candidate exposes or assesses that area of the patient.

This station requires the presence of a simulated trauma victim. The victim should be briefed on his/her role in this station as well as how to respond throughout the assessment by the candidate. Additionally, the victim should have read thoroughly the "Instructions to the Simulated Trauma Victim." Trauma moulage should be used as appropriate. Moulage may range from commercially prepared moulage kits to theatrical moulage. Excessive/dramatic use of moulage must not interfere with the candidate's ability to expose the victim for assessment.

The victim will present with a minimum of an airway, breathing, circulatory problem and one associated injury or wound. The mechanism and location of the injury may vary, as long as the guidelines listed above are followed. It is essential that once a scenario is established for a specific test station, it remains the same for all candidates being tested at that station. This will ensure consistency of the examination process for all candidates.

Candidates are required to conduct a scene size-up just as they would in a field setting. When asked about the safety of the scene, the examiner must indicate the scene is safe to enter. If the candidate does not assess the safety of the scene before beginning patient care, no points should be awarded for the task "Determines the scene is safe".

An item of some discussion is where to place vital signs within a pre-hospital patient assessment. Obtaining precise agreement among various EMT texts and programs is virtually impossible. Vital signs have been place in the focused history and physical. This should not be construed as the only place that

vital signs may be accomplished. It is merely the earliest point in a pre-hospital assessment that they may be accomplished.

The scenario format of a multi-trauma assessment/management testing station requires the examiner to provide the candidate with essential information throughout the examination process. Since this station uses a simulated patient, the examiner must supply all information pertaining to sight, sound, smell or touch that cannot be adequately portrayed with the use of moulage. This information should be given to the candidate **when the area of the patient is exposed or assessed.**

The candidate may direct the trained assistant to obtain patient vital signs. The examiner must provide the candidate with the patient's pulse rate, respiratory rate and blood pressure when asked.

Due to the scenario format and voiced treatments, a candidate may forget what he/she has already done to the patient. This may result in the candidate attempting to do assessment/intervention steps on the patient that are physically impossible. For example, the candidate may have voiced placement of a cervical collar in the initial assessment and then later, in the detailed physical examination, attempt to evaluate the integrity of the cervical spine. Since this cannot be done without removing the collar, you, as an examiner, should remind the candidate that previous treatment prevents assessing the area. This same situation may occur with splints and bandages.

Each candidate is required to complete a detailed physical examination of the patient. The candidate choosing to transport the victim immediately after the initial assessment must continue the detailed physical examination enroute to the hospital. You should be aware that the candidate may accomplish portions of the detailed physical examination during the rapid trauma assessment. If the candidate fails to assess a body area prior to covering the area with a patient care device, no points should be awarded for the task. However, if a candidate removes the device assesses the area and replaces the device without compromising patient care; full points should be awarded for the specific task.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Simulated Trauma Patient

Note: In order to ensure a fair examination environment for each candidate, the simulated victim should be an adult of average height and weight. For example, the use of very small children is discouraged in this station.

The following should be reviewed by the station examiner with the person serving as victim.

When serving as a victim for the scenario today make every attempt to be consistent with every candidate in presenting the appropriate symptoms. The level of respiratory distress acted out by you and the degree of presentation of pain at injury sites must be consistent for all candidates. As the candidate progresses with the examination, be aware of any period in which he/she touches a simulated injured area. If the scenario indicates that you are to respond with deep painful stimuli and the candidate lightly touches the area, do not respond. Only respond according to the situation as you feel a real victim would in a multiple trauma situation. Do not give the candidate any clues while you are acting as a victim. For example, it is inappropriate to moan that your wrist hurts after you become aware that the candidate has not found that injury. Please remember what areas have been assessed and treated because we may need to discuss the candidate's performance after he/she leaves the room.

The station examiner may use information provided by the trained and well coached victim as data in determining the awarding of points for specific steps on the exam sheets.

mstructions to the Candidate

This station is designed to test your ability to perform a patient assessment of a victim of multi-systems trauma and "voice" treats all conditions and injuries discovered. You must conduct your assessment as you would in the field including communicating with your patient. You may remove the patient's clothing down to shorts or swimsuit if you feel it is necessary. As you conduct your assessment, you should state everything you are assessing. Clinical information not obtainable by visual or physical inspection will be given to you after you demonstrate how you would normally gain that information. You may assume that you have two EMTs working with you and that they are correctly carrying out the verbal treatments you indicate. You have (10) ten minutes to complete this station. Do you have any questions?

Sample Trauma Scenario

The following is an example of an acceptable scenario for this station; however, you will use one of the pre-approved scenarios supplied by IDHS.

TRAUMA SITUATION #1 – PATIENT ASSESSMENT/MANAGEMENT

Mechanism of Injury

You are called to the scene of a motor vehicle crash where you find a victim who was thrown from the car. You find severe damage to the front end of the car. The victim is found lying in a field 30 feet from the upright car.

Injuries

The patient will present with the following injuries. All injuries will be moulaged. Each examiner should program the patient to respond appropriately throughout the assessment and assure the victim has read the "Instructions to Simulated Trauma Victim" that have been provided.

Unresponsive

Left side flail chest

Decreased breath sounds, left side

Cool, clammy skin; no distal pulses

Distended abdomen

Pupils equal

Neck veins flat

Pelvis stable

Open injury of the left femur with capillary bleeding

Vital Signs:

Initial: B/P 72/60, P140, RR 26

Upon recheck: B/P 64/48, P 138, RR 44

PSYCHOMOTOR EXAM GUIDELINES –Medical

Instructions to the Evaluator

This station is designed to test the candidate's ability to use appropriate questioning techniques to assess a patient with a chief complaint of a medical nature and to verbalize appropriate interventions based on the assessment findings. This is a scenario based station and will require extensive dialogue between the examiner and the candidate. A simulated medical patient will answer the questions asked by the candidate based on the scenario being utilized. The candidate will be required to accomplish all assessment steps listed on the exam sheet; however, interventions may be spoken instead of physically accomplished. You must establish a dialogue with the candidate throughout this station. Any information pertaining to sight, sound, touch, or smell that cannot be seen but would be evident immediately in a real patient encounter, must be supplied by the examiner.

The scenario should provide enough information to enable the candidate to form a general impression of the patient's condition. Alert patients should perform as indicated in the scenario. The medical condition of the patient will vary depending upon the scenario utilized in the station. It is essential that once a scenario is established for a specific test station, it remains the same for all candidates being tested at that station.

This station requires the presence of a simulated medical patient. You, or the simulated medical patient, should not alter the patient information provided in the scenario and should provide only the information that is specifically asked for by the candidate. Information pertaining to vital signs should not be provided until the candidate actually performs the steps necessary to gain such information. In order to verify that the simulated patient is familiar with his/her role during the examination, you should ensure he/she reads the "Instructions to the Simulated Medical Patient" provided at the end of this essay. You should also role play the selected scenario with him/her prior to the first candidate entering the station.

The scene size-up should be accomplished once the candidate enters the testing station. Brief questions such as "Is the scene safe?" should be asked by the candidate. When the candidate attempts to determine the nature of the illness, you should respond based on the scenario being utilized, i.e.: Respiratory, Cardiac, Altered Mental Status, Poisoning/Overdose, Environmental Emergency or Obstetrics.

For the purpose of this station, there should be only one patient, no additional help is available and cervical spine stabilization is not indicated. The candidate must verbalize the general impression of the

patient after hearing the scenario. The remainder of the possible points relative to the initial assessment and the focused history and physical examination are listed in the individual scenarios.

The point for "Interventions" should be awarded based on the candidate's ability to verbalize appropriate treatment for the medical emergency described in the scenario.

The candidate must assess signs and symptoms during the focused history by asking appropriate questions. Proposed questions have been listed for seven (7) common responses as a guide. For a candidate to receive the all the points for signs and symptoms, the candidate must ask a minimum of four (4) questions related to the signs and symptoms for patient's chief complaint. The candidate may provide questions on their own as long as the questions are pertinent and related to the chief complaint of the scenario. You should record the number of pertinent questions the candidate asked on the evaluation form.

Failure to address or ask a single question relating to the signs and symptoms constitutes a Critical Criteria under "Did not ask any questions about the present illness." Award a zero (0) in the Signs and Symptoms box and check the "Critical Criteria."

Each candidate is required to complete a full patient assessment. The candidate choosing to transport the victim immediately after the initial assessment must be instructed to continue the focused history and physical examination and ongoing assessment enroute to the hospital.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Simulated Medical Patient

Note: In order to ensure a fair examination environment for each candidate, the simulated victim should be of average height and weight for the scenario being used. For example, the use of very small children is discouraged in this station unless the scenario specifically indicates a pediatric patient.

The following should be reviewed by the station examiner with the person serving as patient.

The examination today will require you to role play a patient experiencing an acute medical emergency. You should act as an actual patient would in the real situation. You must answer the candidate's questions using only the information contained in the scenario provided to you by the examiner for this station. Do not overact or add signs or symptoms to the scenario provided. It is important that you be very familiar with the scenario and the required patient responses. When serving as a patient for the scenario today make every attempt to be consistent with every candidate in presenting the appropriate symptoms. The level of responsiveness, anxiety, respiratory distress, etc., acted out by you must be consistent for all candidates. Do not give the candidate any clues while you are acting as a victim. For example, it is inappropriate to say "I am allergic to penicillin" after you become aware that the candidate has not remembered to ask that question during the SAMPLE history. Please remember what questions you have answered and what areas have been assessed because they may need to be discussed after the candidate leaves the room.

The station examiner may use information provided by the trained and well coached victim as data in determining the awarding of points for specific steps in the exam sheets.

Instructions to the Candidate

This station is designed to test your ability to perform patient assessment of a patient with a chief complaint of a medical nature and "voice" treat all conditions discovered. You must conduct your assessment as you would in the field including communicating with your patient. As you conduct your assessment, you should state everything you are assessing. Clinical information not obtainable by visual or physical inspection will be given to you after you demonstrate how you would normally gain that information. You may assume that you have two (2) EMT's working with you and that they are correctly carrying out the verbal treatments you indicate. You have (10) ten minutes to complete this station. Do you have any questions?

Sample Medical Scenarios

RESPIRATORY

You arrive at a home and find an elderly male patient who is receiving oxygen through a nasal cannula. The patient is 65 years old and appears overweight. He is sitting in a chair in a "tripod" position. You see rapid respirations and there is cyanosis around his lips, fingers and capillary beds.

INITIAL ASSESSMENT

Chief Complaint:	"I'm having hard time breathing and I need to go to the hospital."
Apparent Life Threats:	Respiratory compromise.
Level of Responsiveness:	Patient is only able to speak in short sentences interrupted by coughing.
Airway:	Patent
Breathing:	28 and deep, through pursed lips

Circulation:	No bleeding, pulse rate 120 and strong. There is cyanosis around the lips, fingers and capillary beds
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Onset	"I've had emphysema for the past ten years, but my breathing has been getting worse the past couple of days."
Provokes	"Whenever I go up or down steps, it gets really bad."
Quality	"I don't have any pain; I'm just worried because it is so hard to breath. I can't seem to catch my breath"
Radiate	"I don't have any pain."
Severity	"I can't stop coughing. I think I'm dying."
Time	"I woke up about three hours ago. I haven't been able to breathe right since then."
Interventions	"I turned up the flow of my oxygen about an hour ago."
Allergies	Penicillin and bee stings
Medications	Oxygen and a hand held inhaler
Past Medical History	Treated for emphysema for past 10 years
Last Meal	"I ate breakfast this morning.
Events Leading to Illness	"I got worse a couple of days ago. The day it got really cold and rained all day. Today, I've just felt bad since I got out of bed.
Focused physical examination	Auscultate breath sounds.
Vitals	RR 28, P 120, BP 140/88

CARDIAC

You arrive on the scene where a 57 year old man is complaining of chest pain. He is pale and sweaty.

INITIAL ASSESSMENT

Chief Complaint:	"My chest really hurts. I have angina but this pain is worse than any I have ever felt before."
Apparent Life Threats:	Cardiac compromise
Level of Responsiveness:	Awake and alert
Airway:	Patent
Breathing:	24 and shallow
Circulation:	No bleeding, pulse rate 124 and weak, skin cool and clammy.
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Onset	"The pain woke me up from my afternoon nap"
Provokes	"It hurts really bad and nothing I do makes the pain go away."
Quality	"It started out like indigestion but has gotten a lot worse. It feels like a big weight is pressing against my chest. It makes it hard to breath."
Radiate	"My shoulders and jaws started hurting about ten minutes before you got here, but the worse pain is in the middle of my chest. That's why I called you."
Severity	"This is the worst pain I have ever felt. I can't stand it."
Time	"I've had this pain for about an hour, but it seems like days."

Interventions	"I took my nitroglycerin about 15 minutes ago but it didn't make any difference. Nitro always worked before. Am I having a heart attack?"
Allergies	None
Medications	Nitroglycerin
Past Medical History	Diagnosed with angina two years ago
Last Meal	"I had soup and a sandwich about three hours ago."
Events Leading to Illness	"I was just sleeping when the pain woke me up."
Focused physical examination	Assessment baseline vital signs.
Vitals	RR 24, P 124, BP 144/92

ALTERED MENTAL STATUS

When you arrive on the scene you are met by a 37 year old male who says his wife is a diabetic and isn't acting normal.

INITIAL ASSESSMENT

Chief Complaint:	"My wife just isn't acting right. I can't get her to stay awake. She only opens her eyes then goes right back to sleep."
Apparent Life Threats:	Depressed central nervous system, respiratory compromise
Level of Responsiveness:	Opens eyes in response to being shaken
Airway:	Patent
Breathing:	14 and shallow
Circulation:	120 and weak
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Description of Episode	"My wife took her insulin this morning like any other morning but she has had the flu and has been vomiting."
Onset	"It happened so quickly. She was just talking to me and then she just went to sleep. I haven't really been able to wake her up since."
Duration	"She's been this way for about 15 minutes now. I called you right away. I was really scared."
Associated symptoms	"The only thing that I can think of is that she was vomiting last night and this morning."
Evidence of trauma	"She didn't fall. She was just sitting on the couch and fell asleep. I haven't tried to move her."
Interventions	"I haven't done anything but call you guys. I know she took her insulin this morning."
Seizures	None
Fever	Low grade fever
Allergies	Penicillin
Medications	Insulin
Past Medical History	Insulin dependent diabetic since 21 years of age
Last Meal	"My wife ate breakfast this morning."
Events Leading to Illness	"My wife has had the flu and been vomiting for the past 24 hours."
Focused physical examination	Rapid assessment to rule out trauma
Vitals	RR 14, P 120, BP 110/72.

ALLERGIC REACTION

You have arrived to find a 37 year old male who reports eating cookies he purchased at a bake sale. He has audible wheezing, and is scratching red, blotchy areas on his abdomen, chest and arms.

INITIAL ASSESSMENT

Chief Complaint:	"I'm having an allergic reaction to those cookies I ate."
Apparent Life Threats:	Respiratory and circulatory compromise
Level of Responsiveness:	Awake, very anxious and restless
Airway:	Patent
Breathing:	26, wheezing and deep
Circulation:	No bleeding, pulse 120 and weak, cold and clammy skin
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

History of allergies	"Yes I'm allergic to peanuts."
When ingested	"I ate cookies about 20 minutes ago and began itching all over about five minutes later."
How much ingested	"I only ate two cookies"
Effects	"I'm having trouble breathing and I feel lightheaded and dizzy."

Progression	"My wheezing is worse. Now I'm sweating really badly."
Interventions	"I have my epi-pen upstairs but I'm afraid to stick myself."
Allergies	Peanuts and penicillin
Medications	None
Past Medical History	"I had to spend two days in the hospital the last time this happened."
Last Meal	"The last thing I ate was those cookies."
Events Leading to Illness	"None, except I ate those cookies."
Focused physical examination	Not indicated (award point)
Vitals	RR 26 P 120, BP 90/60

POISONING/OVERDOSE

You arrive on the scene where a 3 year old girl is sitting on her mother's lap. The child appears very sleepy and doesn't look at you as you approach.

INITIAL ASSESSMENT

Chief Complaint:	"I think my baby has swallowed some of my sleeping pills. Please don't let her die!"
Apparent Life Threats:	Depressed central nervous system, respiratory compromise
Level of Responsiveness:	Responds slowly to verbal commands
Airway:	Patent
Breathing:	18 and deep
Circulation:	120 and strong
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Substance	"My baby took my sleeping pills. I don't know what kind they are. They just help me sleep at night."
When ingested	"I think she must have got them about an hour ago when I was in the shower. Her older sister was supposed to be watching her."
How much ingested	"My prescription was almost empty. There couldn't have been more than four of five pills left. Now they're all gone. Please do something."
Effects	"She just isn't acting like herself. She's usually running around and getting into everything."
Progression	"She just seems to get sleepier and sleepier by the minute."
Interventions	"I didn't know what to do, so I just called you. Can't you do something for her?"
Allergies	None
Medications	None
Past Medical History	None
Last Meal	"She ate breakfast this morning."
Events Leading to Illness	"She just swallowed the pills."
Focused physical examination	Completes a rapid trauma assessment to rule out trauma
Vitals	RR 18, P 120, BP 90/64

ENVIRONMENTAL EMERGENCIES

You arrive on the scene as rescuers are pulling a 16 year old female from an ice covered creek. The teenager has been moved out of the creek onto dry land, is completely soaked and appears drowsy.

INITIAL ASSESSMENT

Chief Complaint:	"I saw something in the water below the ice. When I tried to get it out, the ice broke."
Apparent Life Threats:	Generalized hypothermia
Level of Responsiveness:	Responsive, but slow to speak
Airway:	Patent
Breathing:	26 and shallow
Circulation:	No bleeding; pulse 110 and strong; pale, wet skin still covered in wet clothing.
Transport Decision:	Immediate transport

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Source	"I fell in the creek when the ice broke. I tried to get out but the current was to strong. Thank God you came."
Environment	"The water was up to my neck. I could stand up, but I couldn't get out of the water."
Duration	"I think I was in the water for ten minutes before they pulled me out. It felt like an hour."
Loss of consciousness	"I feel sick, but I never passed out."
Effects	Lowered body temperature, slow speech patterns, "I can't stop shivering."

Allergies	None
Medications	None
Past Medical History	None
Last Meal	"I ate lunch at school three hours ago."
Events Leading to Illness	"I thought the ice would hold me."
Focused physical examination	Completes a rapid assessment to rule out trauma
Vitals	RR 26, P 110, BP 120/80

OBSTETRICS

You arrive on the scene where a 26 year old female is laying on the couch saying. "The baby is coming and the pain is killing me!"

INITIAL ASSESSMENT

Chief Complaint:	"I'm nine months pregnant and the baby is coming soon."
Apparent Life Threats:	None
Level of Responsiveness:	Awake and alert
Airway:	Patent
Breathing:	Panting, rapid breathing during contractions
Circulation:	No bleeding, pulse 120, skin is pale
Transport Decision:	Unknown

FOCUSED HISTORY AND PHYSICAL EXAMINATION

Are you Pregnant	See chief complaint (award point if mentioned in general impression)

How long pregnant	See chief complaint (award point if mentioned in general impression).
Pain or contractions	"My pains are every 2-3 minutes and it lasts 2-3 minutes."
Bleeding or discharge	None
Do you feel the need to push	"Yes, every time the pain begins."
Crowning	Present (award point if identified in focused physical exam).
Allergies	None
Medications	None
Past Medical History	"This is my third baby."
Last Meal	"I ate breakfast today."
Events Leading to Illness	"The contractions started a few hours ago and have not stopped."
Focused physical examination	Assess for crowning, bleeding and discharge.
Vitals	RR 40 during contractions, P 120, BP 140/80

PSYCHOMOTOR EXAM GUIDELINES -Cardiac Arrest Management/AED

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively manage a pre-hospital cardiac arrest by integrating CPR skills, defibrillation, airway adjuncts, and patient/scene management skills. This includes the integration of people and equipment commonly associated with an ambulance responding to a cardiac arrest scene in a basic life support scenario. The candidate will arrive at the scene and encounter an unresponsive patient. A first responder is arriving at the same time as the candidate. The candidate will be required to make appropriate assessments, utilize an automated external defibrillator and correctly manage the patient.

The current American Red Cross and American Heart Association CPR courses instruct candidates in the techniques of CPR, however, they do not instruct the candidate in the use and integration of adjunctive equipment or how to prepare the patient for transportation as he/she will be required to do in an actual field situation. This station tests the candidate's ability to integrate CPR skills into cardiac arrest scene management and the use of the AED.

The candidate must demonstrate effective history gathering skills by obtaining information about the events leading up to, and during, the event. When gathering the history the candidate must ask, at minimum, the following questions:

How long has the victim been down?

Has CPR been done?

When asked these questions, you should answer that the "victim has been in cardiac arrest for an unknown amount of time and that bystander CPR has been in progress for greater than two minutes."

Although gathering a history on the cardiac arrest event is an assessment item, it should not be construed that it overrides the need for resuscitation. The current standards for CPR should be adhered to at all times during this station. The candidate must assess for the presence of a spontaneous pulse and be informed, by you, that there is no spontaneous pulse. The candidate must direct the resumption of CPR by the assistant EMT or the first responder while he/she prepares the defibrillator for use. You should inform the candidate that there is "no pulse" on any pulse check.

The candidate must direct the EMT assistant and the first responder to initiate two (2) rescuers CPR. The candidate should gather additional information from bystanders about the events leading to the cardiac arrest. When asked questions about the event, you should indicate that **"bystanders did not see the victim collapse and are unaware of any associated medical problems."**

The candidate must integrate the use of an oropharyngeal airway and ventilation adjunct into CPR scenario that is already in progress. The candidate voices that he/she would measure and insert the oropharyngeal airway. He/she than must ventilate or direct the ventilation of the patient using adjunctive equipment. Interruption of CPR should not exceed 30 seconds for measuring and placing the airway. The candidate may choose to use a pocket mask, flow restricted oxygen powered ventilation device or bag-valve mask device to ventilate the patient.

You should not indicate displeasure with the candidate's choice of ventilator adjunct since this station is testing the candidate's ability to integrate adjunctive equipment in to a cardiac arrest scene and not local protocols or variations in equipment. Regardless of the device chosen, it is essential that the candidate connect it to supplemental high flow oxygen. After establishing ventilation using the adjunctive equipment the candidate then must re-evaluate the patient, determine the absence of a pulse and repeat the defibrillation sequence. **You should inform the candidate that there is "no pulse" on any pulse check.**

The candidate is required to verbalize appropriate transportation of the patient.

This station requires the presence of an EMT assistant (the examiner may act as the EMT assistant), a first responder, and a defibrillation mannequin. Candidates are to be tested individually with the EMT assistant and the first responder acting as an assistant who provides no input in the application of skills or equipment. The EMT assistant and first responder should be told not to speak but to follow the commands of the candidate. Errors of omission or commission by the first responder cannot result in failure of the candidate unless they were improperly instructed by the candidate.

Due to the extra individuals involved in this station, it is essential that you observe the actions of the candidate at all times. Do not be distracted by the actions of the first responder or the EMT assistant because he should do only as instructed by the candidate. As you observe the candidate ventilating the patient, remember that the ability to ventilate the patient with adequate volumes of air is not being evaluated. Adequate ventilation of a mannequin is evaluated in the "Non Visualized Airway". You are evaluating scene/situation control, integration skills, and decision making ability.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to manage a pre-hospital cardiac arrest by integrating CPR skills, defibrillation, airway adjuncts and patient/scene management skills. There will be an assistant in this station. The assistant will only do as you instruct him/her. You will be dispatched to an unconscious patient at a factory. A first responder will be present and performing CPR. You must immediately establish control of the scene and begin management of the situation. You will have, and be expected to use an automated external defibrillator. At the appropriate time, the patient's airway must be controlled and you must ventilate or direct the ventilation of the patient using adjunctive equipment. You may use any of the supplies available in this room.

You have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -BLS Airway Management

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively evaluate, initiate, and continue the proper basic life support airway management and ventilation of an apneic patient using a bag-valve-mask device, suctioning the airway, placing an oropharyngeal airway, and properly inserting a non visualized airway. The candidate will enter the station and find an unresponsive and apneic patient with a palpable central pulse after determining responsiveness. The patient is to be considered a non-traumatic patient for the purposes of this station.

The candidate must initially check the manikin for responsiveness, breathing, and a pulse for a period of five to ten (5-10) seconds. The examiner must inform the candidate that "the patient is apneic and unresponsive" after the candidate demonstrates acceptable technique for establishing unresponsiveness. The examiner must inform the candidate that "you palpate a weak carotid pulse of 60" after the candidate has properly assessed the presence of a pulse. The examiner must inform the candidate that "the mouth is full of secretions and vomitus" after the candidate has either opened the airway manually or if the candidate visualizes the oropharynx area of the mouth. The candidate must demonstrate acceptable suctioning technique before attempting to ventilate the manikin or simulated patient manikin. After the candidate has properly demonstrated an acceptable suctioning technique, the examiner should state that "the mouth and oropharynx are now clear". The candidate should re-open the airway and insert a properly sized OP airway into the oropharynx. If the candidate inserts the airway in an acceptable manner into the manikin, the examiner must inform the candidate that "no gag reflex is present and the patient accepts the airway without difficulty". The candidate must immediately open the manikin or simulated patient's airway and initiate ventilation using an appropriate BVM device within thirty (30) seconds. The candidate may initially voice the attachment or attach the high flow oxygen to the BVM device prior to the initial ventilations; however, the attachment of the oxygen to the BVM device must not delay the initiation of ventilations greater than 30 seconds.

The successful completion of this station **requires** the candidate must initiate high-flow oxygen during the station scenario. If the candidate chooses to initially attach high flow oxygen before beginning their first ventilation, the candidate should not be penalized unless that action delays the initial ventilation for greater than 30 seconds, which would be a Critical Criteria. The candidate must either voice the attachment of high flow oxygen or physically attach the oxygen to the BVM device at some point in the station scenario.

When ventilating the manikin, the candidate must provide a minimum breath to make the chest rise and fall adequately. This ventilation should equal the current standards established for appropriate rescue breathing volumes during basic and advanced life support. This may be validated by observing the rise and fall of the chest during ventilation. If unable to observe rise and fall of the chest on your mannequin, please see examination site coordinator for assistance.

If the candidate begins ventilation using a mouth-to-mouth technique, you should advise the candidate that he is required to use a bag-valve-mask device for all ventilations in this station. After the candidate completes the initial 30 seconds of ventilations, the examiner should advise or inform the candidate that the simulated patient manikin is being performed without difficulty and that a non-visualized airway should be inserted by the candidate. The station examiner or assistant should take over the ventilation for the candidate while the candidate assembles and test the equipment prior to insertion of the device. The candidate should direct the assistant or examiner to pre-oxygenate the patient at a rate of 10-20 breaths per minute. The candidate must insert the non-visualized airway device in an acceptable manner within three attempts and within the ten minute time period for completion of the station. If the candidate fails to complete the insertion of the device on the first attempt, the examiner should monitor the time delay to ascertain if a time delay of thirty seconds is exceeded before ventilations are resumed. The candidate must confirm the placement of the device after insertion ventilating the manikin and observing for chest rise and fall and auscultation of the lung fields and epigastrium.

The examiner must recognize that regional medical control may stipulate the type of supraglottic or non-visualized airway device taught in the class. The examiner should be familiar with the various types of airways (Combi-tube, LMA, King Airway, etc.) potentially utilized with the class.

The station examiner should review all of the Critical Criteria prior to testing the first candidate. Identified critical criteria assess the candidate's performance in the psychomotor and affective domains of learning. This station requires the proper integration by the candidate of his/her assessment skills, time management skills, evaluation skills, and various device insertion skills to successfully complete this station.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

ALTERNATIVE SCENARIOS FOR NVA

Option #1 "If a single tube non-visualized airway is used for testing, then there should be successful ventilations when the device is properly placed. If a Combi-tube is used for testing, the Site Coordinator and the State Representative with the station evaluator should decide whether the initial Combi-tube placement is esophageal (resulting in successful ventilations with the first or blue tube) or tracheal (resulting in the need to use the second or white tube). This decision should be reached prior to testing the first candidate and all candidates should be tested accordingly."

Option #2 "If a single tube non-visualized airway is used for testing, then there should be successful ventilations when the device is properly placed. If the Combi-tube is used for testing, then the testing should be conducted as below:

Even numbered test date: The initial Combi-tube placement is esophageal (resulting in successful ventilations with the first or blue tube).

Odd numbered test date: The initial Combi-tube placement is tracheal (resulting in the need to use the second or white tube) for successful breath sounds and absent epigastric sounds.

Instructions to the Candidate

This station requires the proper integration by the candidate of his/her assessment skills, time management skills, evaluation skills, and various device insertion skills to successfully complete this station. This station is designed to test your ability to assess initial responsiveness, assess and manage an airway utilizing appropriate techniques, ventilate a patient using a bag-valve-mask, and inserting a non visualized airway.

As you enter the station, you will find an apparent unresponsive patient. There are no bystanders and artificial ventilation has not been initiated. Patient management required for completion of this station is complete airway management, proper ventilatory support with the bag-valve-mask, and the proper insertion of the non-visualized airway. You must initially ventilate the patient for a minimum of 30 seconds. You will be evaluated on the appropriateness of ventilator volumes.

I will then inform you that a second rescuer has arrived to assist you with ventilations. Medical control will then advise you to provide the patient with a secured airway by using the non visualized airway. You may use only the equipment available in this room. You will have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Spinal Immobilization Seated

Instructions to the Evaluator

This station is designed to test the candidate's ability to provide spinal immobilization on a patient using a short spine immobilization device. The candidate will be advised that the scene size-up, initial assessment and focused assessment have been completed and no condition requiring further resuscitation or urgent transportation are present. The patient will present seated in an armless chair, sitting upright with his/her back loosely touching the back of the chair. The position of the patient should be identical for all candidates.

The candidate will be required to treat the specific, isolated, problem of an unstable spine. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required in this testing station. The candidate will be required to check motor, sensory and circulatory function in each extremity at the proper times throughout this station. Once the candidate has immobilized the seated victim to the half spine device, ask the candidate to explain all key steps he/she would complete while moving the patient to the long backboard. The candidate may check motor, sensory and circulatory function at anytime during the procedure without a loss of points. However, in order to avoid the Critical Criteria, the candidate must check motor, sensory, and circulatory function both before and after immobilization to the device.

If he/she fails to check motor, sensory or circulatory function in all extremities after (verbalizing that the patient is moved to a long backboard), a zero (0) should be placed in the "points awarded" column for that items.

The station instrument was designed to be generic so it could be utilized to evaluate the candidate's performance regardless of the half-spine immobilization device utilized. All manufacturers' instructions describe various orders in which straps and buckles are to be applied when securing the torso to the immobilization devices. This station is not designed to specifically test each individual device but to "generically" verify a candidate's competence in safely and effectively securing a suspected unstable spine in a seated patient.

Therefore, while the specific order of placing and securing straps and buckles is not critical, **it is imperative** that the patient's head be secured to the half-spine immobilization device only **after** the device has been secured to the torso. This sequential order most defensibly minimizes potential cervical

spine compromise and is the most widely accepted and defended order of application to date regardless of the device used.

A trained assistant will be present in the station to assist the candidate by applying manual in-line stabilization of the head and cervical spine only upon the candidate's command. The assistant must be briefed to follow only the commands of the candidate, as the candidate is responsible for directing the actions of the EMT assistant. When directed, the EMT assistant must maintain manual in-line immobilization as a trained EMT would in the field. No unnecessary movement of the head or other "tricks" should be tolerated and are not meant to be a part of this examination station. However, if the assistant is directed to provide improper care, points on the evaluation form relating to this improper care should be deducted and documented. For example; if the candidate directs the assistant to let go of the head prior to its mechanical immobilization, the candidate has failed to maintain manual neutral in-line immobilization. You must check the related statement under "Critical Criteria" and document your rationale. On the other hand, if the assistant accidentally releases immobilization without an order, you should direct the assistant to again take manual in-line immobilization. Immediately, inform the candidate that this action will not affect his/her evaluation. At no time should you allow the candidate or assistant EMT to perform a procedure that would actually injure the simulated patient

This station requires the presence of a simulated victim. The victim should be briefed on his/her role in this station and act as a calm patient would if this were a real situation. The victim should be an adult of average height and weight. You may use comments from the simulated victim about spinal movement and overall care to assist you with the evaluation process after the candidate completes his/her performance and exits the testing station.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to provide spinal immobilization on a patient using a half-spine immobilization device. You and an EMT assistant arrive on the scene of an automobile crash. The scene is safe and there is only one patient. The assistant EMT has completed the initial assessment and no critical condition requiring intervention was found. For the purpose of this station, the patient's vital signs remain stable. You are required to treat the specific, isolated problem of an unstable spine using a half-spine immobilization device. You are responsible for the direction and subsequent actions of the EMT assistant. Transferring and immobilizing the patient to the long backboard should be accomplished verbally. You have (10) ten minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Spinal Immobilization Supine

Instructions to the Evaluator

This station is designed to test the candidate's ability to provide spinal immobilization on a patient using a long spine immobilization device. The candidate will be informed that a scene size-up, initial assessment and focused assessment have been completed and no condition requiring further resuscitation exists. The patient will present in supine, anatomical position. The position of the patient should be identical for all candidates.

The candidate will be required to treat the specific, isolated problem of an unstable spine. Initial and ongoing assessment of airway, breathing, and circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in each extremity at the proper times throughout this station. If the candidate fails to check motor, sensory and circulatory function, a zero (0) should be placed in the points awarded column for those items.

The candidate must, with the help of 2 assistants, move the patient from the ground onto a long spinal immobilization device. There are various acceptable ways to move a patient from the ground onto a long spinal immobilization device, (i.e. logroll, straddle slide, direct patient lift). You should not advocate one method over any others. All methods should be considered acceptable as long as spinal integrity is not compromised. Regardless of the method used, the EMT assistant should control the head and cervical spine while the candidate and evaluator move the patient on the direction of the candidate.

Immobilization of the lower spine/pelvis in line with the torso is required. Lateral movement of the legs will cause angulations of the lower spine and should be avoided. Additionally, tilting the backboard when the pelvis and upper legs are not secured will ultimately cause movement of the legs and angulations of the spine.

A trained assistant will be present in the station to assist the candidate by applying manual in-line stabilization of the head and cervical spine only upon the candidate's command. The assistant must be briefed to follow only the commands of the candidate, as the candidate is responsible for directing the actions of the EMT assistant. When directed, the EMT assistant must maintain manual in-line immobilization as a trained EMT would in the field. No unnecessary movement of the head or other "tricks" should be tolerated and are not meant to be a part of this examination station. However, if the assistant is directed to provide improper care, points on the evaluation form relating to this improper care should be deducted and documented. For example, if the candidate directs the assistant to let go of the

head prior to its mechanical immobilization, the candidate has failed to maintain manual neutral in-line immobilization. You must check the related statement under "Critical Criteria" and document your rationale. On the other hand, if the assistant accidentally releases immobilization without an order, you should direct the assistant to again take manual in-line immobilization. Immediately, inform the candidate that this action will not affect his/her evaluation. At no time should you allow the candidate or assistant EMT to perform a procedure which would actually injure the simulated patient

This station requires the presence of a simulated victim. The victim should be briefed on his/her role in this station and act as a calm patient would if this were a real situation. The victim should be an adult of average height and weight. You may use comments from the simulated victim about spinal movement and overall care to assist you with the evaluation process after the candidate completes their performance and exits the testing station.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to provide spinal immobilization on a patient using a long spine immobilization device. You arrive on the scene with an EMT assistant. The assistant has completed the scene size-up as well as the initial assessment and no critical condition was found which would require intervention. For the purpose of this testing station, the patient's vital signs remain stable. You are required to treat the specific problem of an unstable spine using a long spine immobilization device. When moving the patient to the device, you should use the help of the assistant EMT and the evaluator. The assistant should control the head and secure the cervical spine of the patient while you and the evaluator move the patient to the immobilization device. You are responsible for proper direction of the assistant. You may use any equipment available in this room. You have ten (10) minutes to complete this station.

Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Splinting Long Bone

Instructions to the Evaluator

This station is designed to test the candidate's ability to use various splints and splinting materials to properly immobilize specific musculoskeletal injuries. The candidate is tested on his/her ability to properly immobilize a swollen, deformed extremity using a rigid splint. The candidate will be advised that a scene size-up and initial assessment have been completed on the victim and that during the focused assessment a deformity of a long bone was detected. The victim will present with a non-angulated, closed, long bone injury of the upper or lower extremity - specifically an injury of the radius, ulna, tibia, fibula, or humerus. You may choose the extremity, but it should be consistent throughout the testing procedure.

The candidate will then be required to treat the specific, isolated extremity injury. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required at this testing station. The candidate will be required to assess motor, sensory and circulatory function in the injured extremity prior to applying the splint and after completing the splinting process. Additionally, the use of traction splints, pneumatic splints, and vacuum splints is not permitted and these splints should not be available for use.

The candidate is required to "secure entire injured extremity" after the splint has been applied. There are various methods of accomplishing this particular task. Long bone injuries of the upper extremity may be secured to the torso after a splint is applied. Long bone injuries of the lower extremity may be secured by placing the victim properly on a long spine board or applying a rigid long board splint between the victim's legs and then securing the legs together. Any of these methods should be considered acceptable and points should be awarded accordingly.

When splinting the extremity, the candidate is required to immobilize the associated hand or foot in the position of function.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a closed, non-angulated long bone injury. You are required to treat only the specific, isolated injury to the extremity. The scene size-up and initial assessment have been completed and during the focused assessment a closed, non-angulated injury of the _____ (radius, ulna, tibia, fibula, humerus) was detected. Ongoing assessment of the patient's airway, breathing, and central circulation is not necessary. You may use any equipment available in this room. You have (5) five minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Splinting Joint

Instructions to the Evaluator

The candidate is tested on his/her ability to properly immobilize a joint injury using a sling and swathe. The candidate will be advised that a scene size-up and initial assessment have been completed and that during the focused assessment a joint injury is detected. The victim will present with the extremity positioned at the side. For an elbow or shoulder, have the patient support the lower arm at a 90 degree angle across his/her chest with the uninjured hand. For a knee, have the patient seated on the ground upright with legs extended forward. For this station, the injured extremity should not be positioned away from the body, behind the body, or any position that could not be immobilized by a simple sling and swathe.

The candidate will be required to treat only the specific, isolated injury. Initial and ongoing assessments of the patient's airway, breathing and central circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in the injured extremity prior to splint application and after completing the splinting process.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a non-complicated joint injury. You are required to treat only the specific, isolated injury. The scene size-up and initial assessment have been accomplished on the victim and during the focused assessment a _____ (elbow, knee, ankle, shoulder) injury was detected. Ongoing assessment of the patient's airway, breathing and central circulation is not necessary. You may use any equipment available in this room. You have (5) five minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Traction Splint

Instructions to the Evaluator

The candidate is tested on his/her ability to properly immobilize a mid-shaft femur injury using a traction splint. The candidate will be advised that a scene size-up and initial assessment has been completed and that during a focused assessment a mid-shaft femur injury was detected. The victim will present with a closed, non-angulated, mid-shaft femur injury. The victim will be found laying supine with both legs fully extended. The femur deformity should be an isolated injury with no complicating factors that would concern or distract the candidate.

The candidate will be required to treat only the specific, isolated femur injury. Initial and ongoing assessments of the patient's airway breathing and central circulation are not required at this testing station. The candidate will be required to check motor, sensory and circulatory function in the injured extremity prior to splint application and after completing the splinting process.

There should be various types of traction splints at this testing station--specifically traction splints commonly used in the local EMS system, a bipolar traction splint, and a unipolar traction splint. Carefully note the comments listed on the evaluation form for unipolar versus bipolar splint application.

This requires that an assistant EMT be present during testing. Candidates are to be tested individually. All assisting EMTs should be told not to speak but to follow the commands of the candidate. The candidate is responsible for the conduct of the assisting EMT. If the assisting EMT is instructed to provide improper care, areas on the score sheet relating to that care should be deducted. At no time should you allow the candidate or assisting EMT to perform a procedure that would actually injure the simulated victim.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to properly immobilize a mid-shaft femur injury with a traction splint. You will have an EMT assistant to help you in the application of the device by applying manual traction when directed to do so. You are required to treat only the specific, isolated injury to the femur. The scene size-up and initial assessment have been accomplished on the victim and during the focused assessment a mid-shaft femur deformity was detected. Ongoing assessment of the patient's airway, breathing, and central circulation is not necessary. You may use any equipment available in this room. You have (10) ten minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES -Bleeding Control/Shock

Instructions to the Evaluator

This station is designed to test the candidate's ability to appropriately treat a life threatening hemorrhage and subsequent hypoperfusion. This station will be scenario based and will require some dialogue between you and the candidate. The candidate will be required to properly treat a life threatening hemorrhage.

The victim will present with an arterial bleed from a severe laceration of the extremity. You will prompt the actions of the candidate at predetermined intervals as indicated on the exam sheet. The candidate will be required to provide the appropriate intervention at each interval when the patient's condition changes. It is essential, due to the purpose of this station, that the patient's condition not deteriorate to a point where CPR would be initiated. This station is not designed to test CPR.

The equipment and supplies needed at this station include field dressings and bandages, a tourniquet, a blanket, an oxygen delivery system (may be a mock-up) and a non-rebreather mask.

Acceptable Practices

While the preference for tourniquet application is to use a commercial tourniquet device, improvised tourniquets are acceptable if properly placed and utilized. Improvised tourniquets should be no less than two inches in width. Triangle bandages and blood pressure cuffs are both acceptable mediums for an improvised tourniquet. If a triangle bandage is used, a torquing device such as a pencil or pen must also be made available. The improvised tourniquet is not properly placed unless the torquing device is also utilized. They should be placed approximately 2 inches above the wound. Once a tourniquet is placed, it should not be removed until the scenario is over. Removal of the tourniquet during the scenario will result in a critical fail under the category "uses or orders dangerous or inappropriate intervention." Successful tourniquet placement occurs when the distal pulse is absent and "bleeding ceases."

Due to the scenario format of this station, you are required to prompt the candidate at various times during the exam. When the bleeding is initially managed with a pressure dressing and bandage, you should inform the candidate that the wound is still bleeding. If the candidate places a second pressure dressing over the first, you should again inform him/her that the wound continues to bleed. After the candidate appropriately applies a tourniquet to control the hemorrhage, you should inform him/her that

the bleeding is controlled. Once the bleeding is controlled, you should indicate to the candidate that the victim is in a hypoperfused state by indicating signs and symptoms appropriate for this level of shock (example: cool clammy skin, restlessness, BP 110/80, P 118, R 30).

Controversy exists in the national EMS community concerning the removal of dressings by EMTs when controlling hemorrhage. This station does not require the EMT to remove any dressing once applied. If the candidate chooses to remove the initial dressing to apply direct finger tip pressure, you should award the point for "**applies an additional dressing to the wound**" since this is an acceptable alternative method to control bleeding when the application of an initial pressure dressing fails to stop the flow of blood.

This station requires the presence of a simulated victim. The victim may be an appropriate mannequin or a live person. If used, the mannequin must be a hard shell and anatomically accurate.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Instructions to the Candidate

This station is designed to test your ability to control hemorrhage. This is a scenario based testing station. As you progress through the scenario, you will be given various signs and symptoms appropriate for the patient's condition. You will be required to manage the patient based on these signs and symptoms. A scenario will be read aloud to you and you will be given an opportunity to ask clarifying questions about the scenario, however, you will not receive answers to any questions about the actual steps of the procedures to be performed. You may use any of the supplies and equipment available in this room. You have (10) ten minutes to complete this station. Do you have any questions?

Scenario

You respond to a stabbing and find a 25 year old male victim. Upon examination you find a two (2) inch stab wound to the inside of the right arm at the anterior elbow crease (antecubital fascia). Bright red blood is spurting from the wound. The scene is safe and the patient is responsive and alert. His airway is open and he is breathing adequately. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES –Oxygen Preparation and Application

Instructions to the Evaluator

This station is designed to test the candidate's ability to correctly assemble the equipment needed to administer supplemental oxygen in the pre-hospital setting. The candidate will be required to assemble the oxygen delivery system. During this procedure, the candidate must check the tank/regulator for leaks. If a leak is found and not corrected, you should record a '0' in the points awarded column, and check the critical criteria.

The candidate should administer correct oxygen liter flow to a patient using a non-rebreather mask. The candidate will be informed that the patient does not tolerate a non-rebreather mask and will be instructed to administer oxygen using a nasal cannula.

Oxygen liter flow rates are normally established according to the patient history and patient condition. Since this is an isolated skills test, liter flow rates of greater than 12 liters/minute for the non-rebreather and less than six (6) liters/minute for the nasal cannula are acceptable.

The candidate will be required to discontinue oxygen therapy including relieving all pressure from the oxygen tank regulator.

The equipment need at this station includes an oxygen tank, a regulator with a flow meter, a non-rebreather mask, and a nasal cannula. The oxygen tank at this station must be fully pressurized (air or oxygen) and the regulator/flow meter must be functional. The simulated patient for this station may be a live person or mannequin. If a mannequin is used it must have anatomically correct ears, nose and mouth.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel."

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Due to the nature of this station, infection control measures must be enforced.

You should observe the candidate ventilating the mannequin for a period of 30 seconds. During this time you should pay close attention to volumes. If you observe one ventilation error or less in 30 seconds (volume only) you should award one (1) point. No points should be awarded if you observe two or more ventilation errors in 30 seconds.

Instructions to the Candidate

This station is designed to test your ability to correctly assemble the equipment needed to administer supplemental oxygen in the pre-hospital setting. This is an isolated skills test. You will be required to assemble an oxygen tank and a regulator and administer oxygen to a patient using a non-rebreather mask. At this point you will be instructed to discontinue oxygen administration by the non-rebreather mask and

start oxygen administration using a nasal cannula because the patient cannot tolerate the mask. Once you have initiated oxygen administration using a nasal cannula, you will be instructed to discontinue oxygen administration completely. You may use only the equipment available in this room. You have five (5) minutes to complete this station. Do you have any questions?

PSYCHOMOTOR EXAM GUIDELINES – *Ventilation and Airway Management for Apneic Patient*

Instructions to the Evaluator

This station is designed to test the candidate's ability to effectively ventilate a patient with supplemental oxygen using a bag valve mask technique. The candidate is to be advised that the patient is apneic and has a central pulse. Upon entering the skill station, the candidate with be required to suction the patient and place an oral adjunct appropriately. When ventilating the patient the candidate must provide adequate volume per breath, this should produce visible rise and fall of the chest.

This station requires a mannequin that is capable of being ventilated so that the evaluator can observe the chest rise and call with each ventilation. The equipment need at this station includes an oxygen tank, a regulator with a flow meter, rigid suctioning device, OP airway and a bag valve mask with appropriate mask (adult size) and tubing. The oxygen tank at this station must be fully pressurized (air or oxygen) and the regulator/flow meter must be functional.

AFFECTIVE DOMAIN - measure of candidate's attitudes, behaviors, and professional attributes when providing patient care in the examination setting. Any failure for a critical criteria relating to affective domain should be based upon a clearly defined "offensive" observations by the evaluator and not just "unreasonable" behaviors.

As a guide, but not intended to be exclusive:

"Exhibits unacceptable affect with patient or other personnel"

Lack of INTEGRITY. Cheating, lying, and/or deliberate disrespectful/insubordinate behavior.

Lack of EMPATHY. Deliberate over-bearing or belligerent behavior or repeatedly stepping over the patient.

Lack of PROFESSIONAL APPEARANCE AND PERSONAL HYGIENE to the extent that detracts from the candidate's performance such as inappropriately fitting clothing or poor personal hygiene.

Lack of RESPECT. Deliberate demeaning terms or derogatory language.

"Failure to manage the patient as a competent EMT"

Lack of TEAMWORK AND DIPLOMACY to the extent that the overall treatment effort results in failure to adequately manage the patient.

Lack of COMMUNICATION. Failure to communicate with simulated patient clearly or patient care strategies that are not clearly relayed to other assistants (such as failure to order an organized log roll attempt in a spinal immobilization).

For further guidance, see the complete explanation in the Scoring section of the EMS training manual.

Due to the nature of this station, infection control measures must be enforced.

You should observe the candidate ventilating the mannequin for a period of 30 seconds. During this time you should pay close attention to volumes. If you observe one ventilation error or less in 30 seconds (volume only) you should award one (1) point. No points should be awarded if you observe two or more ventilation errors in 30 seconds.

Instructions to the Candidate

Ventilation and Airway Management for Apneic Patient

This station is designed to test your ability to effectively ventilate a patient with supplemental oxygen using a bag valve mask technique. The patient management required is suctioning of the patient, placement of an oral adjunct and ventilatory support using a bag valve mask technique with supplemental oxygen. You must ventilate the patient for at least 30 seconds. You will be evaluated on the appropriateness of ventilatory volumes. You may use any equipment available in this room. You have five (5) minutes to complete this station.

Do you have any questions?