



NATIONAL CONTINUED COMPETENCY PROGRAM

AEMT EDUCATION UPDATE



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

Revised October 1, 2016

Table of Contents

Airway, Respiration, & Ventilation	4
• Ventilation	4
• Ventilation Skills	6
• Oxygenation	7
• Oxygenation Skills	8
Cardiovascular	9
• Post-Resuscitation Care	9
• Post-Resuscitation Skills	10
• Ventricular Assist Devices	11
• VAD Skills	11
• Stroke	12
• Stroke Skills	13
• Cardiac Arrest	14
• Cardiac Arrest Skills	15
• Pediatric Cardiac Arrest	16
• Pediatric Cardiac Skills	17
• Acute Coronary Syndrome	18
• ACS Skills	18
Trauma	19
• Trauma Triage	19
• Trauma Triage Skills	20
• Central Nervous System (CNS) Injury	21
• CNS Skills	22
• Hemorrhage	23
• Hemorrhage Skills	24
• Fluid Resuscitation	25
• Fluid Resuscitation Skills	25
Medical	26
• Special Healthcare Needs	26
• Special Healthcare Needs Skills	29
• OB Emergencies	30
• OB Skills	32
• Infectious Disease	33
• Infectious Disease Skills	34
• Medication Delivery	35
• Medication Delivery Skills	35
• Pain Management	36
• Pain Management Skills	37
• Psychiatric and Behavioral Emergencies	38
• Psychiatric and Behavioral Skills	41
• Toxicological – Opioids Emergencies	42
• Toxicological Skills	44
• Neurological Emergencies- Seizures	45
• Neurological/Seizures Skills	46
• Endocrine Emergencies- Diabetes	47

• Endocrine Emergencies/ Diabetes Skills	49
• Immunological Emergencies,	
• Allergic Reaction & Anaphylaxis	50
• Immunological Emergencies Skills	51
Operations	52
• At Risk Population	52
• At Risk Population Skills	53
• Ambulance Safety	54
• Ambulance Safety Skills	56
• Field Triage- Disasters/MCIs	57
• Field Triage Skills	58
• Provider Hygiene, Safety, and Vaccinations	59
• Hygiene Skills	60
• Culture of Safety	61
• Culture of Safety Skills	62
• Pediatric Transport	63
• Pediatric Transport Skills	64
• Crew Resource Management	65
• Crew Resource Management Skills	67
• EMS Research	68
• EMS Research Skills	68
• Evidence Based Guidelines	69
• Evidence Based Guideline Skills	70
References	71



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION

ADVANCED EMTS

AIRWAY, RESPIRATION, & VENTILATION

VENTILATION

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION 2 HOURS

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- Review relevant material in an AEMT text
- Review current AHA Guidelines
- Assemble skills laboratory materials:
 - Airway management trainer
 - Bag Valve Mask Resuscitator and assorted masks
 - Oropharyngeal Airways and tongue blades
 - Nasopharyngeal Airways
 - Airway devices
 - Oxygen or simulated oxygen/compressed air source
 - Suction unit with catheters and tubing
 - Airway skills evaluation form

LEARNING OBJECTIVES

- Differentiate between adequate and inadequate breathing
- Differentiate between respiratory distress and respiratory failure
- Explain when to oxygenate and when to ventilate a patient
- Discuss the AHA's position on routine suctioning of the newborn
- Demonstrate effective bag-valve-mask ventilation at a proper rate and depth

LESSON CONTENT

- I. Adequate and inadequate breathing
 - a. Must have an adequate minute ventilation (adequate rate AND adequate tidal volume)
 - b. Inadequate breathing requires immediate management with positive pressure ventilation.
 - i. Inadequate breathing is caused by
 1. An inadequate tidal volume
 2. An inadequate rate
 3. A combination of both
 - c. Adequate breathing does not require positive pressure ventilation
- II. Effect of ventilation on venous return and cardiac output
 - a. In the normal patient, the negative pressure that causes inhalation facilitates venous return necessary for adequate cardiac output and perfusion.
 - i. Cardiac output is the amount of blood ejected from the left ventricle in one minute
 - ii. Cardiac output = stroke volume x heart rate
 1. Stroke volume = amount of blood ejected from the left ventricle with each contraction
 2. Heart rate = number of times the heart contracts in one minute
 - iii. Negative pressure during inhalation allows venous blood return to the right side of the heart, which is necessary for adequate cardiac output
 - b. Artificial ventilation pushes air into the chest (positive pressure ventilation) increasing intrathoracic pressure
 - i. [1“Death by Hyperventilation: A Common and Life-threatening Problem During Cardiopulmonary Resuscitation”](#)
 - ii. Increases in intrathoracic pressure impedes venous blood return to the right side of the heart
 - iii. Excessive ventilation rates during positive pressure ventilation

1. Decreases cardiac output
2. Decreases vital organ perfusion
- iv. For adults, artificial ventilatory rates greater than 12 times per minute (one ventilation every 5-6 seconds) decrease cardiac output and perfusion
 1. Do not exceed a ventilatory rate of 10-12 times per minute (one ventilation every 5-6 seconds).
 2. High artificial ventilatory rates (greater than 12 times per minute, one breath every 5-6 seconds) result in poor patient outcomes

III. Respiratory distress vs. failure

- a. Respiratory conditions are dynamic
 - i. Range from minor respiratory distress to respiratory arrest
 - ii. Can be acute, chronic, or chronic with acute exacerbation
 - iii. Signs/symptoms are dynamic and may change over time depending on the state of patient's disease process
- b. Many patients with respiratory diseases need only comfort care
- c. Important to know when exactly to provide an intervention (such as artificial ventilation) in order to increase the likelihood of patient improvement
- d. In respiratory failure, inadequate alveolar ventilation exhibited by
 - i. Decrease in or excessively high respiratory rate
 1. Reduces tidal volume and amount of air available for alveolar gas exchange
 - ii. Decrease in tidal volume (or both)
 - iii. Patients in respiratory failure are severely ill
- e. Must recognize the transition of a respiratory disease from distress to failure
 - i. Deterioration in mental status, confusion, loss of gag reflex
 - ii. Accessory muscle use, head bobbing, grunting, nasal flaring
 - iii. Decrease in SpO₂
 - iv. Cyanosis
 - v. Hypercarbia

IV. Airway adjuncts

- a. Oropharyngeal (OPA)
 - i. Indications
 1. Respiratory distress/failure
 2. Unconscious, unresponsive patient
 - ii. Contraindications
 1. Gag reflex
 2. Presence of oral trauma (broken teeth, recent oral surgery, etc.)
- b. Nasopharyngeal (NPA)
 - i. Indications
 1. Respiratory distress/failure
 - ii. Contraindications
 1. Presence of head, facial trauma
 2. Presence of skull fracture
- c. Supraglottic
 - i. Examples
 1. Laryngeal mask airway (e.g., LMA™)
 2. Esophageal-tracheal tube (e.g., Combitube™)
 3. Laryngeal tube (e.g., King LT™)
 4. I-Gel™
 - ii. Advantages
 1. Does not require visualization of the glottis (blind insertion)

	<ol style="list-style-type: none"> 2. Initial training and maintenance of skills are easier 3. Chest compressions do not need to be interrupted to insert 4. Minimal equipment required for insertion
	<ol style="list-style-type: none"> iii. Disadvantages <ol style="list-style-type: none"> 1. Contraindicated in patients with a gag reflex 2. Some devices contraindicated in patients at risk for regurgitation which can lead to aspiration (e.g., LMA™) 3. Unrecognized improper placement can occur 4. Additional contraindications common per local protocol
V.	Positioning of the pediatric patient for artificial ventilation <ol style="list-style-type: none"> a. Sniffing position b. Pad behind shoulders
VI.	Newborn care – suctioning the airway <ol style="list-style-type: none"> a. Suctioning the airway in the newborn may cause bradycardia b. Suctioning immediately following birth (including the use of a bulb syringe) should only be done in newborns who have an obvious obstruction to spontaneous breathing or who require positive pressure ventilation c. Presence of meconium does not necessarily require suctioning <ol style="list-style-type: none"> i. Review AHA Guidelines <ol style="list-style-type: none"> 1. Do not suction if newborn exhibits vigorous crying/respirations 2. Suction if newborn exhibits respiratory compromise/distress

AEMT VENTILATION SKILLS	Successful	Unsuccessful
1. Place an OPA		
2. Ventilate an apneic patient (simulated)		
a. Minimum of two minutes		
b. Maintain a mask seal		
c. Appropriate rate (10-12 breaths/min)		
d. Appropriate volume for patient size		
e. Monitor chest rise		
f. No insufflation of stomach, if applicable		
3. Suction the upper airway		
4. Insert appropriately sized supraglottic airway in pediatric patient		
The adjunct and ventilation skills should be practiced as a simulation case. A scenario should be presented which requires the learner to differentiate between a patient that requires supplemental oxygenation and one that requires ventilation.		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

AIRWAY, RESPIRATION, & VENTILATION

OXYGENATION

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- Assemble skills laboratory materials:
 - Airway management trainer
 - Oxygen cylinder and regulator
 - Nasal Cannula
 - Non-rebreather mask
 - Oxygen therapy skills evaluation form

LESSON OBJECTIVES

- Analyze physiology related to oxygen transport and metabolism
- Identify the AHA's guidelines on oxygen therapy in the post cardiac arrest, acute coronary syndrome and stroke patient
- Discuss the role of free radicals related to oxygen therapy

LESSON CONTENT

- I. AHA Guidelines now recommend that patients with suspected acute coronary syndrome (ACS) or stroke not receive oxygen unless
 - a. SpO₂ less than 94% (on room air)
 - i. If pulse oximeter is unreliable or not available, oxygen should be administered
 - b. Presenting with dyspnea
 - c. Has signs and symptoms of shock or heart failure
- II. Oxygenation of chest pain and stroke patients
 - a. 2 L/min via nasal cannula for patients who
 - i. Complain of dyspnea
 - ii. Experience signs and symptoms of shock
 - iii. Experience heart failure
 - iv. Have an SpO₂ of less than 94% (on room air)
 - b. Titrate oxygen to maintain an SpO₂ of at least 94%
- III. Tissue damage may increase
 - a. When high concentrations of oxygen are given to ACS and stroke patient
 - i. Oxygen releases "free radicals;" therefore, it is no longer recommended
 - ii. Free radicals
 1. Byproducts of metabolism
 2. Toxic to neighboring cells
 - a. Destroys their membranes
 - b. Causes increased local tissue damage
 - iii. Reintroducing high concentrations of oxygen to cells that have been functioning anaerobically increases the production of free radicals causing cell membrane damage and tissue death
 - b. Delivering high concentrations of oxygen to ACS and Stroke patients may be more harmful than keeping the patient on room air

AEMT OXYGENATION SKILLS	Successful	Unsuccessful
1. Demonstrate safe handling of oxygen cylinders		
2. Assemble and disassemble a portable oxygen cylinder		
3. Determine full and empty/residual PSIs		
4. Apply nasal cannula to live or simulated patient		



INSTRUCTOR PREPARATIONS

- Review *National EMS Education Standards*
- Review current AHA Guidelines

LESSON OBJECTIVES

- Identify the signs associated with Return of Spontaneous Circulation (ROSC)
- Effectively manage hemodynamic instability
- Investigate possible causes of cardiac arrest
 - Make appropriate treatment choices based on the cause
 - Determine the appropriate destination
- Describe the process of induced hypothermia

LESSON CONTENT

- I. Recognition of Return of Spontaneous Circulation (ROSC)
 - a. CPR must be continued until signs of life are observed
 - i. Presence a pulse after an organized rhythm is observed
 - ii. Patient breathing
 - iii. Patient movement
- II. Optimizing ventilation and oxygenation in the post cardiac arrest patient
 - a. Maintain an SpO₂ of greater than or equal to 94%
 - i. Once your patient's SpO₂ is 94%, more oxygen is not necessarily better
 - b. Avoid excessive ventilation (over-bagging)
 - i. Reduces cardiac output
 - ii. Decreases cerebral blood flow
- III. Hemodynamic instability in the post-cardiac arrest patient
 - a. Monitor vital signs
 - b. Ensure vascular access
 - c. Monitor and manage cardiac hemodynamics
 - i. Hypotension – Systolic BP less than 90mm/Hg
 1. Fluid bolus
- IV. Targeted temperature management in post-cardiac arrest patients
 - a. Shown to increase the favorable neurological outcome in patients with ROSC
 - b. Lowering and controlling core temperature slows cellular metabolism
 - i. Reduces cell damage and death
 - c. Intentional reduction of core body temperature can be accomplished by application of cold packs to the axilla, groin, and neck
 - d. The 2015 AHA Guidelines specifically recommend against the routine out-of-hospital cooling of patients with ROSC. Commonly this is done through rapid infusion of cold intravenous fluids which has been demonstrated to have adverse effects.
- V. System of care to ensure coronary reperfusion
 - a. Most deaths following ROSC occur within the first 24 hours
 - b. Transport to the most appropriate facility
 - i. May include transport or transfer to an alternate facility, such as:
 1. STEMI/PCI Center
 2. Cardiac Center
 3. Therapeutic Hypothermia Centers

AEMT POST RESUSCITATION SKILLS	none
---------------------------------------	------



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

CARDIOVASCULAR
VENTRICULAR ASSIST DEVICES

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*

LESSON OBJECTIVES

- Understand the function of ventricular assist devices (VAD)

LESSON CONTENT

- I. Ventricular Assist Devices (VADs)
 - a. A mechanical device that is placed inside a person's chest, where it helps the heart pump oxygen-rich blood throughout the body.
 - i. Implanted in heart failure patients
 - ii. Replaces the function of the ventricles in circulating blood
 - iii. Sometimes implanted as a temporary treatment, and sometimes used as a permanent solution to very low cardiac output
- II. Assessment
 - a. Initial assessment remains the same
 - b. Most VADs produce continuous flow, therefore these patients may not have a palpable pulse, or measurable blood pressure
 - c. Attempt to auscultate over the left chest for a “whirling” or “smooth, humming” sound indicating that the VAD is working
 - d. SpO₂ readings may be inaccurate because of a weak or absent pulse
 - e. Mental status and skin findings are most helpful with assessment of perfusion
 - f. A cable exits the abdominal wall that connects the device to power and the control unit
 - g. Many VAD patients also have an implanted cardiac defibrillator (ICD)
 - h. Many hospital admissions in VAD patients are secondary to infection, not cardiac problems. Assess for signs of infection (especially at the insertion point) or sepsis
 - i. Your patient and family members will be knowledgeable on the device
 - j. The patient and/or family will have an identification card that has contact information for the VAD coordinator (contact VAD coordinator for assistance with device)
 - k. Review local protocol for transport destination
- III. Management
 - a. Allow the patient and caregiver to guide your interaction with the device
 - b. Keep batteries and controller within reach and secured to the patient
 - c. Use caution when cutting and removing clothes, to avoid damaging the device
 - d. Verify if chest compressions are indicated with the patient’s specific device
 - i. Consult family
 - ii. View VAD identification card
 - iii. Consult with VAD coordinator

AEMT VAD SKILLS

none



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- Review current AHA Guidelines
- [³American Heart/Stroke Association—FAST](#)

LESSON OBJECTIVES

- Identify the options for out-of-hospital stroke assessment tools
- Explain oxygen administration during a stroke emergency
- Discuss the importance of knowing a timeline of stroke events
- Identify patients needing rapid transport to the most appropriate stroke hospital
- Discuss the importance of starting the fibrinolytics check sheet

LESSON CONTENT

- I. Stroke
 - a. Definitive care for the stroke patient is delivered at a hospital that specializes in the management for stroke patients. Optimal out-of-hospital care for the stroke patient is recognition and rapid transport.
 - b. Evaluate blood glucose levels
 - i. Treat only if hypoglycemic, in accordance with local protocols
 - ii. Hyperglycemia is associated with a poor clinical outcome
 - iii. Hypoglycemia may mimic stroke
 - c. Pediatric strokes, while rare, do happen
- II. Out-of-hospital stroke assessment tool
 - a. Specific tool used will be determined by local protocol
 - i. Examples include
 1. [Cincinnati Prehospital Stroke Scale, 1999](#)
 2. [Los Angeles Prehospital Stroke Screen-LAPSS, 2000](#)
 3. [Miami Emergency Neurologic Deficit Checklist, 2001](#)
 - b. Signs and Symptoms assessed by these tools
 - i. Symmetry of the face
 - ii. Weakness of extremities
 - iii. Speech difficulties
 - iv. Coordination
 - c. Communicate assessment findings to the hospital while en route
 - i. Allows for early activation of the stroke team
- III. Management of stroke patients
 - a. Provide supportive care
 - b. Maintain an SpO₂ of 94% to 99% to avoid oxygen toxicity
 - i. Consider 2 L/min O₂ via nasal cannula instead of O₂ via high flow mask
 1. High flow oxygen decreases cerebral blood flow
 2. High levels of oxygen produce free-radicals
 - a. May cause cerebral edema and vasodilation
 - c. Rapid transport to an appropriate receiving facility
- IV. Importance of accurately determining the time that the patient was last seen normal
 - a. Some strokes are treated with fibrinolytics (tPA) which has a limited therapeutic window
 - b. Some strokes are treated with endovascular interventions
 - i. Angioplasty and stenting

- | |
|--|
| ii. Mechanical clot disruption
iii. Clot extraction |
|--|

AEMT STROKE SKILLS

none



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS
CARDIOVASCULAR
CARDIAC ARREST

ADULT PATIENTS: EXPECTED DURATION 2 HOURS

INSTRUCTOR PREPARATIONS

- Review the *National EMS Education Standards*
- Review current AHA Guidelines

LESSON OBJECTIVES

- State the chain of survival
- Describe the current techniques of one and two-rescuer CPR
- Demonstrate the current techniques of one and two-rescuer CPR

LESSON CONTENT

- I. Chain of survival
 - a. There are 5 links in the adult Chain of Survival
 - i. Immediate recognition of cardiac arrest and activation of the emergency response system
 - ii. Early cardiopulmonary resuscitation (CPR) with an emphasis on chest compressions
 - iii. Rapid defibrillation
 - iv. Effective advanced life support
 - v. Integrated post-cardiac arrest care
 - b. A strong chain of survival can improve chances of survival and recovery for victims of heart attack, stroke, and other emergencies.
- II. Optimal chest compressions
 - a. Compress at a rate of 100 – 120/min
 - b. The number of compressions per minute is an important determinant of return of spontaneous circulation and good neurological outcomes
 - c. Heel of one hand over the center of the patient's chest (lower half of the sternum) and the heel of the other hand over the first so the hands are overlapped and parallel
 - d. Compress at least 2 inches but no more than 2.4 inches (5 cm)
 - i. Shallow compressions are associated with lower cardiac arrest survival
 - e. Do not compress more than 2.4 inches (6 cm)
 - i. Non-life threatening injuries may occur
 - f. Allow complete recoil of chest between compressions
 - g. Minimize interruption
 - i. Ventilation/Compression Ratio
 1. 2 breaths after every 30 compressions if no advanced airway is in place
 2. 1 breath every 6 seconds with continuous compressions if an advanced airway is present
 3. Each breath should take about 1 second
 4. Ventilate with enough volume to observe chest rise
 - h. High performance CPR
 - i. Coordinated manner with other practitioners (e.g., pit crew CPR)
 - ii. Function as a team, including team training
 - i. Mechanical CPR devices
 - i. Per AHA Guidelines, there is no clear benefit on the use of mechanical CPR devices vs. manual chest compressions in patients with cardiac arrest; however, mechanical compression devices should be considered in settings where compressions may be challenging or dangerous for a provider (e.g., in

an ambulance during transport).

AEMT CARDIAC ARREST SKILLS	Successful	Unsuccessful
1. Assess patient breathing and responsiveness simultaneously		
2. Assess patient carotid pulse		
3. Perform chest compressions adequately		
4. Demonstrate proper application and utilization of an AED		
5. Apply AED pads correctly on a pregnant patient		
6. Utilize crew resource management techniques		
a. Switch CPR every two minutes		
b. Pit Crew CPR		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

CARDIOVASCULAR

PEDIATRIC CARDIAC ARREST

PEDIATRIC PATIENTS: EXPECTED DURATION 2 HOURS

INSTRUCTOR PREPARATIONS

- Review the *National EMS Education Standards*
- Review current AHA Guidelines

LESSON OBJECTIVES

- Describe the current techniques of one and two-rescuer CPR
- Demonstrate the current techniques of one and two-rescuer CPR

LESSON CONTENT

- I. Techniques of single rescuer CPR
 - a. Infant (less than one year of age)
 - i. 2-fingers just below the inter-mammary (nipple) line
 - ii. 100 – 120 compressions per minute
 1. Number of compressions per minute is an important determinant of return of spontaneous circulation and good neurological outcomes
 - iii. Compress 1/3 the anterior-posterior diameter of the chest (about 1 ½ inches)
 - iv. Allow complete recoil of chest between compressions
 - v. Minimize interruption
 - vi. Ventilation/Compression Ratio
 1. Resuscitation outcomes in infants and children are best if compressions are combined with ventilations
 2. Two breaths after every 30 compressions
 3. Ventilate with only enough volume to observe chest rise
 - b. Child (1 year of age until onset of puberty)
 - i. 100 – 120 compressions per minute
 - ii. Use one or two hands on the lower half of the sternum
 - iii. Compress 1/3 the anterior-posterior diameter of the chest (approximately 2 inches)
 - iv. Allow complete recoil of chest between compressions
 - v. Minimize interruption
 - vi. Ventilation/Compression Ratio
 1. Resuscitation outcomes in infants and children are best if compressions are combined with ventilations
 2. Two breaths after every 30 compressions
 3. Ventilate with enough volume to observe chest rise
- II. Techniques of 2-Rescuer CPR
 - a. Rescuer fatigue can lead to inadequate rate, depth and recoil in CPR in minutes, even when the rescuer does not feel fatigued
 - b. When performing 2-Rescuer CPR, rotate the rescuer who is performing compressions with the rescuer who is performing ventilations every two minutes.
 - c. Infant (less than one year of age)
 - i. Two thumb encircling hands technique, just below the inter-mammary (nipple) line
 - ii. 100 – 120 compressions per minute
 - iii. 1/3 the anterior-posterior diameter of the chest (about 1 ½ inches)
 - iv. Allow complete recoil of chest between compressions
 - v. Minimize interruption
 - vi. Ventilation/Compression Ratio

1. Compressions combined with ventilations greatly improve infant and children resuscitation outcomes
 2. Two breaths after every 15 compressions
 3. Ventilate with enough volume to see chest rise
- d. Child (one year of age until onset of puberty)
- i. Use one or two hands on the lower half of the sternum
 - ii. 100 – 120 compressions per minute
 - iii. 1/3 the anterior-posterior diameter of the chest (about 2 inches)
 - iv. Allow complete recoil of chest between compressions
 - v. Minimize interruption
- e. Ventilation/Compression Ratio
- i. Compressions combined with ventilations greatly improve infant and children resuscitation outcomes
 - ii. Two breaths after every 15 compressions
 - iii. Ventilate with enough volume to see chest rise

AEMT PEDIATRIC CARDIAC ARREST SKILLS	Successful	Unsuccessful
1. Assess patient breathing and responsiveness simultaneously		
2. Assess patient carotid pulse		
3. Perform chest compressions adequately		
4. Apply and utilize an AED appropriately		
5. Utilize length-based resuscitation tape to determine appropriate defibrillation energy		
6. Utilize crew resource management techniques		
a. Switch CPR every two minutes		
b. Pit Crew CPR		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

CARDIOVASCULAR
ACUTE CORONARY SYNDROME

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION 1 HOUR

INSTRUCTOR PREPARATIONS

- Review *National EMS Education Standards*
- Review current AHA Guidelines

LESSON OBJECTIVES

- Demonstrate the proper placement of 12-lead EKGs
- Assess injury patterns on a 12-lead EKG

LESSON CONTENT

- I. Proper placement of 12-lead EKGs
 - a. V1—right of sternum, 4th intercostal space
 - b. V2—left of sternum, 4th intercostal space
 - c. V3—between V2 and V4
 - d. V4—midclavicular line, 5th intercostal space
 - e. V6—mid-axillary line, 5th intercostal space
 - f. RL—right leg, above ankle, below torso
 - g. RA—right arm, between shoulder and elbow
 - h. LL—left leg, above ankle, below torso
 - i. LA—left arm, between shoulder and elbow
- II. Gain familiarity with injury patterns on a 12-lead EKG
 - a. Review the anatomical view of the heart with each lead
 - b. Provide 12-lead examples that demonstrate STEMI's from each area of the heart
 - c. 12-lead crash course – review abnormal examples

AEMT ACS SKILLS	Successful	Unsuccessful
1. Demonstrate placement of 12-lead EKG		



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ⁴[*CDC—Guidelines for Field Triage of Injured Patients, 2011*](#)

LESSON OBJECTIVES

- Identify the triage criteria in the CDC's Field Triage Decision Scheme
- State the four steps of the CDC's Field Triage Decision Scheme
- Examine local protocols

LESSON CONTENT

- I. CDC Field Triage Decision Scheme
 - a. Reference:
 - i. ⁴[*Guidelines for Field Triage of Injured Patients, 2011*](#)
 - b. Four specific steps to consider during triage
 - i. Step 1—Assess vital signs and level of consciousness; they are good predictors of patient's potential outcomes
 1. Glasgow Coma Scale (GCS)
 2. Systolic blood pressure
 3. Respiratory rate
 - ii. Step 2—Assess anatomy of injury
 1. Consider priority transport to a trauma facility if patient is found with:
 - a. Penetrating injuries above the knee
 - b. Unstable chest wall
 - c. Proximal long bone fractures (two or more)
 - d. Extremity that is crushed, degloved, mangled, or pulseless
 - e. Amputation proximal to wrist or ankle
 - f. Pelvic fractures
 - g. Skull fractures (open or depressed)
 - h. paralysis
 - iii. Step 3—Assess mechanism of injury and evidence of high energy impact
 1. Consider priority transport to a trauma facility if the mechanism of injury (MOI) meets any of the following criteria, despite patient assessment findings in steps 1 and 2
 - a. Falls
 - i. Adults >20 feet
 - ii. Children >10 feet or >2x child's height
 - b. Auto crash
 - i. Intrusion >12 inches where occupied or >18 inches on any side
 - ii. Partial or complete ejection from automobile
 - iii. Death in same automobile
 - iv. Vehicle telemetry data that indicates a high risk of injuries
 - c. Pedestrian/bicyclist vs. automobile
 - i. Thrown
 - ii. Run over
 - iii. Impact at speeds >20 mph
 - d. Motorcycle crash >20 mph

<ul style="list-style-type: none"> iv. Step 4—Assess special patient or system considerations <ul style="list-style-type: none"> 1. Consider priority transport to a trauma facility if patient meets these special considerations: <ul style="list-style-type: none"> a. Older adults <ul style="list-style-type: none"> i. 55 years and older have increased chances of injury/death ii. 65 years and older may present with shock if SBP is <110 iii. Mechanism is low impact (ground height falls) b. Children <ul style="list-style-type: none"> i. Consider transporting all children to pediatric trauma centers c. Anticoagulants and bleeding disorders <ul style="list-style-type: none"> i. Head injuries may present with rapid deterioration d. Burns <ul style="list-style-type: none"> i. No other trauma—triage to burn facility ii. Other trauma findings—triage to trauma center e. Pregnancy >20 weeks f. Use provider judgement
<ul style="list-style-type: none"> II. Transport according to local protocol <ul style="list-style-type: none"> a. When in doubt transport to a trauma center

AEMT TRAUMA TRIAGE ACTIVITY	Successful	Unsuccessful
1. Generate a comparison of local triage protocols to the recommendations of the CDC: http://www.cdc.gov/mmwr/pdf/rr/rr6101.pdf		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

TRAUMA

CENTRAL NERVOUS SYSTEM (CNS) INJURY

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION 1 HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ⁵[EMS Spinal Precautions and the use of the long backboard, 2013](#)
- ⁶[Centers for Disease Control and Prevention: HEADS UP](#)
- See additional resources to research

LESSON OBJECTIVES

- Identify the signs and symptoms of a patient with a traumatic brain injury (TBI)
- Differentiate between the various levels of a TBI
- Discuss the current research and practices for the use of selective spinal immobilization

LESSON CONTENT

- I. Traumatic Brain Injury (TBI)
 - a. Signs and symptoms of TBI may include any or all of the following:
 - i. Physical
 1. Headache
 2. Nausea
 3. Vomiting
 4. Balance problems
 5. Dizziness
 6. Visual problems
 7. Fatigue
 8. Light sensitivity
 9. Noise sensitivity
 10. Numbness/tingling
 - ii. Cognitive
 1. Mental foginess
 2. Feeling slowed down
 3. Difficulty concentrating
 4. Difficulty remembering
 - iii. Emotional
 1. Irritability
 2. Sadness
 3. Heightened emotions
 4. Nervousness
 - iv. Sleep
 1. Drowsiness
 2. Sleeping less than/more than usual
 3. Trouble falling asleep
 - b. Differentiate levels of TBI- (Per ATLS Guidelines, 9th ED)
 - i. GCS Score 13-15 = Minor Brain Injury
 - ii. GCS Score 9-12 = Moderate Brain Injury
 - iii. GCS Score 3-8 = Severe Brain Injury
 - c. Advocate for patient transport and proper patient education about the effects of TBI
 - i. Care And Education of the Concussion Patient
 1. If you suspect your patient has a concussion, transport them to the appropriate facility
 2. If the patient refuses transport, educate them over the following

<p>warning signs and tell them if any are present, to seek medical attention</p> <ol style="list-style-type: none"> a. One pupil larger than the other b. Drowsiness or cannot be awakened c. A headache that gets worse and does not go away d. Weakness, numbness, or decreased coordination e. Repeated vomiting or nausea f. Slurred speech g. Convulsions or seizures h. Difficulty recognizing people or places i. Increasing confusion, restlessness, or agitation <ol style="list-style-type: none"> i. Unusual behavior j. Loss of consciousness (even brief) <p>d. “Return to play” considerations and criteria for sports</p> <ol style="list-style-type: none"> i. ⁷CDC—HEADS UP: “Sports Concussion Policies and Laws” ii. Requires specialized assessments that are usually considered beyond the scope of EMS providers. Consult local protocols and standards of practice <p>e. Discuss the current research and practices for the use of selective spinal immobilization.</p> <ol style="list-style-type: none"> i. ⁵EMS Spinal Precautions and the use of the Long Backboard, 2013 ii. ⁹Resource Document to the Position Statement of the National Association of EMS Physicians and the American College of Surgeons Committee on Trauma, 2014

AEMT CNS SKILLS	none
------------------------	------



INSTRUCTOR PREPARATIONS

- Review the National EMS Education Standards
- ¹⁰[*Pre-hospital Haemostatic Dressings: A Systematic Review*](#)

LESSON OBJECTIVES

- Identify and treat severe hemorrhage.
- Differentiate among indications, effects, and contraindications for the use of:
 - Tourniquets
 - Junctional Tourniquets
 - Hemostatic agents

LESSON CONTENT

- I. Identify severe hemorrhage
 - a. External bleeding that cannot be controlled by direct pressure
- II. Tourniquets
 - a. Indications
 - i. External bleeding from an extremity that cannot be controlled by direct pressure
 - ii. Multiple tourniquets may be required
 - b. Effects
 - i. Correctly applied tourniquets should block arterial blood flow
 1. Confirmed by the absence of a distal pulse
 - c. Contraindications of tourniquet use
 - i. None in an emergency situation
- III. Junctional Tourniquets
 - a. Indications
 - i. Treat wounds that are located in the “junctional” areas of the body – where the extremities meet the torso
 - b. [Committee on Tactical Combat Casualty Care \(CoTCCC\)](#) approved a number of devices for these types of wounds
 - i. Some of these devices have been fielded by the US military for use in combat
 - ii. Their use in the civilian setting has not, as of yet, been defined.
 - iii. Examples include:
 1. SAM Junctional Tourniquet
 2. Combat Ready Clamp
 3. Junctional Emergency Treatment Tool
 - c. Additional references/resources
 - i. [SAM Medical-Junctional Tourniquet \(YouTube\)](#)
 - ii. [Combat Ready Clamp \(YouTube\)](#)
 - iii. [JETT-Junctional Emergency Treatment Tool \(YouTube\)](#)
- IV. Hemostatic agents
 - a. Reference: ¹⁰[*Pre-hospital Haemostatic Dressings: A Systematic Review*](#)
 - b. Types
 - i. Powder that is poured onto the wound
 - ii. Gauze that is impregnated with hemostatic material
 - c. Indications
 - i. Bleeding that cannot be stopped with direct pressure and is located on an area of the body where a tourniquet is not practical.

- | |
|---|
| <p>d. Effects</p> <ul style="list-style-type: none"> i. Enhances clotting when packed appropriately into a wound ii. Once applied, direct pressure must be held for a minimum of three minutes iii. Hemostatic impregnated gauze can be combined with the technique of wound packing for greater effectiveness. Consult local protocol |
|---|

AEMT HEMORRHAGE CONTROL SKILLS	Successful	Unsuccessful
1. Apply a tourniquet		
2. Apply 2 nd and 3 rd tourniquets as appropriate		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

TRAUMA

FLUID RESUSCITATION

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*

LESSON OBJECTIVES

- Explain the concept of permissive hypotension
- Discuss research regarding fluid resuscitation

LESSON CONTENT

- I. Fluid Therapy
 - a. Permissive hypotension - allowing specific patients to experience some degree of hypotension in certain settings.
 - i. The goal of fluid resuscitation is to maintain vital organ perfusion
 - ii. Level of consciousness is an indicator of vital organ perfusion
 - iii. Assessment of the level of consciousness may guide the need for fluid administration
 - iv. Normalization of blood pressure through fluid administration may be harmful and is discouraged
- II. Dangers of excessive crystalloid administration
 - a. Dilution of clotting factors and platelets
 - b. Physical disruption of a clot
 - c. Expanding the area of vascular defect as blood pressure increases
 - d. Enhances red blood cell loss, thus reducing the total oxygen carrying capacity of the blood
 - e. Research
 - i. ¹¹[National Institute of Health: Aggressive Early Crystalloid Resuscitation adversely affects outcomes in adult blunt trauma patients](#)
- III. Discuss and understand local fluid resuscitation protocol

AEMT FLUID RESUSCITATION SKILLS

none



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*

LESSON OBJECTIVES

- Identify common special needs patients seen in EMS
- Relate the role of caregivers of the special needs patient to the EMS professional's patient care
- Describe patient assessment of a special needs patient

LESSON CONTENT

- I. What is a special healthcare need?
 - a. A condition requiring medical management, healthcare intervention, and/or use of specialized services or programs. Health care for individuals with special needs requires attention, adaptation, and accommodative measures beyond what are considered routine
 - b. May include one or more of the following:
 - i. Physical limitations
 - ii. Mental limitations
 - iii. Heightened or decreased sensory attributes
 - iv. Behavioral, cognitive, or emotional impairment
 - c. Originations (not limited to these)
 - i. Congenital
 - ii. Developmental
 - iii. Disease related
 - iv. Post trauma
 - v. Environmental related
 - d. Statistics (see HRSA reference)
 - i. 15.1 percent of children under 18 years of age in the United States
 1. 11.2 million children
 - ii. 23.0 percent of U.S. households with children have at least one child with special health care needs
- II. General considerations when managing a special needs patient
 - a. Maintain and support airway, breathing, and circulation (ABCs)
 - b. Involve parents/caregivers in the assessment and management of care
 - i. Medical history
 - ii. Is the patient acting appropriately?
 - iii. Normal baseline vital signs
 - iv. Medications
 - v. Caregiver's "go bag" or "rescue kit" for the patient
 1. Supplies necessary to manage the patient's special needs
 - c. Speak quietly and calmly
 - d. Employ slower movements and firm, secure contact
 - e. Request that the caregiver accompany EMS when transporting the patient
 - f. Take time to explain your actions
- III. Special considerations and questions when assessing a special needs patient
 - a. Latex allergy (greater incidence, especially in Spina bifida patients)
 - b. Developmental level
 - c. Vision or hearing problems
 - d. Do not assume that a patient with a physical disability is cognitively impaired
 - e. Determine preferred hospital

- IV. Common equipment EMS providers may encounter
- a. Tracheostomy tube
 - i. Surgical opening in the trachea (stoma)
 1. Keep clean and dry
 2. Suction as needed
 - ii. Oxygen delivery
 1. Blow-by
 2. Face mask/non-rebreather mask
 3. BVM
 - a. May need an adapter
 - b. Indwelling central venous catheters
 - i. Can provide nutrition or medications parenterally
 - ii. Potential for infection or occlusion
 - c. Feeding tubes
 - i. Provide nutrition to patients who are unable to eat by mouth
 - ii. Common complications
 1. Infection
 2. Occlusion
 3. Malpositioned/dislodged tube
 4. May need transport to ER for tube replacement
 5. Tube deterioration
 - d. Cerebrospinal fluid (CSF) shunts
 - i. Device used to drain excess CSF from the brain
 - ii. Hydrocephalus
 1. Shunt runs from a ventricle in the brain, under the skin, and down the neck into either the peritoneum of the abdomen or the right atrium
 - iii. Common complications
 1. Brain infection
 2. Obstruction, which may lead to increased ICP
 3. Peritonitis
 - e. Dialysis shunts
 - i. Peritoneal Dialysis
 - ii. Hemodialysis
 1. Fistula
 - iii. Indwelling abdominal catheter
 - iv. Common complications
 1. Catheter infection
 2. Peritonitis
 - f. Urinary Catheters
 - i. Foley catheters
 - ii. Suprapubic catheters
 - g. GI Bags
 - i. Colostomy
 1. Divert stool away from colon or large intestine
 - h. Ileostomy
 - i. Diverts stool from the ileum into an external bag
 - ii. Contents do not pass through large intestine at all
 - iii. Content is liquid or semisoft with green appearance
- V. Cognitive Impairments
- a. Cognitively impaired or non-communicative patients may still be aware of your actions and words.

- b. Despite their apparent age, cognitively impaired patients might still need a caregiver.
 - c. Common difficulties encountered in emergency medicine when dealing with cognitively impaired patients in the EMS setting is obtaining an accurate and complete history.
 - i. Accommodations may be necessary when providing patient care.
 - ii. Allow adequate time for
 - 1. Gathering a history
 - 2. Performing an assessment
 - 3. Patient management procedures
 - 4. Preparing the patient for transport.
- VI. Common Cognitive Impairments
- a. Intellectual developmental disorder
 - i. Generalized disorder appearing before adulthood characterized by significantly impaired cognitive functioning and deficits in 2 or more adaptive behaviors
 - ii. Syndromic mental retardation - intellectual deficits associated with other medical and behavioral signs and symptoms
 - iii. Non-syndromic mental retardation - intellectual deficits that appear without other abnormalities
- VII. Down Syndrome (Down)
- a. A complex of symptoms associated with mental retardation caused by chromosomal abnormalities
 - b. Common physical signs
 - i. Intellectual developmental disorder
 - ii. Decreased muscle tone at birth
 - iii. Upward slanting eyes with small skin folds in the corner
 - iv. Small, abnormally shaped ears
 - v. Flat facial features, small nose
 - vi. Wide, short hands with short fingers
 - vii. Hyperflexibility
 - viii. Known cardiac issues
 - ix. C-spine instability
 - x. Large Tongue
 - xi. Thyroid issues
 - xii. Visual problems
 - xiii. 15-20 times more likely to develop leukemia
 - c. Common mental and social complications
 - i. Wandering or running off
 - ii. Obsessive/compulsive behaviors
 - iii. Stubborn/oppositional behavior
 - iv. Impulsive behavior
 - v. Poor judgment
 - vi. Short attention span
 - vii. Slow learning
- VIII. Cerebral Palsy (CP)
- a. A group of chronic, non-progressive disorders caused by damage to the motor centers of the brain in the early stages of life
 - b. Most of these problems occur in the womb, but can happen any time during the first 2 years of life while the brain is developing
 - c. Characterized by
 - i. Abnormal muscle tone and posture
 - ii. Muscular spasms
 - iii. Hearing and vision problems

<ul style="list-style-type: none"> iv. Seizures v. Some communication difficulty d. Cause is difficult to determine <ul style="list-style-type: none"> i. May be caused by <ul style="list-style-type: none"> 1. Low levels of oxygen 2. Infection 3. Head injury 4. RH incompatibility 5. Infections in the mother (e.g. Rubella, Herpes Simplex) e. Transport assistive devices such as walkers or wheelchairs with the patient f. Do not assume cognitive disability based on physical disability. Many CP patients have normal or mildly decreased cognition. IX. Assessing patients with Autism Spectrum Disorder (ASD) <ul style="list-style-type: none"> a. Know that autistic patients are aware of what is happening b. Explain your actions c. Include caregivers in the assessment d. No sudden movements e. Show the patient what you will do (demonstrate on caregiver if available)

AEMT SPECIAL HC NEEDS SKILLS	none
-------------------------------------	------



INSTRUCTOR PREPARATIONS

- Review *National EMS Education Standards*
- Review current AHA Guidelines

LESSON OBJECTIVES

- Identify abnormal presentations present during childbirth
- Discuss management of a patient with an abnormal presentation during delivery
- Describe a nuchal cord presentation
- Discuss the procedures to take when a nuchal cord is present during delivery
- Recognize the need for neonatal resuscitation during delivery
- Discuss the management principles of neonatal resuscitation
- Describe the routine care of a newborn not requiring resuscitation

LESSON CONTENT

- I. Abnormal Presentations In Childbirth
 - a. Breech
 - i. Buttocks or both feet present first
 - ii. Management
 1. Prompt transport (field delivery is not ideal)
 2. When delivery is unavoidable:
 - a. Support buttock and legs
 - b. Do not pull
 - c. If head does not deliver within 3 minutes
 - i. Arrange for immediate transport
 - ii. Insert gloved hand into the vagina and use your fingers to form a “V” on either side of the infants nose
 - iii. Push the vaginal wall away from the infant’s face
- b. Limb presentation
 - i. One leg or arm protruding from vagina
 - ii. Management
 1. Do not touch the limb
 2. Do not attempt field delivery
 3. Provide supportive care and transport in the knee-chest position
- c. Multiple Births
 - i. More than one fetus
 - ii. Management
 1. Manage as normal delivery, recognizing the need for additional equipment and personnel
- d. Prolapsed Cord
 - i. Umbilical cord presents from the vagina prior to fetus
 - ii. Management
 1. Immediate transport in Trendelenburg or knee-chest position
 2. Insert two fingers of a gloved hand into the vagina to remove pressure off the cord
 3. Keep the cord moist with sterile dressing
 4. Do not attempt to pull the cord or push the cord back into the vagina
- e. Shoulder dystocia
 - i. Shoulders unable to pass beyond pubic symphysis

- ii. “Turtle sign”- head delivers but retracts back into the perineum because the shoulders are trapped.
 - iii. Management
 1. McRoberts maneuver- (buttocks off the end of the bed with thighs flexed upward) and apply firm pressure with your hand above the pubic symphysis
 2. Transport immediately (even if delivery attempt is unsuccessful)
 - f. Nuchal cord
 - i. Cephalic presentation but the umbilical cord is around the neck
 - ii. Common finding during delivery and rarely associated with adverse outcomes
 - iii. Management
 1. Attempt to slip the cord over the infant’s head.
 2. If unable to slip the cord up and over the head, clamp and carefully cut the cord
- II. Neonatal resuscitation
- a. Assessment
 - i. If “yes” is answered to these three questions, the infant stays with the mother, and standard care continues, including maintaining the newborn’s temperature
 1. Full term gestation?
 2. Good muscle tone?
 3. Breathing or crying adequately?
 - ii. If “no” is answered to ANY of the above assessment questions, resuscitation efforts should be attempted in this sequence:
 1. First 30 seconds postpartum
 - a. Dry the infant, then, warm and maintain normal temperature
 - b. Position airway
 - c. Clear secretions
 - d. Stimulate
 2. 30-60 seconds postpartum
 - a. Heart rate below 100 /min or gasping/apnea
 - i. Initiate positive pressure ventilation and monitor SpO₂
 - b. Labored breathing or persistent cyanosis
 - i. Position and clear the airway, monitor SpO₂, supplementary O₂ as needed
 3. After one (1) minute postpartum
 - a. Heart rate >100/min
 - i. Provide post resuscitation care
 - b. Heart rate <100/min
 - i. Check chest movement
 - ii. Correct ventilations as needed
 1. Laryngeal mask or appropriate supraglottic airway
 - c. Heart rate <60/min
 - i. Begin chest compressions coordinated with PPV and 100% O₂
 - ii. Place on ECG monitor
 - iii. Considerations
 1. IO line or emergency umbilical vein cannulation (UVC)
 2. Advanced airway
- III. 2015 AHA/ECC Guidelines for Neonatal Resuscitation when meconium is present:

<ul style="list-style-type: none"> a. Suctioning in the presence of meconium staining <ul style="list-style-type: none"> i. Vigorous neonates with good respiratory effort and muscle tone born through meconium stained amniotic fluid <ul style="list-style-type: none"> 1. Do not benefit from suctioning 2. Should stay with the mother to receive the initial steps of newborn care 3. Gentle clearing of meconium from the mouth and nose with a bulb syringe may be done if necessary ii. Presence of fetal distress, poor muscle tone, respiratory compromise when born through meconium-stained amniotic fluid <ul style="list-style-type: none"> 1. Immediately initiate resuscitation efforts 2. Initiate PPV if heart rate less than 100/min <p>IV. Umbilical Cord Management</p> <ul style="list-style-type: none"> a. Delayed cord clamping <ul style="list-style-type: none"> i. Reference: ¹³American Heart Association-Part 13-Neonatal Resuscitation ii. Wait 30 seconds after delivery to clamp the cord <ul style="list-style-type: none"> 1. Reduces intraventricular hemorrhage 2. Increases blood pressure/blood volume 3. Reduces need for transfusion after birth 4. Reduces necrotizing enterocolitis iii. Adverse findings <ul style="list-style-type: none"> 1. Increased level of bilirubin 	none
AEMT OB SKILLS	none



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ¹⁴[Centers for Disease Control and Prevention](#)

LESSON OBJECTIVES

- Describe drug resistant infections
- State how the transmission of influenza virus (flu) occurs
- Investigate the role of the EMS provider in disease reporting
- Compare an epidemic and pandemic
- Assess the differences between sepsis and septic shock

LESSON CONTENT

- I. Anti-microbial resistance
 - a. Microbes resist the effects of medications/treatments
 - i. Germs are not killed; growth is not stopped
 - b. Difficult to treat
 - c. Anyone is susceptible; some must be more cautious, such as those with:
 - i. Weakened immune systems
 - ii. Open skin wounds
 - iii. Recent surgery
 - iv. Invasive procedures (PICC lines, IVs, in-dwelling catheters, etc.)
 - d. Occurrence
 - i. World-wide
 - ii. Ongoing battles within institutions (hospitals, clinics, etc.)
 - e. Common antibiotic resistant infections
 - i. MRSA
 - ii. VRE
 - iii. VRSA
 - iv. TB
 - v. Clostridium difficile (C-Diff)
- II. Influenza (flu)
 - a. ¹⁵[CDC Information and Statistics](#):
 - i. The combination of influenza and pneumonia is currently the eighth leading cause of death in the U.S.
 - ii. More people die from it than from kidney disease or suicide
 - b. Influenza viruses
 - i. Spread from person to person via
 1. Large-particle respiratory droplet transmission
 - a. Requires close contact between source and recipient persons
 2. Contact with respiratory-droplet contaminated surfaces
 3. Airborne transmission by small-particle residue of evaporated droplets
 - ii. Typical incubation period is 1-4 days (average: 2 days)
 - iii. Contagiousness begins the day before symptoms start and lasts 5-10 days
 - iv. Children may be contagious several days before becoming symptomatic, lasting ten or more days after onset
 - v. Severely immunocompromised persons can shed virus for weeks or months
 - vi. Influenza vaccines
 1. 60% effective (varies with vaccine and flu strain)

2. Selected based on forecasts from CDC
 3. Seasonal flu vaccine is usually trivalent (three component)
 - a. Each component selected to protect one of three main flu viruses
- III. Sepsis and Septic Shock
- a. The body's response to infection.
 - i. Life threatening
 - ii. Tissue damage
 - iii. Organ failure
 - b. Septic shock
 - i. Sepsis with refractory hypotension or signs of hypo perfusion despite adequate fluid resuscitation
 1. End organ dysfunction
 2. Oliguria
 3. Altered mental status
 - c. [SOFA or quick SOFA Score](#) (calculation tool)
 - i. Evaluates for poor outcomes in infected patients based on:
 1. Altered mental status
 2. Respiratory rate
 3. Blood pressure
- IV. Emerging Infectious Diseases
- a. Incidence in humans has increased in past two decades
 - b. Threatens to continue increasing
 - c. Knows no national boundaries
 - d. New infections resulting from changes or evolution of existing organisms
 - e. Known infections spreading to new geographic areas or populations
 - f. Previously unrecognized infections appearing in areas undergoing ecologic transformation
 - g. Past infections reemerging
 - i. Result of antimicrobial resistance in known agents or breakdowns in public health measures



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION

ADVANCED EMTS

MEDICAL

MEDICATION DELIVERY

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION 1 HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- Review Local Protocols

LESSON OBJECTIVES

- Analyze the benefits of intramuscular (IM) administration compared to the subcutaneous (SQ) route
- Critique the delivery of medication with a nasal atomizer to other routes of administration

LESSON CONTENT

- I. Benefits of intramuscular (IM) drug administration over the subcutaneous (SQ) route
 - a. With certain drugs (e.g. epinephrine) IM drug administration is more consistent than SQ in the prehospital setting
 - i. Obese patients
 - ii. Pediatrics
 - iii. Movement of the ambulance
 - b. Out-of-hospital medications previously given via the SQ route are transitioning to the IM route
 - i. More predictable absorption in critical patients
 1. Peripheral vasoconstriction or poor perfusion (e.g. shock)
 - c. Larger volumes of medication can be given via the IM route compared to the SQ route
- II. Intranasal delivery of medications
 - a. Combines a method of measuring a unit dose of medication
 - i. Delivered with a syringe or unit dose pump with a spray tip
 - ii. Medication is aerosolized into fine particles as it is being sprayed into the nose
 - iii. Results in a broader distribution of the medication across the nasal mucosa and an increased bioavailability
 - b. Not all medications can be delivered intranasally
 - i. Must have the correct pharmacokinetics
 - c. Medications that can be delivered via intranasal route include but are not limited to
 - i. Naloxone
 - ii. Glucagon
 - d. Split dosage between nares
 - e. Max volume in each nare is 1.0 mL

AEMT MEDICINE ADMINISTRATION SKILLS

See toxicological and immunological emergencies



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- Review Local and Regional Protocols

LESSON OBJECTIVES

- Conduct pain assessments appropriately by patient's age
- Critique clinical protocols for pain management
- Discuss non-pharmacological pain management options
- Determine the differences between acute and chronic pain management
- Critique the position paper published by the National Association of EMS Physicians regarding Prehospital Pain Management

LESSON CONTENT

- I. Pain Assessment
 - a. Adequate pain control is not routinely provided for a number of reasons
 - i. Most common—underestimation of patient's needs
 - ii. EMS personnel may base their judgment on past, similar patients
 - iii. Prehospital protocols should require
 1. Assessment of pain severity
 2. Reassessment of pain level after every intervention
 3. Document of every intervention
 - b. Tools for pain assessment
 - i. Use the same scale to assess and reassess
 - ii. Interpretation of the signal includes the following dimensions:
 1. Physiologic
 2. Psychological
 3. Emotional
 4. Behavioral
 - iii. Assessment instrument – document
 1. Presence of pain
 2. Intensity of pain
 3. Change in pain severity with time and treatment
 - c. Types of scales
 - i. Numeric Rating Scale
 1. "Rate your pain on a scale of 0-10"
 2. Proven more reliable in trauma
 - ii. Graphic Scale
 1. Commonly used in pediatric patients
- II. Clinical protocols for prehospital pain management
 - a. Must list clear indications and contraindications for each form of analgesic intervention
 - b. Should be in accordance with protocols from local and regional trauma centers
 - c. Consensus of opinion and acceptance by receiving physicians
- III. Non-pharmacologic interventions for pain management
 - a. Careful use of appropriate wording
 - b. Distraction away from painful stimuli
 - c. Parents' presence typically reduces the level of distress in infants and children
 - d. Traditional interventions should be provided, for example:
 - i. Immobilization of fractures

<ul style="list-style-type: none"> ii. Elevation iii. Ice iv. Padding of spinal immobilization <p>IV. Pediatric pain management</p> <ul style="list-style-type: none"> a. Reference: ¹⁷ACEP—Reducing Pediatric Pain and Anxiety <ul style="list-style-type: none"> i. Optimizing the environment <ul style="list-style-type: none"> 1. Combat anxiety and reduce pain by improving the physical environment ii. Assessing pain <ul style="list-style-type: none"> 1. Self-reporting pain scale examples <ul style="list-style-type: none"> a. Wong-Baker FACES® b. FACES and FACES revised c. OUCHER® 2. Non-self-reporting pain scale examples <ul style="list-style-type: none"> a. FLACC Scale <ul style="list-style-type: none"> i. Faces, Legs, Activity, Cry, Console ii. Utilizes presenting history and physical exam b. Non-invasive pain management <ul style="list-style-type: none"> i. Multidisciplinary/complimentary methods ii. Distraction <p>V. Neo-natal pain management</p> <ul style="list-style-type: none"> a. Reference: ¹⁷ACEP—Reducing Pediatric Pain and Anxiety 	
---	--

AEMT PAIN MANAGEMENT SKILLS	none
------------------------------------	------



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS MEDICAL

PSYCHIATRIC AND BEHAVIORAL EMERGENCIES
ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION 1 HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ¹⁸ [*White Paper Report on Excited Delirium Syndrome*](#)
- ¹⁹ [*National Library of Medicine—Excited Delirium*](#)
- ²⁰ [*CDC—Suicide Risk Factors*](#)

LESSON OBJECTIVES

- Describe the components of a mental status examination
- Perform effective patient restraint methods (verbal and physical)
- State the risk factors for suicide
- Analyze the effects of opioids and excited delirium
- Identify common synthetic stimulants and natural or synthetic THC
 - Recognizing the effects
 - Synthetic stimulants
 - Natural and synthetic THC

LESSON CONTENT

- I. Mental status examination
 - a. Mechanism of injury or nature of illness?
 - i. Injuries/illnesses can cause altered behavior
 1. Head injuries
 2. Hypoglycemia
 3. Hypoxia
 4. Stroke
 5. Dementia
 - ii. Medication side effects
 - b. Mental health history
 - c. General appearance
 - i. Dress
 - ii. Grooming
 - iii. Posture
 - iv. Wringing of hands
 - v. Facial grimaces
 - vi. Mannerisms
 - vii. Actions
 - viii. Violence
 - d. Speech
 - i. Spontaneous or pressured
 - ii. Slow or fast
 - iii. Soft or loud
 - iv. Understandable or not
 - v. Appropriate or inappropriate
 1. Mixed/confused words (word salad)
 2. Full words inappropriately used together
 3. Delusional
 - vi. Mood
 1. Depressed
 2. Euphoric

3. Manic
4. Anxious
5. Angry
6. Agitated
7. Fearful
8. Guilty
- vii. Area of thought
 1. Racing thoughts
 2. Hallucinations
 - a. Auditory
 - b. Visual
 - c. Somatic (strange body sensations)
 3. Obsessive
 4. Delusions (false beliefs)
 5. Suicidal
 6. Unconnected
 7. Disturbed or distorted
- viii. Once you have completed a mental status examination, you should report
 1. General appearance
 2. Speech
 3. Mood
 4. Area of thought

II. Restraint techniques

- a. Physical restraints
 - i. Attempt verbal de-escalation prior to physical restraint, if safe
 - ii. Provider safety
 1. Ensure scene safety
 2. Leave the scene if weapons are present
 - iii. Restrain only those who can be overpowered with the physical forces available to you
 - iv. Use only the force necessary to maintain control and prevent injury to all involved
 - v. Five people should be available to apply full body restraint
 1. one for each limb and one for restraint application
 - vi. Pre-plan each provider's role during restraint
 1. Know your communication signals or verbal cues
 - vii. Swift, coordinated action is most effective
 - viii. Talk to the patient continually
 - ix. Do not remove restraints in the out-of-hospital setting
 - x. Thoroughly document restraints
 1. Legal considerations
 - a. In law enforcement custody
 - b. Age
 - xi. Transportation
 1. Ensure continued ability to restrain
 2. Ensure adequate personnel and equipment
 - xii. Principles of restraining motion
 1. Understand normal range of motion
 2. Restraining range of motion
 3. Understand muscle groups
 - xiii. Patient considerations

1. Pregnant
 2. Pediatric
 3. Geriatric
 - b. Environmental restraint
 - i. Stabilize the environment (calm patient via therapeutic communication techniques)
 - ii. Separate stimulus from environment
 1. (e.g., separate two fighting people, remove law enforcement from direct view)
- III. Agitated Delirium/Excited Delirium
- a. Reference: ¹⁸[*White Paper Report on Excited Delirium Syndrome*](#)
 - b. Reference: ¹⁹[*National Library of Medicine—Excited Delirium*](#)
 - c. Stay calm, and do not cause more harm to the patient
 - d. Characterized by a sudden onset of extreme agitation and extremely irrational or combative behavior
 - i. Bizarreness, aggressiveness, agitation, ranting, hyperactivity, paranoia, panic
 - ii. Reported to result from substance intoxication, psychiatric illness, alcohol withdrawal, head trauma, or a combination of these
 - iii. Patient may exhibit hypertension, tachycardia, diaphoresis, dilated pupils, tachypnea, abnormal tolerance to pain, hyperthermia, noncompliance, and endless endurance and strength
 - iv. May lead to respiratory and cardiac arrest
 1. Restraints may increase the risk
- IV. Suicide/Depression (refer to the resources in the instructor preparations section)
- a. ²⁰[Risk Factors For Suicide](#)
 - i. History of depression and other mental disorders
 - ii. Previous suicidal gestures/attempts
 - iii. History of family/child abuse (non-accidental trauma)
 - iv. Feelings of hopelessness
 - v. Unwillingness to seek mental health care (stigma attached)
 - vi. Feeling of being isolated from others
 - vii. History of impulsive or aggressive behavior
 - viii. Inability to access mental health
 - ix. Recent diagnosis of a serious illness, especially an illness that signals a loss of independence
 - x. Recent loss of a loved one, job, money or social loss
 - xi. Access to firearms
 - xii. PTSD
 - xiii. Alcohol or drug abuse
 - xiv. Loss of relationship
 - xv. Gives away personal belongings/cherished possessions
 - xvi. Physical or mental stress
 - xvii. Major physical stress such as surgery and long periods of sleep deprivation
 - xviii. Expression of a clear plan for committing suicide
 - xix. Ability of the mechanisms to carry out suicide

AEMT PSYCHIATRIC SKILLS	Successful	Unsuccessful
1. Demonstrate proper verbal de-escalation techniques		
2. Apply soft restraints		



INSTRUCTOR PREPARATIONS

- Review *National EMS Education Standards*
- Poison Control: 1-800-222-1222
- ²¹[CDC—“Protecting Kids from Environmental Exposure”](#)
- ²²[Poison Control Centers: Poison & Prevention Information by Age](#)

LESSON OBJECTIVES

- Identify common synthetic stimulants and natural or synthetic THC
 - Recognize the effects
 - Synthetic stimulants
 - Natural and synthetic THC
- Identify common opioids
 - Recognize the effects
- Explain common treatment options for a person experiencing opioid overdose

LESSON CONTENT

- I. Poison control: 1-800-222-1222
- II. Toxicological Emergencies
 - a. Synthetic stimulants
 - b. Tetrahydrocannabinol (THC - natural/synthetic)
 - c. Opioid
- III. Synthetic Stimulants
 - a. Effects of synthetic stimulants
 - i. Psychological
 1. Agitation, insomnia, irritability, dizziness, depression, paranoia, delusions, suicidal thoughts, seizures, and panic attacks
 - ii. Somatic (effects on the body)
 1. Hyperthermia (significant with MDMA)
 2. Rapid heart rate - can lead to heart attacks and strokes
 3. Chest pains, nosebleeds, sweating, nausea, and vomiting
 - b. Bath Salts
 - i. Bliss, Blue Silk, Ivory Wave, White Dove, White Knight, White Lightning
 - ii. Usually sold as a powder
 1. White to off-white in color
 2. Can also be sold in capsule
 - iii. Usually inhaled nasally
 1. Can also be taken orally, intravenously, or smoked
 - c. Methamphetamine
 - i. Crank, Crystal Meth, Glass, Ice, Tweak, Yaba
 - ii. Usually sold as crystals
 1. White to off-white in color
 2. Yellow/red crystalline powder
 - iii. Usually smoked, snorted or injected IV
 - d. MDMA (methylenedioxymethamphetamine)
 - i. Ecstasy, E, X, XTC, Smarties, Scooby-Snacks, Skittles
 - ii. Usually sold in tablets or capsules
 1. Can also be sold in liquid drops, snorted, or smoked
 2. Can be any color

- IV. Tetrahydrocannabinol (THC)
- a. Natural
 - i. Weed, bud, doobie, Mary Jane, pot, blunt, herb, hemp, grass, etc.
 - ii. A green, brown or gray mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant
 - iii. Usually smoked in a cigarette or pipe
 - b. Synthetic
 - i. Characterized by mimicking natural THC
 - ii. Can cause psychosis
 - iii. K2, spice, black mamba, Bombay blue, genie, zohai
 - iv. Similar appearance to natural THC
 - c. Effects of THC
 - i. Impaired short term memory
 - ii. Decreased concentration and attention
 - iii. Impaired balance and coordination
 - iv. Increased heart rate and blood pressure
 - v. Increased appetite
- V. Opioids
- a. Synthetic or semi-synthetic opioids act on the Central Nervous System as a depressant to:
 - i. Decrease the perception of pain
 - ii. Decrease the reaction to pain
 - iii. Increase pain tolerance
 - b. May be prescribed for acute pain, debilitating pain, or chronic pain as part of palliative care
 - c. May be abused to induce euphoria
 - d. Prolonged use may lead to tolerance and/or addiction
 - e. Common effects:
 - i. Respiratory depression
 - ii. Drowsiness
 - iii. Constipation
 - iv. Constricted pupils
 - v. Dry mouth
 - vi. Itching
 - vii. Nausea and vomiting
 - f. Common opioids
 - i. Heroin
 - ii. Morphine
 - iii. Oxycodone (Percocet[®])
 - iv. Codeine
 - v. Fentanyl
 - vi. Hydrocodone (Vicodin[®])
 - vii. Hydromorphone (Dilaudid[®])
 - viii. Meperidine (Demerol[®])
 - ix. Methadone
 - g. Treatment for opioid emergencies
 - i. Naloxone (Narcan[®])
 1. Opioid antagonist
 2. Reverses CNS and respiratory depression caused by opioid overdose
 3. NOT effective against non-opioid drugs
 4. Available intranasally or auto-injector
 - a. First responders and bystanders may have administered prior to

	EMS arrival; always ask before administering additional doses
	5. Contraindications
	a. Known hypersensitivity to naloxone hydrochloride
VI.	Pediatric toxicology/ingestion
	a. Poison Control: 1800-222-1222
	b. Risks for accidental ingestion
	i. ²² Poison Control Centers: Poison & Prevention Information by Age
	c. Hazardous environment exposure
	i. ²¹ CDC—"Protecting Kids from Environmental Exposure"
VII.	Cannabinoid Hyperemesis Syndrome
	a. Reference: ²³ NIH—Cannabinoid Hyperemesis Syndrome
	b. Be aware of patients who experience
	i. Chronic cannabis use
	ii. Cyclic episodes of nausea and vomiting
	iii. Frequent hot bathing (associated with cannabis use)
	c. Treat findings accordingly

AEMT TOXICOLOGICAL EMERGENCY SKILLS	Successful	Unsuccessful
1. Assemble a Mucosal Atomization Device (MAD) for use		
2. Demonstrate administration of intranasal naloxone		
3. Measure pediatric and adult dosages of naloxone (may be simulated)		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

MEDICAL

NEUROLOGICAL EMERGENCIES-SEIZURES

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- Review *National EMS Education Standards*

LESSON OBJECTIVES

- Define altered mental status (AMS)
- State common causes of altered mental status
- Define status epilepticus/seizures
- Explain complications associated with seizures

LESSON CONTENT

- I. Altered mental status definition and causes
 - a. Definition: change in a person's level of awareness
 - b. Causes (AEIOU-TIPPSS— acronym for assessment of AMS patient)
 - i. Alcohol
 - ii. Epilepsy (seizures)
 - iii. Insulin (diabetic condition)
 - iv. Oxygen (lack of)
 - v. Uremia (kidney failure)
 - vi. Trauma
 - vii. Infection
 - viii. Psychiatric
 - ix. Poisoning (including drug overdose)
 - x. Shock
 - xi. Stroke
- II. Types of seizures
 - a. Generalized
 - i. Tonic-clonic
 - ii. Absence
 - b. Partial
 - i. Simple
 - ii. Complex
 - c. Status epilepticus
 - i. ²⁴[Epilepsy Currents-AESG—“Evidence Based Guideline: Treatment of Convulsive Status Epilepticus in Children and Adults: Report of the Guideline Committee of the American Epilepsy Society”](#)
 1. A continuous seizure lasting more than 30 minutes
 2. Two or more seizures without regaining consciousness between any of them
 3. Prolonged seizures last between 5 and 30 minutes
 - a. Should be treated as status epilepticus
 - ii. Complications
 1. Aspiration
 2. Bone and spine fractures
 3. Brain damage from lack of oxygen and/or depletion of glucose
 4. Dehydration
- III. Causes
 - d. Medication non-compliance
 - e. Rapid increase in body temperature (febrile)

	<ul style="list-style-type: none"> f. Infection g. Hypoxia h. TBI i. Alcohol or drug withdrawal j. Stroke k. Hypoglycemia l. Eclampsia m. Seizure disorder n. Electrolyte disturbances o. Poisoning
IV.	<p>Assessment findings</p> <ul style="list-style-type: none"> p. Spasms/muscle contractions/shaking or tremors q. Sweating r. Cyanosis during seizure activity s. Increased secretions t. Incontinence u. Postictal state
V.	<p>Management</p> <ul style="list-style-type: none"> v. Protect from further injury; position on side to protect airway w. Ensure open airway, adequate ventilations, and oxygenation <ul style="list-style-type: none"> i. Consider using an NPA x. Provide emotional support; reduce stimulants that may trigger more seizures

AEMT NEUROLOGICAL/SEIZURE SKILLS	none
---	------



INSTRUCTOR PREPARATIONS

- Review the *National EMS Education Standards*

LESSON OBJECTIVES

- Explain the role glucose plays on the cells
- Explain the role of insulin
- Identify symptoms commonly associated with hypo/hyperglycemia
- Identify commonly prescribed medications used to treat diabetes
- Discuss metabolic syndrome
- Explain the management of hyperglycemia
- Explain the management of hypoglycemia
- Compare the functions of different insulin pumps

LESSON CONTENT

- I. Glucose
 - a. Sugar
 - b. Fuel for cells
 - c. Proper amounts of glucose in blood ensures proper brain and cell functioning
 - i. Changes in levels may result in altered behavior
 - ii. Regulated by the pancreas
 - iii. Rise in blood sugar stimulates secretion of insulin
 1. Insulin acts as a “carrier” for glucose to enter the cells and be used
 - iv. Insulin release slows as blood sugar drops toward normal
 - v. Excess glucose
 1. Stored in the liver and muscles as glycogen
 2. Pancreas releases glucagon
 - a. Glucagon stimulates the liver
 - i. Liver breaks down the glycogen into glucose
- II. Diabetes
 - a. Condition in which insulin is nonexistent, minimal, or nonfunctioning
 - b. Without treatment it leads to high blood sugar
 - c. Two types of diabetes
 - i. Insulin dependent diabetes (IDDM, Type 1)
 1. Early age of onset
 2. Lack of insulin production
 - ii. Non-insulin dependent diabetes (NIDDM, Type 2)
 1. Later age of onset
 2. Associated with obesity
 3. Some cases are resolved with weight loss
 4. Cells are less receptive to insulin
 - a. Medication required to improve insulin sensitivity
 - b. Common medications
 - i. Metformin
 - ii. Chlorpropamide
 - iii. Glyburide
 - c. Some may take insulin
- III. Hypoglycemia
 - a. Rapid onset and changes in mental status

- b. Sweating
 - c. Hunger
 - d. Rapid pulse
 - e. Rapid, shallow respirations
 - f. Seizures, come (late)
 - g. Bizarre behavior (sudden onset and abnormal for patient)
- IV. Hypoglycemia management
- a. Ensure an open airway, adequate breathing, circulation, and ability to swallow
 - b. Determine blood glucose level
 - c. Check for and deactivate insulin delivery device (insulin pump)
 - i. Administer medication as appropriate
 - 1. Oral glucose
 - 2. Dextrose (IV)
 - 3. Glucagon
 - d. Supportive care
- V. Hyperglycemia
- a. Slow onset and changes in mental status
 - b. Rapid breathing, sweet breath odor
 - c. Dehydration, pale, warm, dry
 - d. Weakness, nausea, vomiting
 - e. Weak, rapid pulse
 - f. Polyuria, polydipsia, polyphagia
- VI. Hyperglycemia management
- a. Ensure an open airway, adequate breathing and circulation
 - b. Determine the blood glucose level (if available)
 - c. Supportive care
 - i. Blood sugar needs to be lowered slowly and monitored closely, usually in the ICU
 - ii. Field management should focus on ABC's and counteracting dehydration
 - d. Transport
- VII. Insulin Pumps
- a. Pager or smart phone appearance
 - b. Secrete short acting insulin over 24 hours
 - c. Attached subcutaneously by catheter
 - d. Suspend pump administration or disconnect when treating a patient with hypoglycemia
 - e. Tracks/stores helpful information that may assist in determining when and why a hypoglycemic episode occurred
- VIII. Metabolic syndrome
- a. Named for a group of risk factors that increase the risk for coronary artery disease, stroke and type 2 diabetes
 - i. Central obesity
 - 1. Extra weight around the middle and upper parts of the body
 - 2. Often described as "apple-shaped"
 - ii. Insulin resistance
 - 1. Body uses insulin less effectively than normal
 - 2. Insulin is needed to help control the amount of sugar in the body.
 - a. Blood sugar and fat levels rise
 - iii. Increased long-term risk for developing
 - 1. Heart disease
 - 2. Type 2 diabetes
 - 3. Stroke

<ol style="list-style-type: none"> 4. Kidney disease 5. Diminished blood supply to the legs.
--

AEMT ENDOCRINE/DIABETES SKILLS	Successful	Unsuccessful
1. Troubleshoot an insulin pump malfunction (may be simulated)*		
2. Suspend/disconnect pump administration		
3. Administer IV Dextrose		
*This skill may be practiced using diagrams of various types of insulin pumps. The use of a physical pump is not mandatory.		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

MEDICAL

IMMUNOLOGICAL EMERGENCIES

ALLERGIC REACTION & ANAPHYLAXIS ADULT &
PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- Review the *National EMS Education Standards*
- ²⁵ [National Institute of Health: Visual Representation of ...Criteria for Anaphylaxis](#)

LESSON OBJECTIVES

- Discuss the physiology related to allergies and anaphylaxis
- Differentiate between a mild/localized allergic reaction and anaphylaxis
- Explain the actions of medications used to treat anaphylaxis
 - Epinephrine

LESSON CONTENT

- I. Allergic reaction
 - a. Hyperactive, localized immune response to an allergen
 - b. Some histamine is released
 - c. Localized: redness, swelling, hives, itching
 - d. May cause nausea, vomiting, and/or diarrhea
 - e. Usually requires minimal supportive therapies
 - f. Repeat exposures may lead to anaphylaxis (e.g., insect stings, foods, etc.)
- II. Anaphylaxis
 - a. Multiple body systems are affected, not just a localized reaction like allergies
 - b. Life threatening reaction of the immune system to an allergen
 - c. Large quantities of histamine are released throughout the body
 - d. Vasodilation and increased capillary permeability
 - e. May lead to shock
 - f. Bronchoconstriction and mucous production
 - g. May lead to respiratory distress
 - i. Soft tissue swelling of the upper airway
 - ii. Airway obstructions
- III. Treatment for Anaphylaxis
 - a. Out-of-hospital treatment
 - i. Ensure adequate airway, ventilation, and oxygenation
 - ii. SpO₂ <94% administer oxygen
 - iii. Assist patient with epinephrine auto-injector if available
 - iv. Establish an IV or IO, administer fluids
 - v. Epinephrine (subcutaneous or intramuscular)
 1. First line medication of choice
 - a. Reverses many of the effects of the histamine
 - i. Bronchodilation
 - ii. Vasoconstriction
 - b. Requires continuous reassessment
 - c. Consider additional dosing due to short half-life
 - vi. Consider Albuterol (via nebulizer)
 1. Bronchodilator
 2. Review local protocol
 - vii. Transport to an appropriate facility for evaluation

AEMT IMMUNOLOGICAL EMERGENCIES SKILLS	Successful	Unsuccessful
1. Demonstrate assisting a patient in administering medication with an auto-injector		



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ²⁷[Department of Homeland Security—Blue Campaign: Human Trafficking](#)
- ²⁸[Florida State University—The National Prevention Toolkit on Domestic Violence for Medical Professionals](#)
- ²⁹[The Journal of Law-Medicine: Improving the Emergency Medical Services System's Response to Domestic Violence](#)

LESSON OBJECTIVES

- Determine training resources for special populations
 - Human trafficking
 - Domestic violence
- Recognize the unique characteristics of at-risk populations
- Determine the appropriate actions of EMS professionals in the presence of at-risk patients
- Recognize circumstances that may indicate abuse
 - Domestic abuse
 - Human trafficking
 - Non-accidental trauma
- State appropriate actions of EMS professionals in the presence of abused patients

LESSON CONTENT

- I. Training resources
 - a. ²⁷[Human Trafficking](#)
 - b. ²⁸[Domestic Violence](#)
- II. Unique characteristics of at-risk populations
 - a. Pediatric
 - i. Wide range in development
 1. Neonatal to young adult
 - ii. Non-verbal to highly communicative
 - iii. Response to shock changes with organ development
 - iv. Injury and illness patterns change with development
 - v. Depend on adults for protection and prevention
 - b. Geriatric
 - i. Fragility is a better indicator of risk than age in years
 - c. Polypharmacy is common
 - i. May have certain drug interactions
 - d. Be aware of potential medication overdoses
 - e. Age-related cognitive impairment
 - i. Dementia
 - ii. Delirium
 - f. Loss of independence
 - g. May have reduced uptake of certain medications
- III. Indications of abuse
 - a. Training resource: ²⁸[Domestic Violence](#)
 - b. Documented studies report that domestic violence wounds are most likely to occur at the following anatomical sites (listed from most to least likely)
 - i. Face and neck
 - ii. Arms

<ul style="list-style-type: none"> iii. Head iv. Back and buttocks v. Breasts vi. Abdomen (Increases during pregnancy) vii. Genitals c. Victims may be repeatedly <ul style="list-style-type: none"> i. Injuries in different stages of healing <p>IV. Indications of trafficking victims</p> <ul style="list-style-type: none"> a. Training resource: ²⁷Human Trafficking b. Bruises in various stages of healing caused by physical abuse c. Scars, mutilations, or infections due to improper medical care d. Urinary difficulties, pelvic pain, pregnancy, or rectal trauma e. Chronic back, hearing, cardiovascular, or respiratory problems as a result of forced manual labor in unsafe conditions f. Poor eyesight and/or eye problems due to dimly lit work sites g. Malnourishment and/or serious dental problems h. Disorientation, confusion, phobias, or panic attacks <ul style="list-style-type: none"> i. Results of daily mental abuse, torture, and culture shock <p>V. EMS professionals' actions and considerations with at-risk patients</p> <ul style="list-style-type: none"> a. Assessment challenges <ul style="list-style-type: none"> i. Unreliable historians ii. Difficulty in relaying information <ul style="list-style-type: none"> 1. Previous medical history 2. Medications 3. Other current therapies iii. Reliance on caregivers iv. Proper interpretation of the patient's verbal and non-verbal communication <ul style="list-style-type: none"> 1. Interpretation of physical examination findings often drive care v. Assess the environment in which patient was found and the need for additional follow-up b. Treatment <ul style="list-style-type: none"> i. Provide supportive care ii. Treat injuries and illnesses as usual iii. Document findings iv. Know whether state law requires mandatory reporting of abuse 	
---	--

AEMT AT-RISK POPULATION SKILLS	none
---------------------------------------	------



INSTRUCTOR PREPARATIONS

- ³⁰[*NHTSA Advances Ground Ambulance Safety...*](#)
- ³¹[*Real Stories Behind Ambulance Safety Data*](#)
- ³²[*NHTSA and Ground Ambulance Crashes April 2014*](#)
- ³³[*When Ambulances Crash: EMS Provider & Patient Safety*](#)
- ³⁴[*Strategy for a National EMS Culture of Safety*](#)

LESSON OBJECTIVES

- Discuss federal initiatives developed to monitor and analyze ground ambulance crashes
- Identify the significance of ambulance crashes through the use of national data
- State specific factors that contributed to injuries and fatalities sustained during ambulance crashes
- Evaluate the policies and procedures at each participant's own EMS service related to protecting patient and provider safety during ground ambulance transport

LESSON CONTENT

- I. Discuss federal initiatives developed to monitor and analyze ground ambulance crashes
 - a. Reference: ³⁰[*NHTSA Advances Ground Ambulance Safety...*](#)
 - b. The National Highway Traffic Safety Administration (NHTSA) collects, reports, and analyzes data on crash characteristics in which an ambulance is involved
 - c. The NHTSA Office of EMS (OEMS) has collaborated with NHTSA's Special Crash Investigations Program (SCI) to conduct more in depth analysis on ambulance crash data in order to identify common data sets among events. The data gleaned can inform decisions and recommendations in the future.
 - i. Efforts include creating a common reporting system, the Model Minimum Uniform Crash Criteria (MMUCC)
 - d. NHTSA strives to collaborate with national and other stakeholder partners to improve safety for EMS personnel, patients, and the general public in relation to ground ambulance transport
 - e. Data is disseminated in order to assist national stakeholders, state, and local officials in developing policies and procedures to protect EMS personnel and patients, as well as the general public
 - f. NHTSA participates in monitoring ambulance defects as cause of crashes
 - g. NHTSA promotes the implementation of *National Strategy for EMS Culture of Safety*
 - h. NHTSA participates in efforts to improve ground ambulance standards
 - i. Participation with National Fire Protection Agency (NFPA) and National Institute for Occupational Safety and Health (NIOSH).
- II. Identify the significance of ambulance crashes through the use of national data
 - a. Reference: ³⁰[*NHTSA Advances Ground Ambulance Safety...*](#)
 - b. Reference: ³²[*NHTSA and Ground Ambulance Crashes April 2014*](#)
 - c. Average of 4,500 crashes/year
 - i. 1,500 of these are "injury crashes" with approximately 2,600 injured persons
 - ii. 59% while in emergency use
 - iii. Annual mean of 29 fatal crashes/year with 58% while in emergency use
 - iv. 42% non-emergency use
 1. Of the fatalities
 - a. 4% ambulance driver
 - b. 21% ambulance passenger
 - c. 63% occupant of other vehicle

- d. 12% non-occupant
- 2. Of the injuries:
 - a. 17% ambulance driver
 - b. 29% ambulance passenger
 - c. 54% occupant of other vehicle
- d. Limitations of data
 - i. Only includes crashes that occur on a road way customarily open to the public
 - ii. Not all vehicle crashes in the country are reported to the police
 - iii. Police may not record ambulances accurately on crash report
 - iv. Does not distinguish between ambulance types
 - v. Does not determine when the crash occurred (en-route to scene, en-route to hospital)
 - vi. Does not collect data showing the proportion of time an ambulance is on the road
 - vii. Does not currently differentiate ambulance occupants in the passenger seat or patient compartment of the ambulance
 - viii. In the future Model Minimum Uniform Crash Criteria (MMUCC) will improve data collection and lead to better analyses.
- e. Specific factors that contributed to injuries and fatalities during ambulance crashes
 - i. References:
 - 1. ³⁰[NHTSA Advances Ground Ambulance Safety by Tracking and Investigating Crashes](#)
 - 2. ³³[Infographic—When Ambulances Crash: EMS Provider and Patient Safety](#)
 - ii. Statistics
 - 1. 84% were unrestrained EMS providers
 - 2. Unsecured patients (both shoulder and lateral restraints)
 - a. 33% were secured by both restraints
 - 3. 44% of patients were ejected from the cot in serious crashes
 - 4. 61% of patients were restrained with lateral belts only
 - 5. 38% had shoulder harnesses available but were unused
- f. Evaluate the policies and procedures at each participant's own EMS service related to protecting patient and provider safety during ground ambulance transport
 - i. Participants should consider and discuss the following questions:
 - 1. What are your agency's current policies/guidelines regarding securing a patient to the cot during transport?
 - a. Are those adequate to prevent injury in the event of an ambulance crash?
 - 2. What changes would you recommend to reduce the risk of patient injury in the event of an ambulance crash?
 - 3. What are your agency's current policies/guidelines regarding securing EMS providers in the patient compartment during transport?
 - a. Are those adequate to prevent injury in the event of an ambulance crash?
 - 4. What changes would you recommend to reduce the risk of EMS provider injury in the event of an ambulance crash?
 - 5. What are your agency's policies/guidelines regarding securing equipment and supplies in the patient compartment?
 - a. Are those adequate to prevent patient and/or EMS provider injury in the event of an ambulance crash (or during transport)?
 - 6. What preventative measures does your agency have in place regarding driving an ambulance to decrease the risk of ambulance crashes?

AEMT AMBULANCE SAFETY SKILLS	none
-------------------------------------	------



INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ³⁵ [*National Implementation of the Model Uniform Core Criteria for Mass Casualty Incident Triage 2013 \(MUCC\)*](#)

LESSON OBJECTIVES

- Relate MUCCs impact on the development of the CDC Field Triage Decision Scheme and SALT
- Analyze the triage methods for
 - SALT
 - START
 - JumpSTART

LESSON CONTENT

- I. MUCC (Model Uniform Core Criteria)
 - a. Reference:
 - i. ³⁵ [*National Implementation of the Model Uniform Core Criteria for Mass Casualty Incident Triage 2013*](#)
 - b. A science and consensus-based national guideline that recommends 24 core criteria for all mass casualty triage systems
 - c. Used as the basis for CDC Field Triage Decision scheme and SALT (Sort, Assess, Lifesaving Interventions, Treatment/Transport)
- II. SALT Triage
 - a. Reference: [Sort, Assess, Lifesaving interventions, Treatment/transport](#)
 - b. Steps to consider during triage
 - i. Sort: Global sorting
 1. Obvious life threat
 2. Purposeful movement
 3. Walk
 - ii. Individual assessment
 1. Perform lifesaving interventions as indicated
 2. Perform ongoing reassessments
 - iii. Treatment and/or transport
- III. START (adult triage)
 - a. Reference: [Simple Triage and Rapid Treatment](#)
 - b. Steps to consider during triage
 - i. Assess respirations
 - ii. Assess perfusion
 - iii. Assess mental status
 - c. Immediate or delayed transport depends on the assessment findings
- IV. JumpSTART (pediatric triage)
 - a. Reference: [Pediatric MCI Triage Tool](#)
 - b. First, triage patients who do not walk independently (based on age)
 - c. Steps to consider during triage
 - i. Assess respirations
 - ii. Assess perfusion
 - iii. Assess mental status
 - d. Determine immediate or delayed transport based on assessment findings

AEMT FIELD TRIAGE SKILLS/ACTIVITIES	Successful	Unsuccessful
1. Outline the differences between trauma triage and disaster/MCI triage		
2. Triage patients, in accordance with local protocol, using the SALT or the START/JumpSTART algorithm in a simulated multi-casualty scenario		



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

OPERATIONS

EMS PROVIDER HYGIENE, SAFETY, AND VACCINATIONS

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- *National EMS Education Standards*
- ³⁶[CDC—Hand Hygiene Guideline](#)
- ³⁷[APIC—Guide to Infection Prevention in Emergency Medical Services](#)

LESSON OBJECTIVES

- Identify proper hand washing technique
- Identify appropriate use of alcohol-based hand cleaner
- Discuss the CDC's recommendations of vaccines for healthcare providers
- Assess eye safety indications and measures

LESSON CONTENT

- I. Always wash hands
 - a. Before and after patient contact
 - b. Before eating
 - c. After cleaning the ambulance or equipment
 - d. After using the restroom
 - e. After nose blowing, coughing, or sneezing
- II. CDC Recommendations for washing with soap and water
 - a. Reference: ³⁶[CDC—Hand Hygiene Guideline](#)
 - b. Remove all jewelry
 - c. Wet hands with clean running water
 - d. Apply soap
 - e. Scrub the back of hands
 - f. Clean underneath fingernails
 - g. Continuously rub hands for at least 20 seconds
 - h. Rinse hands well under running water
 - i. Dry hands using a clean towel or air dry
- III. Alcohol-based hand cleaner/sanitizer
 - a. Should contain at least 60% alcohol
 - b. Reduces number of germs
 - c. Does not eliminate all types of germs
 - d. Does not kill viruses
 - i. Creates inhospitable environments for viruses to live
 - e. Ineffective when hands are visibly dirty
 - f. Techniques for using hand sanitizer
 - i. Know that soap and water is more effective than hand sanitizer
 - ii. Apply to palm of one hand
 - iii. Rub hands together
 - iv. Rub all surfaces of hands and fingers until dry
 - v. Wash hands when soap and water become available
- IV. Eye and face protections
 - a. Eye protection is recommended by the CDC when workers may be at risk of acquiring infectious diseases via ocular exposure
 - i. Adenovirus
 - ii. Herpes simplex
 - iii. Staphylococcus aureus
 - iv. Hepatitis B and C

- v. HIV
- vi. Rhinoviruses
- b. Eye protection devices
 - i. Goggles
 - ii. Face Shields
 - iii. Safety glasses
 - iv. Full-face respirators
- V. Vaccinations for healthcare providers
 - a. Reference: ³⁸[CDC—Vaccines: Healthcare Provider/Professionals](#)
 - b. Recommended vaccines (not exhaustive)
 - i. Hepatitis B
 - ii. Influenza
 - iii. MMR (measles, mumps and rubella)
 - iv. Varicella
 - v. Pertussis
 - vi. Consider vaccines recommended for disaster response
 - c. Vaccines
 - i. Help prevent transmission of certain diseases
 - ii. Some are attenuated (weakened or killed) viruses
 - iii. Some mimic certain diseases
 - 1. Produce antibodies in the blood
 - iv. Some provide antibodies directly

AEMT HYGIENE SKILLS	none
----------------------------	------



INSTRUCTOR PREPARATIONS

- ³⁴[*Strategy for a National EMS Culture of Safety*](#)

LESSON OBJECTIVES

- Define culture of safety
- Identify and explain the six core elements necessary to advance an EMS Culture of Safety
- Identify the role of the EMS providers in establishing a culture of safety within EMS organizations

LESSON CONTENT

- I. Define culture of safety
 - a. Reference: ³⁴[*Strategy for a National EMS Culture of Safety*](#)
 - b. “The enduring value and priority placed on worker and public safety by everyone in every group at every level of an organization. It refers to the extent to which individuals and groups will commit to personal responsibility for safety; act to preserve, enhance and communicate safety concerns; strive to actively learn, adapt and modify (both individual and organizational) behavior based on lessons learned from mistakes; and be rewarded in a manner consistent with these values.”
- II. Identify and explain the six core elements necessary to advance an EMS Culture of Safety as described in the 2013 *Strategy for a National EMS Culture of Safety*
 - a. Just Culture
 - i. Development of environments in which EMS personnel are safe to report errors
 1. Focus on the various factors that contributed to the error
 - ii. Assess risks in order to identify means of overcoming factors that contribute to errors
 1. Systems factors and individual factors are examined in order to make improvements to avoid future errors
 - iii. Blaming or punishing is not an option in a Just Culture
 - b. Coordinated support and resources
 - i. Creation of a guidance and resource coordination body
 1. e.g., EMS Safety Resource Center (EMSSRC)
 - a. Purpose is to determine the best way to effectively serve EMS in the support role
 - b. Partner with governing bodies to serve as a conduit of information and resources for EMS Safety
 - c. No oversight or authority
 - d. Suggested support areas:
 - i. Outreach and Resources for EMS and other stakeholders
 - ii. Resources for Public Outreach
 - iii. Measuring Progress and Success
 - c. EMS Safety Data System
 - i. Data driven decisions and policies related to EMS safety can only be made if all data is accessible on a national level.
 - ii. A robust, secure system would allow access to researchers, decision makers, and national stakeholder groups.
 - iii. Data sets have been identified; data will be analyzed and used to inform future plans, initiatives, processes, and policies in order to protect the health and well-being of EMS personnel, their patients, and the general public

1. Injuries
 2. Illnesses
 3. Incidents
- d. EMS Education Initiatives
 - i. Safety starts with EMS leaders and educators and involves everyone
 - ii. Initial EMS programs must encourage a culture of safety throughout the program
 - iii. Continuing education and new employee onboarding must infuse culture of safety throughout the curricula
 - e. EMS safety standards
 - i. Safety standards for patient and responder safety must be developed using data and evidence
 - ii. EMSSRC can coordinate the efforts to combine work and data completed by various EMS stakeholders and projects
 - f. Requirements for reporting and investigation
 - i. Mandates for reporting safety are necessary so a common language and data set can be created to improve responder and patient safety
 1. Steps may include:
 - a. Determining what data are already mandated and available
 - b. Determining what data are necessary and useful
 - c. Learning from those with hands-on experience
 - d. Assigning and obtaining authorization for an investigative body
 - e. Identifying existing best practices
- III. Consider these questions in regards to the policies, practices, and daily operations in your organization/agency:
- a. What changes are needed to encourage the development of a culture of safety?
 - b. How are mistakes handled if one is made during a patient care encounter?
 - c. How should it be handled if applying the concept of Just Culture?

AEMT CULTURE OF SAFETY SKILLS	none
--------------------------------------	------



INSTRUCTOR PREPARATIONS

- ³⁹[*Working Group Best Practice Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances*](#)

LESSON OBJECTIVES

- Explain how to appropriately secure a child safety restraint to a wheeled ambulance stretcher
- Differentiate between the NHTSA recommendations for safe ambulance transport of children based on the condition of the child
- Discuss the on-going initiatives to increase the safety of children during ambulance transport
- Discuss the limitations of the current recommendations

LESSON CONTENT

- I. Explain guiding principles of safely transporting pediatric patients
 - a. All ambulances should have seats and restraints appropriate for securing children from newborn on up
 - b. All Child seats/restraints in ambulances should be tested to FMVSS 213 ATD injury criteria using the pulse criteria from J3026
 - c. Child seats/restraints should only be attached to cots, cot mounts and restraints that have been tested and comply with standards of J3027
 - d. Child seats/restraints should only be attached to seating positions that pass the appropriate standard when tested as a system together
 - e. A child passenger, especially a newborn, must never be transported on an adult's lap.
 - f. It is NOT appropriate to transport children, even in a child restraint system, on the multi-occupant squad bench located in the patient compartment of ground ambulances
- II. Differentiate between the NHTSA recommendations for safe ambulance transport of children based on the condition of the child
 - a. Situation 1: For a child who is uninjured/not ill (child who is accompanying an injured or ill patient)
 - i. Transport the child in a vehicle other than an emergency ground ambulance
 - ii. When other transportation not possible/available
 1. Transport in a size-appropriate child restraint system that complies with FMVSS NO. 213, installed appropriately in the front passenger seat, with airbags in the "off" position
 2. Transport in the forward-facing EMS provider seat in a size appropriate child restraint system that complies with FMVSS NO. 213
 3. Transport in the rear-facing EMS provider seat in a size-appropriate child restraint system that complies with FMVSS No. 213; or
 4. Leave the uninjured/not ill child under appropriate adult supervision on scene
 - b. Situation 2: For a child who is ill and/or injured and whose condition does not require continuous and/or intensive medical monitoring and/or interventions
 - i. Appropriately secure and transport the child on the cot in a size-appropriate child restraint system that complies with the injury criteria of FMVSS No. 213
 - ii. Situation 3 For a child whose condition requires continuous and/or intensive medical monitoring and/or interventions
 1. Appropriately secure and transport the child on the cot in a size-appropriate child restraint system that complies with the injury criteria of FMVSS No. 213

- c. Situation 4: For a child whose condition requires spinal immobilization and/or lying flat
 - i. Secure the child to a size appropriate spine board
 - ii. Secure the spine board to the cot
 - 1. Head first, with a tether at the foot (if possible) to prevent forward movement
 - 2. Use three horizontal restraints across the torso (chest, waist, and knees)
 - 3. Use a vertical restraint across each shoulder
 - d. Situation 5: For a child or children who require transport as part of a multiple patient transport (newborn with mother, multiple children, etc.)
 - i. When possible, transport each as a single patient according to the guidance shown for Situations 1 through 4.
 - ii. Transport in the forward-facing EMS provider's seat in a size-appropriate child restraint system that complies with FMVSS No. 213
 - iii. For mother and newborn, transport the newborn in an approved size-appropriate child restraint system that complies with the injury criteria of FMVSS No. 213
 - 1. In the rear-facing EMS provider seat that prevents both lateral and forward movement
 - 2. Transport the mother on the cot
 - 3. Do not use a rear-facing only seat in the rear-facing EMS provider's seat
 - 4. Consider using an integrated child restraint system certified by the manufacturer to meet the injury criteria of FMVSS No. 213.
- III. Discuss the ongoing initiatives to increase the safety of children during ambulance transport
- a. NASEMSO leads the Safe Transport of Children Committee with the following goals:
 - i. To recommend the criteria or specifications for proper restraint of children in ambulances. Such criteria will be evidence-based and will consider safety of both patients and providers
 - ii. To have the recommended criteria adopted by one or more accredited standard setting organizations.
 - iii. To develop a strategy and resources for educating EMS providers on safely transporting children in ground ambulances based on the recommended criteria or standards.
- IV. Discuss the limitations of the current recommendations
- a. Available research on child- restraint systems only rates the safety in normal use, not in ambulances
 - b. Not enough evidence from research on simulated ambulance crashes involving child restraint systems to recommend evidence-based guidelines
 - c. All child restraint systems are only as effective as the manner in which they are secured to a cot and in an ambulance



INSTRUCTOR PREPARATIONS

- ⁴⁰[*IAFC Crew Resource Management Manual*](#)

LESSON OBJECTIVE

- Define Crew Resource Management (CRM)
- Explain the benefits of CRM to EMS
- State the guiding principles of CRM and briefly explain each
- Explain the concept of communication in the team environment using advocacy/inquiry or appreciative inquiry
- State characteristics of effective team leaders
- State characteristics of effective team members
- Explain how the use of CRM can reduce errors in patient care


LESSON CONTENT

- I. Define Crew Resource Management
 - a. Reference: ⁴⁰[*IAFC Crew Resource Management Manual*](#)
 - b. Effectively using all resources in an effort to minimize errors, improve safety, and improve performance.
 - c. Based on crew resource management training created by the aviation industry
 - i. Their mission is “preventing accident by improving crew performance through better crew coordination.” U.S.D.O.T., F.A.A., 2004
 - d. Addresses various human factors that contribute to errors
 - e. Created to optimize human performance by reducing the effect of human error through the use of all resources, including:
 - i. People
 - ii. Hardware
 - iii. Information
- II. Benefits of Crew Resource Management to EMS
 - a. Overarching aim is to minimize errors
 - b. Improved safety for patients and care providers
 - c. Improved team performance
 - i. Conflict resolution
 - ii. Improved communication
 - iii. Increased feedback
 - iv. Better workload management; task assignments
 - v. Improved clinical decision making
 - d. Improved situational awareness
 - e. All team members have equal value and input
 - f. All members of the organization participate in CRM and CRM training
- III. Five guiding principles of Crew Resource Management
 - a. Situational Awareness
 - i. Awareness of surroundings
 - ii. Evaluation of options
 - iii. Communicating options with team members
 - b. Decision making
 - i. Life threatening vs. non-life-threatening
 - ii. Entire team should be aware of all necessary information
 - iii. Collective team knowledge and experience should be utilized to make a

- iv. Team leader is ultimate authority on final decision but relies on input from all members with equal weight, incorporating experience and knowledge of team
 - c. Workload/Task management
 - i. Tasks should be divided among all team members to optimize functioning of team as a whole
 - ii. Team leaders and members must recognize and communicate limitations
 - d. Teamwork
 - i. Teams are comprised of leaders and followers
 - ii. There are competencies for each role: leadership and followership
 - iii. Development of leadership and followership allows teams to resolve conflicts during stressful situations and stay on task with the mission of the team
 - iv. Team leaders and team members must develop accurate self-assessment skills (meta-cognition) to be effective in their roles
 - e. Communication
 - i. Involves transmitting and receiving messages
 - ii. Possibility of transmitting erroneous information
 - iii. Possibility of interpreting information incorrectly
 - iv. Clarification is necessary in both transmission and reception of information
 - v. Clarify and agree on the message between individuals and gain agreement prior to any proposed action (closed-loop communication) in order to reduce errors
- IV. Advocacy and Inquiry Communication; appreciative inquiry
- a. Four steps to using inquiry/advocacy or appreciative inquiry to improve communication among teams
 - i. Alert the other members of the team to a situation or action of concern
 - ii. State the problem as it is seen
 - iii. State a solution or alternative
 - iv. Obtain agreement among the team to alter plan or action
- V. Characteristics of effective team leaders
- a. Creates, implements and revises an action plan
 - b. Communicates accurately and concisely while listening and encouraging feedback
 - c. Receives, processes, verifies, and prioritizes information
 - d. Reconciles incongruent information
 - e. Demonstrates confidence, compassion, maturity, and command presence
 - f. Demonstrates a role of authority for the group and scene
 - g. Maintains accountability for team’s actions/outcomes
 - h. Assesses situation and resources and modifies accordingly
 - i. Maintains situational awareness
 - j. Utilizes appreciative inquiry/ inquiry/advocacy when miscommunication or potential errors occur
 - k. Uses closed-loop communication
 - l. Reports progress on tasks
 - m. Performs tasks accurately and in a timely manner
 - n. Addresses safety concerns and is safety conscious at all times
 - o. Treats all team members as equals and with equal level of respect, regardless of rank or experience level
- VI. Characteristics of effective team members
- a. Communicates accurately and concisely while listening and accepting feedback
 - b. Demonstrates followership—is receptive to leadership
 - c. Demonstrates confidence, compassion, maturity

	<ul style="list-style-type: none"> d. Maintains situational awareness e. Utilizes appreciative inquiry, advocacy/inquiry when miscommunications or potential errors occur f. Uses closed-loop communication g. Reports progress on tasks h. Performs tasks accurately and in a timely manner i. Advocates safety concerns and is safety conscious at all times j. Treats all team members as equals and with equal level of respect, regardless of rank or experience level k. Immediately suggests corrective action if a harmful intervention is ordered/performed by others
VII.	<p>Effects of using Crew Resource Management to reduce errors in patient care</p> <ul style="list-style-type: none"> a. Increased communication among crew (team leader and team members) can reduce potential safety concerns for the crew b. Increasing patient safety, mitigation or elimination of errors, and increasing the overall effectiveness of a team are benefits of increased communication and effective communication techniques, such as: <ul style="list-style-type: none"> i. The process of identifying a potential or actual error, ii. Supplying information, iii. Suggesting alternative actions, iv. Agreeing on a new plan, c. Team members experience a safe environment in which to identify human errors and suggest ways to mitigate or eliminate errors. d. Routine training and practice of CRM can increase self-awareness and self-efficacy for all personnel.

AEMT CREW RESOURCE SKILLS	none
----------------------------------	------

 National Registry of Emergency Medical Technicians® THE NATION'S EMS CERTIFICATION		ADVANCED EMTS OPERATIONS EMS RESEARCH
ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR		
<u>INSTRUCTOR PREPARATIONS</u>		
<ul style="list-style-type: none"> • ⁴¹National EMS Research Agenda 2001 • ⁴²Safety in Numbers: EMS Data IS Important (course handout) • ⁴³CARES in Action 		
<u>LESSON OBJECTIVES</u>		
<ul style="list-style-type: none"> • Identify national initiatives and resources that promote and enable EMS Research • Explain the practical use of research in EMS care • Explain the scientific method • Differentiate among the different research methods • Explain the process of conducting a literature review 		
<u>LESSON CONTENT</u>		
<ol style="list-style-type: none"> I. National initiatives and resources that promote and enable EMS Research <ol style="list-style-type: none"> a. Federal Interagency Committee on EMS (FICEMS) included “data-driven and evidence-based EMS systems that promote improved patient care quality” as a strategic goal, published in 2014. b. National Highway Traffic Safety Administration (NHTSA) supports the development of evidence based guidelines through the use of standardization and improvement of EMS data collection using NEMSIS c. The National Institute of General Medical Sciences coordinates EMS research efforts, promotes ideas for research funding and collaboration II. Practical use of research in EMS <ol style="list-style-type: none"> a. Ensures that care provided will glean the best, safest possible results and patient outcomes <ol style="list-style-type: none"> i. Reference: ⁴³CARES in Action ii. Supported by evidence and expert experience b. Demonstrates value of EMS care with reportable outcomes c. Improves working conditions-safety research can be focused on EMS providers d. Encourages accurate and complete documentation III. Describe the scientific method <ol style="list-style-type: none"> a. Ask a question b. Conduct literature review to seek answers c. Determine a hypothesis based on literature review d. Test the hypothesis e. Analyze the data to prove or disprove hypothesis, consider limitations f. Report findings, discuss limitations g. Repeat with adjustments or refine hypothesis and begin again 		
AEMT RESEARCH SKILLS	none	



National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

ADVANCED EMTS

OPERATIONS

EVIDENCE BASED GUIDELINES

ADULT & PEDIATRIC PATIENTS: EXPECTED DURATION ½ HOUR

INSTRUCTOR PREPARATIONS

- ⁴⁴[NASEMSO—Statewide Implementation of an Evidence-Based Guideline](#)
- ⁴⁵[NASEMSO—Statewide Implementation of an EBG: References](#)
- ⁴⁶[National Prehospital Evidence-based Guideline Model Process](#)

LESSON OBJECTIVES

- Define evidenced based medicine and practice
- Identify resources available through NASEMSO to aid states and agencies in developing evidence based guidelines
- Explain the benefits of EBG to patients

LESSON CONTENT

- I. Define evidenced based medicine and practice
 - a. Statements developed through rigorous scientific inquiry that inform EMS systems, medical directors and EMS personnel on standards of care that have been vetted by research
 - b. The National Prehospital Evidence-base Guideline Model Process has been approved by the Federal Interagency Committee on EMS and the National EMS Advisory Council
 - c. The Process is cyclical in nature:
 - i. System Inputs
 - ii. EMS Evidence Accumulation & Evaluation
 - iii. Establish Priorities for Guideline Development
 - iv. EMS Protocol Development
 - v. Dissemination of Guidelines/Protocols
 - vi. Implementation
 - vii. Evaluation of Effectiveness/Outcomes
 - viii. EMS Evidence Accumulation
 - ix. Repeat
- II. Resources available to aide states and agencies in developing EBGs
 - a. Resource: ⁴⁴[NASEMSO—Statewide Implementation of an Evidence-Based Guideline](#)
 - b. NASEMSO was awarded a grant
 - i. Focus on pediatric patients
 1. To implement an evidence-based guideline on pre-hospital pain management
- III. Patients benefit from EBGs
 - a. Ensures high quality patient management
 - i. Standardized, consistent approach
 - ii. Proven successful through expert practice and clinical evidence.

AEMT EVIDENCE BASED GUIDELINES ACTIVITY	Successful	Unsuccessful
1. Create an outline or a synopsis of one or more of the following EMS Evidence Based Guidelines		
a. ⁴⁷ An Evidence-based Guideline for Pediatric Prehospital Seizure Management Using Grade Methodology		
b. ⁴⁸ An Evidence-based Guideline for Prehospital Analgesia in Trauma		
c. ⁴⁹ An Evidence-based Guideline for the Air Medical Transportation of Prehospital Trauma Patients		

References

1. Aufderheide T.P., Lurie K.G. (2004). Death by hyperventilation: a common and life-threatening problem during cardiopulmonary resuscitation. *Critical Care Medicine*. 32 (9). Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/15508657>
2. Kodali, Bhavani-Shankar (2014). Capnography. Retrieved from <http://www.capnography.com/Homepage/HomepageM.htm>
3. American Heart Association/American Stroke Association (2016). Spot a stroke FAST. Retrieved from http://www.strokeassociation.org/STROKEORG/WarningSigns/Stroke-Warning-Signs-and-Symptoms_UCM_308528_SubHomePage.jsp
4. Centers for Disease Control and Prevention (2011). Guidelines for field triage of injured patients: recommendations of the national expert panel on field triage, 2011. *Morbidity and Mortality Weekly Report*, 60 (1). Retrieved from <http://www.cdc.gov/mmwr/pdf/rr/rr6101.pdf>
5. National Association of EMS Physicians and American College of Surgeons Committee on Trauma (2013). EMS spinal precautions and the use of the long backboard. *Prehospital Emergency Care*. Retrieved from <http://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.773115?needAccess=true>
6. Centers for Disease Control and Prevention (2015). HEADS UP to health care providers. Retrieved from <http://www.cdc.gov/headsup/providers/index.html>
7. Centers for Disease Control and Prevention (2015). Sports concussion policies and laws. Retrieved from <http://www.cdc.gov/headsup/policy/>
8. National Institute of Neurological Disorders and Stroke (2016). NINDS traumatic brain injury information page. Retrieved from <http://www.ninds.nih.gov/disorders/tbi/tbi.htm>
9. White IV, C., Domeier, R., Millin, M., Standards and Clinical Practice Committee (2014). Resource Document to the position statement of the National Association of EMS Physicians and the American College of Surgeons Committee on Trauma. *Prehospital Emergency Care*. Retrieved from <http://www.tandfonline.com/doi/pdf/10.3109/10903127.2014.884197?needAccess=true>
10. Granville-Chapman, J., Jacobs, N., and Midwinter, M.J. (2010). Pre-hospital haemostatic dressings: a systematic review. *Academic Department of Military Surgery and Trauma, Royal Centre for Defense Medicine (United Kingdom)*. Retrieved from <http://citerahiadesgenettes.hautetfort.com/media/00/01/3315550226.pdf>
11. Kasotakis, G., Sideris, A., Yang, Y., de Moya, M., Alam, H., King, D., Tompkins, R., Velmahos, G., and the Inflammation and Host Response to Injury Investigators (2013). *Journal of Trauma, Acute Care, and Surgery* 74(5). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984883/>
12. The Taskforce on Hypertension in Pregnancy (2013). Hypertension in pregnancy. *The*

American College of Obstetricians and Gynecologists: Women's Healthcare Physicians.

Retrieved from

<https://www.acog.org/~media/Task%20Force%20and%20Work%20Group%20Reports/public/HypertensioninPregnancy.pdf>

13. American Heart Association (2015). Neonatal resuscitation. *American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*. Retrieved from <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/part-13-neonatal-resuscitation/?strue=1&id=1-1>
14. Centers for Disease Control and Prevention (2016). Antibiotic/antimicrobial resistance: biggest threats. Retrieved from http://www.cdc.gov/drugresistance/biggest_threats.html
15. Centers for Disease Control and Prevention (2016). Influenza (flu). Retrieved from <http://www.cdc.gov/flu/>
16. American College of Emergency Physicians (2016). Out of hospital use of analgesia and sedation: Policy Statement. Retrieved from [http://www.annemergmed.com/article/S0196-0644\(15\)01604-2/pdf](http://www.annemergmed.com/article/S0196-0644(15)01604-2/pdf)
17. Kosoko, A. and Ahn, J. (2013). Reducing pediatric pain and anxiety. *ACEP News*. Retrieved from <http://www.acepnow.com/article/reducing-pediatric-pain-anxiety-2/?singlepage=1&theme=print-friendly>
18. ACEP Excited Delirium Task Force (2009). White Paper Report on Excited Delirium Syndrome. *ACEP*. Retrieved from <http://www.fmhac.net/assets/documents/2012/presentations/krelsteinexciteddelirium.pdf>
19. Takeuchi, A., Ahern, T., and Henderson, S., (2011). Excited Delirium. *Western Journal of Emergency Medicine*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088378/>
20. Centers for Disease Control and Prevention (2016). Suicide: risk and protective factors division of violence prevention. Retrieved from <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>
21. Centers for Disease Control and Prevention (2015). Protecting kids from environmental exposure. Retrieved from <http://www.cdc.gov/features/pehsu/>
22. Poison Control Centers (2012). Poison and prevention information by age. Retrieved from <http://webpoisoncontrol.org/by-age>
23. Galli, J., Sawaya, R., Friedenber, F. (2011). Cannabinoid hyperemesis syndrome. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3576702/pdf/nihms353647.pdf>
24. Glauser, T., Shinnar, S., Gloss, D., Alldredge, B., Arya, R., Bainbridge, J., Bare, M., Bleck, T., Dodson, E., Garrity, L., Jagoda, A., Lowenstein, D., Pellock, J., Riviello, J., Sloan, E., and Treiman, D. (2016). Evidence-based guideline: treatment of convulsive status epilepticus in

- children and adults: report of the guideline committee of the American Epilepsy Society. *Epilepsy Currents*, 16(1). Retrieved from <http://www.epilepsycurrents.org/doi/pdf/10.5698/1535-7597-16.1.48>
25. Manivannan, V., Decker, W., Stead, L., Li, J., and Campbell, R. (2009). Visual representation of National Institute of Allergy and Infectious Disease and Food Allergy and Anaphylaxis Network criteria for anaphylaxis. *International Journal of Emergency Medicine*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2672985/>
 26. Campbell, R., Li, J., Nicklas, R., and Sadosty, A. (2014). Emergency department diagnosis and treatment of anaphylaxis: a practice parameter. Retrieved from <https://www.aaaai.org/Aaaai/media/MediaLibrary/PDF%20Documents/Practice%20and%20Parameters/Anaphylaxis-Practice-Parameter-2014.pdf>
 27. Department of Homeland Security. Human trafficking awareness training. *Blue Campaign*. Retrieved from <https://www.dhs.gov/blue-campaign/awareness-training>
 28. The Florida State University (2016). National Prevention Toolkit on Domestic Violence for Medical Professionals. Retrieved from <http://dvmedtraining.csw.fsu.edu/training/introduction/>
 29. Oehme, K., Stern, N., Donnelly, E., and Melvin, R. (2016). Improving the emergency medical services system's response to domestic violence. *Health Matrix: The Journal of Law-Medicine*. Retrieved from <http://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1590&context=healthmatrix>
 30. The National Highway Traffic Safety Administration (2015). NHTSA Advances ground ambulance safety by tracking and investigating crashes. Retrieved from <http://www.ems.gov/newsletter/marapr2015/ground-ambulance-safety.html>
 31. The National Highway Traffic Safety Administration. Real stories behind ambulance Safety data. Retrieved from <http://www.ems.gov/newsletter/novdec2015/real-stories.html>
 32. The National Highway Traffic Safety Administration (2014). The National Highway Traffic Safety Administration and ground ambulance crashes. Retrieved from <https://www.naemt.org/Files/HealthSafety/2014%20NHTSA%20Ground%20Amulance%20Crash%20Data.pdf>
 33. The National Highway Traffic Safety Administration (2011). When ambulances crash: EMS provider and patient safety. Retrieved from <http://media.cygnus.com/files/base/EMSR/document/2015/09/NHTSAOEMSAmbulanceInfographic.pdf>
 34. The National Highway Traffic Safety Administration, Health Resources and Services Administrations' EMS for Children Program, and the American College of Emergency Physicians (2013). Strategy for national EMS culture of safety. Retrieved from

- <http://www.emscultureofsafety.org/wp-content/uploads/2013/10/Strategy-for-a-National-EMS-Culture-of-Safety-10-03-13.pdf>
35. Federal Interagency Committee on Emergency Medical Services (2013). National implementation of the Model Uniform Core Criteria for mass casualty incident triage. Retrieved from <http://www.ems.gov/nemsac/dec2013/FICEMS-MUCC-Implementation-Plan.pdf>
 36. Centers for Disease Control and Prevention (2016). Hand hygiene guideline. Retrieved from <http://www.cdc.gov/handhygiene/providers/guideline.html>
 37. Association for Professionals in Infection Control and Epidemiology (2013). Guide to infection prevention in emergency medical services. Retrieved from https://www.ems.gov/pdf/workforce/Guide_Infection_Prevention_EMS.pdf
 38. Centers for Disease Control and Prevention (2016). Healthcare providers/professionals vaccination guide. Retrieved from <http://www.cdc.gov/vaccines/hcp/index.html>
 39. The National Highway Traffic Safety Administration (2012). Working group best practice recommendations for the safe transportation of children in emergency ground ambulances. Retrieved from <http://webcache.googleusercontent.com/search?q=cache:JOhTzZ9Ie48J:www.nhtsa.gov/staticfiles/nti/pdf/811677.pdf+&cd=1&hl=en&ct=clnk&gl=us>
 40. International Association of Fire Chiefs (2002). Crew resource management: a positive change for the fire service. Retrieved from http://www.iafc.org/files/ISAFEhealthSHS/pubs_CRMmanual.pdf
 41. The National Highway Traffic Safety Administration and the Maternal Child Health Bureau (2001). National EMS research agenda. Retrieved from http://www.ems.gov/pdf/National_EMS_Research_Agenda_2001.pdf
 42. The National Highway Traffic Safety Administration (2014). Safety in numbers: EMS data is important. Retrieved from https://www.ems.gov/pdf/ems-data/Provider-Resources/SafetyInNumbers_EMS_May2014.pdf
 43. Cardiac Arrest Registry to Enhance Survival (2014). CARES in action. Retrieved from <https://mycares.net/sitepages/uploads/2015/CARES%20in%20Action%20Abridged.pdf>
 44. National Association of State EMS Officials (2016). Statewide implementation of evidence based guidelines. Retrieved from <https://www.nasemso.org/Projects/ImplementationOfEBG/index.asp>
 45. National Association of State EMS Officials (2016). Statewide implementation of evidence based guidelines references. Retrieved from https://www.nasemso.org/Projects/ImplementationOfEBG/documents/EBG_Project_References_v2.0.pdf
 46. National Prehospital Evidence based Guideline Model Process. Retrieved from

<https://www.nasemso.org/Projects/ImplementationOfEBG/documents/National-Prehospital-Evidence-Based-Guideline-Model-Process.pdf>

47. Shah, M., Macias, C., Dayan, P., Weik, T. Brown, K., Fuchs, S., Fallat, M., Wright, J., and Lang, E. (2013) An evidence-based guideline for pediatric prehospital seizure management using GRADE methodology. *Prehospital Emergency Care*. Retrieved from <http://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.844874?needAccess=true>
48. Gausche-Hill, M., Brown, K., Oliver, Z., Sasson, C., Dayan, P., Eschmann, N., Weik, T., Lawner, B., Sahni, R., Falck-Ytter, Y., Wright, J., Todd, K., and Lang, E. (2013). An evidence-based guideline for prehospital analgesia in trauma. *Prehospital Emergency Care*. Retrieved from <http://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.844873?needAccess=true>
49. Thomas, S., Brown, K., Oliver, Z., Spaite, D., Lawner, B., Sahni, R., Weik, T., Falck Ytter, Y., Wright, J., and Lang, E. (2013). Evidence-based guideline for the air medical transportation of prehospital trauma patients. *Prehospital Emergency Care*. Retrieved from <http://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.844872?needAccess=true>

END OF DOCUMENT