KING COUNTY EMERGENCY MEDICAL SERVICES **RECERTIFICATION**	**SKILLS CHECKLIST** **2003 CBT 442 STROKE**

EMT NAME & #	PLEASE PRINT YOUR NAME	**DATE**	

Goal: Early recognition, meaningful treatment, and safe rapid transport to the appropriate facility.

Objective: Given a partner, relevant equipment and a patient with stroke symptoms, the EMT will demonstrate recognition and treatment as specifically identified in the KC BLS Patient Care Guidelines.

SCENE SIZE-UP

• Scene Safety	• Body Substance Isolation	• Additional Resources

INITIAL ASSESSMENT

• Level of Consciousness	• Airway	• Breathing	• Circulation and C-Spine Precaution	• Bleeding

SUBJECTIVE (FOCUSED HISTORY)

- Reassured and tried to calm patient
- Found out patient's chief complaint (SAMPLE & OPQRST)
- Determined *time* of symptom onset
- Record Medications
- Record stroke risk factors

OBJECTIVE (FOCUSED PHYSICAL EXAM)

- Recorded and documented baseline vital signs
- Evaluated patient using the Cincinnati Stroke Scale (Facial Droop, Arm Drift, and Speech)
- Checked swallowing ability (if indicated)
- Describe stroke affects not covered by Stroke Scale
- Followed up with second set of vital signs

ASSESSMENT (IMPRESSION)

- State opinion on patient's condition
- State ALS indicators and/or BLS indicators

PLAN *(TREATMENT)*

- Requested medics if indicated
- Position patient upright
- Opened and managed patient's airway
- Delivered high flow oxygen, ventilatory assistance as necessary
- Maintained normal body temperature
- Protected paralyzed limbs
- Monitored vital signs

COMMUNICATION

- Delivered **Short Radio Report** within 60 seconds

DOCUMENTATION

- Completed **SOAP** narrative portion of Medical Incident Report Form

RECERTIFY	**YES?**	**NO?**	**EVALUATOR**	PLEASE PRINT YOUR NAME AND SIGN

KING COUNTY EMERGENCY MEDICAL SERVICES **RECERTIFICATION**	**SKILLS CHECKLIST** **2003 CBT 432 CHEST PAIN**

EMT NAME & #	PLEASE PRINT YOUR NAME	**Date**	

Goal: Early recognition, meaningful intervention, and safe rapid transport to ER.

Objective: Given a partner, equipment and a patient with chest pain demonstrate treatment as specifically identified in the KCEMS CBT & BLS Patient Care Guidelines.

SCENE SIZE-UP

• Scene Safety	• Body Substance Isolation	• Additional Resources

INITIAL ASSESSMENT

• Level of Consciousness	• Airway	• Breathing	• Circulation	• Defibrillation

SUBJECTIVE (FOCUSED HISTORY)

- Established report with patient and obtained consent to treat
- Reassured and calmed patient
- Obtained names of current medications
- Found out patient's chief complaint and followed SAMPLE & OPQRST investigation

OBJECTIVE (FOCUSED PHYSICAL EXAM)

- Recorded and documented baseline vital signs
- Examined HEENT
- Followed up with second set of vital signs and compared to baseline vital signs
- Attached cardiac monitor and recorded strip, if authorized

ASSESSMENT (IMPRESSION)

- Stated type of "chest pain"
- Determine if ALS indicators present

PLAN (TREATMENT)

GENERAL CARE
- Positioned patient appropriately
- Administered appropriate O2
- Assisted with Nitro if BP ^100
- Assisted with a BVM if appropriate
- Suctioned if necessary
- Prepared patient for transport
- Monitored patient's vitals

ADMINISTRATION OF NITRO
- Asked patient and checked prescription info
- Positioned patient before admin meds
- Checked Nitro expiration date & dosage
- Handed Nitro to patient
- Checked for effectiveness (did it burn?)
- Monitored and documented V/Signs

COMMUNICATION

- Delivered short radio report within 60 seconds

DOCUMENTATION

- Completed SOAP narrative portion of Medical Incident Report.

RECERTIFY	**YES?**	**NO?**	**EVALUATOR**	PLEASE PRINT YOUR NAME AND SIGN

KING COUNTY EMERGENCY MEDICAL SERVICES **RECERTIFICATION**	**SKILLS CHECKLIST** **2003 CBT445 HEAD & SPINAL INJURIES**

EMTNAME & #	PLEASE PRINT YOUR NAME	**DATE**	

Goal: Early recognition, meaningful treatment, and safe rapid transport to the appropriate facility.

Objective: Given a partner, relevant equipment and a patient with a head and /or spinal injury demonstrate treatment as specifically identified in the BLS Patient Care Guidelines.

SCENE SIZE-UP

• Scene Safety	• Body Substance Isolation	• Additional Resources

INITIAL ASSESSMENT

• Level of Consciousness	• Airway	• Breathing	• Circulation and C-Spine Precaution	• Bleeding

SUBJECTIVE (FOCUSED HISTORY)

- Found out about Mechanism of Injury
- Found out about patient's complaint from neurologic injury
- Reassured and tried to calm patient

OBJECTIVE (FOCUSED PHYSICAL EXAM)

- Recorded and documented baseline vital signs
- Used Glasgow Coma Scale
- Exposed and examined injury for location
- Followed up with second set of vital signs
- Evaluated for peripheral effects of injury
- Evaluate for additional injuries

ASSESSMENT (IMPRESSION)

- Stated type of head and/or spinal injury
- State opinion of type of head or spinal injury
- State ALS indicators and/or BLS indicators
- Determined treatment plan based on head and/or spinal injury
- Considered severity and need for ALS intervention (intubation, IV's or medication)

PLAN (TREATMENT)

- Request medics if indicated
- Insure open airway
- Use high flow oxygen
- Ventilate as needed
- Apply C-collar and immobilize on backboard
- Maintain body temperature

COMMUNICATION

- Delivered short radio report within 60 seconds

DOCUMENTATION

- Completed **SOAP** narrative portion of Medical Incident Report Form

RECERTIFY	**YES?**	**NO?**	**EVALUATOR**	PLEASE PRINT YOUR NAME AND SIGN

KING COUNTY EMERGENCY MEDICAL SERVICES **RECERTIFICATION**	**SKILLS CHECKLIST** **2003 CBT 450 DIABETIC EMERGENCIES**

EMT NAME & #	PLEASE PRINT NAME	**DATE**	

Goal: Early recognition, meaningful treatment, and safe rapid transport to the appropriate facility.

Objective: Given a partner, relevant equipment and a patient with a diabetes emergency treatment as specifically identified in the BLS county protocols.

SCENE SIZE-UP

• Scene Safety	• Body Substance Isolation	• Additional Resources

INITIAL ASSESSMENT

• Level of Consciousness	• Airway	• Breathing	• Circulation and C-Spine Precaution	• Bleeding

SUBJECTIVE (FOCUSED HISTORY)

- Reassured and tried to calm patient
- Found out patient's chief complaint (**SAMPLE & OPQRST**)
- Record patient's medicines
- Found out about Mechanism of Injury

OBJECTIVE (FOCUSED PHYSICAL EXAM)

- Recorded and documented baseline vital signs (HR, BP, Skin Vitals)
- Exposed and examined injury for location and severity
- Checked swallowing ability if decreased LOC
- Checked and assessed GCS
- Obtained recent glucometer reading
- Followed up with second set of vital signs

ASSESSMENT (IMPRESSION)

- Stated suspicions (hypoglycemia, hyperglycemia or DKA)
- Considered severity and need for ALS intervention (intubation, IV's or medication)

PLAN (TREATMENT)

- Requested medics as indicated
- Maintain airway
- Assisted conscious patient with oral glucose
- Administered oxygen appropriately (nasal cannula, non-rebreather mask or bag valve mask)
- Kept patient warm
- Re-evaluated vital signs in response to sugar
- Observed additional oral intake if responded to glucose
- Reviewed patient's usual treatment for hyperglycemia
- Position patient appropriately (upright)
- Prepare patient for transport if needed

COMMUNICATION

- Delivered short radio report within 60 seconds

DOCUMENTATION

- Completed SOAP narrative portion of Medical Incident Report Form

RECERTIFY	**YES?**	**NO?**	**EVALUATOR**	PLEASE PRINT NAME AND SIGN