1. This organization develops standards

B. Department of Labor
   1. EMS task analysis
   2. Some standards and guidelines
   3. Curricula

C. Department of Energy
   1. Curricula: transportation of hazardous materials and radioactive materials

D. Centers for Disease Control
   1. For infectious disease (ID) curricula materials
   2. Many provided as text, PowerPoint and Adobe Acrobat files as free non-copyrighted materials
   3. Email listservers provide access to updated reports and news items free of charge

E. Occupational Safety and Health Administration
   1. For ID and worker safety standards and guidelines
   2. Curricula

F. Federal Emergency Management Agency
   1. Standards and guidelines
   2. Curricula: disaster management, mass casualty, etc.

G. Department of Transportation: National Highway Traffic Safety Administration (NHTSA)
   1. National Standard Curricula for all levels of EMS provider including refresher training and instructor training curricula
   2. Many resources provided as text, brochures and computer based presentations
   3. Many provided free of charge

H. US Department of Health and Human Services
   1. Pediatric curricula
   2. Family support services materials
   3. General health data and epidemiological resources

I. Emergency Medical Services for Children
   1. Pediatric curricula (PEPP and others)
   2. National clearinghouse for pediatric resources
   3. Many resources provided as text, brochures and computer based presentations
   4. Many provided free of charge

J. National Registry of EMTs
   1. Private organization that is a national licensing body for EMS that many states participate in
   2. Practical skills sheets that detail many EMS skills
   3. Available on-line free of charge
   4. Practice tests (computerized and "correspondence type")

IX. Allies or mentors may be found within other public service agencies
   A. Fire service based
      1. National Fire Academy
      2. International Fire Service Training Instructors
   B. Police based
      1. NFPA

X. National EMS professional associations
   A. NAEMT
   B. Unions accepting EMS workers
   C. National EMS educational organizations
      1. NAEMSE
      2. Sub-groups within other EMS organizations

XI. Groups focusing on EMS administration
   A. NASEMSTC

B. National EMS State Directors
C. AAA American Ambulance Association

XII. Other groups that may be useful sources of information
A. Physician based groups
B. Nursing and allied health groups with EMS focus
C. Individual state EMS educators association

XIII. Groups with established training programs (continuing education)
A. AHA: ACLS, BCLS, PALS, AED
B. ARC: BLS, AED
C. ATLS
D. BTLS International: BTLS, PBTLS, Access
E. Wilderness Medic
F. Farmedic
G. AMLS
H. PHTLS (including combat Medic module)
I. Pediatric Education for Prehospital Professionals (PEPP)
J. Traumatic Brain Injury Program
K. Other programs also exist and more are being added all the time
1. Many of these programs, or parts of these programs may be available for you to use even if you are not offering the course for certification

XIV. Accrediting bodies
A. CAAHEP Commission for the Accreditation of Allied Health Education Programs
B. CoAEMSP Committee on Accreditation of EMS Programs
C. CECBEMS Continuing Education Coordination Board for EMS
D. College and university accrediting boards and groups
1. Accreditation for Internet based programs and schools
a. Scrutinize these groups closely to determine who they are
b. College and university accrediting bodies may know of these groups

XV. Internet based resources
A. Evaluate site for bias, quality, and age of the material
B. List of Internet addresses with free resources (attachment 3)

XVI. Medical and EMS trade journals and magazines
A. Peer reviewed is generally the most scientific
1. Many are devoted to sub-specialties of EMS like rescue, administration, legal issues, etc
B. Continuing education resources
1. Refer to previous list
2. CECBEMS is one of several organizations that accredits continuing education offerings by organizations
3. State EMS agency may have a process or standard in place for quality assurance

XVII. Refresher training
A. NREMT has a standard in place that many states follow
B. Publishers of EMS and health related materials have resources
C. Test banks - may be provided when an institution purchases a large volume of texts
D. Instructor resource guides - often include lesson plans, outlines, lecture aids (e.g., computerized presentations, handouts, overheads, etc.)

XVIII. Skill sheets
A. May accompany textbooks
B. Downloadable from some websites (e.g., NREMT)

XIX. Computerized and multimedia resources
A. Realistic looking and reacting manikins

B. Videotapes
C. Audiotapes
D. CD-Rom, DVD, and other technology based programs with case studies, simulations, games, and learning content

XX. Moulage kits
A. Available from medical appliance manufacturers
B. Build your own
C. Keep an eye out for old clothes, toys and discarded items to use in your own kit
D. Yard and garage sales, and thrift shops
E. Buy make-up from a clearance bin or after holidays like Halloween when it is significantly marked down
F. Attend a class on theatrical make-up or moulage techniques
G. Develop a relationship with a local theatre group
H. Local mortuary may be a resource for make-up and a make-up artist

XXI. Your medical director is one of your best resources
A. He or she should be involved in your program and course design and development
B. He or she should be visiting regularly with your students
C. He or she may also be called upon to teach in your program, but remember, being a medical director does not mean instructional ability

XXII. Other faculty members in your program
A. A team approach leads to the best students
B. Other instructors help solve problems and may have a better perspective on an issue
C. They may have resources to share or teaching tips and tricks

XXIII. Your clinical preceptors as a resource
A. The integration of the clinical aspects of your program with the didactic is critical to a successful program
B. Provide preceptors with a written feedback tool
C. Use preceptors' opinions as a measure of the success of the delivery of content
D. Invite preceptors to participate in meetings and decision making
E. Affective domain evaluations on students should be completed by preceptors

XXIV. Your program advisory board
A. You may have access to the members of your program's advisory board (or some other group of individuals who have been brought together to provide guidance to your program)
B. These individuals are generally representing groups and agencies that work closely with your students
C. They can be valuable sources of information for you as you plan instruction or can provide feedback on how your students are performing on the job
D. This group should meet at least annually to review the success of the program (e.g., review testing results) and should recommend curriculum changes when appropriate

XXV. Graduated students and communities of interest surveys
A. Surveys allow graduates to provide anonymous feedback about the program
1. Did the program adequately prepare them for testing and working as a Paramedic?
B. Surveys of EMS agencies in your service area allow employers to provide anonymous feedback about interns and graduates now employed by them

XXVI. The role of community service in professional development
A. Fulfills the mission of the EMS Agenda for the Future
B. Provides public education on injury prevention
C. Providing presentations to public groups allows you to hone your presentation skills in a less threatening environment than the EMS classroom
1. Provides growth opportunities for students as well
D. Provides an opportunity to educate the public about our mission

E. Helps us develop or maintain a positive image with the public
F. You have the opportunity to "give something back" to the EMS community when you volunteer to help out at an EMS course
G. May develop new markets for EMS by making the public aware of the depth and breadth of knowledge in EMS

Module 23: Research

Cognitive goals

At the completion of this module, the student-instructor will be able to:

1. Describe the nature and characteristics of research as it relates to the practice of EMS
2. Understand the common types and methods of conducting research
3. Distinguish between the different types of research commonly conducted in the EMS setting
4. Understand how research studies are designed and conducted
5. Describe methods used to read the research literature with understanding
6. Identify sources for locating relevant research materials and findings

Psychomotor goals

There are no psychomotor objectives for this section

Affective goals

At the completion of this module, the student-instructor will be able to:

1. Defend the importance of teaching research methods in the curriculum
2. Value the importance of research in the clinical and educational settings of EMS
3. Value the need to assist in the research process and data collection activities
4. Explain the value of research to the EMS provider and the EMS Educator

Declarative

I. Why this module is important
   - A. The professional literature of EMS is expanding every year
     1. Most of that literature deals with research results
   - B. Historically, EMS have relied on observation and common sense approaches to treatment and clinical interventions
     1. Currently the focus is on scientific evidence to determine the efficacy of treatment and clinical interventions
   - C. EMS educators should design and conduct educational research that forms a scientific basis for instructional methodologies and interventions dealing with EMS education settings
   - D. EMS providers and educators should be familiar with research
     1. Should participate in research
     2. Possess an understanding of the basic tenets of the research process
        - a. Instill knowledge about and appreciation for the research process in students
        - b. Model appreciation of benefits of research
          - i. Participating in and design research projects for clinical and education practice
   - E. Research is a tool
     1. Allows our profession to expand and provides for meaningful advancement of knowledge in EMS education and practice
     2. Responsibility of professional EMS educators to strive to understand what leads to student's success, retention of information, retention of skills and transference of classroom experiences into successful clinical experiences and career satisfaction

II. Overview of EMS research
   - A. EMS Agenda for the Future
   - B. Revision of BLS and ALS curricula
   - C. NAEMSE Educator NSC development

III. The nature of research
   - A. Research should be empirical, valid, reliable and follow a scientific method

- B. Empirical
  1. Empiricism is the doctrine that all knowledge is derived from experience
  2. Evidence derived from research is in the form of some type of data
  3. Research is directed towards one of two outcomes
     a. Extension of existing knowledge
     b. The solution of an existing problem
- C. Validity
  1. Internal validity: The extent to which the results can be accurately interpreted External validity: The extent to which the results can be generalized to populations
- D. Reliable
  1. Consistency of the study
  2. Ability of other researchers to replicate the study
  3. Necessary for validity
- E. Systematic in approach
  1. Scientific method
     a. Identification of problem
     b. Reviewing of existing information related to problem
     c. Collecting data
     d. Analyzing data
     e. Drawing conclusions from data
  2. EMS research should be systematic
     a. Systematic research increases both the reliability and validity of the findings

IV. Activities in the research process
- A. Identification of the research problem
- B. Hypothesis are generated (tentative guesses about what is being studied)
  1. Review of the existing literature (to determine what others have done and how they designed their research)
  2. Identification of what data will be collected (variables of the study)
- C. Data collection
  1. The experiment is conducted at this point and observations are made
  2. Data is assembled and prepared for analysis
- D. Analysis
  1. Data are summarized
  2. Statistical analysis is conducted
- E. Summarize results and draw conclusions
  1. Conclusions drawn as to how the results relate to the research problem
  2. Conclusions drawn as to how the results relate to the existing knowledge
  3. Possible explanations of the results are provided

V. Classification of research
- A. Basic research
  1. Primary purpose is the extension of knowledge
- B. Applied research
  1. Primary purpose is the solution of an immediate problem

VI. Qualitative research
- A. Conducted for the purpose of understanding social phenomena
- B. Relies on the researcher inclusion in the situation being studied
- C. Relies on narrative descriptions

VII. Quantitative research
- A. Conducted to determine the relationship and effects and causes of the relationship
- B. Relies on statistical results represented as numbers
- C. This is the type of research most often conducted in EMS clinical and educational settings

VIII. Experimental research

A. A type of quantitative research
B. Involves situations in which at least one variable is deliberately manipulated or varied by the researcher to determine the effects of the variation
    1. The researcher determines the variable and the extent to which it will be varied
    2. Possible to have more than one variable in an experiment
C. Participants are randomly assigned to groups
D. Researcher controls all of the factors that could bias or slant the outcome of the experiment
E. Considered the "gold standard" for clinical research design
    1. Virtually impossible to conduct in true emergency settings, since it requires withholding of standard treatment from a randomly selected patient
    2. This research design has a high probability of producing valid and correct findings

IX. Quasi-experimental research
A. Similar to experimental research, but the participants are in naturally assembled groups, for example, a paramedic class
B. Not conducted in a laboratory but in a natural setting
C. Results are less straightforward than true experimental research and more susceptible to ambiguity when interpreted

X. Survey research
A. Deals with the incidence, distribution and relationships between educational, psychological and sociological variables
B. No experimental variables are manipulated
C. Variables are studied as they exist in a natural situation

XI. Understanding the components of a research article
A. Introduction section
    1. Defines the topic being investigated in clear specific terms
    2. Terms used in describing the research problem are defined
B. Review of the literature
    1. Provides the background and context for the research problem
    2. Establishes need for further research in the area
    3. Establishes that the researcher has a good understanding of the topic to be researched
C. Methods
    1. The heart of the research project
    2. Describes the measurement instruments used or developed.
    3. Describes the individuals participating in the research (subjects.)
    4. Describes the sample (design and numbers.)
    5. Describes the data collection methods
    6. Describes the specific data analyses methods used
D. Results
    1. The products of the data analyses
    2. Descriptive statistics
E. Conclusions
    1. Identifies all noteworthy results
    2. Interprets results relative to the research problems and in the context of related research and theory to draw conclusions
    3. Explains any inconsistency
    4. Discusses the limitations of the study
    5. Identifies directions for future research
    6. Address the degree to which the results of the study can be generalized to a larger population or group

XII. The role of statistical analysis in the research process
1. Descriptive statistics
    1. Summarize or describe the characteristics of a set of data in a clear and convenient manner

a. Example: your grade point average is a convenient summary of all the grades you received in school

2. Inferential statistics
    1. Makes it possible to draw inferences about what is happening in the entire population based on a sample from the population
        a. A population is defined an entire group of people, objects, or events having at least one characteristic in common
        b. Populations are typically very large
        c. A sample is a subgroup selected from the complete population
            i. A sample must be selected in such a manner that it is representative of the entire population
            ii. Use of random selection processes makes certain the every person, object or event from the population has an equal chance of being included in the sample
            iii. In this way, inferences can be drawn from sample regarding the population
                a. This is referred to as the ability to "generalize" the results of research conducted on a sample to the entire population
        d. Using the techniques and mathematics of inferential statistics it is possible to be reasonably confident that the results are representative of the entire population

a. Statistics help the researcher decide if the results are true differences or just coincidences

XIII. The value of understanding research methods and literature

. Three major reasons why knowledge of research methods is essential for EMS providers and educators
    1. To understand the professional literature
    2. To understand the rationale underlying research in EMS
        a. Ability to comprehend the essential nature of the strengths and weaknesses of the techniques used to collect information and draw conclusions
    3. To conduct or to assist in the conduction of research projects
        a. Can influence change in professional standards and practice

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APPENDIX I: ACTION VERBS USEFUL FOR WRITING OBJECTIVES

COGNITIVE DOMAIN

Knowledge:	Arrange, Define, Describe, Identify, Label, List, Name, Identify, Match, Memorize, Order, Recognize, Recall, Recite, Repeat
Comprehension:	Classify, Discuss, Distinguish, Explain, Identify, Indicate, Locate, Review, Rewrite, Summarize, Tell, Translate
Application:	Apply, Choose, Compute, Demonstrate, Operate, Practice, Prepare, Solve
Analysis:	Analyze, Calculate, Compare, Contrast, Criticize, Diagram, Differentiate, Distinguish, Examine, Experiment, Evaluate, Relate, Separate, Select
Synthesis:	Assemble, Compose, Construct, Create, Combine, Design, Formulate, Organize, Prepare, Set up, Summarize, Tell, Write
Evaluate:	Appraise, Evaluate, Judge, Score

PSYCHOMOTOR DOMAIN

- ☐ Imitation: Repeat, Mimic, Follow
- ☐ Manipulation: Practice with minimal assistance, Create, Modify
- ☐ Precision: Perform without error, Perform without assistance
- ☐ Articulation: Demonstrate proficiency, Perform with confidence, Perform with style or flair
- ☐ Naturalization: Perform automatically

AFFECTIVE DOMAIN

- ☐ Receiving: Accept, Attempt, Willing
- ☐ Responding: Challenge, Select, Support, Visit
- ☐ Valuing: Defend, Display, Offer, Choose
- ☐ Organization: Judge, Volunteer, Share, Dispute
- ☐ Characterization: Consistently, Join, Participate

ACTION VERBS FOR WRITING GOALS

- ☐ Know
- ☐ Realize
- ☐ Enjoy
- ☐ Believe
- ☐ Understand
- ☐ Appreciate
- ☐ Value
- ☐ Comprehend
- ☐ Aware
- ☐ Tolerate
- ☐ Be familiar with
- ☐ Desire
- ☐ Feel
- ☐ Write

Appendix II: Academic Honesty College Procedure

Title: 10.02.01 ACADEMIC HONESTY

College Policy Number/Title: 10.02/Academic Honesty

A. General Statement

Academic honesty is a matter of concern to anyone connected with Howard Community College. A clearly and carefully thought-out policy and set of procedures can guide students and faculty members toward the accomplishment of academic honesty. Communication of these procedures will be accomplished through the following sources:

1. All catalogues, class schedules and course outlines will contain at least the statement: *"Academic honesty, as defined in the Student Handbook, is expected of all students."*
2. A statement of Policies and Procedures will be contained in the Faculty and Student Handbooks.

B. Definition

1. Academic Honesty means the use of one's own thought and materials in the writing of papers, taking of tests, and other classroom related activities. Any students intentionally aiding another student in any infraction of the academic honesty policy is considered equally guilty.
2. Students are expected to give full credit for the borrowing of other's words or ideas. Intentional or unintentional use of another's words or ideas without acknowledging this use constitutes plagiarism. There are four common forms of plagiarism:
   a. The duplication of an author's words without quotation marks and accurate references or footnotes.
   b. The duplication of an author's words or phrases with footnotes or accurate references, but without quotation marks.
   c. The use of an author's ideas in paraphrase without accurate references or footnotes.
   d. Submitting a paper in which exact words are merely rearranged even though footnoted.
3. Misrepresentation is the submission of materials for evaluation that are not the student's own.
4. Unauthorized use of notes or another individual's materials, copying, using another individual's materials, or unauthorized prior knowledge of the contents of tests, quizzes or other assessment instruments shall be considered a violation of the Academic Honesty Policy.

C. Penalties

As the college expects academic honesty, there must be procedures for dealing with intentional infractions of the Academic Honesty Policy.

1. First Infraction

For the first infraction of the Academic Honesty Policy the faculty member shall give the student an "F" or its equivalent on the paper, examination, or presentation in question. **The faculty member will notify the student and explain the reason for the grade.** This action could result in a lower final grade. The appropriate division chairperson will be informed of the infraction in writing and the Vice President of Student Services will notify the student in writing of the consequences and implications of this infraction.

2. Second Infraction

A second infraction of academic dishonesty, either in the same course or in another course, will result in an automatic "F" in the course in which the second infraction occurred. The student will be dropped from the course and barred from further class participation. The appropriate division chairperson will be informed of the incident in writing and will notify the Vice President of Student Services. **In cases where the second infraction occurs in the same course, the faculty member will notify the student and explain the reason for the "F" in the course. In other cases, the Vice President of Student Services will notify the student of the "F" in the course.** The Vice President of Student Services will notify the Director of Records and Registration that the student is to receive an "F" grade for the course. The Vice President of Student Services will meet with the student involved and apprise the student of the implication of this second infraction.

3. Third Infraction

A third infraction of academic dishonesty, either in the same course or in another course, will result in an

automatic "F" in the course in which the third infraction occurred. The student will be barred from further class participation. The appropriate division chairperson will be informed of the incident in writing and will notify the Vice President of Student Services. In cases where the third infraction occurs in the same course, the faculty member will notify the student and explain the reason for the "F" in the course. Otherwise, the Vice President of Student Services will notify the student of the "F" in the course. The Vice President of Student Services will notify the Director of Records and Registration that the student is to receive an "F" grade for the course. A third instance of plagiarism or any behavior involving an infraction of the Academic Honesty Policy will result in disciplinary action as determined by the Student Judicial Process

APPENDIX III: Classroom Behavior, "A Practical Guide for Faculty"

Classroom Disruption is a Disciplinary Offense
The term "classroom disruption" means behavior a reasonable person would view as substantially or repeatedly interfering with conduct of a class. Examples range from persisting to speak without being recognized, to resorting to physical threats or personal insults.

Academic Freedom
College policies on classroom disruption cannot be used to punish lawful classroom dissent. The lawful expression of a disagreement with a teacher or other students is not itself "disruptive behavior."

Rudeness, incivility, and disruption are often distinguishable, even though they may intersect.
In most instances, it's better to respond to rudeness by example and suasion (e.g., advising a student in private that he or she appears to have a habit of interrupting others.) Rudeness can become disruption when it is repetitive, especially after a warning has been given.

Strategies to Prevent & Respond to Disruptive Behavior

Clarify standards for the conduct of your class. For example, if you want student to raise their hands for permission to speak, say so.

Serve as a role model for the conduct you expect from your students.

If you believe inappropriate behavior is occurring, consider a general word of caution, rather than warning a particular student (e.g., "we have too many contemporaneous conversations at the moment; let's all focus on the same topic.")

If the behavior is irritating, but not disruptive, try speaking with the student after class. Most students are unaware of distracting habits or mannerisms, and have no intent to be offensive or disruptive.

There may be rare circumstances when it is necessary to speak to a student during class about his or her behavior. Do so in a firm and friendly manner, indicating that further discussion can occur after class.

A student who persists in disrupting a class may be directed by the faculty member to leave the classroom for the remainder of the class period. The student should be told the reason(s) for such action, and given an opportunity to discuss the matter with the faculty member as soon as practicable. Prompt consultation should be undertaken with the department chair and the dean of students. Suspension for more than one class period requires disciplinary action, in accordance with the Code of Student Conduct.

If a disruption is serious, and other reasonable measures have failed, the class may be adjourned, and campus security should be summoned.

Code of Conduct Violation
Disruptive classroom behavior is a disciplinary violation under the HCC's Student Code of Conduct. As such, students accused of this type of violation are subject to a disciplinary conference or hearing, depending upon the nature and frequency of the disruption.

Procedural Protections
Students accused of disciplinary violations are entitled to the following procedural protections:

To be informed of the specific charges against them, and the identity of the complainant.

To be allowed to request an informal resolution of the case.

To be allowed reasonable time to prepare a defense.

To hear and respond to all evidence upon which a charge is based.

To call and confront relevant witnesses.

To be assured of confidentiality, in accordance with the terms of the *Family Educational Rights and Privacy Act of 1974*.

To be allowed to request that any person conducting a disciplinary conference, or serving as a discipline conference committee member or chair, be disqualified on the ground of personal bias.

To be provided with a copy of these rights prior to any conference of discipline hearing.

To be considered innocent of the charges until proven guilty by clear and convincing evidence.

Sources: HCC Conduct Code *Synfax Weekly Report,* April 1, 1996

APPENDIX IV: Student Counseling Report (Sample)

This counseling report will be made part of the following student's file.
Student Name:_____Date: _____
Person Issuing Counseling:_____Title: _____

Section I:
Behavioral: The following deficiency has been noted in your behavior while participating in the Emergency Medical Services program.

Penalty: First offense will be met with a counseling. Second offense will be met with a one-week suspension from participation in the program. Third offense will be met with a failing grade in the course and the possibility of permanent discharge from the program. A first or second offense, if judged severe enough by the program coordinator, can lead to a failing grade in the course and the possibility of permanent discharge from the program.

1. Integrity: Being of sound moral principle; honesty and sincerity.
2. Empathy: An understanding of another person's situation / illness.
3. Self-Motivation: The ability to show inner drive toward good intention.
4. Appearance / Personal Hygiene: Neat, clean and non-malodorous.
5. Teamwork and Diplomacy: Working in a cooperative manner with respect for others.
6. Respect: To show consideration with deference or courtesy.
7. Patient Advocacy: Acting in the best interest of / for the patient.

Section II:
Conduct: The following action(s) has / have been noted as unacceptable while participating in the Emergency Medical Services program.

Penalty: A Group I offense will be met with a failing grade in the course and the possibility of permanent discharge from the program. A Group II offense will be met with the rules as stated in Penalty of Section I.

Group I

1. Obtaining, possessing, selling or using marijuana, unprescribed narcotics or alcohol while within the confines of the program. Reporting to class, lab or a clinical site under the influence of any of these substances.

2. Theft, abuse, misuse or destruction of any property or equipment of any patient, visitor, student, college employee, clinical employee, the college or clinical sites.
3. Disclosing confidential information without proper authorization.
4. Immoral, indecent, illegal or unethical conduct.
5. Possession, wielding or threatening to use any weapon while within the confines of the program.
6. Assault and/or battery on any patient, visitor, student or faculty.
7. Misuse or falsification of patient, student or official records.
8. Removal of patient, student or official records without prior authorization.
9. Cheating on any test, form or official record of the program.

The following Group I offense(s) has/have occurred: #____,____,____, ____
Explanation:

_____

_____

Group II

1. Engaging in disorderly conduct that could ultimately threaten the physical well being of any patient, visitor, student, faculty or clinical site employee.
2. Leaving class, lab or a clinical area without proper authorization.
3. Sleeping during class, lab or scheduled hospital clinical.
4. Restricting or impeding clinical output.
5. Insubordination and/or refusal to obey the orders of any faculty, administrative representative of the college or clinical site employee.
6. Inconsiderate treatment of patients, visitors, students, faculty or clinical site employees.
7. Excessive absences.
8. Failure to be ready for a clinical assignment at the starting time.
9. Failure to perform or to exercise reasonable care in the performance of responsibilities.
10. Violation of safety regulations or failure to use safety equipment provided.
11. Misuse of clinical time.
12. Unauthorized use of equipment.
13. Smoking in restricted areas.
14. Unauthorized posting, removing, or tampering with bulletin board notices.
15. Unauthorized soliciting, vending, or distribution of written or printed material.
16. Creating or contributing to unsafe or unsanitary conditions.
17. Threatening, intimidating or coercing other students, patients, visitors, faculty or clinical site employee.
18. Individual acceptance of gratuities from patients.
19. Inappropriate dress or appearance based on program regulations.
20. Other ◆ as deemed necessary by College personnel.

The following Group II offense has occurred: #____,____,____,____,____, ____
Explanation:

_____

_____

_____

Follow up: (include specific expectations, clearly defined positive behavior, actions that will be taken if the behavior continues, dates of future counseling sessions, etc.):

_____

_____

_____Edison College Personnel (printed): _____

Title: _____
Signature: _____

I have read this notice, have spoken with my instructor and have had a chance to discuss this. I understand this report and agree to abide by the rules of the College and the program.
Student Name (printed): _____

Signature: _____
Comments:

_____

I have reviewed this counseling record.
Coordinator:_____Date: _____
Medical Director:_____Date: _____
Comments:

_____

_____

Appendix V: Affective Domain Evaluation Tools

(Excerpt from 1998 EMT-P: NSC)

INSTRUCTIONS FOR AFFECTIVE STUDENT EVALUATIONS

There are two primary purposes of an affective evaluation system: 1) to verify competence in the affective domain, and 2) to serve as a method to change behavior. Although affective evaluation can be used to ultimately dismiss a student for unacceptable patterns of behavior that is not the primary purpose of these forms. It is also recognized that there is some behavior that is so serious (abuse of a patient, gross insubordination, illegal activity, reporting for duty under the influence of drugs or alcohol, etc) that it would result in immediate dismissal from the educational program.

The two forms included in the EMT-Paramedic: National Standard Curricula were developed by the Joint Review Committee on Educational Programs for the EMT-Paramedic. They represent extensive experience in the evaluation of student's affective domain. The nature of this type of evaluation makes it impossible to achieve complete objectivity, but these forms attempt to decrease the subjectivity and document affective evaluations.

In attempting to change behavior it is necessary to identify, evaluate, and document the behavior that you want. The eleven affective characteristics that form the basis of this evaluation system refer to content in the Roles and Responsibilities of the Paramedic unit of the curriculum. Typically, this information is presented early in the course and serves to inform the students what type of behavior that is expected of them. It is important that the instructor is clear about these expectations.

Cognitive and psychomotor objectives are relatively easy to operationalize in behavioral terms. Unfortunately, the nature of the affective domain makes it practically impossible to enumerate all of the possible behaviors that represent professional behavior in each of the eleven areas. For this reason, the instructor should give examples of acceptable and unacceptable behavior in each of the eleven attributes, but emphasize that these are examples and do not represent an all inclusive list.

The affective evaluation instruments included in this curriculum take two forms: A Professional Behavior Evaluation and a Professional Behavior Counseling Record. The Professional Behavior Evaluation should be completed regularly (i.e. every other week, once a month, etc.) by faculty and preceptors for each student. It is recommended that as many people as practically possible complete this form and that it becomes part of the students record. The more independent evaluations of the student, the more reliable are the results.

The only two options for rating the student on this form are "competent" and "not yet competent". For each attribute, a short list of behavioral markers is listed that indicates what is generally considered a demonstration of competence for entry-level paramedics. This is not an all-inclusive list, but serves to help the evaluator in making judgments. Clearly there are behaviors that warrant a "not yet competent" evaluation that are not listed. Any ratings of "not yet competent" require explanation in the space provided.

Establishing a cut score to use in conjunction with the Professional Behavior Evaluation instrument is important. A cut score can be established by judgment of the local programs community of interest. The question the community should ask is, "What percent score do we expect of graduates of our education program to achieve in the affective domain in order to demonstrate entry-level competency for an (first month, second semester, graduate, etc.) entry-level student?"

When the cut score judgment is made on acceptability or deviation of competent behavior for each characteristic a percent score can be achieved. For example, a student may have received 10 competent checks out of 11 (10 of 11 = 91%), or 5 of 7 (because 4 areas were not evaluated) for a score of 71%. This student may then continue to obtain scores of 91%, 91% 82%, etc and have a term grade of 86% in the affective domain. Each student in the program would receive an average score. Results of multiple evaluations throughout the program would indicate if the score set by the community of interest were too high or too low. When a number of evaluations had evolved adjustments in acceptable score would yield a standard for the community. This standard coupled with community of interest

judgments based upon graduate student and employer survey feedbacks would identify additional validity evidence for the cut score each year. A valid cut score based upon years of investigation could then be used as a determining factor on future participation in the education program.

For all affective evaluations, the faculty member should focus on patterns of behavior, not isolated instances that fall outside the student's normal performance. For example, a student who is consistently on time and prepared for class may have demonstrated competence in time management and should not be penalized for an isolated emergency that makes him late for one class. On the other hand, if the student is constantly late for class, they should be counseled and if the behavior continues, rated as "not yet competent" in time management. Continued behavior may result in disciplinary action.

The second form, the Professional Behavior Counseling form is used to clearly communicate to the student that their affective performance is unacceptable. This form should be used during counseling sessions in response to specific incidents (i.e. cheating, lying, falsification of documentation, disrespect/insubordination, etc.) or patterns of unacceptable behavior. As noted before, there is some behavior that is so egregious as to result in immediate disciplinary action or dismissal. In the case of such serious incidents, thorough documentation is needed to justify the disciplinary action. For less serious incidents, the Professional Behavior Counseling form can serve as an important tracking mechanism to verify competence or patterns of uncorrected behavior.

On the Professional Behavior Counseling form, the evaluator checks all of the areas that the infraction affects in the left hand column (most incidents affect more than one area) and documents the nature of the incident(s) in the right hand column. Space is provided to document any follow-up. This should include specific expectations, clearly defined positive behavior, actions that will be taken if the behavior continues, and dates of future counseling sessions.

Using a combination of these forms helps to enable the program to demonstrate that graduating students have demonstrated competence in the affective domain. This is achieved by having many independent evaluations, by different faculty members at different times, stating that the student was competent. These forms can also be used to help correct unacceptable behavior. Finally, these forms enable programs to build a strong case for dismissing students following a repeated pattern of unacceptable behavior. Having numerous, uncoberrated evaluations by faculty members documenting unacceptable behavior, and continuation of that behavior after remediation, is usually adequate grounds for dismissal.

PROFESSIONAL BEHAVIOR EVALUATION

Student's Name: _____

Date ofevaluation: _____

1. INTEGRITY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent honesty; being able to be trusted with the property of others; can be trusted with confidential information; complete and accurate documentation of patient care and learning activities.		
2. EMPATHY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Showing compassion for others; responding appropriately to the emotional response of patients and family members; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.		
3. SELF - MOTIVATION	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement; consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner; taking advantage of learning opportunities		
4. APPEARANCE AND PERSONAL HYGIENE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Clothing and uniform is appropriate, neat, clean and well maintained; good personal hygiene and grooming.		
5. SELF - CONFIDENCE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Demonstrating the ability to trust personal judgment; demonstrating an awareness of strengths and limitations; exercises good personal judgment.		
6. COMMUNICATIONS	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations		
7. TIME MANAGEMENT	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent punctuality; completing tasks and assignments on time.		
8. TEAMWORK AND DIPLOMACY	Competent [ ]	Not yet competent [ ]

Examples of professional behavior include, but are not limited to: Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.		
9. RESPECT	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.		
10. PATIENT ADVOCACY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Not allowing personal bias to or feelings to interfere with patient care; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.		
11. CAREFUL DELIVERY OF SERVICE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Mastering and refreshing skills; performing complete equipment checks; demonstrating careful and safe ambulance operations; following policies, procedures, and protocols; following orders.		

Use the space below to explain any "not yet competent" ratings. When possible, use specific behaviors, and corrective actions.

	- Faculty Signature

PROFESSIONAL BEHAVIOR EVALUATION

Student's Name: *Janet L.*
Date of evaluation: *September 1998*

1. INTEGRITY	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent honesty; being able to be trusted with the property of others; can be trusted with confidential information; complete and accurate documentation of patient care and learning activities.		
2. EMPATHY	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Showing compassion for others; responding appropriately to the emotional response of patients and family members; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.		
3. SELF - MOTIVATION	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement; consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner; taking advantage of learning opportunities		
4. APPEARANCE AND PERSONAL HYGIENE	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Clothing and uniform is appropriate, neat, clean and well maintained; good personal hygiene and grooming.		
5. SELF - CONFIDENCE	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Demonstrating the ability to trust personal judgement; demonstrating an awareness of strengths and limitations; exercises good personal judgement.		
6. COMMUNICATIONS	Competent [ ]	Not yet competent [✓]
Examples of professional behavior include, but are not limited to: Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations		

7. TIME MANAGEMENT	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Consistent punctuality; completing tasks and assignments on time.		
8. TEAMWORK AND DIPLOMACY	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.		
9. RESPECT	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.		
10. PATIENT ADVOCACY	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Not allowing personal bias to or feelings to interfere with patient care; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.		
11. CAREFUL DELIVERY OF SERVICE	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Mastering and refreshing skills; performing complete equipment checks; demonstrating careful and safe ambulance operations; following policies, procedures, and protocols; following orders.		

Use the space below to explain <u>any</u> "not yet competent" ratings. When possible, use specific behaviors, and corrective actions.

◆	*Janet's run reports, written case reports, and home work are illegible and*
	disorganized. She has numerous spelling and grammatical errors.
◆	*Janet repeatedly hands in assignments after due dates. She does not complete*

	clinical time in a organized, organized manner. She did not report for five
	scheduled clinical shifts this semester and reported to medic 6 twice
	when she was not scheduled. Janet has not completed the required clinical for this semester.

John Brown	- Faculty Signature

PROFESSIONAL BEHAVIOR EVALUATION (EXAMPLE)

Student's Name: *Steve R,*
Date of evaluation: *November 1999*

1. INTEGRITY	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent honesty; being able to be trusted with the property of others; can be trusted with confidential information; complete and accurate documentation of patient care and learning activities.		
2. EMPATHY	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Showing compassion for others; responding appropriately to the emotional response of patients and family members; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.		
3. SELF - MOTIVATION	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement; consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner; taking advantage of learning opportunities		
4. APPEARANCE AND PERSONAL HYGIENE	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Clothing and uniform is appropriate, neat, clean and well maintained; good personal hygiene and grooming.		
5. SELF - CONFIDENCE	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Demonstrating the ability to trust personal judgement; demonstrating an awareness of strengths and limitations; exercises good personal judgement.		
6. COMMUNICATIONS	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations		
7. TIME MANAGEMENT	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent punctuality; completing		

tasks and assignments on time.		
8. TEAMWORK AND DIPLOMACY	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.		
9. RESPECT	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.		
10. PATIENT ADVOCACY	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Not allowing personal bias to or feelings to interfere with patient care; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.		
11. CAREFUL DELIVERY OF SERVICE	Competent [◆]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Mastering and refreshing skills; performing complete equipment checks; demonstrating careful and safe ambulance operations; following policies, procedures, and protocols; following orders.		

Use the space below to explain <u>any</u> "not yet competent" ratings. When possible, use specific behaviors, and corrective actions.

#2, 5, 6, 8, & 9 Steve has demonstrated inappropriate classroom behavior by
monopolizing class time, answering questions intended for other students, and making
sarcastic remarks about other students answers. Steve demonstrates a superiority
complex over fellow classmates belittling and has repeatedly belittled their experience,
while boasting and exaggerating about his field experience.

T. Jones	- Faculty Signature

PROFESSIONAL BEHAVIOR EVALUATION (EXAMPLE)

Student's Name: *Steve R.*
Date of evaluation: *December 1999*

1. INTEGRITY	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent honesty; being able to be trusted with the property of others; can be trusted with confidential information; complete and accurate documentation of patient care and learning activities.		
2. EMPATHY	Competent [ ]	Not yet competent [✓]
Examples of professional behavior include, but are not limited to: Showing compassion for others; responding appropriately to the emotional response of patients and family members; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.		
3. SELF - MOTIVATION	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement; consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner; taking advantage of learning opportunities		
4. APPEARANCE AND PERSONAL HYGIENE	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Clothing and uniform is appropriate, neat, clean and well maintained; good personal hygiene and grooming.		
5. SELF - CONFIDENCE	Competent [ ]	Not yet competent [✓]
Examples of professional behavior include, but are not limited to: Demonstrating the ability to trust personal judgement; demonstrating an awareness of strengths and limitations; exercises good personal judgement.		
6. COMMUNICATIONS	Competent [ ]	Not yet competent [✓]
Examples of professional behavior include, but are not limited to: Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations		
7. TIME MANAGEMENT	Competent [✓]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent punctuality; completing tasks and assignments on time.		

8. TEAMWORK AND DIPLOMACY	Competent [ ]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.		
9. RESPECT	Competent [ ]]	Not yet competent [◆]
Examples of professional behavior include, but are not limited to: Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.		
10. PATIENT ADVOCACY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Not allowing personal bias to or feelings to interfere with patient care; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.		
11. CAREFUL DELIVERY OF SERVICE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Mastering and refreshing skills; performing complete equipment checks; demonstrating careful and safe ambulance operations; following policies, procedures, and protocols; following orders.		

Use the space below to explain <u>any</u> "not yet competent" ratings. When possible, use specific behaviors, and corrective actions.

#2	*Steve is constantly disrupting class with irrelevant questions. He is disrespectful*
	to guest instructors, classmates and the program.
#5	*Steve seems to have an impression that he is better than the others students because*
	he has more field experience. He is overconfident and overbearing.
#6	*Steve has not changed his communication skills despite verbal counseling.*
#8	*Steve◆s disruptions are destructive to the team environment by placing his needs*

	above those of the group.
#9	*Disruptions are disrespectful.*

A. Cox	- Faculty Signature

PROFESSIONAL BEHAVIOR COUNSELING RECORD

Student' s Name:
Date of counseling:
Date of incident:

_	Reason for Counseling	Explanation (use back of form if more space is needed):
	Integrity	
	Empathy	
	Self - Motivation	
	Appearance/Personal Hygiene	
	Self - Confidence	
	Communications	
	Time Management	
	Teamwork and Diplomacy	
	Respect	
	Patient Advocacy	
	Careful delivery of service	

Follow-up (include specific expectations, clearly defined positive behavior, actions that will be taken if behavior continues, dates of future counseling sessions, etc.):

	-Faculty signature
I have read this notice and I understand it.	
	-Student signature
	-Administrative or Medical Director Review

PROFESSIONAL BEHAVIOR COUNSELING RECORD

Student's Name: *Steve R.*
Date of counseling: *December 14, 1998*
Date of incident: *November and December 1999*

–	Reason for Counseling	Explanation (use back of form if more space is needed):
	Integrity	*This counseling session was in response to the two Professional*
◆	Empathy	*Behavior Evaluations file by Instructors Cox and Jones.*
	Self - Motivation	*They both indicated that Steve has been disruptive in classes*
	Appearance/Personal Hygiene	*(see attached)*
◆	Self - Confidence	
	Communications	
	Time Management	
◆	Teamwork and Diplomacy	
◆	Respect	
	Patient Advocacy	
	Careful delivery of service	

Follow-up (include specific expectations, clearly defined positive behavior, actions that will be taken if behavior continues, dates of future counseling sessions, etc.):

Student was advised that his behavior is inappropriate and unacceptable. Continuation of this behavior will result in dismissal from class.
.

◆ Written warning from program director.
◆ Instructors Cox and Jones to complete Professional Behavior Evaluations bi-weekly throughout
next semester

M. Travis	*-Faculty signature*
I have read this notice and I understand it.	
Steve R.	*-Student signature*
Dr. O◆Hara	*-Administrative or Medical Director Review*

PROFESSIONAL BEHAVIOR COUNSELING RECORD (EXAMPLE)

Student's Name: *Joe L.*
Date of counseling: *February 23, 1999*
Date of incident: *February 21, 1999*

_	**Reason for Counseling**	**Explanation (use back of form if more space is needed):**
	Integrity	*Joe reported to a field rotation 16 minutes late, he was not wearing*
	Empathy	*(nor did he have in his possession) a uniform belt and with*
	Self - Motivation	*"at least 2 days beard growth" according to field supervisor*
_	Appearance/Personal Hygiene	*Johnson. When Joe was approached regarding this situation*
	Self - Confidence	*he became argumentative and told Mr. Johnson to*
	Communications	*"...mind your own business." Joe was asked to leave.*
_	Time Management	*Others that witnessed this exchange were Paramedics*
	Teamwork and Diplomacy	*Davis and Lawrence.*
_	Respect	
	Patient Advocacy	
	Careful delivery of service	

Follow-up (include specific expectations, clearly defined positive behavior, actions that will be taken if behavior continues, dates of future counseling sessions, etc.):

Reviewed clinical Policies and Procedures manual section referring to personal appearance and hygiene, time management, and respect. I also reviewed the conduct at clinical rotations with Joe.
Asked Joe to write a letter of apology to field supervisor Johnson, and Paramedics Davis and Lawrence, which he agreed to do.

I informed Joe that any further display of disrespectful behavior will result in dismissal from the program.
A continued pattern of poor time management and/or poor appearance/personal hygiene could also result in dismissal.

Bill Smith	*-Faculty signature*
I have read this notice and I understand it.	
Joe L.	*-Student signature*
Dr. Jones	*-Administrative or Medical Director Review*

APPENDIX VI: Rubric Affective Domain Tool

Background

There are two primary purposes of an affective evaluation system: 1) to verify competence in the affective domain, and 2) to serve as a method to change behavior. Although affective evaluation can be used to ultimately dismiss a student for unacceptable patterns of behavior that is not the primary purpose of these forms. It is also recognized that there is some behavior that is so serious (abuse of a patient, gross insubordination, illegal activity, reporting for duty under the influence of drugs or alcohol, etc) that it would result in immediate dismissal from the educational program.

The two forms included in the EMT-Paramedic: National Standard Curricula were developed by the Joint Review Committee on Educational Programs for the EMT-Paramedic. These forms have been modified somewhat to meet the needs of the XX EMS Program. They represent extensive experience in the evaluation of student's affective domain. The nature of this type of evaluation makes it impossible to achieve complete objectivity, but these forms attempt to decrease the subjectivity and document affective evaluations.

In attempting to change behavior it is necessary to identify, evaluate, and document the behavior that you want. The eleven affective characteristics that form the basis of this evaluation system refer to content in the Roles and Responsibilities of the Paramedic unit of the curriculum. Typically, this information is presented early in the course and serves to inform the students what type of behavior that is expected of them. It is important that the instructor is clear about these expectations.

For all affective evaluations, the faculty member should focus on patterns of behavior, not isolated instances that fall outside the student's normal performance. For example, a student who is consistently on time and prepared for class may have demonstrated competence in time management and should not be penalized for an isolated emergency that makes him late for one class. On the other hand, if the student is constantly late for class, they should be counseled. Continued behavior may result in disciplinary action.

The second form, the Professional Behavior Counseling form is used to clearly communicate to the student that their affective performance is unacceptable. This form should be used during counseling sessions in response to specific incidents (i.e. cheating, lying, falsification of documentation, disrespect/insubordination, etc.) or patterns of unacceptable behavior. As noted before, there is some behavior that is so egregious as to result in immediate disciplinary action or dismissal. In the case of such serious incidents, thorough documentation is needed to justify the disciplinary action. For less serious incidents, the Professional Behavior Counseling form can serve as an important tracking mechanism to verify competence or patterns of uncorrected behavior.

On the Professional Behavior Counseling form, the evaluator checks all of the areas that the infraction affects in the left hand column (most incidents affect more than one area) and documents the nature of the incident(s) in the right hand column. Space is provided to document any follow-up. This should include specific expectations, clearly defined expected positive behavior, actions that will be taken if the behavior continues, and dates of future counseling sessions.

Using a combination of these forms helps to enable the program to demonstrate that graduating students have demonstrated competence in the affective domain. This is achieved by having many independent evaluations, by different faculty members at different times, stating that the student was competent. These forms can also be used to help correct unacceptable behavior. Finally, these forms enable programs to build a strong case for dismissing students following a repeated pattern of unacceptable behavior. Having numerous, uncorroborated evaluations by faculty members documenting unacceptable behavior, and continuation of that behavior after remediation, is usually adequate grounds for dismissal.

Please rate the student according to your observations only. The categories identify professional behaviors described as desirable attributes of EMS medical professionals. The descriptions within each category represent the behaviors generally expected for the individual.

Each category will receive a score between 1 and 5. **A score of 3 is considered average and represents the expected acceptable level of conduct for that category.** If asked, you should be able to provide verification (as written or verbal proof as appropriate) for any score other than "3." If the individual you are evaluating is performing as an entry-level provider they should obtain scores of "3" in most categories.

Student Name: _____

Affective Domain Evaluation:_____Date:_____

1. **Integrity**

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Major infraction of 1 (or more) areas of #3 or many minor infractions in most areas of #3.
	2	Minor infractions of 1 area of #3 but otherwise compliant with all aspects described in #3.
	3	Consistent honesty, being able to be trusted with property and confidential information, complete and accurate documentation of patient care and learning activities.
	4	Consistent honesty, assists other classmates in understanding confidential issues and in developing their documentation skills.
	5	Always honest, leads by example and models exemplary behaviors regarding integrity. Consistently turns in paperwork that is complete and accurate prior to due date.

2. **Empathy**

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Being deliberately disrespectful of others, making fun of others, being condescending or sarcastic to others, clearly uncomfortable dealing with emotions of patients.
	2	Being uncompassionate to others or responding inappropriately to emotional responses because you are unconformable with their emotional displays. Acting coolly towards patients in distress and not acting as a patient advocate.
	3	Showing compassion to others, responding appropriately to emotional responses by others, demonstrating respect to others, being supportive and reassuring.

4	Able to show compassion and respond appropriately while maintaining professional demeanor, demonstrating a strong desire to advocate for the patient, can direct patients and their families to available community resources.
5	Seeks out opportunities to serve in the community, when the situation arises can provide contact information on assistance agencies, has the ability to set troubled patients at ease and actively listens to their problems and concerns.

3. Self-motivation

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Consistently failing to meet established deadlines, unable to demonstrate intrinsic motivating factors requiring extra extrinsic motivation from instructors, failing to improve even after corrective feedback has been provided by faculty, requiring constant supervision to complete tasks or being asked to repeat a task that is incorrectly performed.
	2	Failing to meet 1-3 tasks as described in #3 but obviously making attempts to attain acceptable standards.
	3	Taking initiative to complete assignments, taking initiative to improve or correct behavior, taking on and following through on tasks without constant supervision, showing enthusiasm for learning and improvement, consistently striving for improvement in all aspects of patient care and professional activities, accepting constructive criticism in a positive manner, taking advantage of learning opportunities.
	4	Occasionally completing and turning in assignments before the scheduled deadline, volunteering for additional duties, consistently striving for excellence in all aspects of patient care and professional activities, seeking out a mentor or faculty member to provide constructive criticism, informing faculty of learning opportunities.
	5	Never missing a deadline and often completing assignments well ahead of deadlines, reminding other students of deadlines, supporting faculty in upholding the rules and regulations of the program, taking seriously opportunities to provide feedback to fellow students, seeking opportunities to obtain feedback, assisting faculty in arranging and coordinating activities.

4. Appearance and Personal Hygiene

Your		Required attributes to obtain the recommended score

recommended score: _____	1	Inappropriate uniform or clothing worn to class or clinical settings. Poor hygiene or grooming.
	2	Appropriate clothing or uniform is selected for a majority of the time, but the uniform may be unkempt (wrinkled), mildly soiled, or in need of minor repairs, appropriate personal hygiene is common, but occasionally the individual is unkempt or disheveled.
	3	Clothing and uniform is appropriate, neat, clean and well-maintained, good personal hygiene and grooming.
	4	Clothing and uniform are above average. Uniform is pressed and business casual is chosen when uniform is not worn. Grooming and hygiene is good or above average.
	5	Uniform is always above average. Non-uniform clothing is business-like. Grooming and hygiene is impeccable. Hair is worn in an appropriate manner for the environment and student is free of excessive jewelry. Make-up and perfume or cologne usage is discrete and tasteful.

5. Self-confidence

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Does not trust personal judgment, is unaware of strengths or weaknesses, and frequently exercises poor personal judgment.
	2	Needs encouragement before not trusting personal judgment, is aware of strengths but does not readily recognize weaknesses, sometimes makes poor personal choices.
	3	Demonstrating the ability to trust personal judgment, demonstrating an awareness of strengths and limitations, exercises good personal judgment.
	4	Stands by his/her choices when challenged by an authority figure, aware of strengths and weaknesses and seeks to improve, exercises good personal judgment and often serves as a mentor for classmates.
	5	Stands by and can defend personal choices when challenged by an authority figure, actively seeks to improve on weaknesses, seeks out opportunities to assist other classmates in developing their self-confidence.

6. Communications

Your		Required attributes to obtain the recommended score

recommended score: _____		
	1	Unable to speak or write clearly and is unable to correct their behavior despite intervention by instructors, does not actively listen (requires instructions to be repeated or appears unable to follow directions,) resistant to learning new communications strategies.
	2	Needs work to speak or write clearly, knows how to actively listen although sometimes is unable to model good listening skills, able to identify alternative communication strategies needed in various situations but is still developing the skill to perform alternative strategies.
	3	Speaking clearly, writing legibly, listening actively, adjusting communications strategies to various situations.
	4	Working on improving speaking and writing abilities, models active listening skills, able to modify communication strategies easily in various situations and able to effectively communicate a message in these various settings.
	5	Working on self and assisting classmates in improving speaking and writing abilities, models and is able to demonstrate active listening techniques to other students, is comfortable utilizing a variety of communication styles, may have proficiency in another language, including sign language.

7. Time management

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Often late to class or clinical sites, upon arrival needs additional time to be ready to begin (changing into uniform, gathering supplies, etc.), frequently late in turning in assignments, requires constant reminders about due dates and will blame others if a due date is missed.
	2	Occasionally late in arriving to class or clinical sites, occasionally late in turning in assignments or requires reminding about deadlines.
	3	Consistent punctuality, completing tasks and assignments on time.
	4	Seldom late to class or clinical, generally ready to begin class or clinical prior to the actual start time, completes tasks and assignments by due date (and occasionally in advance of due date) with minimal need for reminders of due dates.
	5	Punctual (or early) nearly 100% of the time, completes tasks and assignments prior to the due date, seldom requires reminding about deadlines or due dates, may assist instructor

	in reminding classmates about due dates.

8. Teamwork and diplomacy

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Manipulating the team or acting with disregard to the team, being disrespectful of team members, being resistant to change or refusing to cooperate in attempts to work out solutions.
	2	Sometimes acting for personal interest at the expense of the team, acting independent of the team or appearing non-supportive, being somewhat resistant to change or occasionally unwilling to work out a solution.
	3	Placing the success of the team above self interest, not undermining the team, helping and supporting other team members, showing respect for all team members, remaining flexible and open to change, communicating with others to resolve problems.
	4	Placing success of the team above self interest, supporting and holding up the team by shouldering additional responsibilities, actively seeking to include all members of the team in decision making processes were appropriate, welcoming change and remaining flexible, helping to open the lines of communication.
	5	Placing success of the team above self interest (even if that means a negative outcome to self,) taking a leadership role and using good management skills while leading, involving all appropriate team members in the decision making process, suggesting and implementing changes to benefit the team, seeking ways to keep communications and dialogue going.

9. Respect

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Disrespect of authority, being argumentative, using inappropriate words or outbursts of anger, deliberately undermining authority in words or actions or trying to provoke others, frequently unable to act in a professional manner.
	2	Being polite when required, occasionally overheard using demeaning or derogatory language but confining it to situations other than in patient care settings, occasionally acting unprofessional on the job.

3	Being polite to others, not using derogatory or demeaning terms, behaving in a manner that brings credit to the profession.
4	Being polite even when a situation is not going in his/her favor, always using respectful language when describing situations even when not in public areas, modeling good professional behaviors.
5	Serving as a "peacemaker" in volatile situations, able to take abusive language or disrespect from patients without reacting negatively towards the individual, modeling good professional behaviors even when outside of the classroom or off of the job.

10. Patient advocacy

Your recommended score: _____		Required attributes to obtain the recommended score
	1	Unable to deal with patients because of personal biases, actively demeaning or degrading patinets with words or deeds, unconcerned about patient rights, feelings or considerations, frequently takes shortcuts during care of patients because it is "easier" or "faster."
	2	Occasionally has difficulty dealing with patients because of personal bias or feelings, not always able to place the needs of the patient first,
	3	Not allowing personal bias or feelings to interfere with patient care, placing the needs of patients above self-interest, protecting and respecting patient confidentiality and dignity.
	4	Not allowing personal bias or feelings to interfere with patient care despite strong negative feelings or biases towards a patient or situation, actively advocating for patient rights, protecting confidentiality.
	5	Models patient advocacy and able to defend the need to advocate for patient rights, seeks out opportunities to help fellow classmates learn the principles of patient advocacy, when the opportunity presents itself can be called upon to follow through on an advocacy issue even if it means it on their off time.

11. Careful delivery of services

Your		Required attributes to obtain the recommended score

recommended score: _____	1	Unable to perform skills at entry level or requiring constant monitoring or reinforcement to perform skills, required to recheck tasks because of omissions or inaccuracies in performance or documentation, unwilling to learn policies, procedures or protocols, deliberate unwillingness to follow the letter or spirit of rules or regulations.
	2	Occasionally performing skills below the entry-level, requiring monitoring to ensure completeness and accuracy in completing tasks, occasional minor breeches in policies, procedures or protocols attributed to lack of knowledge of it but willing to learn, may follow the letter of, but not always the spirit, of rules and regulations.
	3	Performing skills at an entry-level capacity a majority of the time, performing complete equipment and supply checks, demonstrating careful and safe ambulance operations, following policies and procedures and protocols, following orders.
	4	Can be trusted to function independent of all but minor supervision, does not need to be reminded to perform routine maintenance checks, follows the letter and spirit of all rules, regulations, policies and procedures.
	5	Functions independently and able to correct mistakes by self-reflection, able to assist in the development of rules, regulations, policies and procedures, will assist in monitoring fellow students in the completion of tasks and may be able to assist fellow students identify weaknesses and strengths.

General Comments:

_____ _____

Signature of person completing form Date

~~Printed Name Title~~ _____

_____

Student Signature

Student should sign form only if conference is held following evaluation. Student agreement of ratings is not required for form to be completed and forms may be completed anonymously.

APPENDIX VII: Guidelines for activities and classroom exercises on ethical issues

Activities and classroom exercises

A. Sources of ethical issue material
    1. Internet sites
    2. Print based
    3. Current events
    4. Actual EMS calls and scenarios
    5. Colleges and universities
    6. Ethical think tanks and centers
B. Group discussion/debate
    1. Present a case or scenario of an ethical issue
    2. Divide the class into 6 groups and assign one of the theories just presented to a group for discussion
    3. After 15-20 minutes have each group defend a particular ethical theory as it relates to a case or scenario you presented
C. Case scenarios
    1. Provide several short case scenarios and ask students to do the following:
        a. List decisions open to you in each scenario
        b. State what decision you think is the right one
        c. Explain why you think your decision is the right one
        d. Explain what theory you are aligned with in making your decision
    2. Allow students 5-10 minutes to think about each scenario before comparing information with the class
D. Role-playing
    1. Choose a case study and have volunteers role-play various sides of the issue to present "their side of the story"
    2. The purpose of this is to help student gain perspective by attempting to learn another point of view
    3. If you already have knowledge of students opinions on certain issues it may be helpful to have a student role-play an opinion that is diametrically opposed to their personal feeling and beliefs
E. Debates
    1. Present a case and allow students some time to prepare their viewpoint on the issue.
    2. Conduct the session like a real debate and allow students to challenge and defend each other's opinions

Appendix VIII: Classroom Arrangement Strategies

Traditional Lecture

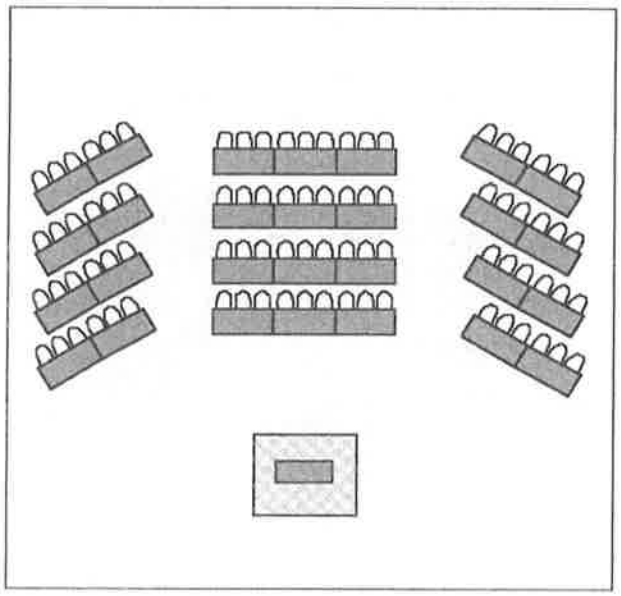


Figure 4. Standard Schoolroom Setup

Theater Style

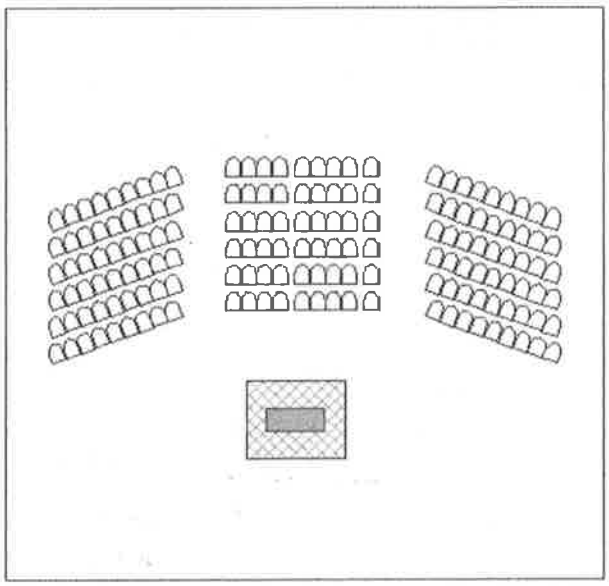
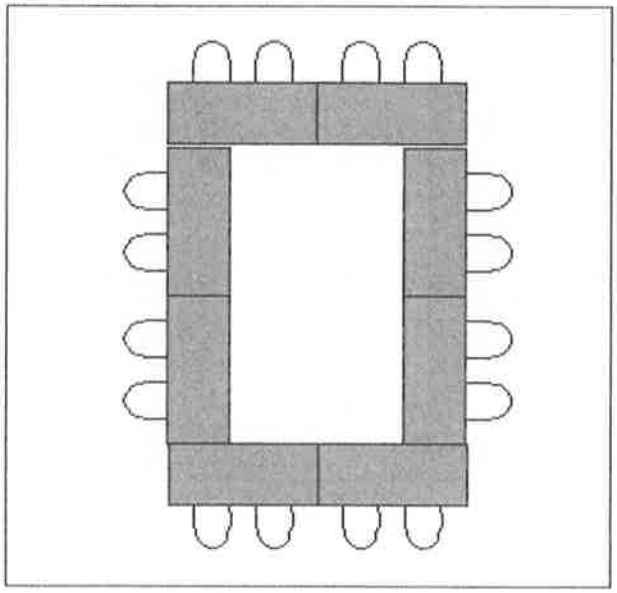
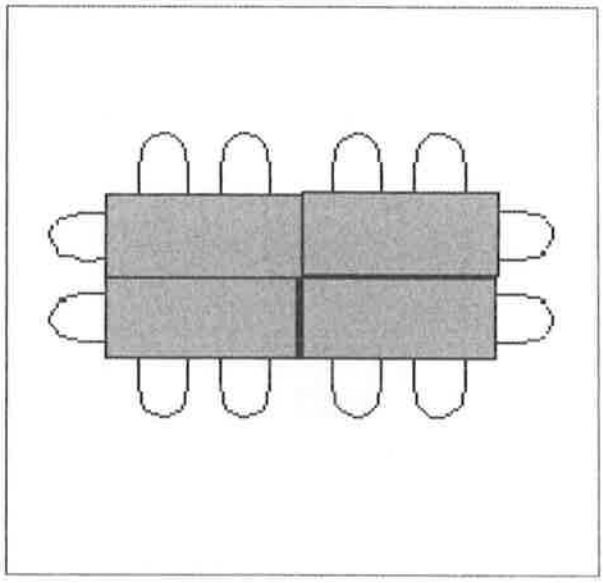


Figure 3. Auditorium or Theater-style Setup

Circle, Square and Rectangle – Open



Circle, Square and Rectangle – Closed



Partial with Open Area

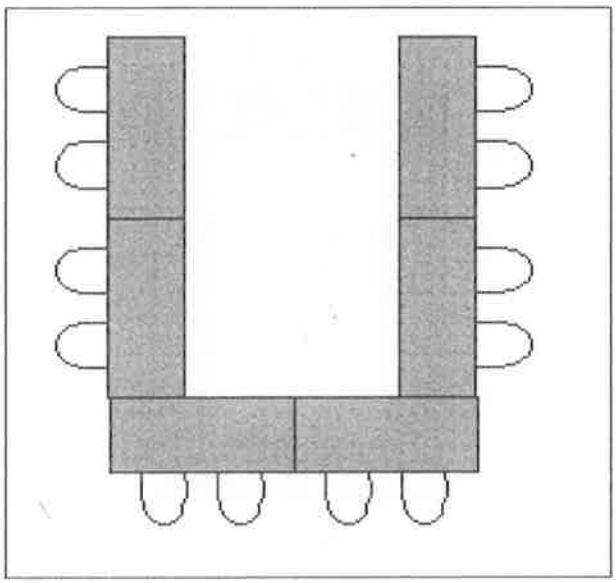
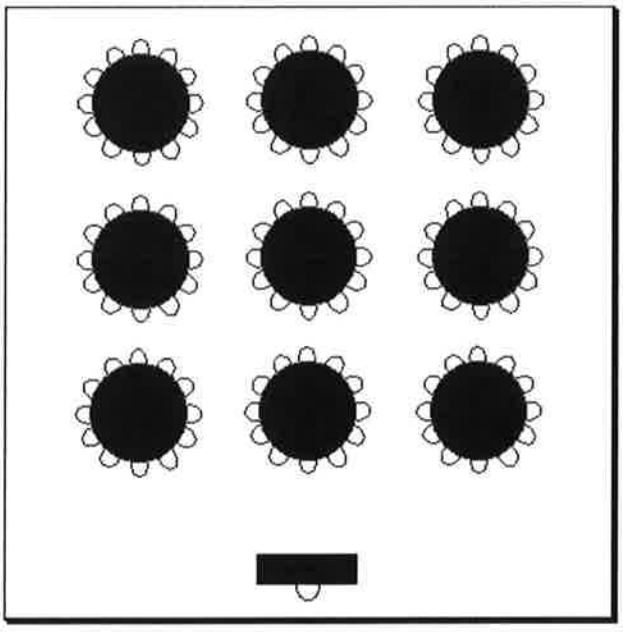


Figure 7. U-shape Setup

Group Work



APPENDIX IX: Bloom's Taxonomy of the Domains of Learning

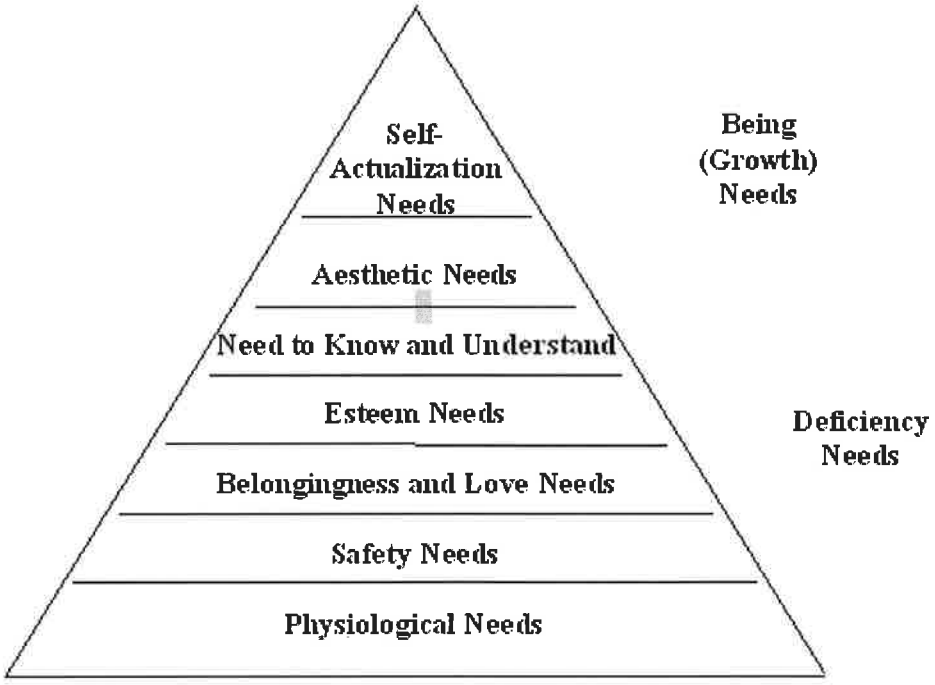
Figure 8-III-A: Bloom's Taxonomy of the Domains of Learning by Degrees of Sophistication

Cognitive Domain	Psychomotor Domain	Affective Domain
Knowledge	Imitation	Receiving
Comprehension	Manipulation	Responding
Application	Precision	Valuing
Analysis	Articulation	Organization
Synthesis	Naturalization	Characterization
Evaluation		

Figure 8-III-B: Bloom's Taxonomy by Level

Level	Cognitive Domain	Psychomotor Domain	Affective Domain
Level 1: Knowledge (low level)	Knowledge Comprehension	Imitation Manipulation	Receiving Responding
Level 2: Application (intermediate level)	Application	Precision	Valuing
Level 3: Problem solving (high level)	Analysis Synthesis Evaluation	Articulation Naturalization	Organization Characterization

APPENDIX X: Maslow's Hierarchy of Needs



Maslow's Hierarchy of Needs

APPENDIX XI: Lesson Plan Outline

I. Audience description
II. Pertinent needs assessment information and prerequisites
III. Lesson goal(s)
IV. Cognitive objectives
V. Psychomotor objectives
VI. Affective objectives
VII. Recommended list of equipment and supplies
VIII. Recommended schedule
IX. Suggested motivation activity
X. Content outline

APPENDIX XII: Unit #1 - Pathophysiology and Management of Anaphylaxis (EXAMPLE)

OBJECTIVES

After this unit of study, the student should be able to:

1. Describe the structures and functions associated with the immune system.

2. Discuss antigens:
a. Examples
b. Four routes of introduction into the body.
3. Explain the production of antibodies (the antigen/antibody reaction).

4. Detail the physiology and pathophysiology of anaphylaxis.

5. Explain the acid/base and electrolyte imbalances resulting from anaphylaxis.

6. Discuss the effects of the pathological anaphylactic reaction on the following:
   a. Respiratory system
   b. Cardiovascular system
   c. Skin
   d. Central nervous system
   e. Gastrointestinal system

7. Identify the two substances released by mast cells during anaphylaxis.

8. Identify the signs and symptoms of a patient with pathological anaphylaxis as related to:
   a. Respiratory system
   b. Cardiovascular system
   c. Skin
   d. Central nervous system
   e. Gastrointestinal system

9. Describe the assessment and history (including pertinent negatives) of the patient with anaphylactic shock.

10. Identify the causes and treatments for anaphylaxis.

11. List the priorities of patient assessment and treatment for anaphylaxis.

12. Complete a drug card and discuss the following aspects for epinephrine, benadryl, Solu-Medrol® steroid, to include (*information for both pediatric and adult):
   a. trade name
   b. generic name
   c. classification
   d. actions
   e. dosage and route(s)
   f. indications
   g. contraindications
   h. precautions
   i. side-effects
   j. indications

k. toxic effects
13. Define and explain the following terms:
a. anaphylaxis
b. antigen
c. antihistamine
d. bronchospasm
e. histamine
f. hives
g. immune system
h. mast cell
i. shock
j. steroid
k. urticaria

Pathophysiology and Management of Anaphylaxis

lesson	**Topic Outline**	**Assigned Reading**	
1	Review Shock Syndrome	Paramedic Emergency Care	Chapter 12,
	definition parameters aerobic metabolism anaerobic metabolism		
	Antigens	Paramedic Emergency Care	Chapter 25 (& other assigned readings)
	definition examples method of introduction		
2	Antibodies	Physiology for the Health Related Professions	Chapter 3
	immune system definition production		
	Anaphylaxis	Physiology for the Health Related Professions	Chapter 3
	pathophysiology effects on systems signs and symptoms patient assessment patient history management		
3	Pharmacological Agents	drug cards and master	

		file	
	oxygen epinephrine a) 1:1000 b) 1:10,000 diphenhydramine 4) aminophylline		
4	Skills practice selecting medication - epinephrine 1:1000 or 1:10,000 benadryl 25mgs or 50mgs Medication checklist - right medication, right route, right patient, right dose, clarity, date, etc. select site - obtain informed consent - administer medication - observe for action, reaction and side effects		*note: these skills are taught in another course and are only to be practiced here

-

Course Schedule (EXAMPLE)

EMC 340
Tuesdays & Thursdays 09:15 - 11:30
Spring 2000 Dizney 234
(Refer to complete syllabus for further details)

Date	Lesson	Topic	Reading
01/18	1	Anaphylaxis	Paramedic Emergency Care Chapter 12 & 25
01/20	2	Anaphylaxis	Paramedic Emergency Care Chapter 12 & 25
01/25	3	Anaphylaxis	Anaphylaxis Paramedic Emergency Care Chapter 12 & 25
01/27	4	Anaphylaxis (skills)	

-
-

APPENDIX XIII: Daily Lesson Plan - Anaphylaxis Unit (Sample)

1. **Review Shock Syndrome**
2. **Reason for lesson:**
   a. **To review the basic pathophysiology of shock, hypoperfusion and hemodynamic instability**
   b. **To review basic treatments for clinical conditions caused by shock, hypoperfusion and hemodynamic instability**
3. **Points to be reviewed:**
   a. **Definition of shock, hypoperfusion and hemodynamic instability**
   b. **Clinical signs and symptoms that are the parameters for assessing / diagnosing shock, hypoperfusion and hemodynamic instability**
   c. **Describing the causes, methods of differential diagnosis and treatments for aerobic metabolism**
   d. **Describing the causes, methods of differential diagnosis and treatments for anaerobic metabolism**

4. **Content and activities**

Minutes	Content		Activities
00 - 20:00	Description of homeostasis, statistically normal vital signs		Students will be asked to explain the significance of each vital sign
20:00 - 1:00:00	Description of pH, aberrations of acid-base with metabolic and or respiratory etiologies		Scenarios appropriate to either metabolic or respiratory acid-base problems will be presented, students will make differential diagnoses
1:15:00 - 2:15:00	Descriptions of general treatments for acid-base with metabolic and or respiratory etiologies		After correctly assessing the etiology of the acid-base problem, students will describe general treatments (e.g., fluid versus oxygen and airway control)
2:25:00 - 3:00:00			Practical demonstration of medication selection, drug dose calculation and administration using manikins and oranges

Summarizing the above concepts:

5. **Evaluation: a simple quiz on the material covered above will be given. This quiz will include multiple choice and fill-in -the-blank items. Each item will be associated with a scenario similar to the ones covered in class.**
6. **Assignment: a set of 5 scenarios will be given for students to assess. These scenarios will include cases that acid-base problems that include both respiratory and metabolic components in each scenario.**

APPENDIX XIV: Confined Space Rescue Awareness (Sample)

Course Description:

This course is designed to provide adequate education and training for personnel who have potential to be first responders to a confined space rescue incident. This course provides information on identification of confined spaces, common hazards associated with confined spaces, and operational limitations for the first responder.

Course Objectives

Terminal Objective:

To offer safe scene management and emergency operations during a confined space incident. This is designed to prevent injury or death to the rescue worker while operating within applicable laws and administrative policies.

Enabling Objectives:

Upon completion of this course, the firefighter shall demonstrate the ability to:

Related Performance Standards:

- NFPA 1001: 4-4.2 (1997 edition)
- WAC 296-305-05003
- WAC 296-62-145, Part M

Course Materials

Suggested Materials:

- Essentials of Firefighting, IFSTA 4th Edition, chapter 7
- Applicable policies and procedures
- Video "Confined Space Rescue, First Due Rescue Company; American Safety Video Publishers
- Student handout "Confined space entry permit
- Confined space quiz and answer key

Course Overview

Preparation	**15 Minutes**
Introduction/Motivation	
I. Presentation	**175 Minutes**
Definitions/Training Levels	
Types of Confined Space	
Associated Hazards	
Video-Confined Space Rescue	
Roles and Responsibilities	
Legal requirements	
Conclusion	
II. Application	**30 Minutes**
Discussion Questions	
III. Evaluation	**20 Minutes**
Quiz (20 questions)	

I - Preparation	15 Minutes
1. Introduction/Motivation Introduce self, class, and any special concerns or conveniences. **Cover course objectives.**	
II - Presentation	**90 Minutes**
Explain: **1. Define confined space and training levels** This tends to be a High risk / Low frequency type of incident, however, with the area growth and vast amount of construction the potential for an incident is much greater. TECHNITIAN (40-60 hours training) - Special skills and retrieval systems, patient evacuation, communications and command, familiarity with various types of confined spaces, monitoring-assessment-ventilation techniques. **THIS IS NOT YOU!!!** OPERATION (several days training) - Safe entry and rescue techniques, atmospheric monitoring, assess hazards and risks. **THIS IS NOT YOU!!!** AWARNESS (few hours training) ◆ Recognize, secure, and call for resources. **THIS WILL BE YOU!!!**	

2. Other key definitions

-

These are not the only definitions associated with Confined space rescue, but are the critical ones you should know and understand.

3. Types of confined space

Trench / excavation: (Be sure to cover Trench in detail explaining to students that while considered by standards to be different from confined space techniques, Awareness level roles and responsibilities remain the same.)

- All soils considered unstable for rescuers concern; after all, rescuers are most likely there because of a previous collapse
- Trench defined as excavation deeper than it is wide
- ≥ 4' depth requires shoring, >20' requires engineered shoring
- Means of exit required w/in 25' of work area
- Spoil pile must be >2' from excavation
- Required shoring material is 6"x6" stock (Rescue argues 4"x4" is acceptable).

Vaults:

Most common vaults in our area are underground utility and mechanical Vaults.

Manholes:

Could be access to a vault but more common in our area to be access to sewer, water, and storm drain systems.

Storage tanks:

Above or below ground holding tanks for fuel, water, septic, or other.

Building collapse:

Being in an earthquake prone area and having older structures that have not been retrofitted, we have a good potential for structural collapse. Explain how voids can be created within a fallen structure.

Silos:

Luckily we don't have many, if any at all, within our area. These are death traps with special considerations. Used in grain and other such material storage.

Caves or mines:

Again, we don't have many to worry about. Keep in mind atmospheric and collapse problems.

4. Hazards associated with confined space

Atmospheric problems - This is the greatest reason for concern in most confined space situations and account for 60% of confined space deaths. In confined spaces, many gasses linger and present an IDLH condition both in the form of inhalation dangers as well as flammable / combustible (LEL) dangers. Many of these gasses, which displace the oxygen, are colorless, odorless, tasteless, and deadly. Discuss briefly some of the effects of gasses that may be present in a confined space such as CO, CO2, Methane, and Hydrogen Sulfide.

Fall hazards - Most confined space configurations are below ground or elevated and are accessed by steep ladders. These ladders are usually slippery and are made with small foot surfaces (i.e. steps in a manhole)

Electrical or mechanical hazards - Vaults that store these items will create an extra hazard inside a confined space. If possible secure power to reduce risk.

Engulfment danger - This is a special consideration in confined space where the area can be immediately Filled or flooded with gas, liquid, or fire with little or no warning.

Collapse potential - In trench rescue or building collapse scenarios where scene is already unstable (thus the reason for rescue), expect further deterioration of the area.

Equipment limitations - Bunker gear while being good heat protection is poor protection from chemical and/or corrosive agents. SCBA's are limited in confined space because of their bulkiness. Need proper tools and equipment to ensure safe operation, including fall protection, which we may not have.

Improper training / manpower - Rescuers do not plan to die when trying to help those in need. These are good people with good intentions that lack understanding of the situation. They are unable to recognize all hazards and lack knowledge on potential risks. Confined space emergencies are VERY labor intensive; make sure you have ample manpower.

II ◆Presentation, Video **Show video ◆** Confined Space Rescue	**25 Minutes**
II ◆Presentation, continued	**60 Minutes**

5. Roles and responsibilities of the first responder

IMS

For a successful operation, it is imperative that command structure is developed early. Start IMS to handle the worst and downgrade as necessary for it is easier to reduce command structure than to expand it after operations begin.

Evaluate

Figure out if there is a confined space emergency to begin with, determine the number of patients (if any), and determine if it is rescue vs. recovery.

Hazards

Identify if any hazards are present, to what extent, and special considerations because of hazards. Is there any type of contamination present or possible (HazMat)? If so, figure type, extent, and problems it may create like where contaminants are going.

Handout

Points / persons of interest

If possible, identify job foreman or someone else involved in incident prior to emergency and DO NOT let this person go. They are a valuable source of information. Identify MSDS, existing ventilation systems, points of entry, and if there is an entry permit. Fire department can use their entry permit if available. If not, department can produce their own. In any case, one must be present before entry is made.

Shut down / lock out

When performing shut down, be careful that it won't shut down or disable essential systems such as ventilation equipment.

Ventilation

Begin ventilation procedures if possible, the earlier the better. Do not ventilate with pure O2.

Secure / reduce hazards

Establish hot, warm, and cold zones and stay out. Restrict access by everyone, evacuate necessary areas, and shut off, move, or stabilize equipment around site.

II ◆Presentation, continued	20 Minutes
6. Legal requirements These are in accordance with NFPA 1001 and WAC 296	
III ◆Application	**20 Minutes**
1. Review / recap Restate in summary the course objectives to confirm student understanding.	
Discuss **2. Suggested Discussion Questions** Lead d a guided discussion based on the following photographs: 1. Type = vault, manhole, tank; Hazards = IDLH atmosphere, fall, engulfment, mechanical; Actions = identify, set up command, isolate. 2. Type=trench; Hazards = IDLH atmosphere, fall, collapse; Actions = identify, set up command, isolate. 3. Type = well, manhole; Hazards = IDLH atmosphere, fall, engulfment; Actions = identify, set up command, isolate.	 
III ◆Application, continued	
Lead a guided discussion based on safety systems in the following photographs: 1. Ventilation, equipment, training levels. 2. Shoring, equipment, training levels.	

4. Conclusion If you leave this class with anything, the most important thing to remember is, First responders must not enter confined spaces!!! Even if there are victims that may be rescued.	
III. Evaluation	**20 minutes**
1. Performance Evaluation Have each student complete quiz.	

APPENDIX XV: Use of Safety Gear inside A Fire Scene (Sample)

Instructor pre-planning:
LESSON OBJECTIVE: By the end of this lesson, the student will be able to discuss at least four concepts involving safety inside a burning building, using case studies and role-play.

TASK ANALYSIS: Concepts to be introduced include CAL-OSHA mandates, exiting the fire scene when the Vibra-Alert sounds, activation of PASS alarm prior to entering the building, and proper fastening of safety gear.

The Lesson Plan
Warm up/ Review: Distribute roles for students to act out during the discussion. Once students are ready to play their "part", introduce the safety lesson by preparing the participants for watching a video described below.
Presentation or Demonstration: Play the video that presents the case studies of the two firefighters who were seriously injured during a fire.
Student Practice: After the video is completed, lead a whole group discussion about safety issues that were encountered by the firefighters. Allow pros and cons to develop, but ensure that ultimately the message of mandatory safety practices is brought out.
Evaluation/Closure: To conclude this session, ask each participant of the discussion to answer a summary question based upon the task analysis. Questions to be presented include:

1. Who mandates our use of safety equipment during the fire scene?
2. When should one begin exiting the fire scene, in order to avoid potential problems with the SCBA equipment?
3. Why should the PASS alarm be activated prior to entering the fire scene?
4. How should the outer firefighter safety clothing be worn during the fire scene?

APPENDIX XVI: EMS Student Handbook Sample

EMERGENCY MEDICAL TECHNICIAN-BASIC

TRAINING PROGRAM
TABLE OF CONTENTS

MISSION STATEMENT

(Place here)

The Mission of the Fire Department is to:

- Protect the lives and property of the people of our area from fires, natural disasters, and hazardous materials incidents;
- Save lives by providing emergency medical services;
- Prevent fires through prevention and education programs; and,
- Provide a work environment that values cultural diversity and is free of harassment and discrimination.

Introduction

Welcome to the EMS Academy EMT-Basic Training Program. On July 1, 1997 the Fire Department assumed the role as the primary EMS provider in this city and county. The EMS Division was created to:

- Receive all 911 requests for emergency medical service;
- Initiate appropriate response of personnel and response;
- Treat and stabilize prehospital emergencies;
- Alleviate pain and suffering of the sick and injured; and,
- Transport the ill and wounded in a safe and expeditious manner to the appropriate medical facility.

When you complete this program, you will join the 70% of the Fire Department uniform rank that make up the cornerstone of the EMS Division - the Emergency Medical Technician - Basic. Of all of the calls for service the Fire Department handles annually, nearly 80% of them are for medical assistance. The EMT-B will respond to a large proportion of these calls, will provide the bulk of the initial field care, and will assist the EMT-Paramedic in providing further medical intervention.

As the EMS system evolves it will be likely that the role of the EMT will expand in both scope and responsibility. Therefore it is imperative that you become proficient in your skills and practice of prehospital medicine. The EMS Academy staff will support you in your education and practice; however they will not carry you! You must embrace this course as you would with all other courses at the Fire College. This is an intensive course, and you must avoid falling behind. Please read through these first few pages to determine what will be expected of you.

Finally, recognize that being an EMT-B fits in with the role of being a Firefighter: This program will help prepare you for a rewarding, life long profession of providing protection and service to our citizens and visitors.

General Information

Location

The EMS Academy EMT-Basic Program is (insert location here.)

Hours

The EMT-Basic Program will generally meet on Mondays, beginning May 18, 1998. The hours of the program will be from 0800 to 1730 hours. A mandatory CPR class will be held on Thursday May 14.
Lunch will be from 1230 to 1310 hours, unless scheduling mandates a change.
In general the classrooms and labs are open Monday through Friday, from 0730 to 1700 hours. Office hours for instructors will be listed.

Daily Schedule

The daily schedule will generally follow this format:
0700 - 0800 Remediation (makeup period for quizzes, skills)
0800 - 0830 Quiz
0845 - 0900 Pretest
0900 - 1230 Lectures
1230 - 1310 Lunch
1310 - 1700 Skills Lab
1700 - 1730 House chores
The program schedule may be found beginning on page 14. This schedule lists the reading assignments and exam schedule for the program.

Parking

You may park in the lot near the Log Cabin, found near the building. The US Parks Police Department has asked everyone to not park in the front or side of their building.

Attendance

This is a very intensive course, with large amounts of information and practice scheduled for each session. It is required by the state that each EMT-B student must attend 110 hours of instruction. Therefore it is imperative that you are punctual. Class will begin on time; if you arrive more than 1 minute late you will marked as "tardy" for that day. If you arrive more than 30 minutes late you will be marked "Absent Without Leave - AWOL". You may not miss more than two (2) classes during the didactic (classroom) phase. Being marked absent from more than 2 sessions will result in being dropped from the program. You may not miss ANY sessions during the ride-a-long phase.
If you know that you will miss a class for the rare unforeseen emergency, i.e., "Rules for Recruit Members #18 - Injuries", you must contact the primary instructor prior to that class. All hours missed will need to be made up in the form of essays on the information presented that day. The test or exam must be made up during the remedial hour of the following week.

Smoking

Smoking is prohibited in the building.

Chemical Substance Use

If you are seen or suspected of drinking alcohol or using illicit drugs during program hours, you will be immediately suspended from the program, pending investigation. You will be reported to the DOT Captain in charge of Probationary Training. Refer to the Department Policy and Procedure Manual for further information.

Discrimination

It is the policy of the EMS Academy to provide equal opportunity for training and education regardless of race, gender, sexual orientation, religion, age or ethnicity.

Rules for Recruit Members

Other Division of Training Rules for Recruit Members will apply during the EMT-Basic training program.

Staff and Contact Numbers

(Your Program Contact information would be inserted here.)

Program Responsibilities

Performance Standards

Tests - You must score 75% or better on each test to complete the program. You will be able to remediate tests or exams as necessary. Remediation will be in the form of 1) a review session that identifies your weaknesses, and 2) a remediation test. Each remediation must occur within one (1) week of the original test. The remediation test or exam may not be presented in the same format as the original test.

Exams - You must score 75% or better on the midterm and Final exam. The remediation policy is as listed above. If you do not achieve a 75% or better on the remediation quiz or exam, you will be recommended for termination through the Chief of the Department.

You may also be recommended for termination if after three (3) original (not remediation) consecutive weekly tests, a score of 100% on the next quiz would be insufficient to attain a 75% average.

Skills - You must score a 75% or better on every manipulative skill. If you fail to attain a passing grade on a given skill, you will be scheduled for re-evaluation. If, after two re-evaluations, you fail to attain a passing grade, you will be recommended for termination through the Chief of the Department.

You will accrue EMT deficiency points for skill scores below 75%. The schedule is similar to the Fire College schedule:

74% - 72% One (1) EMT deficiency point
71% - 68% Two (2) EMT deficiency points
67% - 64% Three (3) EMT deficiency points
63% - 60% Four (4) EMT deficiency points
59% - below Five (5) EMT deficiency points

EMT deficiency points are cumulative throughout the recruit training period. You will be sent to the Deputy Chief of Administration for a conference when you accumulate a total of ten (10) EMT deficiency points in any combination derived from substandard performance in manipulative skills. If you accrue a total of fifteen (15) EMT deficiency points or more, you will be recommended for termination through the Chief of the Department. Whenever an EMT deficiency point is assigned for substandard performance, a conference with the supervising Captains will be scheduled.

Textbook

The Program will be using the eighth edition of *Emergency Care,* by Brady Publishing. The Department will issue books before class begins. You are encouraged to purchase the book for your own reference. If you do not purchase the book, you must keep it in a neat and presentable condition. The textbook shall be returned to the Program upon completion of the course.

Ambulance Ridealong

You will be required to attend one (1) ambulance ridealongs during the Program. During the ridealong you will expected to participate in direct patient care activities. You will also be required to document at least two patient contacts per ridealong. These contacts will be documented on the Clinical Report Forms, which may be found in the appendix of this handbook.

The paramedic will review your activities during the ridealong, and document his/ her comments on the Student Evaluation form. Your hours of contact time must also be documented, on the Verification Form. This is also found in the appendix.

Emergency Department Rotation

Currently the program is not mandating observation time in the Emergency Department setting. However, if you would like to spend time in this setting, you may do so after completing the required immunizations and release forms. Please contact the Program staff if you are interested.

Dress Code

You are expected to wear your probationary firefighter uniform during the didactic phase of the Program; however you are permitted to wear your PT clothing during class. During the ride-a-long phase you will wear blue pants, a white shirt, and dark shoes.

Professional Conduct

It is the intent of all instructors to provide you with an environment that is conducive to learning. Conduct disrupting the classroom, or showing lack of respect for staff, guests, or other students will not be tolerated, and shall reported to the DOT Captain in charge of Probationary Training.

Building Maintenance

You are expected to clean the classrooms and common areas of the building at the end of each class. House chores will be done between 1700 - 1730 hours.

Successful Completion Criteria

Upon successful completion of this program, you will be eligible for the EMT-B certification process as provided by the County EMS Agency. Successful completion include all of the following:

1. **Attending all sessions of the program, or makeup of hours as assigned.**
1. **Completing all assigned homework.**
2. **Achieving a score of 75% or better over a three weekly test average.**
3. **Achieving a score of 75% or better on the Midterm and Final exams.**
4. **Achieving a score of 75% or better on all skill exams.**

You will be issued a course completion certificate that will permit you to apply for EMT certification in *(insert your city/state information here.)*

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EMERGENCY MEDICAL TECHNICIAN - BASIC

TRAINING PROGRAM

SECTION 5: COURSE SCHEDULE
97th Class Course Schedule

Week and Date	Pretest will cover	Exam will cover	Reading Preparation	Materials Presented	Skill(s) Lab
1: May 14, 1998	BLS Healthcare Provider	BLS Healthcare Provider	AHA BLS Text Brady pp. 797 - 823	Introduction to course CPR	CPR
2: May 18	Week 2 reading	None	Chapters 1, 2, 3, 14, 15 Appendix B: Stress in EMS Medical terms pp. 842 - 849	Introduction to EMS Well Being of the EMT Ethical/Legal Issues Communications Documentation	Documentation Scenarios
3: May 28	Week 3 reading	Week 2	Chapters 4, 5, 7,8, 9 pp. 826 - 837	Anatomy & Physiology Vital Signs and History Scene Size-up Intro Assessment	Vital Signs Lifting/moving Scene Assess Initial assessment
4: June 1	Week 4 reading	Week 3	Chapters 10, 11, 12, 13	Assessment - Trauma Assessment - Medical Assess.- pedi + geriatric	Assessments
5: June 8	Week 5 reading	Week 4	Chapter 6	Airway A&P Airway and Ventilation Adjuncts and Oxygen Intro Advanced Airway	Basic Airway Review Assess.
6a: June 15	Week 6a reading	Week 5	Chapters 25, 26	Trauma A& P Bleeding and Shock Soft Tissue Injuries	Bleeding Control Shock Mgt.
6b: June 18	Week 6b reading	Week 6a	Chapters 27, 28	Musculoskeletal Care Head and Spinal Injuries	c/spine supine c/spine seated splinting

Week and Date	Pretest will cover	Exam will cover	Reading Preparation	Materials Presented	Skill(s) Lab
7: June 22	Week 7 reading	Week 6b	Review 25 -28	Major Systems Trauma Review for Midterm	Skills Review Assessment Review
8: June 29	**None**	**Midterm 1-6b**		**None**	**Skills Examination**
9: July 6	Week 9 reading	Week 7b	Chapter 16, 17	General Pharmacology Respiratory A&P Respiratory Emergencies	Respiratory Scenarios

10: July 13	Week 10 reading	Week 9	Chapter 18	Cardiac A&P Cardiac Emergencies	Cardiac Scenarios
11: July 20	Week 11 reading	Week 10	Chapters 19, 20, 21	Diabetic A&P Diabetic Emergencies Allergies and Poisonings	Diabetic/ Allergies/ Poisoning Scenarios
12a: July 27	Week 12a reading	Week 11	Chapters 22, 23	Environmental Behavioral	Environmental/ Behavioral
12b: July 31	Week 12b reading	Week 12a	Chapter 24	OB/GYN	OB/GYN Scenarios
13: August 3	Week 14 reading	Week 12b	Chapter 29	Pediatric Emergencies	Peds Scenarios
14: August 10	Week 15 reading	Week 13	Chapters 30, 31, 32	Ambulance Operations Gaining Access Overviews (MCI, HazMat) Review for Final	MCI Drill Review
15: August 17	**None**	**Final 1 -14**	**Review 1 -32**	**All**	**Skills Exam**

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EMERGENCY MEDICAL TECHNICIAN-BASIC TRAINING PROGRAM

SECTION 6: CHAPTER OBJECTIVES

CHAPTER 1: INTRODUCTION TO EMERGENCY MEDICAL CARE

1. Describe the brief history of EMS development
1. Be able to explain the various components of the EMS system.
2. Describe the role and function of the Emergency Medical Technician - Basic.
3. Describe the responsibilities related to personal safety.
4. Describe the process of quality improvement.
5. Define the role of medical direction and medical control.

CHAPTER 2: THE WELL-BEING OF THE EMT - BASIC

1. Understand the reactions and changes that the EMT-Basic may feel when faced with stress.
1. Describe the different stages people may go through when dealing with death and dying.
2. Explain how the EMT might recognize and deal with stress from within as well as from outside factors.
3. Explain the importance of establishing scene safety.
4. Describe the concept of body substance isolation.
5. Describe the steps an EMT should take for personal protection from airborne and bloodborne pathogens.

CHAPTER 3: MEDICAL/LEGAL AND ETHICAL ISSUES

1. Define and explain the following legal concepts: scope of practice, duty to act, negligence, and abandonment.
1. Define and describe the following legal concepts: various forms of consent, refusal of medical care, role of minors, Do Not Resuscitate orders.
2. Describe the difference between assault and battery, and their implications to the EMT.
3. Explain the importance of maintaining patient confidentiality.
4. Describe the steps an EMT should take when protecting a crime scene.
5. Explain when an EMT is required to make notifications to law enforcement or other agencies.

CHAPTER 4: THE HUMAN BODY

1. Identify various topographic terms.
1. Describe the difference between anatomy and physiology.
2. Describe the anatomy and physiology of the major body systems.

CHAPTER 5: LIFTING AND MOVING PATIENTS

1. Explain why knowledge of body mechanics protects the EMT.
1. Describe the safety precautions and guidelines as applied to lifting and moving techniques.
2. Explain when an emergency move of a patient may be necessary.
3. Explain the uses of various patient-carrying devices.

CHAPTER 6: AIRWAY MANAGEMENT

1. Describe the general anatomy of the respiratory system.
1. Describe the patient with the signs of respiratory distress.
2. Explain why aggressive airway management affects the survivability of the patient.
3. Explain why a mechanism of injury may affect the opening of an airway.
4. Describe the performance of a head tilt, chin lift.
5. Describe the performance of a jaw thrust.
6. Explain why suction is important in maintaining patency of an airway.
7. Describe the function of artificial ventilation.
8. Explain the various techniques of providing artificial ventilation.

9. Describe the importance and use of airway adjuncts.
10. Define the components of an oxygen delivery system.
11. Explain why increased concentrations of oxygen affect the survivability of the critical patient.
12. Contrast and compare the uses of the nasal cannula and nonrebreather mask.

CHAPTER 7: SCENE SIZE-UP

1. Describe the various hazards an EMT might encounter at a scene.
1. Explain how an EMT might survey the scene in a consistent manner.
2. Describe common mechanisms of injury.
3. Explain the importance of identifying the number of patients encountered.
4. Explain the reason for identifying the need for additional resources.

CHAPTER 8: THE INITIAL ASSESSMENT

1. Explain the importance of establishing an early general impression of the patient's condition.
1. Describe the steps in the initial or primary assessment.
2. Explain how the EMT would establish an early impression of the patient, based upon the findings of the initial assessment.
3. Explain how the EMT would identify and correct problems encountered in the initial assessment.
4. Explain how an EMT would prioritize a patient for transport, based upon findings from the initial assessment.

CHAPTER 9: BASELINE VITAL SIGNS AND SAMPLE HISTORY

1. Explain the importance of establishing baseline vital signs.
1. Describe how the various vital signs are ascertained and recorded: pulse, breathing, skin signs, pupillary reaction, and blood pressure.
2. Explain what blood pressure measures, and the meaning of systole and diastole.
3. Explain what SAMPLE is, and how it pertains to gathering history.
4. Describe the difference between a sign and a symptom.
5. Explain the importance of reassessing vital signs on a regular basis.

CHAPTER 10: THE FOCUSED HISTORY AND PHYSICAL EXAM: TRAUMA

CHAPTER 11: THE FOCUSED HISTORY AND PHYSICAL EXAM: MEDICAL

1. Compare and contrast the trauma and medical based focused history and examination approaches.
1. Explain why differences exist between trauma and medical histories.
2. Explain why differences exist between trauma and medical focused exams.
3. Explain why mechanism of injury is important to the assessment of the trauma patient.
4. Describe the steps necessary to complete a rapid trauma exam.
5. Identify the components of the detailed physical exam.
6. Explain the importance of the detailed physical exam in relationship to the focused assessment.
7. Describe the differences between the trauma and medical patient in the context of the detailed physical exam.
8. Describe how a medical history and assessment may be conducted on the unresponsive patient.
9. Explain the SAMPLE history pneumonic.
10. Explain why knowledge of past medical history affects the medical assessment and history taking.

CHAPTER 12: ONGOING ASSESSMENT

1. Discuss the reasons why assessments should be repeated during patient contact.
1. Identify and discuss the components of the ongoing assessment.

CHAPTER 13: PEDIATRIC, ADOLESCENT, AND GERIATRIC ASSESSMENT

1. Identify the developmental considerations for the following age groups: infants, toddlers, preschoolers, school age, and adolescents.
1. Describe differences in anatomy and physiology of the infant, child, and adult patients.
2. Differentiate the response of the ill or injured infant or child (age specific) from that of an adult.

CHAPTER 14: COMMUNICATIONS

1. Identify the order of patient information during a radio call.
1. Discuss the legal implications during communications.
2. Discuss the communication skills that are used between the EMT and patient, family, bystanders, and other health care providers.

CHAPTER 15: DOCUMENTATION

1. Identify the components of the written report.
1. Describe how patient information should be entered into the medical record.
2. Explain the legal aspects of accurate documentation of the patient record.

CHAPTER 16: GENERAL PHARMACOLOGY

1. Identify the medications that EMT◆s are able to deliver in the prehospital field.
1. Identify the prescribed medications that the EMT may be able to assist the patient in administration.
2. Describe the "four rights" of drug administration.
3. Identify methods of drug administration.
4. Describe the six most common categories of medication.

CHAPTER 17: RESPIRATORY EMERGENCIES

1. Describe the basic anatomy of the respiratory system.
1. Discuss the physiology of breathing.
2. Identify the signs and symptoms of respiratory distress.
3. Identify signs of inadequate gas exchange.
4. Discuss the difference between ventilation and oxygenation.
5. Describe the patient with COPD.
6. Describe the patient with asthma.
7. Describe the management of the patient in respiratory distress.

CHAPTER 18: CARDIAC EMERGENCIES

1. Describe the basic anatomy of the cardiac system.
1. Discuss the physiology of the cardiovascular system.
2. Describe the pathophysiology of CAD, angina, AMI, and CHF.
3. Describe the patient experiencing cardiac compromise.
4. Describe the management of the patient in cardiac distress.
5. Explain the concept of the "chain of survival".
6. Explain the importance of aggressive airway management and oxygenation in the cardiac arrest patient.
7. Explain the importance of early defibrillation in the cardiac arrest patient.
8. Describe the management of the patient in cardiac arrest.
9. Discuss the importance of solid interaction and coordination between EMS providers during a cardiac arrest.

CHAPTER 19: DIABETIC EMERGENCIES AND ALTERED MENTAL STATUS

1. Describe the basic components of the endocrine system.
1. Describe the pathophysiology of diabetes mellitus.
2. Identify the patient experiencing a diabetic emergency.
3. Describe the differences between diabetic coma and insulin shock.
4. Describe the management of the diabetic patient.

5. Describe the components of AEIOUTIPS.

CHAPTER 20: ALLERGIES

1. Describe the basic anatomy of the immune system.
1. Describe the pathophysiology of an allergic reaction.
2. Identify the patient with anaphylaxis.
3. Describe the management of an allergic reaction.

CHAPTER 21: POISONING AND OVERDOSE EMERGENCIES

1. Describe how poisons enter the body.
1. Identify the patient experiencing an overdose or poisoning.
2. Describe the management of the poisoned or overdosed patient.
3. Discuss the issues associated with substance and alcohol abuse.

CHAPTER 22: ENVIRONMENTAL EMERGENCIES

1. Explain the physiology of heat generation.
1. Describe the pathophysiology of excessive heat gain and loss.
2. Describe the patient with hyperthermia.
3. Describe the management of the hyperthermic patient.
4. Describe the patient with hypothermia.
5. Describe the management of the hypothermic patient.
6. Describe the management of the patient with a localized cold injury.
7. Discuss the management of the near-drowning patient.
8. Discuss the management of the patient experiencing a SCUBA emergency.
9. Discuss the management of the patient with bites and stings.

CHAPTER 23: BEHAVIORAL EMERGENCIES

1. Define the behavioral emergency.
1. Explain the physiological factors for behavioral emergencies.
2. Discuss the management of the patient experiencing an emotional or psychiatric emergency.
3. Discuss the special considerations associated with the suicidal patient.
4. Identify the patient displaying aggressive or hostile behavior.
5. Describe the management of the aggressive or hostile patient.

CHAPTER 24: OBSTETRICS AND GYNECOLOGY

1. Identify the basic anatomy of the obstetrical patient.
1. Discuss the differences between the pregnant and non-pregnant patient.
2. Describe the stages of labor.
3. Describe the management of normal childbirth.
4. Describe the assessment and management of the newborn.
5. Describe the assessment and management of the mother.
6. Identify the childbirth complications.
7. Describe the assessment of the complicated childbirth.
8. Identify predelivery emergencies.
9. Describe the management of the predelivery emergency.
10. Discuss the considerations associated with sexual assault.

CHAPTERS 25: BLEEDING AND SHOCK

1. Describe the condition of shock.
1. Identify the stages of shock.
2. Identify the types of shock.
3. Identify the differences between venous and arterial bleeding.

4. Identify the differences between internal and external bleeding.
5. Describe the management of the patient in shock.
6. Describe the management of the bleeding patient.

CHAPTER 26: SOFT TISSUE INJURIES

1. Identify the anatomy of the skin and soft tissue.
1. Identify the major functions of the skin.
2. Describe the differences between closed and open wounds.
3. Describe the different types of open wounds.
4. Describe the management of the patient with blunt and penetrating trauma.
5. Identify the steps in the management of an open neck wound.
6. Identify the steps in the management of the open chest wound.
7. Identify the steps in the management of the abdominal injury.
8. Identify the types of burns.
9. Describe the classification of burns.
10. Identify the steps in the management of burns.
11. Describe the management of electrical injuries.
12. Describe the general principles of bandaging and dressing.
13. Describe the patient with pneumothorax, tension pneumothorax, traumatic asphyxia, hemothorax, and cardiac tamponade.

CHAPTER 27: MUSCULOSKELETAL INJURIES

1. Identify the anatomy of the muscular and skeletal system.
1. Describe the mechanisms of injury associated with musculoskeletal injuries.
2. Describe the general principles of splinting.
3. Describe the considerations associated with a midshaft femur fracture.
4. Describe the management of the patient with a musculoskeletal injury.

CHAPTER 28: INJURIES TO THE SPINE AND HEAD

1. Identify the anatomy of the nervous system.
1. Identify the anatomy of the brain, skull and spine.
2. Describe the mechanisms of injury associated with injuries to the head, neck and spine.
3. Describe the patient with a brain injury.
4. Describe the patient with a spinal injury.
5. Describe the management of a patient with a head or spinal injury.

CHAPTER 29: INFANTS AND CHILDREN

1. Define the pediatric patient.
1. Describe the developmental characteristics of infants and children.
2. Discuss the differences between pediatric and adult patients.
3. Describe the general approach and management principles with pediatric patients.
4. Discuss the broad categories of pediatric emergencies.
5. Describe the considerations of pediatric patients and trauma.
6. Describe the considerations of pediatric patients and abuse.
7. Describe the considerations of SIDS.
8. Identify the pediatric patient with croup and epiglottitis.

CHAPTER 30: AMBULANCE OPERATIONS

1. Identify the phases of an ambulance call.
1. Discuss the operations of an emergency vehicle in the context of motor vehicle law.
2. Identify basic equipment that should available in an ambulance.
3. Describe the methods used to clean and disinfect an ambulance and its equipment.

4. Explain the rationale for having an ambulance and its equipment for each response.

CHAPTER 31: GAINING ACCESS

1. Describe the purpose of extrication.
1. Identify personal safety equipment for emergency personnel during extrication.
2. Identify personal safety equipment for the patient during extrication.
3. Explain the importance of training for extrication.

CHAPTER 32: SPECIAL OPERATIONS

1. Describe the general management principles of a hazardous materials event.
1. Describe the general management principles of a multi-casualty incident.
2. Discuss the concept of triage.
3. Describe the incident command system and the role of the EMT.

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EMERGENCY MEDICAL TECHNICIAN - BASIC

TRAINING PROGRAM

SECTION 7: MANIPULATIVE SKILLS

MANIPULATIVE SKILL: Airway Management
OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a patient's airway using the appropriate equipment.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	5
OXYGEN ADMINISTRATION	25
1. "Cracks" full oxygen tank to clear valve outlet	2
2. Attaches regulator to oxygen tank. Ensures O-ring is in place Tightens regulator to tank securely with hand only Determines that regulator is in "Off" position	4
3. Opens main valve at least 1 turn Checks pressure on regulator Checks for leaks	3
4. Attaches oxygen adjuncts	5
Nasal cannula - places prongs in nose, tightens tubing around ears	
Nonrebreather mask - fills reservoir with oxygen, securely fits mask seal around mouth and nose	
5. Administers oxygen to patient	5
Nasal cannula - 4 - 6 liters per minute flow	
NRB mask - 10 - 15 lpm, allowing the reservoir to drain and fill with each respiration	
6. Reassess ventilatory status	3
7. Turns off regulator and drains pressure from system	3
BAG VALVE MASK	20

1. Opens airway with head tilt - chin lift or modified jaw thrust	5
2. Selects and inserts appropriate airway adjunct	2
3. Creates tight seal between mask and face	3
4. Ventilates patient by squeezing bag completely and steadily Observes for chest rise and fall Checks for gastric distention Checks for leaks	3
5. Hyperventilates patient with room air	2
6. Attaches BVM to oxygen tank	2
7. Sets regulator flow to at least 15 lpm	2
8. Ventilates patient at appropriate rate	1
ORAL PHARYNGEAL AIRWAY	15
1. Opens airway with head tilt - chin lift or modified jaw thrust	5
2. Determines correct size of OPA Measured from tip of earlobe to corner of mouth	4
3. Inserts OPA correctly Inserts with tip toward roof of mouth until it passes apex of tongue, then rotates airway 180 degrees	4
4. Reassesses ventilatory status	2
NASAL PHARYNGEAL AIRWAY	15
1. Opens airway with head tilt - chin lift or modified jaw thrust	5
2. Determines correct size of NPA Measured from tip of earlobe to tip of nose	2
3. Lubricates NPA with water soluble lubricant	2
4. Inserts NPA into right nares first, pushing straight down	4
5. Reassesses ventilatory status	2
FLEXIBLE (SOFT) SUCTION CATHETER	10

1. Prepares suctioning equipment Connects catheter and tubing to suction machine	2
2. Tests suction for vacuum	1
3. Determines depth of catheter insertion Nose - tip of earlobe to tip of ear Mouth - tip of earlobe to corner of mouth	1
4. Inserts catheter to measured depth	1
5. Creates vacuum	2
6. Suctions while withdrawing catheter, maximum 10 seconds	2
7. Reassesses ventilatory status	1
RIGID (HARD) SUCTION CATHETER	10
1. Prepares suctioning equipment Connects catheter and tubing to suction machine	2
2. Tests suction for vacuum	1
3. Determines depth of catheter insertion Mouth - tip of earlobe to corner of mouth	1
4. Inserts catheter to measured depth	1
5. Creates vacuum	2
6. Suctions while withdrawing catheter, maximum 10 seconds	2
7. Reassesses ventilatory status	1
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Controlling profuse bleeding

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively control profuse bleeding utilizing direct pressure, elevation, and pressure points. You will also be able to verbalize that the use of the tourniquet is a last resort measure to control a severe bleed.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Applies direct pressure to site of bleeding a) Uses sterile dressings b) Bandages securely with roller gauze or tape	15
3. If bleeding continues, applies more dressings without removing original bandaging	15
4. If bleeding continues, elevates affected extremity while maintaining direct pressure.	15
5. If bleeding still continues, applies enough pressure to pressure points to stop bleeding a) Femoral or brachial artery sites b) Use of the heel of hand or fingers	15
6. As a last resort, applies tourniquet to stop bleeding a) Placed just above wound site b) Wide band c) Tighten band with lever until bleeding stops d) Note time when tourniquet applied	10
7. Applies high flow oxygen to the patient	10
8. Places patient in modified trendelenburg position, if possible	10
TOTAL	100

COMMENTS:

MANIPULATIVE SKILL: Cardiac Arrest

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a cardiac arrest with two other assistants. You will be able to competently demonstrate the operation of a Department semiautomatic defibrillator.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Performs initial assessment of patient's **A**irway and **B**reathing	15
3. Instructs Assistant #1 to ventilate patient 2 times with BVM	15
4. Assesses patient's **C**irculation.	15
5. Begins chest compressions, with 5:1 ratio a) Assistant #1 inserts OPA b) Supplies BVM to 100% oxygen	15
6. Instructs Assistant #2 to apply defib pads to patient's chest a) Assistant #2 places pads "to sandwich the heart" - posterior chest wall below left scapula, anterior chest wall below left nipple b) Attaches cables to pads c) Turns defib on d) Advises other crew members to stop BVM and compressions e) Depresses "analyze" function	10
7. Crew waits for "analyze" function to complete a) If "***no shock indicated***", EMT assesses for carotid pulse **(-) pulse, (-) breathing**: crew continues CPR for one minute, proceed to step 8 **(+) pulse, (-) breathing**: Assistant #1 continues BVM, Assistant #2 attempts blood pressure, EMT attempts **SAMPLE** history, proceed to step 8 **(+) pulse, (+) breathing:** Assistant #1 assesses adequacy of breathing, assistant #2 attempts blood pressure, EMT attempts **SAMPLE**, proceed to step 8 b) If "***shock indicated***" Assistant #2 assesses for crew safety Depresses "shock" function If condition 7(b) exists, delivers 2nd shock when prompted If condition 7(b) exists, delivers 3rd shock when prompted EMT assesses for carotid pulse, crew proceeds to 7(a)	10
8. Assistant #2 depresses "analyze" function a) If "*no shock indicated*", repeat step 7(a) b) If "*shock indicated*", Assistant #2 repeats 7(b)	10

9. No further shocks are delivered, unless stacked shocks are interrupted	
TOTAL	100

COMMENTS:

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MANIPULATIVE SKILL: Application of EKG leads

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to assist the EMT-Paramedic in attaching the patient to EKG leads.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Attaches cable end to monitor	10
3. Attaches electrodes to cable leads	15
4. Bears chest appropriately.	10
5. Attaches the white negative electrode to patient's right pectoris	15
6. Attaches the black ground electrode to patient's left pectoris	15
7. Attaches the red positive electrode to patient's left lateral chest wall at the level of T10	15
8. Turns monitor on	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Emergency Childbirth

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to safely and effectively deliver a newborn infant in the prehospital setting.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	5
2. Determines if delivery is imminent a) Due date of baby (EDC) - premature, term, late b) Gravida/Para condition c) Prenatal care/ expected complications d) Waters break/ bloody show e) Timing of contractions f) Urge to bear down or move bowels g) Checks for crowning	10
3. Prepares equipment for delivery a) Drape area if possible b) Bulb suction c) Clamps d) Towels, blankets, cap	5
4. As head appears, applies gentle pressure to head to reduce tearing of perineum	5
5. Suctions mouth, then nose of newborn w/ bulb syringe	10
6. Checks for cord around newborns neck If present, attempts to loosen cord with one finger, if too tight, rapidly clamps cord in two places and cut	5
7. Assists in delivery of shoulders and torso	5
8. Rapidly stimulates, dries and warms the newborn	10
9. Assesses newborn: a) If baby does not begin crying or turning pink within 30 seconds, begin blow by oxygen b) If baby does not begin breathing or has respiratory rate < 30, begin BVM respirations c) If pulse rate is < 60, begin chest compressions a) If baby cries, turning pink, and has spontaneous movement, assess APGAR at 1 minute	10
10. Clamp cord a) First clamp 6 - 8 inches from baby b) Second clamp 2 - 3 inches away from first clamp	5
11. Cut cord with scalpel or scissors	5

12. Wrap baby in dry blanket, give to mother, attempt nursing	5
13. Deliver placenta, place into plastic bag for evaluation	5
14. Massage fundus to encourage bleeding control	5
15. Assess baby 5 minute APGAR score	5
16. Assesses mother's vital signs	5
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: BVM use with an endotracheal tube

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a patient's airway using a Bag Valve Mask with an ET tube previously inserted by the EMT-P.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	20
2. Attaches BVM to ET tube	20
3. Visually note depth of tube by markings on ET tube	20
4. Ventilates patient at appropriate rate	20
5. Observes adequacy of ventilation a) Observes chest rise and fall b) Feels for compliance of BVM c) Observes color changes of end tidal CO2 cap d) Has assistant auscultate lung sounds and gastric sounds	20
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Long bone extremity injury

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a suspected extremity injury with the appropriate technique and equipment.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Directs assistant to support affected extremity	10
3. Exposes injury site	10
4. Assesses patient's CSM function in extremity **C**irculation - presence of pulse, equal to unaffected side May also check nail blanching **If pulse or blanching is absent, and extremity is cold to touch, attempt to straighten extremity once to restore circulation.** **S**ensory - patient feels physical stimulus applied to fingers or toes **M**otor - patient able to move fingers or toes	20
5. If open injury is noted, applies sterile dressing to site	5
6. If closed injury is noted, applies ice to site	5
7. Applies appropriate sized splint to extremity	5
8. Pads voids	5
9. Immobilizes extremity above and below injury	10
10. Immobilizes joints above and below injury a) Utilize sling and swath for upper extremity injuries, including shoulder b) Elevate lower extremity after splinting	10
11. Reassesses patient's CSM function	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Helmet Removal

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively remove a helmet from a patient's head while maintaining manual cervical spine stabilization.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Directs assistant to maintain cervical spine stabilization by reaching under the helmet and grasping mandible and occipital head	20
3. Releases helmet strap	10
4. Begins to remove helmet by expanding sides of helmet	15
5. Tilts helmet backward to clear tip of nose	15
6. Slowly rocks helmet from behind head	10
7. Exchanges manual stabilization with assistant	10
8. Maintains manual stabilization until spinal immobilization is complete.	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Impaled Object

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively stabilize an impaled object, with emphasis on a penetrating eye injury.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. If possible, places patient in supine position on backboard	10
3. Controls profuse bleeding if present	10
4. Stabilizes impaled object a) Cuts a stack of 4 x 4 gauze pads b) Places pads aroundobject c) Tapes pads intoplace	10
5. Treats patient for shock with positioning and high flow oxygen	10
If the additional conditions are encountered:	
PENETRATING EYE INJURY	25
1. Covers patient s uninjured eye -Explains to patient	6
2. Stabilizes penetrating injury, or damaged globe	7
3. Covers injured eye -Uses paper cup or cone if possible	6
4. Secures covering	6
IMPALED OBJECT COMPROMISING ORAL AIRWAY	25
1. Inspects oropharynx for depth of penetration	6
2. If both ends of object are seen, removes the object by pulling it out in the direction that it entered the cheek.	7
3. If the tip of the object is impaled, or cannot be seen, object is stabilized in place	6
4. Suctions airway a necessary to maintain patent airway	6
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Intravenous setup

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to assist the EMT-P in setting up an intravenous (IV) infusion.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Receives IV solution from EMT-Paramedic	5
3. Confirms that the solution is appropriate, clear, non-expired	10
4. Attaches an extension set to an appropriate administration set	10
5. Closes roller clamp	5
6. Pulls protective caps off the IV solution bag and IV tubing	10
7. Inserts IV tubing into bag using aseptic technique	10
8. Squeezes drip chamber until half full with solution	10
9. Opens roller clamp	5
10. Allows fluid to run through tubing, expelling all air	10
11. Closes roller clamp	5
12. Maintains aseptic technique throughout procedure	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Auscultation of Breath Sounds

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to auscultate and describe breath sounds using appropriate technique and equipment.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Exposes chest appropriately	10
3. *Medical:* Places bell of stethoscope against area of right lung apex, posterior chest wall	5
4. Asks patient to take a deep breath	5
5. Notes lung sound Full or diminished Clear or crackling, wheezing	5
6. Repeats steps 3 - 5 in the following locations Left lung apex Left lung base Right lung base	20
7. Compares equality of lung sounds	5
8. Repeats steps 3 - 7 on the anterior chest wall	25
9. *Trauma:* Places bell of stethoscope against left lateral aspect of lung field, asks patient to take a deep breath, notes lung sound; repeats over right lateral aspect of lung field	15
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Oral Glucose Administration

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively administer oral glucose to a conscious patient with altered mental status.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Determines patient's past medical history a) Patient states diabetic history b) Medic alert tag c) Oral hypoglycemics d) Insulin in refrigerator, syringes	20
3. Determines that patient is awake and cooperative sufficiently to self administer oral glucose paste	20
4. Opens glucose tube, or mixes sugar into a liquid	10
5. Directs patient to take tube or glass from hand	10
6. Observes patient self administer glucose or liquid	10
7. Encourages patient to continue self administration	10
8. Assesses patient mental status over next several minutes	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Patient Assessment

OBJECTIVE: Upon completion of this skill, you will have demonstrated a logical, concise and complete assessment on any patient.

MANIPULATIVE STEPS:

SCENE SIZE-UP	15
1. Puts on appropriate body substance precautions	5
2. Checks for scene safety	3
3. Determines nature of illness/mechanism of injury	3
4. Determines number of patients	1
5. Determines need for additional resources	1
6. Takes c/spine precautions as necessary	2
INITIAL ASSESSMENT	30
1. Determines level of consciousness (LOC)	5
AVPU: Is the patient **A**lert, or responds to **V**erbal/**P**ainful stimulus, or is **U**nresponsive	
2. Determines chief complaint/life threats/mechanism of injury	4
3. Assesses ABCDE's and takes appropriate steps to correct life threats	
Airway: patent (speaking) or compromised	5
Breathing: non-labored, labored, shallow, absent	5
Circulation: strength, rate, location of pulse	5
Life threatening bleeding	
Skin signs	
Disability: AVPU	3
Expose: removes clothing as necessary	3
CONDUCTS APPROPRIATE FOCUSED HISTORY AND PHYSICAL EXAM	50

PERFORMS ONGOING ASSESSMENT	5
TOTAL SCORE	

FOCUSED HISTORY AND PHYSICAL EXAM - Responsive medical	50
1. Assesses History of Present Illness/Injury (HPI)	10
Onset of signs/symptoms **P**rovocation **Q**uality **R**egion/radiation **S**everity **T**ime	
2. Assesses medical condition	10
Signs/symptoms **A**llergies to medicine **M**edications currently taking **P**ast medical history **L**ast oral intake **E**vent leading to present illness/injury	
3. Performs focused physical exam Assesses affected body system	10
4. Assesses vital signs Respiratory rate and quality Pulse rate and quality Blood pressure Skin signs Pupil status (PERRL)	10
5. Initiates appropriate interventions	5
6. Determines transport mechanism	5
ONGOING ASSESSMENT	5
1. Repeats initial assessment	2
2. Repeats vital signs	2
3. Repeats focused assessment	1

TOTAL POINTS	

FOCUSED HISTORY AND PHYSICAL EXAM - Unresponsive medical	50
1. Performs rapid physical exam	15
Head **D**eformities **B**urns **C**ontusions **T**enderness **A**brasions **L**acerations **P**enetrations **S**welling	4
Neck DCAP-BTLS, stoma, medic alert, JVD Accessory muscle use	1
Chest DCAP-BTLS, chest rise, paradoxical movement, retractions, lung sounds, scars	3
Abdomen DCAP-BTLS, distention, masses, scars	2
Pelvis DCAP-BTLS, incontinence, pregnancy	2
Legs DCAP-BTLS, CSM, medic alert, track marks	1
Arms DCAP-BTLS, CSM, medic alert, track marks	1
Back DCAP-BTLS, scars	1
2. Assesses History of Present Illness/Injury (Family/bystanders)	10
Onset of signs/symptoms **P**rovocation **Q**uality **R**egion/radiation **S**everity **T**ime	

3. Assesses medical condition (Family/bystanders)	10
Signs/symptoms **A**llergies to medicine **M**edications currently taking **P**ast medical history **L**ast oral intake **E**vent leading to present illness/injury	2
4. Assesses vital signs Respiratory rate and quality Pulse rate and quality Blood pressure Skin signs Pupil status	5
5. Initiates appropriate interventions	5
6. Determines transport mechanism	5
ONGOING ASSESSMENT	5
1. Repeats initial assessment	2
2. Repeats vital signs	2
3. Repeats focused assessment	1
TOTAL POINTS	100

FOCUSED HISTORY AND PHYSICAL EXAM - Significant Trauma	50
1. Performs rapid physical exam	15

Head **D**eformities **B**urns **C**ontusions **T**enderness **A**brasions **L**acerations **P**enetrations **S**welling	4
Neck DCAP-BTLS, stoma, medic alert, JVD Accessory muscle use	1
Chest DCAP-BTLS, chest rise, paradoxical movement, retractions, lung sounds, scars	3
Abdomen DCAP-BTLS, distention, masses, scars	2
Pelvis DCAP-BTLS, incontinence, pregnancy	2
Legs DCAP-BTLS, CSM, medic alert, track marks	1
Arms DCAP-BTLS, CSM, medic alert, track marks	1
Back DCAP-BTLS, scars	1
2. Assesses vital signs Respiratory rate and quality Pulse rate and quality Blood pressure Skin signs Pupil status	15
3. Assesses patient history	10
Signs/symptoms **A**llergies to medicine **M**edications currently taking **P**ast medical history **L**ast oral intake **E**vent leading to present illness/injury	
4. Initiates appropriate interventions	5

5. Determines transport mechanism, initiates transport	5
6. Performs detailed physical exam if possible	
7. Determines need for detailed physical exam	
Head **D**eformities **B**urns **C**ontusions **T**enderness **A**brasions **L**acerations **P**enetrations **S**welling	
Face DCAP BTLS	
Eyes PERRL, conjunctiva, conjugate gaze	
Nose Nasal flaring, drainage	
Mouth Teeth, drainage, tongue	
Neck DCAP-BTLS, stoma, medic alert, JVD Accessory muscle use	
Chest DCAP-BTLS, chest rise, paradoxical movement, retractions, lung sounds, scars	
Abdomen DCAP-BTLS, distention, masses, scars	
Pelvis DCAP-BTLS, incontinence, pregnancy	
Legs DCAP-BTLS, CSM, medic alert, track marks	
Arms DCAP-BTLS, CSM, medic alert, track marks	
Back DCAP-BTLS, scars	

ONGOING ASSESSMENT	5
1. Repeats initial assessment	2
2. Repeats vital signs	2
3. Repeats focused assessment	1
TOTAL POINTS	100

FOCUSED HISTORY AND PHYSICAL EXAM - No significant trauma	50
1. Performs focused physical exam Assesses affected body system **(DCAP-BTLS)** Reassesses mechanism of injury	15
2. Assesses vital signs Respiratory rate and quality Pulse rate and quality Blood pressure Skin signs Pupil status	10
3. Assesses patient history	10
Signs/symptoms **A**llergies to medicine **M**edications currently taking **P**ast medical history **L**ast oral intake **E**vent leading to present illness/injury	
4. Initiates appropriate interventions	5
4. Determines transport mechanism, initiates transport	5
ONGOING ASSESSMENT	5
1. Repeats initial assessment	2

2. Repeats vital signs	2
3. Repeats focused assessment	1
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Sitting Immobilization

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively immobilize a sitting patient whom you suspect may have a potential cervical spine injury.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	5
2. Directs assistant to maintain manual cervical spine immobilization	10
3. Assesses patient's CSM function **C**irculation - presence of pulses **S**ensory - patient feels physical stimulus applied to fingers and toes **M**otor - patient able to grip hands and move feet	10
4. Applies appropriately sized cervical collar a) Measures first b) Applies from the front of patient's neck	10
5. Places vest type device between patient and assistant, with "wings" of vest placed directly under patient's axillae	10
6. Applies torso straps first In order: middle - bottom - top	10
7. Applies leg straps	5
8. Immobilizes head and neck to vest Fills void between head and vest	10
9. Reassesses patient's CSM function	8
10. Moves patient to supine position on backboard Supports legs while positioning patient	5
11. Releases leg straps	5
12. Secures patient to backboard	5
13. Reassesses patient's CSM function	2
14. Directs assistant to release manual stabilization	5
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Spinal Immobilization

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively immobilize a patient whom you suspect has a potential cervical spine injury.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	5
2. Directs assistant to maintain manual cervical spine immobilization	10
3. Assesses patient's CSM function **C**irculation - presence of pulses **S**ensory - patient feels physical stimulus applied to fingers and toes **M**otor - patient able to grip hands and move feet	10
4. Applies appropriately sized cervical collar a) Measures first b) Applies from the front of patient's neck	10
5. If necessary places patient arms besides body	5
6. Places backboard besides patient, with top of board located approximately 3 inches above top of head	5
7. Log rolls patient onto side toward rescuers	10
a) Directs second assistant to support hips and legs	
b) Directs first assistant to coordinate log roll	
c) Controls patient's torso and hips	
8. Sweeps the patient's back for injury or bleeding	5
9. Has first assistant direct log roll onto backboard	5
10. Secures body to backboard using appropriate straps a) Pads all voids b) Secures hips and shoulders	10
11. Immobilizes head and neck to backboard	10
12. Asks first assistant to release manual stabilization	5
13. Evaluates patient's CSM function	10
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Sucking chest wound

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a sucking chest wound utilizing appropriate technique and equipment.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	
2. Checks patient's ventilatory status	
3. Inspects chest wound for sounds and bubbling	
4. Applies a nonporous dressing to site a) If possible, ask patient to exhale completely b) Applies dressing with palm of hand c) Tapes securely on three sides	
5. Applies high flow oxygen using nonrebreather mask	
6. Reassess patient's ventilatory status Auscultate lung sounds for equality and depth	
7. Assesses for developing signs of tension pneumothorax Releases dressing if signs develop	
8. Places patient in high fowler's position if possible or onto affected side if patient is in shock	
9. Reassess patient's ventilatory status continuously	
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Traction Splinting

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to effectively manage a mid-shaft femur fracture using appropriate technique and equipment.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	10
2. Exposes injury site on femur	10
3. Determines this injury to be located mid-shaft	10
4. Assesses patient's CSM function in extremity **C**irculation - presence of pulse, equal to unaffected side May also check nail blanching **If pulse or blanching is absent, and extremity is cold to touch, attempt to straighten extremity once to restore circulation** **S**ensory - patient feels physical stimulus applied to fingers or toes **M**otor - patient able to move fingers or toes	10
5. Directs assistant to apply manual traction May apply ankle hitch prior to applying traction	10
6. Measures traction splint against good leg, extending splint 6 to 8 inches beyond foot	10
7. Applies appropriate sized splint to affected extremity	5
8. Applies groin strap	5
9. Applies ankle strap Tighten ankle hitch until patient feels relief Direct assistant to release manual traction	10
10. Immobilizes extremity above and below injury Distribute straps above and below joints	5
11. Reassesses patient's CSM function	10
12. Position patient onto backboard	5
TOTAL POINTS	100

COMMENTS:

MANIPULATIVE SKILL: Vital Signs

OBJECTIVE: At the end of this skill, you will have demonstrated that you are able to correctly ascertain a patient's vital signs using the appropriate equipment and techniques.

MANIPULATIVE STEPS:

1. Takes or verbalizes appropriate body substance isolation precautions	5
PULSE	25
1. Selects pulse site Adult - radial, then brachial, carotid, femoral Pedi - brachial, then carotid, femoral, apical	6
2. Palpates pulse	6
3. Determines pulse rate Counts number of beats in 15 seconds and multiplies by 4	7
4. Determines quality of pulse a) Regularity - regular or irregular b) Strength - full or weak, thready	6
RESPIRATIONS	25
1. Observes or feels rise and fall of chest	8
2. Determines rate of respirations Counts number or breaths in 15 seconds and multiplies by 4	9
3. Determines quality of respirations a) Regularity - regular or irregular b) Effort - non-labored, labored	8
BLOOD PRESSURE	25
1. Applies cuff to proximal arm a) Just above elbowbend b) Snug fitting c) Center of bladder over artery d) Bare skin	4

2. Locates brachial arterial pulse	4
3. Places diaphragm of stethoscope over site	4
4. Inflates cuff until sphygmomanometer reads 170 mm Hg	4
5. Positions ear pieces	4
6. Deflates cuff slowly a) Notes when heartbeat is first heard (systolic) b) Notes when heartbeat is no longer heard (diastolic)	5
c) Accuracy to within 10 mm Hg	
PUPILLARY ASSESSMENT	20
1. Examines eyes for pupil size Equal/unequal	5
2. Examines pupils for shape Round/misshapen	5
3. Examines pupils for reactivity a) Brisk, sluggish, fixed b) Equal, unequal reaction	5
4. Examines pupils for light accommodation	5
5. Checks eyes for symmetry Conjugate, disconjugate, doll's eyes	5
TOTAL POINTS	100

COMMENTS:

-
-
-
-
-

EMERGENCY MEDICAL TECHNICIAN-BASIC

TRAINING PROGRAM

SECTION 8: APPENDIX

EMS ACADEMY
EMT STUDENT CLINICAL REPORT FORM
Student Name: Date / Time:
Evaluator Name: Rescue #:

This form is required for each patient contact. The form must be typed or neatly printed.
Patient: Age: Sex: Wt (kg): CMED #

Chief Complaint: *Include all pertinent information about chief complaint, PQRST, signs & symptoms, etc.*

Vitals Signs: Resp: Pulse: B/P:

Pertinent Medical History:

Physical Assessment Findings:

Treatment / Response:

Suspected Diagnosis:

Explain Diagnosis:

EMS ACADEMY
EMT STUDENT VERIFICATION FORM

On student performed
Date Print Student's name

his/her field observation on Ambulance
Unit #

from _____ hrs to _____ hrs. Starting time Ending time

Student:
Print name Signature

Preceptor:
Print name Signature

Training officer:
Name Signature

EMS ACADEMY
EMT STUDENT FIELD PERFORMANCE EVALUATION
Student's Name:_____Evaluator:_____Date:_____

SKILLS EVALUATION:
4 = Superior 3 = Satisfactory 2 = Marginal / Inconsistent 1 = Unsatisfactory N/O = Not observed
1. Assessment / Vitals 4 3 2 1 N/O 6. Child Birth 4 3 2 1 N/O
2. Airway Management 4 3 2 1 N/O 7. Back Boarding 4 3 2 1 N/O
3. CPR 4 3 2 1 N/O 8. MAST 4 3 2 1 N/O
4. Bleeding Control 4 3 2 1 N/O 9. ALS Interaction 4 3 2 1 N/O
5. Splinting 4 3 2 1 N/O 10. KED 4 3 2 1 N/O
OVERALL EVALUATION:
4 = Superior 3 = Satisfactory 2 = Marginal / Inconsistent 1 = Unsatisfactory N/O = Not observed
1. Student / Patient Interaction 4 3 2 1 N/O
2. Identification of Patient care priorities 4 3 2 1 N/O
3. Leadership skills / Professional demeanor 4 3 2 1 N/O
4. Relates to Ambulance personnel 4 3 2 1 N/O
5. Remains calm 4 3 2 1 N/O
6. Accept advice and constructive criticisms 4 3 2 1 N/O
7. Overall impression of students performance 4 3 2 1 N/O

COMMENTS:
Evaluation discussed with student? [ ] Yes [ ] No
Student Signature:_____Date:_____
Paramedic Evaluator Signature:
_____Date:_____

APPENDIX XVII: Emergency Medical Health Services Program Student Handbook

(O.D.P.S. #1-002-004)

THE ACME EMS EDUCATION PROGRAM
The College of 911

Jane Doe
Program Director

Content Outline:

I. Program Purpose

This program is designed for individuals interested in providing care to patients in the prehospital setting. It will provide the participant with opportunities to gain information, skills, and attitudes necessary for certification as an Emergency Medical Technician-Paramedic in the State of Ohio.

II. Program Description

The Department of Public Safety approves this program. It addresses information and techniques currently considered to be the responsibilities of the EMT-Paramedic, according to the most current version of United States Department of Transportation's Emergency Medical Technician-Paramedic (EMT-P), National Standard Curriculum. The program consists of didactic (lecture) instruction, practical skills training, and clinical observation and training.

III. Program Goals

The program will contain information and skill practice opportunities, which will enable a properly motivated and capable participant to:

A. Demonstrate an understanding of human anatomy and physiology and the rationale and fundamentals of prehospital care and treatment of the sick and injured.

B. Perform a primary and secondary patient survey.

C. Understand, recognize, and provide appropriate ALS care for life threatening and non life-threatening emergencies.

D. Learn and demonstrate correct application and utilization of advanced life-support equipment in the prehospital setting.
E. File a run report of occurrences for the use of the receiving hospital as well as a permanent record for local use.
F. Transmit necessary information from the emergency vehicle to on line medical control in an orderly manner using mobile communication equipment.

A. Understand and discuss the rationale of patient/rescuer safety and care at the scene and through transport to a receiving medical facility.

IV. Instructional Materials

A. Several textbooks, workbooks and review manuals are available in The Acme EMS Education Program bookstore. The required and recommended books are listed by course number in the bookstore at the beginning of each semester. The costs for books varies each year but average cost is $200-$250 for the entire course.
B. The Laboratory Skill Manual must be purchased as a course pack from the bookstore.
C. Additional supplies and materials required (Lab coat, Shoulder Patch, stethoscope and EKG Calipers) at approximately $50.00
D. Although the textbook selected for the course will be the primary textbook for the entire curriculum, the student will be responsible for obtaining the following supplemental textbooks:
Advanced Cardiac Life Support, American Heart Association
Pediatric Advanced Life Support, American Heart Association
Basic Trauma Life Support, American College of Emergency Physicians
Basic Pediatric Life Support, American College of Emergency Physicians

V. Program Fees

There will be a tuition and general fee for all students. Students must obtain a student ID card to participate in activities and have access to the computer labs, libraries, and events.

Lab Fee/Liability insurance $75 per year

Additionally, in accordance with the clinical experience policy, each participant in an EMT education program must submit the original test results from all required laboratory tests and a physician's statement of fitness to perform the required clinical activities prior to the third week of the fall semester.
Upon successful completion of the EMT program verified by the Medical Director and the Program Director an examination fee of $35 will be due to the National Registry of EMTs. The Acme EMS Education Program will arrange for and provide space for the National Registry of EMT's examination at the completion of the program. There is a $150.00 examination site fee payable by the participant to The Acme EMS Education Program. This is non-refundable and payable at each examination attempt.
Students who wish to purchase certificate of completion cards for ACLS, PALS, PBTLS and BTLS may do so by paying the appropriate fee at the end of each specialty course. Generally these cards cost between $8.00 and $15.00 each.

VI. Class Location

Classes and laboratory sessions are conducted in the Clinical Laboratory Building, unless otherwise noted in the class syllabus. Please refer to the schedules for room locations. Laboratory sessions are held in the Clinical Laboratory Building Room 123.

VII. Class Time

Classes meet from 6:00 p.m. to 9:00 p.m. on Monday and Wednesdays. Laboratory sessions meet on Tuesday evenings from 6:00 p.m. to 9:30 p.m. Periodically during the course of instruction, class times and meeting sites will change to accommodate specialized education and testing programs. Students will be informed of such changes at the beginning of each semester.

VIII. Clinical Experience

The clinical coordinator, in cooperation with a medical facility, medic unit, ambulance service, life squad, and/or dispatch center will provide the opportunity for the program participants to observe and train in a clinical setting.

A. Clinical instruction and experiences are offered each semester.

1. The clinical experience is designed to meet and enhance the specific learning needs of the student. Each area of clinical experience has been selected to correspond with a specific area of didactic classroom instruction and to meet the clinical skill objectives outlined in the USNSTC.

2. The number of successful skill completions is designated for each specific area of clinical experience (see Appendix 1) and must be met by each student in order to successfully complete the program.

Areas used for clinical experience include the following:

a) Coronary Care Unit
b) Emergency Department
c) Life Squad
d) Obstetrics
e) Intubation Experience
f) Burn Unit
g) Pediatric ED
f) Dispatch Center

B. Clinical Attendance

1. Clinical assignments are made for each student. The student is expected to report 15 minutes before the start of the shift. The student is expected to stay in the area for the entire designated shift. If the student is unable to meet the schedule, they must notify the Clinical Coordinator at the phone numbers supplied to the students at the beginning of each semester. The coordinator will then notify the specific clinical area that the student will not be in attendance.

2. Due to the complexity of scheduling students into limited clinical affiliates, there will be no change in the assigned clinical training. Students must be in the specific area that they are assigned. Make-up time is available only at the end of the semester and only on a limited basis.

3. If a student is ill, they must make-up the time based upon availability. Absence from clinical areas is permitted only for true emergencies. A written excuse from a physician must be presented for an accepted excuse for failure to meet assigned clinical rotations.

4. Unexcused (no call, no show) absences from two clinical assignments in any one semester will result in the students' grade being lowered by one full letter grade.

5. More than two unexcused absences in any one semester will be grounds for dismissal from the program and the assignment of letter grade F for the clinical course.

6. The stated hours for each clinical area are based on the student successfully completing the objectives. This is a minimum requirement and at the discretion of the director of the program, the student may be asked to participate in further clinical learning experiences.

7. The students must have their hours of attendance verified by the preceptor on the Acme EMS Education Program form. The completed form must be submitted to the director to be recorded. Falsification of these forms will be grounds for dismissal from the program.

8. In order to document the quantity and quality of clinical experiences in each clinical field, the student will keep a clinical log to be reviewed by the clinical coordinator on a weekly basis. Failure to have the forms completed and reviewed by the director will result in the student being asked to repeat the specific clinical experience.

9. Clinical logs are due one week prior to the end of the semester. Clinical logs submitted for review after that time will be subject to a drop of one full letter grade.

1. Falsification of these forms will be grounds for dismissal from the program.

C. Dress Code for Clinical Experience

1. Students should wear a white, collared shirt, dark blue pants, black shoes, and a short white lab coat, which the student provides. Students must wear the Acme EMS Education Program patch on the left shoulder of the shirt and on the front pocket of the laboratory coat. Students must clearly display their picture student ID card while in the clinical setting. The laboratory coat will not be worn during life squad, ambulance or communication center experiences.

2. Official Student ID Nametags should be visible at all times during in-hospital clinical experience. ID tags will not be worn during life squad and ambulance experience, however the student must present the picture ID to the preceptor when reporting for duty. Students without picture ID will be asked to leave the clinical site.

3. No jeans, sandals, t-shirts, cowboy boots or other inappropriate attire during clinical experience. Students should have hair up and off the collar and be free of heavy jewelry, perfume, and inappropriate make-up. No body pierced jewelry is allowed to be visible during clinical experience

D. Performance on Duty

1. Each student must utilize self-initiative in the clinical area in which they are assigned.

2. The clinical coordinator/director reviews and coordinates the clinical experience, but they are not responsible for providing specific activity. Hospitals may vary somewhat in their approach to the students.

3. The student must tell preceptors which areas they would like more experience in. The request must conform to the guidelines of paramedic responsibilities. (See specific Clinical Objectives for each area.) Students should utilize the check-off list provided to ensure completion of objectives.

4. The student is expected to be tactful and courteous at all times. If a problem arises during clinical activities, the student is required to contact the clinical coordinator of the program to intervene.

5. Students may perform activities only under the direct guidance and observation of the registered nurse, physician, EMS Dispatcher, or certified paramedic. If the student is unfamiliar with the duty or has never performed the function outside the classroom, they must relay this information to the preceptor and observe. Subsequent availability of these specific experiences warrants a request by the student to actively participate.

6. Students must conform to all rules and regulations of the clinical affiliate during clinical experience. Students who display unprofessional appearance, substandard hygiene, unprofessional or inappropriate attitude, or misconduct as defined by the clinical affiliates employees handbook and the programs clinical guidelines will be subject to dismissal from the program.
In view of the limited time for clinical experience, there should be no area too menial or repetitious for the students to participate. The student should be aware of, and make use of, the vast learning opportunities available in every clinical situation and respect the clinical expertise of the preceptors working in those areas.

IX. Attendance Policies

Due to the volume of the material to be covered and the speed at which it will be presented, attendance will be expected at all classes. The maximum allowable number of absences and make-up arrangements is two per semester. Unexcused (no call, no show) absences from two classes in any one semester will result in the students' grade being lowered by one full letter grade. More than two unexcused absences in any one semester will be grounds for dismissal from the program and the assignment of letter grade F for the semester coursework. Exceptions to these regulations will be made on a case-by-case basis as determined by the program director and medical director.

Participants are expected to take responsibility for getting class notes, handouts, and make-up assignments when necessary. The Instructor is NOT responsible for supplying the student with these items. It is suggested that students designate another student to make sure that all classroom material is obtained.

When a student misses a scheduled quiz, the quiz will be made available to the student for study purposes; however, the student will not be allowed to make up the quiz for a recorded score.

X. Participant attire

Participants will be required to adhere to clinical guidelines when in an assigned clinical setting.

XI. Participant Progress Conference

The program director may request program participants to attend progress conference(s) during the course of the program.

XII. Examinations/Grading

Each student is expected to complete the reading assignment and workbook assignment prior to attending the class sessions. The lectures are based on the US DOT National Standard Curriculum. The lectures vary in sequence from the textbook. The material presented in lectures, textbooks, and assigned readings will be utilized in preparing the mid-term and final examinations.

All assignments must be completed before a grade will be assigned to the student. Quizzes and workbook assignments offer guidelines for individual study and for faculty appraisal of the student's progress. Late assignments will be not be reviewed or evaluated.

A mid-term examination will be given each semester. A final examination, which is comprehensive in design, is given at the end of each semester. Students must obtain at least a 75% on the final examination to successfully complete the course.

Academic dishonesty is grounds for immediate dismissal from the program. Please refer to The Acme EMS Education Program Catalogue for statement on academic dishonesty. No hats, ball caps, or sunglasses should be worn during examinations. In addition, no pagers, cell phones, PDA or other forms of electronic transmission of information are allowed during examinations.

Grading Scale:

Letter Grade	Point	Range
A	4.0	95-100
B+	3.33	90-94
B	3.0	85-89

C+	2.33	81-84
C	2.0	75-80
D	1.0	70-74
F	0.0	<69

Grades will be determined by the following weighting:
Mid-term: 20%; Final: 50%; Quizzes: 20%; and, Homework 10%

Written examinations are the most appropriate and effective process for measurement and assessment of the participants' success in converting content into knowledge. Practical skills provide feedback to both the instructor and participant on the ability of the participant to perform specific tasks. Results of written and practical skills and observational reports detailing participants' attendance and participation will be considered on the final grade.

Practical skill examinations will be administered three times during the program and must be successfully completed in order to continue in the program. At the instructor's discretion, a second opportunity to demonstrate competency on skills (prior to the end of the program) may be arranged.
Successful completion of the course will be determined by:

- Minimum 75% grade on the final examination
- Overall course grade of 75%
- Successful completion of AHA/ACLS provider level and other certificate courses as required (BTLS, PALS, PTLS)
- Practical skills score of 100%
- Satisfactory performance (completion of all quantified skill exposures) and a grade of C or higher in clinical courses
- Attendance at 80% or better of all classes and clinical assignments

Failure to successfully complete the above will result in ineligibility to sit for the initial attempt at the State Certification examination, until the time the student has completed remediation as required by the program director, program medical director and program faculty.

XIII. State Examination Requirements
Upon program completion of all final written and practical examinations and completion of all quantified clinical experiences as addressed in the objectives and in Appendix I, the participant will be permitted to take the National Registry of EMTs examination required for State certification. A site fee of $150.00 is assessed by the Acme EMS Education Program to cover the cost of staging the examination. These fees are above and separate from any fee charged by the National Registry of EMTs.

XVI. Continuing Education
This course is only the beginning of the participant's experience in EMS. The participant should plan to devote sufficient time and effort to continuing education to maintain certification in compliance with requirements set by the State and to maintain an appropriate level of knowledge and proficiency with patient care skills. Specific requirements for annual recertification training are available from the State and the National Registry of Emergency Medical Technicians.

XV. Participant Safety
Good mental and physical health is necessary for an individual to maintain the pace and physical demands that this course entails.

The program director or part-time faculty and clinical preceptors will oversee all student performance in both the classroom and clinical setting. Each student should address any problems or concerns that he or she may have regarding his or her safety immediately to the individual directly involved with the training in progress. Directions given by program personnel should be followed accurately, and if not understood, should be questioned to prevent problems and misunderstandings.
All students will perform with normal regard for personal safety as well as the safety of patients and others involved with patient care. At no time will the student perform any act that he or the preceptor deems unsafe or that the student/preceptor feels is inappropriate action for the student to take.
Any student who has an infectious disease (common cold, flu, hepatitis, herpes, or cold sore, etc.) should not participate in activities in the lab or the clinical setting. Students will be expected to attend class - if their condition permits - and observe others in the practical stations. The student will make-up practical time at the discretion of the program director. The student will be held responsible for the instruction and will be expected to practice on his or her own time to maintain skill levels in keeping with class progress.

In the case of any illness which requires the student to miss two or more classes, the student will be required to have a medical release by a physician before being allowed to return to class.

All manikins, airway adjuncts, and other equipment will be properly cleaned with disinfectant between each student's use (each student will have clean equipment). Due to the nature of the training, it is imperative that all students maintain good personal hygiene habits at all times. A sink and disinfecting soap is available in the laboratory and will routinely be used by students when working within the laboratory setting.

Any student with a history of chronic health problems, pregnancy, recent surgery, or back injury will be required to present a medical release from a physician. The program director and the medical director have the option to request such a release at his or her discretion.

Students should be able to lift 100-150 pounds; however, all students will exercise prudent physical exertion in labs and on calls - cot lifting, patient lifting, scene safety precautions, etc.

Any time a student suffers an injury while functioning as an EMT student, he or she will immediately report the occurrence to the preceptor who will in turn make an immediate report to the program director. A written incident report will be filed with the program director and medical director within 24 hours of the occurrence.
The paramedic on an EMS call or the clinical preceptor has complete authority over the student during his or her clinical rotation. If at any time the student performs actions not approved by the paramedic or preceptor, the student will be dismissed from the program.

While riding in emergency vehicles, students will be seated in the proper seat with their seat belt on.
No student is allowed to drive EMS vehicles at any time. Failure to comply with this rule will result in the automatic dismissal of the student from the program.

XVI. Statement of Understanding
I have received and read the student handbook for the program.
I understand the contents of the student handbook and agree to abide by the policies specified in it.

(Student's Name) (Date)

NOTE: This form must be signed and returned to the program director before the first scheduled examination. Failure to return the form will result in the student being ineligible to participate in the examination.

APPENDIX XVIII: BUDGET CONSIDERATIONS

Salaries and Honoraria

- Instructors
- Other course assistants
- Administrative support staff
- Evaluators
- Medical director

Fees

- Business
- Course approval
- Attorney
- Accountant
- Taxes
- Insurance (liability, property, etc.)

Facilities

Classroom(s)

1. Space with adequate parking
2. Tables
3. Chairs

- Office

1. Desk(s)
2. Chair(s)
3. Computer (ISP)
4. Telephone
5. Answering machine
6. File cabinet (with lock)
7. Photocopier
8. Facsimile machine
9. Miscellaneous office equipment
10. Office supplies
11. Cleaning supplies

Materials

Recruiting

1. Flyers, letters, etc. to relay course information
2. Postage
3. Registration forms

- Training

1. Teaching aids (blackboard, flip chart, computer, projector, TV, VCR, paper, pens, markers, etc.)
2. Training equipment (mannequins, simulators, defibrillators, etc.)
3. Disposable supplies (bandaging, tubing, etc.)
4. Cleaning supplies

Course

1. Syllabus, handbook, curriculum
2. Records
3. Handouts
4. Instructor resources
5. Textbooks

- Refreshments

Travel

- Per diem
- Mileage

APPENDIX XIX: Glossary of Terms

Accreditation	To give official authorization to or approval of; to recognize (an educational institution) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice.
Affective domain	Part of Bloom's taxonomy, the affective domain deals with feelings, thoughts and values.
Analytic learner	Learning preference dealing with how a learner prefers to take in information. An analytic learner prefers to look at details, steps and minute elements. The opposite of an analytic learner is a global learner.
Attribution	Regarding education, attribution is a thought process where an individual assigns responsibility for something. Example; a student performs poorly on a practical examination. When reviewing the reasons for poor performance, what does this student attribute to the cause? (lack of preparation time, poor teaching by the instructor, misunderstanding of the procedure, unprepared for testing on that day, etc.) Attribution is important in remediation because it shows how much responsibility a student accepts for their failures.
Auditory preference	A learner preference describing how a learner prefers to receive information. An auditory learner prefers the sense of hearing over other senses.
Certification	The issuing of a certificate by a private agency based upon standards adopted by that agency that are based upon competency.
Clinical instructor	A member of the EMS education team whose focus in teaching is the clinical setting. This individual must possess a high level of proficiency in the performance of skills in addition to their development as an EMS educator. The clinical instructor often works very closely with students in a real patient care

environment.

Clinical setting — Generally an actual patient care environment where student will interact with real or simulated patients to practice skills or to demonstrate skills proficiency.

CoAEMSP — Committee on Accreditation of Educational Programs for the Emergency Medical Service Profession provides accreditation services for paramedic programs. Its primary goal is to foster partnerships with educational programs in continuous quality improvements.

Cognitive domain — Part of Bloom's taxonomy, the cognitive domain deals with thinking and knowledge.

Cohort Group — Several students who are attending a course together.

Continuing education — The continual process of life-long learning that involves learning new content materials. It is different from refresher education which is a review of previously learned content.

Curriculum — A particular course of study, offered in a special field. For EMS education it is has traditionally included detailed lesson plans.

Depth and breadth — Depth refers to how far into a level of learning one should go in teaching it and breadth refers to the amount of material to cover (width). The greater the depth and breadth the more fully the material is covered.

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Didactic instruction — Designed or intended to teach. Didactic instruction generally deals with cognitive material needed for learning to take place in the cognitive, affective and psychomotor domain. Didactic instruction can be presented through a variety of methods, including lecture, small group work, problem-based learning, etc.

Discipline	Orderly or prescribed conduct or pattern of behavior.
Domains of learning	A method of categorizing learning into like groupings. Bloom used three domains: cognitive, affective and psychomotor. Other educational researchers have used more.
DOT-NSC Curriculum	Department of Transportation National Standard.
Educational Objective	The outcome/goal of the teaching/training conducted; the desired knowledge to be imparted.
Entry level	Refers to the novice or new EMS educator who has completed a formalized course of study of the body of knowledge proscribed by the EMS instructor curricula. This individual may possess teaching experience or credentials from another allied health field or education setting, but has limited experience teaching EMS content.
Emergency Medical Services	Collective name for all levels of certification or licensure for individuals who provide out-of-hospital patient care.
EMS Agenda for the Future	Public document finalized in 1996 that focuses on aspects of EMS related to emergency care outside traditional health care facilities. Serves as guidance for EMS providers, health care organizations/institutions, governmental agencies and policy makers committed to improving the health of their communities and to ensure that EMS efficiently contributes to that goal.
Emergency Medical Technician	A member of the EMS team who provides out-of-hospital emergency care; includes certification of EMT-Basic, EMT-Intermediate, and EMT-Paramedic which identify progressively advancing levels of care.
Formative evaluation	Process of evaluation that is conducted while training is in progress. It may be formal or informal but is generally designed to provide the instructor and student with a snapshot of where they are currently compared to where they want to be.

Goals — The end toward which effort is directed, goals in education are the primary reason a course or program is being taught.

Global learner — Learning preference dealing with how a learner prefers to take in information. A global learner prefers to look at the big picture first and then break it up into chunks to study. The opposite of a global learner is an analytic learner.

Kinesthetic preference — A learner preference describing how a learner prefers to receive information. A kinesthetic learner prefers the sense of touch over the other senses to learn.

Laboratory instructor — Member of the EMS education team whose primary responsibility is to assist students in learning psychomotor skills. This individual must possess a high level of proficiency in the performance of skills in addition to their development as an EMS educator. The laboratory instructor often works very closely with students in simulated patient care environment, but they may work with actual patients.

Laboratory setting — Generally a simulated patient care environment designed to allow students to practice skills and techniques on simulated patients.

Learning preference — Another term for learning style. A learning preference is the preferred mode or method a learner has for learning.

Learning style — A preferred mode or method a learner has that is unique to the way the perceive, store and retrieve knowledge and information.

Lesson plan — An instructional tool that allows the educator to map out their plan for learning for a given time frame.

Mastery level — EMS instructor who has demonstrated proficiency in all areas of the art and science of education. This individual often serves as a mentor to other instructors while continuing to grow and develop their own skills.

Memory degradation	Loss of memory that occurs over time.
Metacognition	The process of thinking about thinking. Taking deliberate steps to look at the processes one goes through to problem solve.
Motivation (intrinsic and extrinsic)	Intrinsic motivation comes from within an individual and is the force driving someone to learn. Extrinsic motivation is the driving force that is provided from outside of the individual that serves to build within them a desire to learn.
Objective	Expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations.
Pedagogy	The art, science, or profession of teaching.
Performance agreement	The process where goals, objective and content from a lesson plan are compared to determine if they are working towards achieving the same ends.
Portfolio	A method of compiling educational products (lesson plans, tests, slide presentations, games, etc.) generated by an instructor that allows the instructor to present a representative body of work for review and comment.
Primary instructor	This member of the educational team is the individual who is the main educator in charge of a cohort group of students who are attending a course. In addition to providing and coordinating classroom instruction, the primary instructor also coordinates other aspects of the course or works closely with a program director in the coordination of a course.
Professional educator	An individual who is committed to lifelong learning and who strives to increase their depth and breadth of knowledge and skills of education.

Program director This member of the educational team is the individual who has administrative oversight over one or several EMS courses.

Psychomotor domain Part of Bloom's taxonomy, the psychomotor domain deals with skills, manipulations of objects, and muscular control.

Rubric An explanatory or introductory commentary, rubrics are also learning tools that provide descriptions and help clarify subjective information. For example, an objective may state that a student must demonstrate proficiency in starting an IV. A rubric will break down the grading scheme so students can see exactly what criteria are required to demonstrate proficiency.

Skills instructor Similar to a laboratory instructor, the skills instructor is a member of the EMS education team whose primary responsibility is to assist students in learning psychomotor skills. This individual must possess a high level of proficiency in the performance of skills in addition to their development as an EMS educator. The skills instructor often work with students in simulated patient care environment or with actual patients.

Student handbook Instructional tool that describes the rules and regulations pertinent to the specific program or course the student is enrolled in.

Summative evaluation Process of evaluation that is conducted at the completion of training. It is generally formal, but may be informal, and is designed to test if students achieved the goals and objectives identified for the course.

Taxonomy The study of the general principles of scientific classification.

Visual preference A learner preference describing how a learner prefers to receive information. A visual learner prefers the sense of sight over other senses.