Rookie, Probie, Intern...

INTERN TO RELEASED PROVIDER

EDU-813

EMS Operations Manger Brian Hricik, NREMT-P
EMS Supervisor Ray Whatley, MBA, NREMT-P

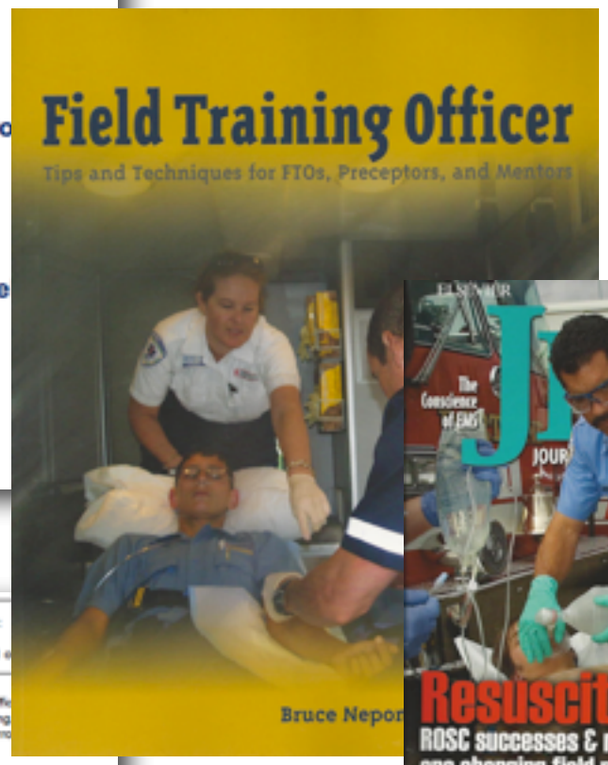
F.T.O.

SKAMANIA COUNTY EMS

Field Training and Evaluation Pro
(FTEP)

Lead Paramedic Trainee

Standards and Evaluation Guide



DELAWARE TECH

Manual

For

Paramedic Students

and

Field Instructors

This document includes:

Criteria for successful completion of the Field Internship Semester

nance Guidelines for Paramedic Students, Paramedic Instructors and Field Training Officers

Pertinent forms and documents for use in Field Internship, EMT 290

Revised and edited by the Paramedic Technology Program Faculty
Delaware Technical & Community College
May 2010

CITY OF CARROLLTON FIRE DEPARTMENT
ADMINISTRATIVE PROCEDURE 411
Field Training Officer Manual

Issued:

Page 1 o

OBJECTIVE: The purpose of this manual is to provide the Field Training Offi
a reference and information source while orientating, educating
evaluating new paramedics and other EMS employees of Carro
Department.

The FTO is a vital link between classroom training and the creation of a quality health care provider. Employees should benefit from field application of skills and judgment from the FTO.

The purpose of the FTO program is to ensure and continually improve employee performance. It is the FTO's responsibility to assist employees of Carrollton Fire Department to reach that goal.

411.01FIELD TRAINING PROGRAM

The FTO has five areas of responsibility for new medics:

1.1 Orientation

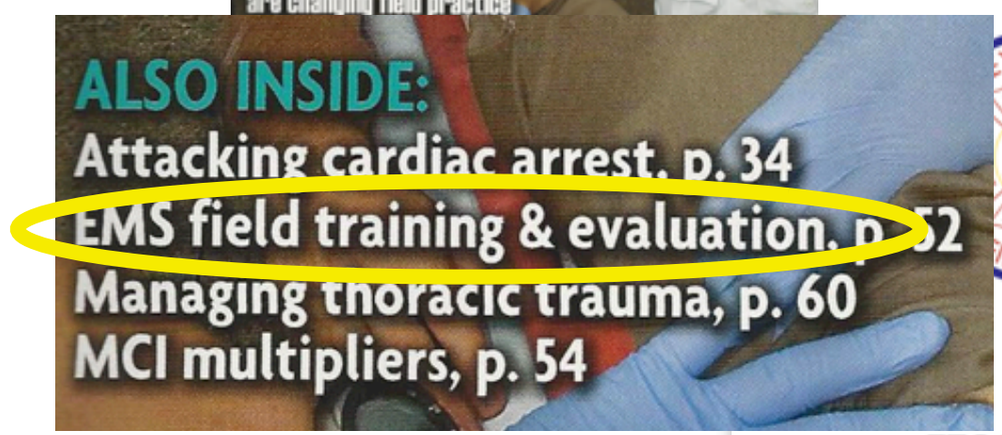
By the end of the orientation process, new medics should have a good understanding of the scope and responsibilities of the CFD operation, know their way around the MICU, know where to find equipment, and have a working knowledge of personnel resources.

1.2 Cultural Development*

CFD is a highly focused provider of clinical care and customer service. There is a "way that we do things" in the accomplishment of our mission that sets us apart from other EMS organizations. It is the FTO's responsibility to help new medics adopt the style and traits of CFD into their personal practice.

1.3 Education*

The FTO should play an important role in education of all CFD medics. The new medic typically has a gap between formal education and the streetwise education. Since high standards of clinical care are expected by our organization, the FTO's responsibility is to assess and discover these gaps and help the new medic close them.

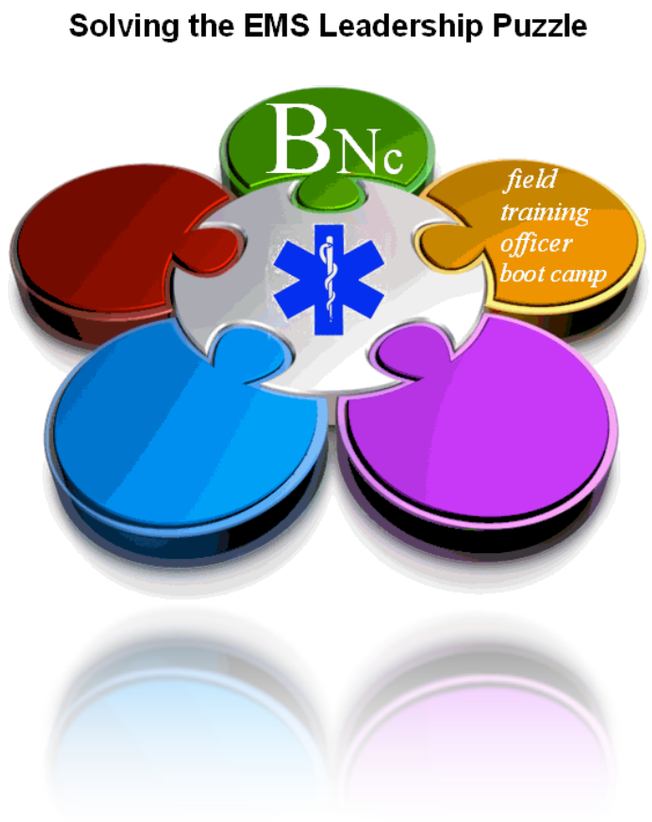


ALEXANDRIA FIRE DEPT. FIRE-EMS

FTO MANUAL

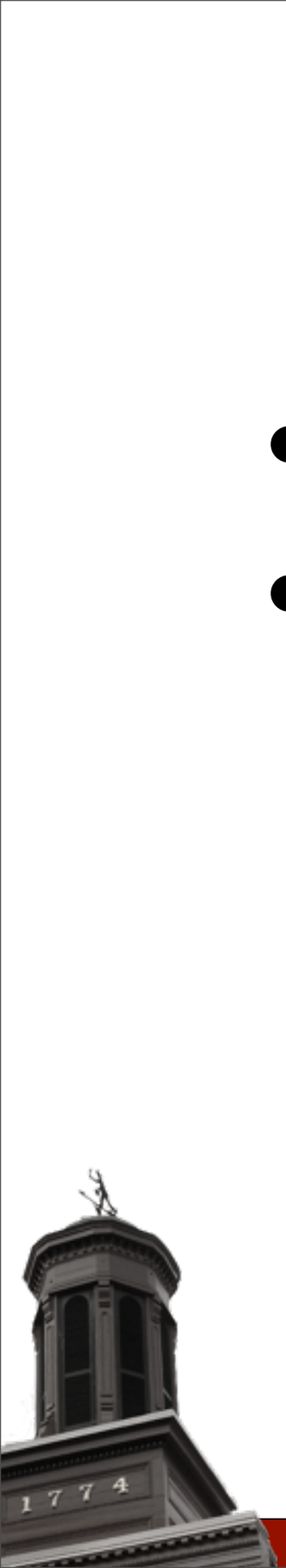
Menu

- Recruit knowledge - ALS vs BLS
- FTO Selection - students need to be reinforced from classroom
- Internship Process: points, KSAs, patient contacts
- Understanding each other teacher/mentor
- Oversight
- Documentation examples
- PIPs...a process to succeed
- OMD Involvement
- Final Evaluation



Recruitment/Interns

- BLS Providers
- ALS Providers
  - EMT-I
  - EMT-P



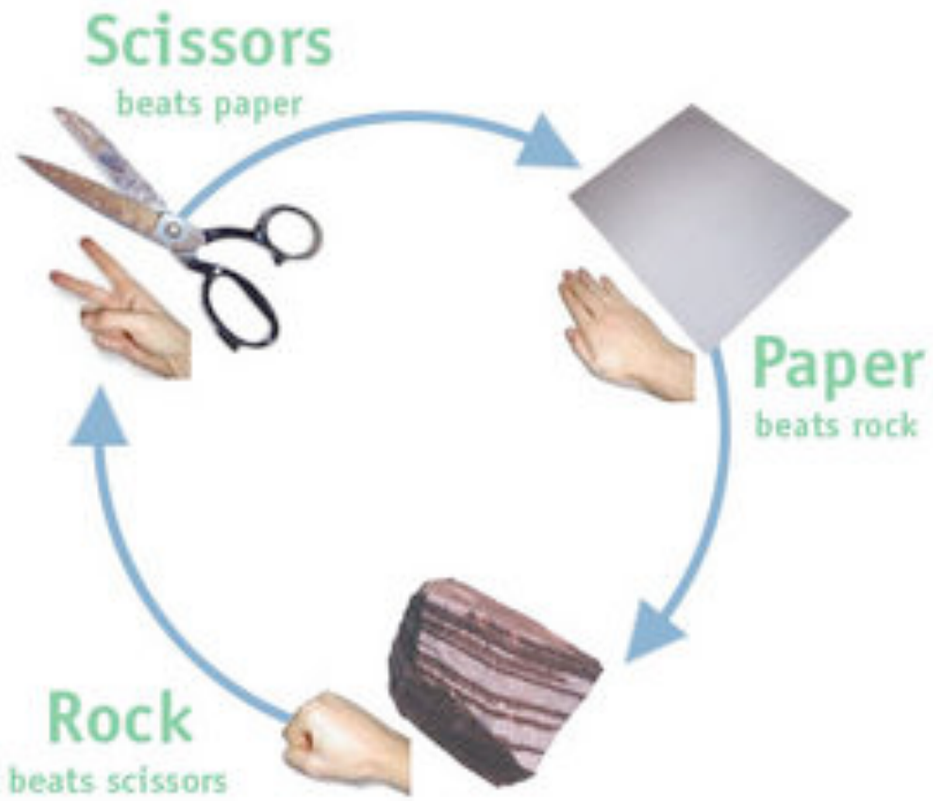
Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	OEMS use	EMR	EMT	AEMT	I	P
Specific tasks in this document shall refer to the Virginia Education Standards.								
AIRWAY TECHNIQUES								
Airway Adjuncts								
	Oropharyngeal Airway			●	●	●	●	●
	Nasopharyngeal Airway			●	●	●	●	●
Airway Maneuvers								
	Head tilt jaw thrust			●	●	●	●	●
	Jaw thrust			●	●	●	●	●
	Chin lift			●	●	●	●	●
	Cricoid Pressure			●	●	●	●	●
	Management of existing Tracheostomy				●	●	●	●
Alternate Airway Devices								
	Non Visualized Airway Devices	Supraglottic			●	●	●	●
Cricothyrotomy								
	Needle							●
	Surgical							●
Obstructed Airway Clearance								
	Manual			●	●	●	●	●
	Visualize Upper-airway		direct laryngoscopy			●	●	●
Intubation								
	Nasotracheal							●
	Orotracheal - Over age 12						●	●
	Pharmacological facilitation with paralytic	Adult Neuromuscular Blockade						●
	Pharmacological facilitation without paralytic							●
	Confirmation procedures				●	●	●	●
	Pediatric Orotracheal							●
	Pediatric paralytics							●
	Pediatric sedation							●
** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic								

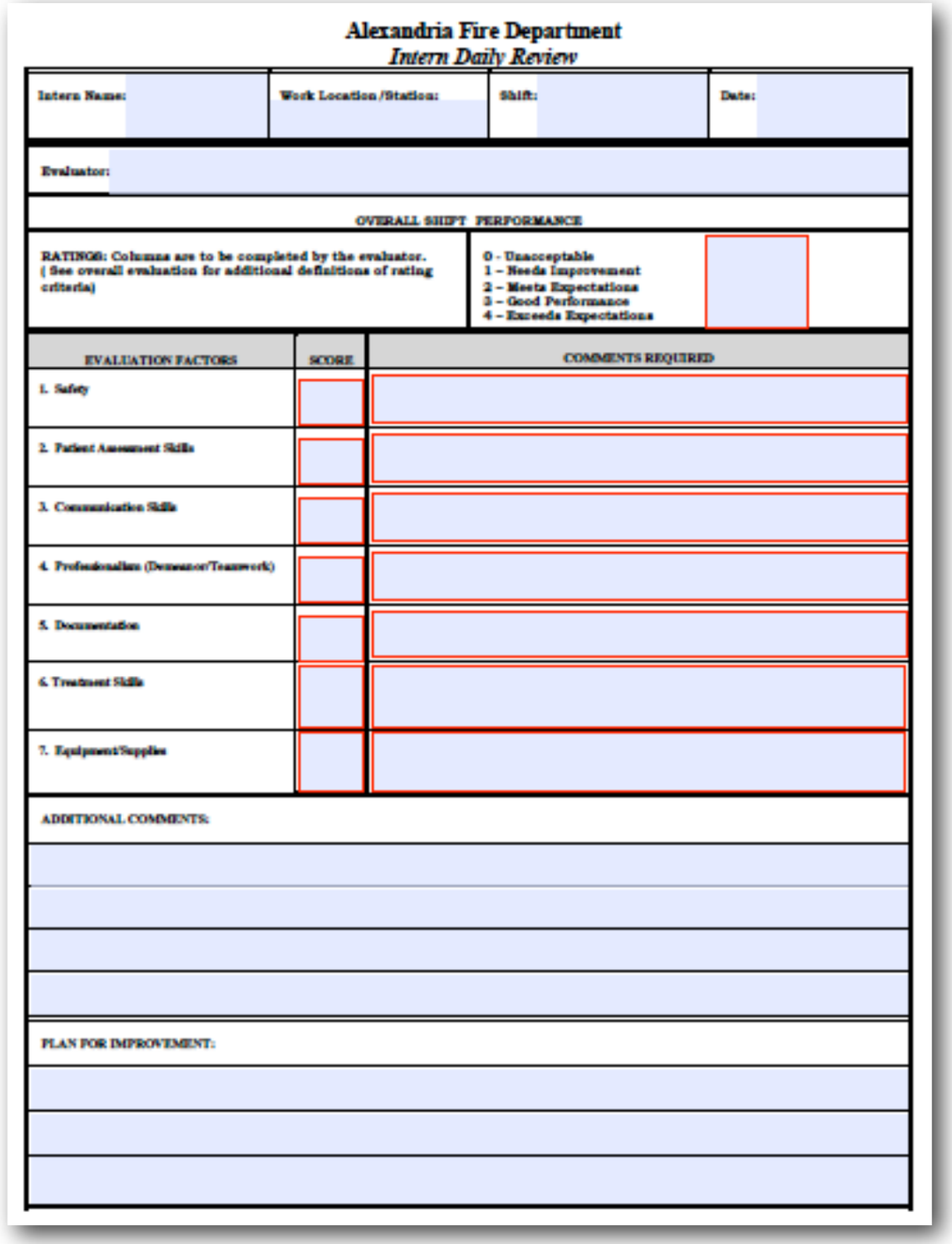
FTO Selection Process

- What makes a good FTO?
  - Senior member
  - Volunteer vs. selected
  - Evaluated
  - Motivation
  - Certification level



Internship Process

- KSA based
- Call reviews
  - By incident
- Evaluations
  - Daily
  - Monthly review
- Final Evaluation Process



Alexandria Fire Department
Intern Daily Review

Intern Name:	Work Location /Station:	Shift:	Date:
Evaluator:			

OVERALL SHIFT PERFORMANCE

RATINGS: Columns are to be completed by the evaluator. (See overall evaluation for additional definitions of rating criteria)

0 - Unacceptable
1 – Needs Improvement
2 – Meets Expectations
3 – Good Performance
4 – Exceeds Expectations

EVALUATION FACTORS	SCORE	COMMENTS REQUIRED
1. Safety		
2. Patient Assessment Skills		
3. Communication Skills		
4. Professionalism (Demeanor/Teamwork)		
5. Documentation		
6. Treatment Skills		
7. Equipment/Supplies		

ADDITIONAL COMMENTS:

PLAN FOR IMPROVEMENT:

Teacher/Mentor

Alexandria Fire Department
Emergency Medical Services Division

Advanced Life Support Protocol # 28

Chemical Solution for the Agitated and/or Delirious Pati

Date: October 2008

Chemical sedation should be reserved for those patients who remain violently agitated and/or delirious despite verbal de-escalation attempts and physical restraint, and in the judgment of the medic, poses a continued risk to themselves and/or to the EMS providers on scene or during transport. Chemical sedation is a measure to be employed as a last resort and should only be used after all other less invasive means of control have been exhausted under the direction of medical control. Chemical sedation should never be administered as a "convenience" measure.

Patients may remain uncooperative and verbally abusive after physical restraint, most of these patients usually will not necessarily require chemical sedation.

The use of physical restraints is covered in Standard Operating Procedure EMS 7: Patient Transport Procedures.

FOCUSED ASSESSMENT

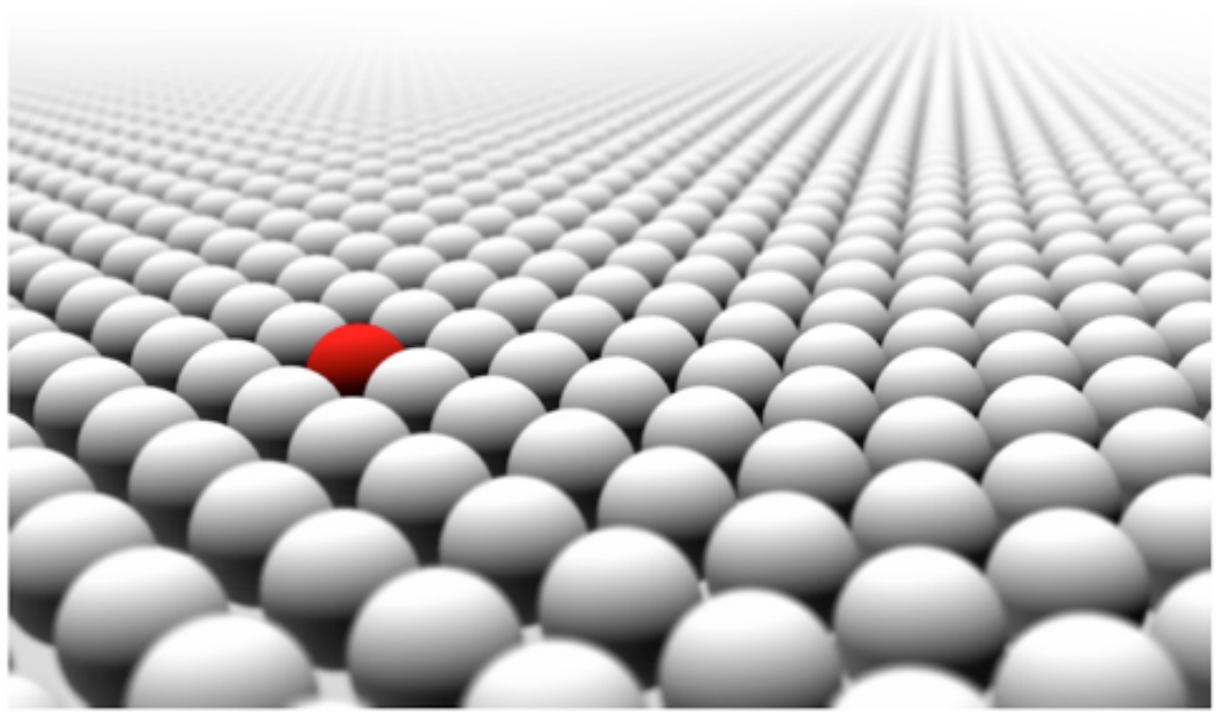
During initial assessment note:

1. Response to disability check (AVPU).
2. Possible mechanism of injury and consider C-spine stabilization (refer to ALS POLICY AND PROCEDURE # 15 – Spinal Motion Restriction).
3. Alertness to person, place, time and events or circumstances that led to EMS being called.
4. Further history to include: (AEIOU – TIPS)
   - Alcoholic beverage intake or suspected alcohol intoxication
   - Epilepsy (seizure history)
   - Infections (sepsis)
   - Overdose
   - Uremia (kidney failure)
   - Trauma, hernia, tumor
   - Insulin (diabetic history)
   - Psychosis
   - Stroke

Page 1 Chemical Sedation

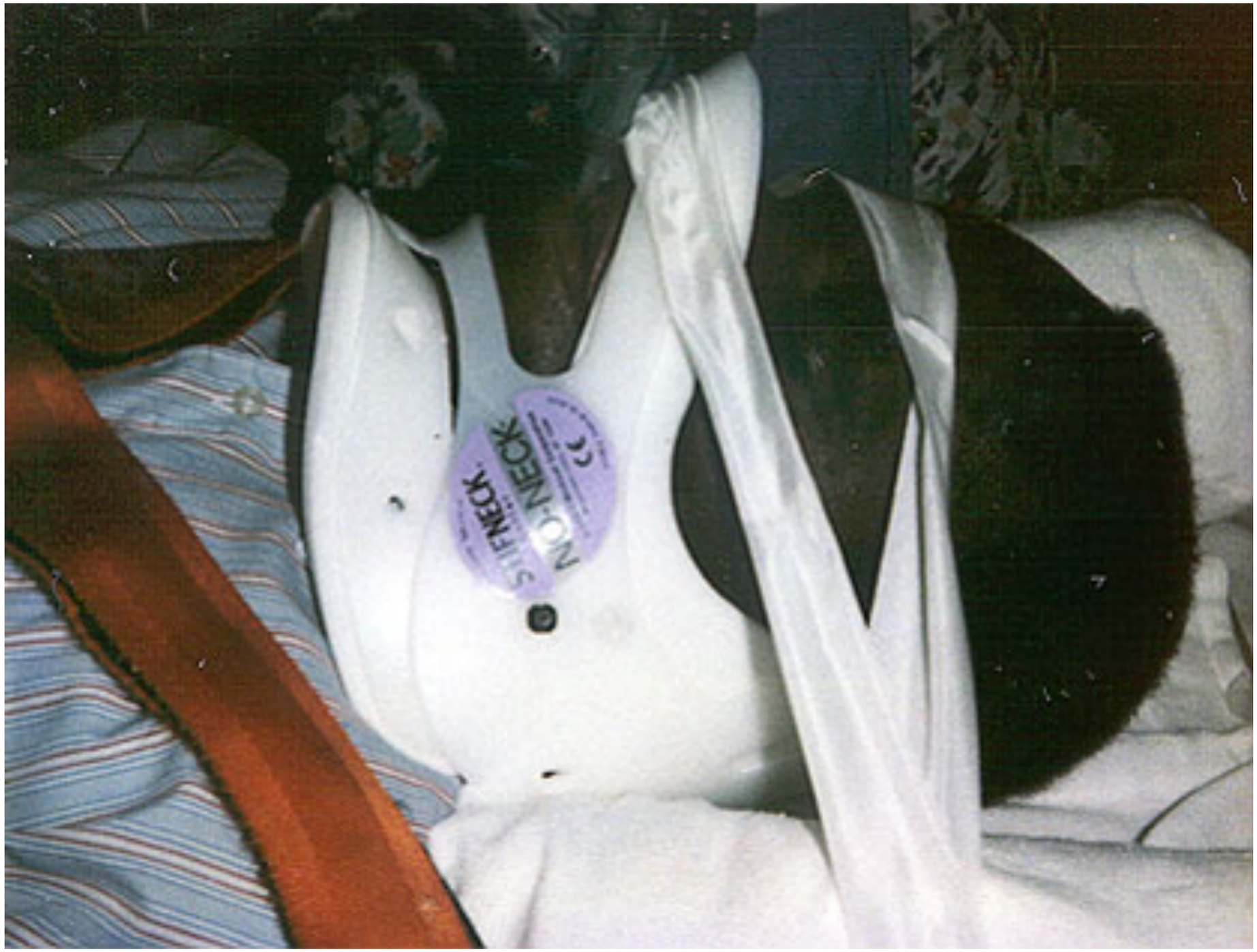
Different is not wrong

- Understanding "I did it this way at..."
- Learning challenges
- Personalities
- Stepping back
- Letting them fall



What can we learn from this?

Or this?

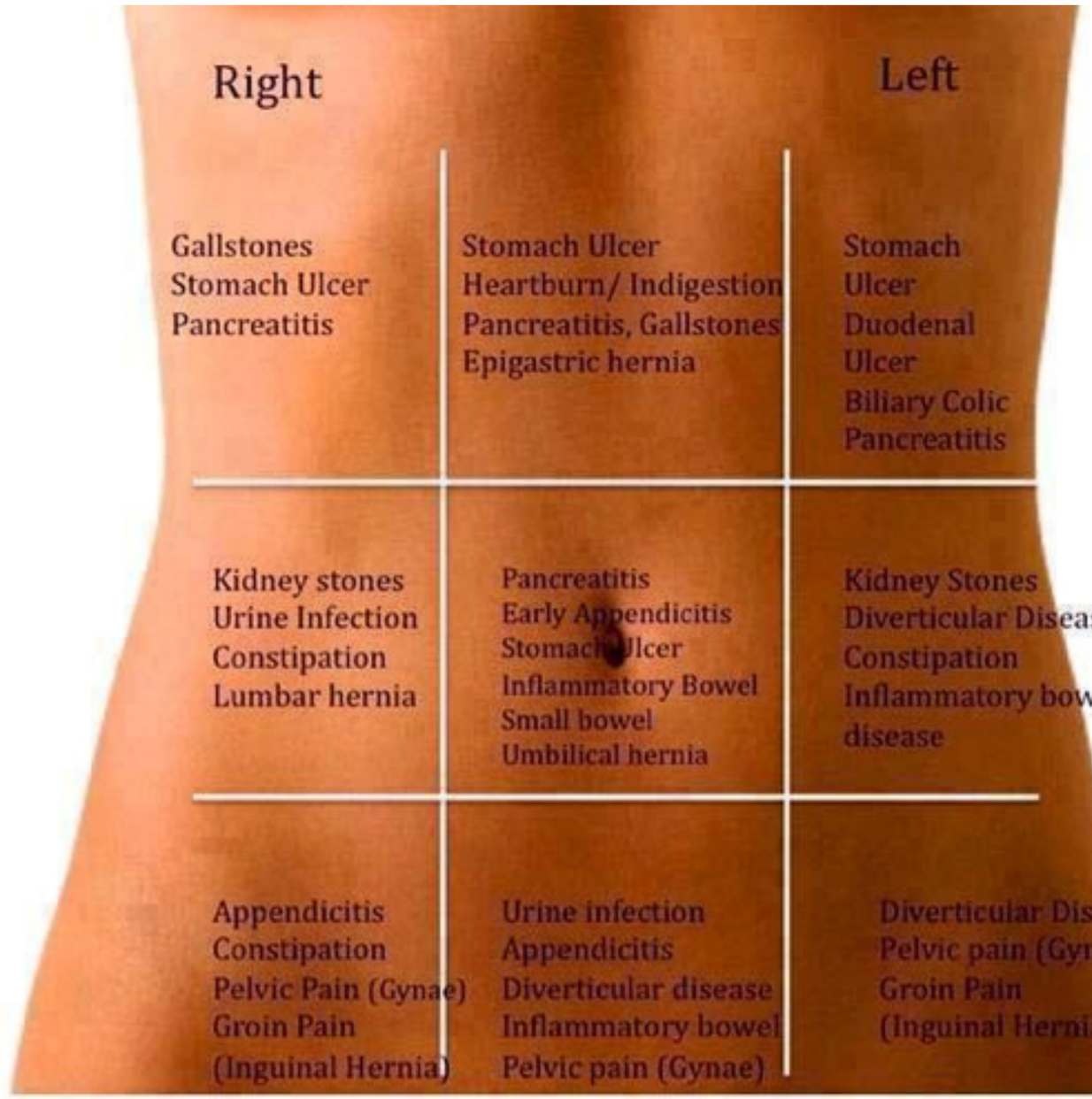


Practice Makes Perfect

- Knowledge exams
- Scenarios
- Actual incidents

If it isn't written...

- Documentation, Why????



Provider I

Treatment & Assessments

14:29 BP 100/60, Manual Cuff; MAP 73; P 84, Regular; R 18, Normal; Glucose 79 mg/dl; AVPU Unresponsive; Pain No Pain; MOEX4; Position Semi Fowlers

14:30 Skin unremarkable Head unremarkable Face unremarkable Neck unremarkable Chest unremarkable Lungs clear and equal…Eye, Left reactive Eye, Right reactive Neurological Status unremarkable

Provider I

Treatment & Assessments

14:29 BP 100/60, Manual Cuff; MAP 73; P 84, Regular; R 18, Normal; Glucose 79 mg/dl; **AVPU Unresponsive**; Pain No Pain; MOEX4; Position Semi Fowlers

14:30 Skin unremarkable Head unremarkable Face unremarkable Neck unremarkable Chest unremarkable Lungs clear and equal…Eye, Left reactive Eye, Right reactive **Neurological Status unremarkable**

Narrative 14:21

ATF 36 yo w/f lying on floor of classroom. staff report generalized seizure. pt was lowered to floor. staff report the school nurse administered Diastat- pr to help abate the seizure.

pt appears postictal. strong muscle tone in upper extremities. home health aid reports 4 / 10-15 sec seizures on Saturday and 3 / 10-20 sec seizures. no medications administered for the weekend events.

pt normally somnolent post seizure for 20-30 min. clinical @ noted. tx uneventful.

Provider 2

Treatment & Assessments

02:24 P 72, Regular, Palpated; R 20, Normal; Glucose 27; GCS 4+2+4=10, GCS has legitimate values without intervention; AVPU Awake & alert; Orientation Oriented to Person, Place Disoriented to Time, Oriented to Event; Pain No Pain; MOEX4; Position Prone or supine

02:26 Normal Saline, 200 mL; Response Improved

02:26 Procedure Intravenous Line Established 18 g Left Hand

02:30 Dextrose 50%, 25 gr IV; Response Improved

02:31 Skin diaphoretic Lungs clear and equal Neurological Status unremarkable

02:48 BP 130/90, Manual Cuff; MAP 103; P 84, Regular, Palpated; R 12, Normal; Glucose 109; GCS 4+5+6=15; AVPU Awake & alert; Orientation Oriented to Person, Place, Time, Event; Pain No Pain; MOEX4; Position Semi Fowlers

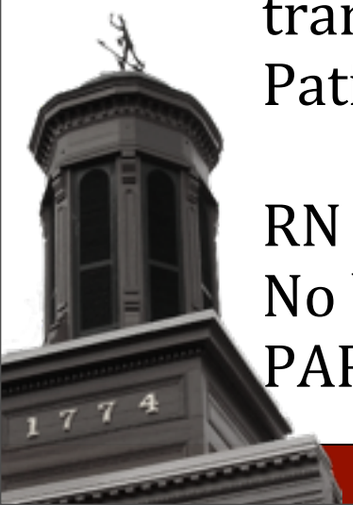
Narrative: 02:17

Called for subject going in and out. Arrived at residence to find 66 yom patient lying supine in bed with obviously altered level of conciseness in presence of family. Family states the patient's BG has been dropping all evening and that he hasn't been feeling good or acting like his normal self. Last BG by family was approx. 90 mg/dl. Patient has a recent Hx significant for starting chemotherapy for liver cancer. Per family he has had frequent diarrhea with his new cancer medications.

Neuro: awake, inappropriate sounds, withdraws from pain. Cardic: Intact, Respiratory: Intact, spontaneous/unlabored, clear. Skin/Ext: warm/ diaphoretic/pink. HEENT: Constricted, PERRL.

v/s assessed, BG 27 mg/dl, EMS initiated IV NS and administered d50. Post administration patient's BG increased to 109 mg/dl and his level on consciousness returned to normal. Patient also became nauseated, and had diarrhea. Patient walked self to stretcher with minor assistance, secured with all straps in semi-fowlers position, loaded and began transport. Transported without incident or change in condition to ER. Patient moved self to bed 18, care given to HEY NURSE, RN.

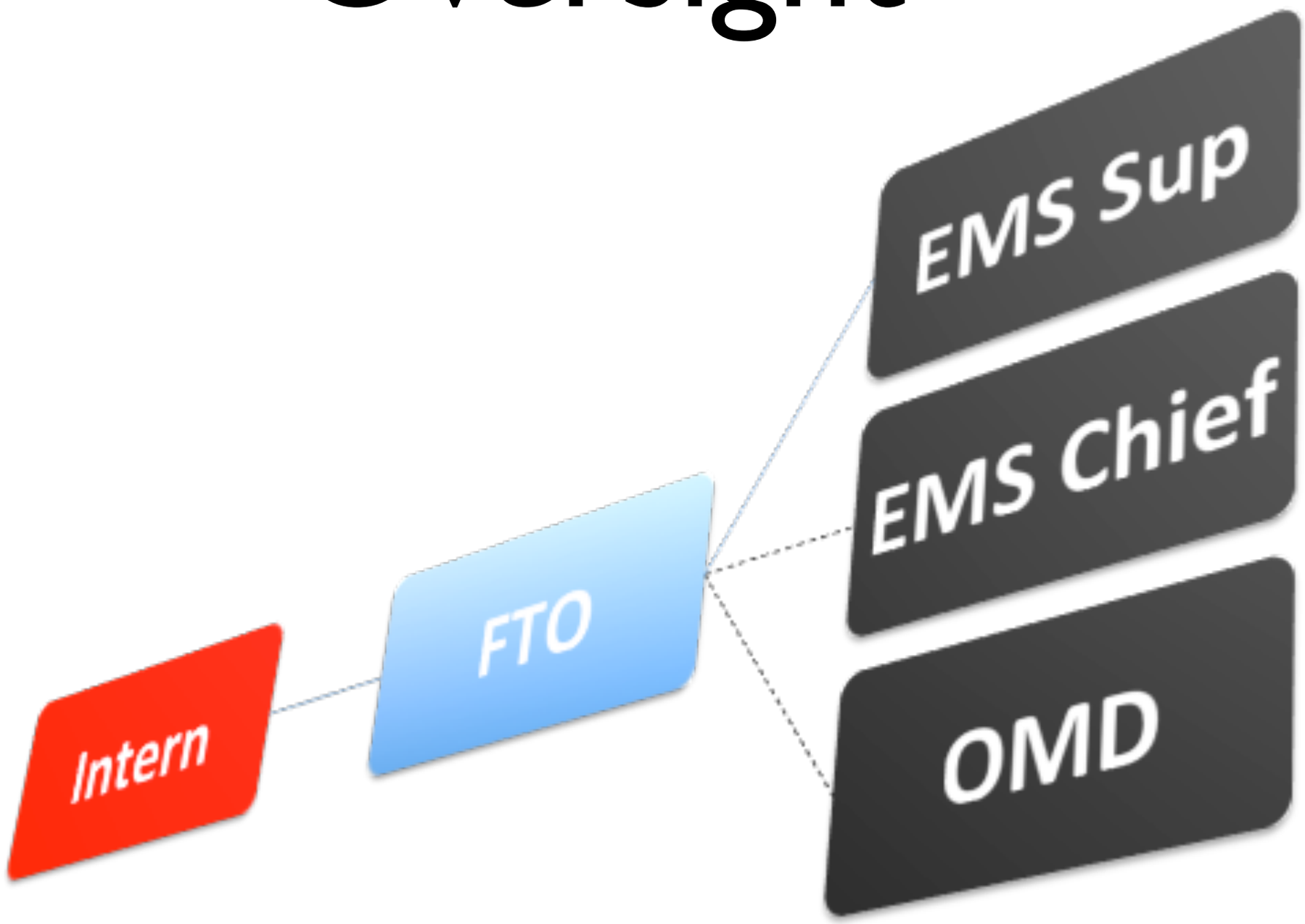
RN signed for patient, patient states he doesn't fee like signing.
No belongings transported by EMS.
PARAMEDIC, NREMT-P



FTO Support System

- Peers
- Leadership and Administration
- Human Resources

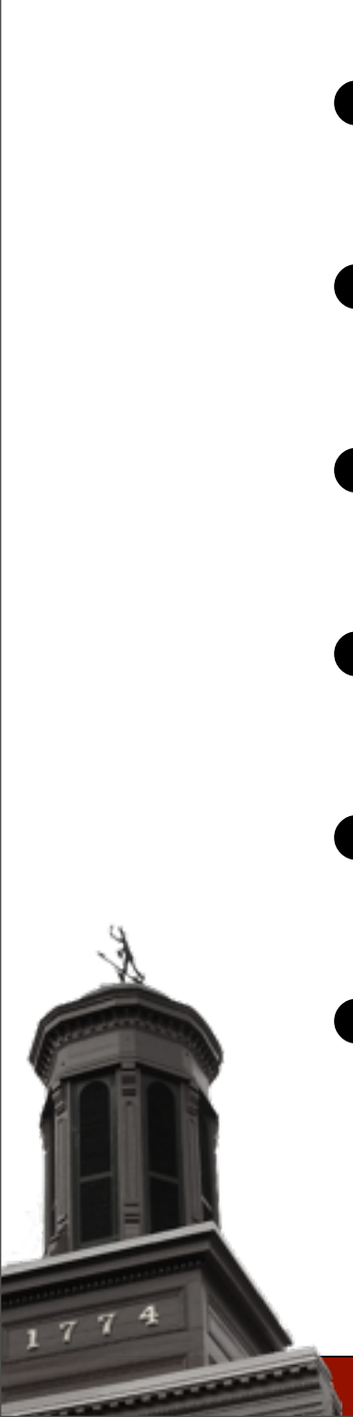
Oversight

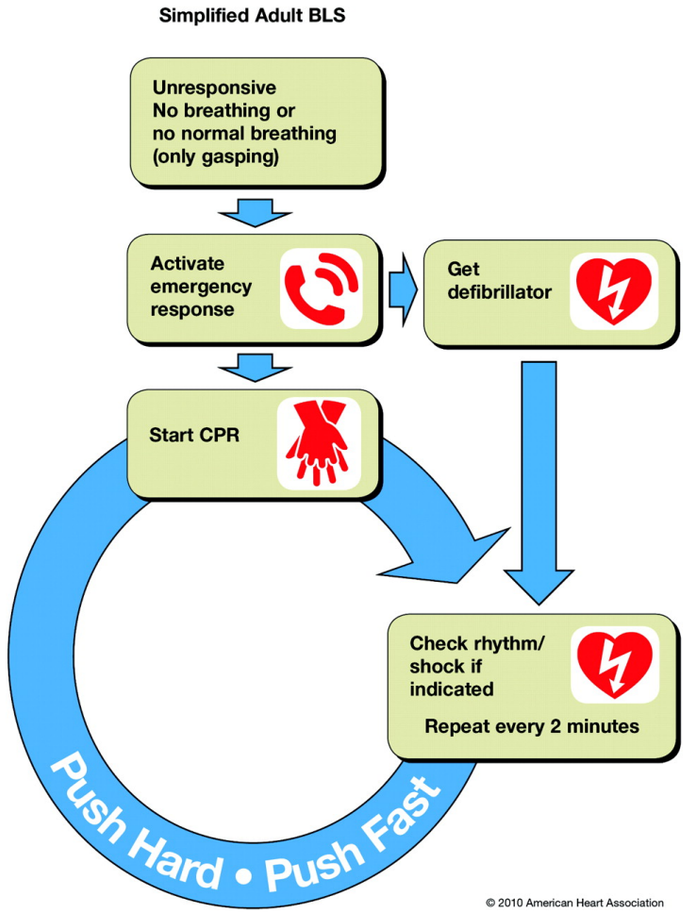


Performance Improvement

Help them understand how to succeed

- Plan for teamwork
- Making sure the FTO understands.....
- Identifying deficiencies
- Expectations
- Corrective actions
- Time line





Identify Deficiencies

1. **Deficiency Noted – Patient Care (Initial Assessment, Ongoing Assessment, Status Determination, Patient Management)**
    a. Recognizing and acting upon immediate life threatening situations
    b. Prioritize treatment properly
    c. Making a thorough exam of patient
    d. Recognizing and understanding medical conditions and their severity
    e. Recognizing need for Advanced Life Support
    f. Demonstrating flexibility and adaptability to changing patient conditions
2. **Deficiency noted – Scene Control**
    a. Taking charge and controlling the incident scene
    b. Providing needed direction to other EMS and Fire personnel on the incident
3. **Deficiency noted – Performance Under Stress**
    a. Displays self-confidence
    b. Making quick and accurate decisions

Action Required

1. **Daily ALS based patient care drills** with your FTO with documentation provided to your Supervisor.
2. **Assigned as Attendant in Charge (AIC)** on all patients requiring Advanced Life Support – patient's status to be determined by your FTO.
3. **Provide your FTO with a copy of each PCR** with an Incident Evaluation Sheet attached for all calls in which you are AIC. This is to be done upon return to the station after completing the call and discussed before the end of each shift. Copies of the evaluation sheets should be provided to your Supervisor.
4. **Complete a self evaluation daily** using the monthly EMS Probationary Evaluation Report. Review these with your FTO at least once a tour. Copy should be provided to your Supervisor.
5. **Participate in biweekly drills** coordinated through your Supervisor, Operational Medical Director or designee to evaluate your progress during this Performance Improvement Plan. This may include written evaluations, patient scenarios or skill stations.

Time Line

During the next six months, your performance will be carefully monitored on a regular basis in order to determine your ability to continue with your ALS Internship. This determination will be made with input from your Field Training Officer (FTO), your Supervisor, the EMS Training Officer, the EMS Operations Manager and the Assistant Fire/EMS Chief Operations **before July 20, 2012**, based on your performance evaluations and biweekly evaluations of this Performance Improvement Plan.

What happens if?

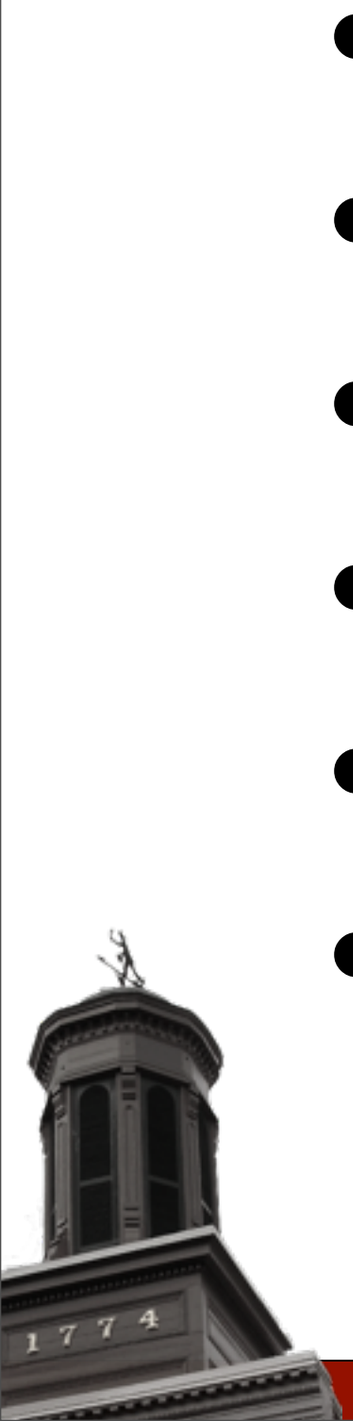
Evaluation Time

- Comprehensive written exam
- Scenarios
  - Manikin based
    - SimLab
    - Actor
- Congratulations

- What do you call your endorsed providers?
- Incentives?

OMD Role

- Hiring - Should they be involved?
- Operations = Agency
- Practice = OMD
- Training
- Final Evaluation
- Endorsement



AFD FTO Manual

We are happy to share our FTO/Internship Manual with you. Simply email me at ray.whatley@alexandriava.gov

This presentation is dedicated to Paramedic/Educator Joshua Weissman LODD February 9, 2012

One of the principal authors of the
Alexandria Fire Department ALS Field Internship Manual

The Ultimate Challenge

It's About Time!

http://www.ultimate-challenge.org/

Air Medical Memorial
National EMS Memorial

Thank you for what YOU do each and every day and THANK YOU to our VETERANS

Brian Hricik
brian.hricik@alexandriava.gov

Ray Whatley
ray.whatley@alexandriava.gov