Texas EMS Education Programs may use these at their discretion as approved by the Program Course Coordinator, Education Program Medical Director, and advisory committee if applicable.

PREAMBLE

The Texas EMS Skills Competency Packet is a resource being made available to all Texas EMS Education Programs. Based on the National Education Standards, the Packet does not prescribe the use of these skills sheets but is merely a tool that EMS Education Programs may use. All EMS Education Programs shall adhere to their respective Self Study to ensure Texas DSHS compliance. The skills sheets may be used for initial certification and for individuals needing late certification renewals.

Skills proficiency testing and demonstration is an integral part of the evaluation process required of EMS responders. The Skills Competency Packet evaluates vitals skills in which students must demonstrate competency to meet course completion requirements. This package aims to provide EMS education programs with instruments and methods to facilitate the consistent recording of student performances and instructions to the evaluator focused on improving inter-rater reliability. The use of this package serves to document psychomotor competency, which is a prerequisite to EMS certification.

Various instructors may teach the students information and skills throughout the course. It is essential that students be taught this information in a consistent manner. Each skill will require a careful demonstration by the instructor, associated lecture, and simulation instruction during the course of the class. Competency in psychomotor skills is not possessed after one successful demonstration of that particular skill. Competency requires repeated student skill demonstrations (practice) until the demonstration of that skill can be automatically delivered during stressful times, in unfamiliar places, and to patients who are severely ill or injured.

While not required, it is recommended that students be taken through a three-phase approach to ensure psychomotor skills competency. The three phases are the Introductory, Application, and Comprehensive.

While this EMS Skills Competency Packet is provided to EMS Education programs as a resource for initial education, it is the responsibility of the EMS Provider Medical Director and the EMS Provider to establish EMS Personnel competency for credentialing to independent duty.

INTRODUCTORY PHASE
The introductory phase introduces the student to the steps to perform a skill successfully. The introductory phase is the student's first exposure to the skill; it is not designed to assess the student's ability to manage a patient. The introductory phase encompasses the majority of the demonstration (practice).
It is recommended that the program document the student's performance on each skill and keep the records in the student's file as proof of proficiency.

APPLICATION PHASE
The application phase is where patient assessment is introduced. The introductory skills should be incorporated into the patient assessment, and an "assess-treat-reassess" approach should be implemented. The application phase is still intended as a learning phase, not a testing phase for the students.

For example, during the patient assessment, if the student finds inadequate breathing, the student should intervene (using at least one of the introductory skills) and then reassess for affectedness before moving on. The student would repeat these steps as they continue through their patient assessment and find problems or injuries that need to be addressed.

Injuries in the patient presentation should be straightforward and noncomplex for the initial part of the application phase. As students progress further into the application phase, the patient presentation, injuries, and illness should increase in severity and complexity.

When building scenarios for the application phase, the patient presentation, vitals, and responses should be realistic and based on a real patient. For example, patients that were not intended to go into cardiac arrest should not deteriorate to cardiac arrest unless realistic to the student's actions (lack of performance).

COMPREHENSIVE PHASE
The comprehensive phase is intended for students who have demonstrated an adequate understanding and ability to manage a patient in the prehospital setting. This can be assessed based on the student's performance in the application phase, which assesses their ability to assess, use introductory skills, and manage the patient as a whole.

SKILLS SHEETS
In an effort to remove subjectivity, all criteria on the skills sheets are absolutes. If a student does not perform or inadequately performs any criteria listed on the skills sheet, they have failed the skill and will need to retest the skill. The only exception is the BLS Integrated Out-of-Hospital Scenario Skill Sheet, which has a minimum passing score of seven (7) points. For a student to pass the BLS Integrated Out-of-Hospital Scenario, they must have a minimum of seven (7) points and must not score a zero (0) in any category.

An adequate sample of skills and patient presentations must be obtained as part of EMS education. A student shall be evaluated with patients with multiple injuries or illnesses. The EMS education program must ensure that its students have an appropriate opportunity to see adequate numbers of simulated patients with varying illnesses and injuries throughout their educational experience. Evaluators must ensure to keep an objective perspective when evaluating students and Education Programs are responsible for maintaining inter-rater reliability.

It should be understood that the following skills are not a complete description of every skill that an EMS responder is expected to perform. However, these skills provide a method to satisfactorily ensure that EMS personnel can perform at a prescribed standard in most prehospital medical emergencies.

EMS Education Programs may use the skill sheets as follows during formative or summative testing.

- Standalone Skills
- Scenario evaluation
- Combination of standalone and scenario

The following skill sheets are contained here.

Skill	ECA (EMR)	EMT
BLS Medical Assessment	X	X
BLS Trauma Assessment	X	X
Vital Signs	X	X
Mechanical Aids to Breathing	X	X
Cardiac Arrest-AED	X	X
Bleeding Control	X	X
Bandaging	X	X
Splinting	X	X
SI Seated	X	X
SI Supine	X	X
SVN		X
Epi-Auto Injector		X
Epi-IM		X
SGA (OPTIONAL)		X
CPAP (OPTIONAL)		X
Integrated Out-Of-Hospital (OOH) Scenario	X	X
TEMPLATE OOH Integrated Scenario		
Proposed OOH Integrated Scenarios		
MVC **(in packet)**	X	X
Adult/Pediatric Cardiac Arrest **(in packet)**	X	X
Adult Chest Pain **(in the packet)**	X	X
Adult/Pediatric Respiratory Distress **(in packet)**	X	X
Adult/Pediatric Blunt Trauma **(in packet)**	X	X
Adult/Pediatric Injury with Bleeding **(in packet)**	X	X
Adult/Pediatric Injury with Fracture **(in packet)**	X	X
Adult/Pediatric Allergic Reaction **(in packet)**	X	X

Integrated Out-Of-Hospital Scenario Skill Matrix

The following is a potential skills matrix for various Out-Of-Hospital Integrated patient care scenarios. Each skill listed is paired to the potential scenario it can be contained within.

Skill	MVC	Adult/Pediatric Cardiac Arrest	Adult Chest Pain	Adult/Pediatric Respiratory Distress	Adult/Pediatric Blunt Trauma	Adult/Pediatric Injury with Bleeding	Adult/Pediatric Trauma with Fracture	Adult/Pediatric Allergic Reaction
BLS Medical Assessment		X	X	X				X
BLS Trauma Assessment	X				X	X	X	
Vital Signs	X		X	X	X	X	X	X
Mechanical Aids to Breathing		X	X	X	X	X		X
Cardiac Arrest-AED		X						
Bleeding Control	X					X	X	
Bandaging	X				X	X	X	
Splinting	X				X		X	
SI Seated	X				X			
SI Supine	X				X			
SVN				X				X
Epi-Auto Injector				X				X
Epi-IM				X				X
SGA (OPTIONAL)		X						
CPAP (OPTIONAL)				X				

The following banding and splinting injury list should be used as a guide when teaching the individual skills. Students should have an awareness of each of the injuries and should practice each of the injuries. This list may be expanded be the individual programs.

BLEEDING CONTROL/BANDAGING INJURY LIST

*B1. Avulsed eye
*B2. Amputated hand (fist to be used as stump)
B3. Burned extremity (Examiner to specify location and position)
B4. Impaled object (extremity)
*B5. Lacerated cheek
*B6. Lacerated eyeball
B7. Lacerated joint (Examiner to specify)
*B8. Lacerated neck (Examiner to specify location)
*B9. Lacerated scalp (cranium depressed)
*B10. Lacerated scalp (no fracture)
B11. Lacerated arm (extremity)
B12. Lacerated leg (extremity)

* = These injuries do NOT require check of distal circulation, motor function, and sensation.

SPLINTING INJURY LIST

S1. Dislocated shoulder (adducted)
S2. Fractured knee (Examiner to specify position)
S3. Fractured ankle
S4. Fractured clavicle
S5. Fractured elbow (Examiner to specify position)
S6. Fractured hand (Examiner to specify position)
S7. Fractured humerus
S8. Fractured wrist (angulated, Examiner to specify position)
+S9. Fractured radius/ulna (open)
+S10. Fractured tib/fib (open)
S11. Isolated Femur Fracture CLOSED

+ = These injuries combine bandaging and splinting skills.

BANDAGING INJURIES
B1. Avulsed eye** ***Does NOT require check of distal circulation, motor function, and sensation.
B2. Amputated hand (fist to be used as stump)** ***Does NOT require check of distal circulation, motor function, and sensation.
B3. Burned extremity (Examiner to specify location and position)
B4. Impaled object (extremity)
B5. Lacerated cheek** ***Does NOT require check of distal circulation, motor function, and sensation.
B6. Lacerated eyeball** ***Does NOT require check of distal circulation, motor function, and sensation.
B7. Lacerated joint (Examiner to specify)
B8. Lacerated neck (Examiner to specify location)** ***Does NOT require check of distal circulation, motor function, and sensation.
B9. Lacerated scalp (cranium depressed)** ***Does NOT require check of distal circulation, motor function, and sensation.
B10. Lacerated scalp (no fracture)** ***Does NOT require check of distal circulation, motor function, and sensation.
B11. Lacerated arm (extremity)
B12. Lacerated leg (extremity)

SPLINTING INJURIES
S1. Dislocated shoulder (adducted)
S2. Fractured knee (Examiner to specify position)
S3. Fractured ankle
S4. Fractured clavicle
S5. Fractured elbow (Examiner to specify position)
S6. Fractured hand (Examiner to specify position)
S7. Fractured humerus
S8. Fractured wrist (angulated, Examiner to specify position)
S9. Fractured radius/ulna (open) ***Combines bandaging and splinting skills.***
S10. Fractured tib/fib (open) ***Combines bandaging and splinting skills.***
S11. Isolated Femur Fracture CLOSED

MINIMUM Recommended Equipment list for OOH Integrated Scenarios

It is recommended that these items be "KITTED" as a true EMS Kit that providers in your local area may use. However, the EMS Education program can "kit" equipment as they see fit. This list is a recommendation. Programs should provide at a minimum the items below; however, they can add to this list.

PPE and Assessment Supplies

- Nitrile, vinyl, or other disposable gloves
- Face shield or safety glasses
- Facemask
- Trauma shears
- Blood pressure cuff
- Stethoscope
- Penlight

Trauma Supplies

- Triangular bandages
- Universal trauma dressing
- Sterile gauze dressing 4X4in (10 X 10cm)
- Sterile dressing (Abdominal pads) 6 X 9in (15 X 23cm) or 8 X 10in (20 X 25cm)
- Adhesive Strips
- Adhesive tape in various widths
- Self-adhering soft roll bandage 4in X 5yd (10cm X 5m) and 2in X 5yd (5cm X 5m)
- Tourniquet
- Variety of splinting devices (air, vacuum, rigid, flexible, traction, pillow, etc.)

Cardiac Arrest and Airway Supplies

- AED
- Portable suctioning unit
- Oropharyngeal airway in adult, child, Infant*
- Nasopharyngeal airway in adult, child, and infant*
- Bag value mask for adult children and infant*
- Nonrebreather mask adult children and infant*
- Nasal cannula adult children and Infant*
- O2 portable tank

*Items may be carried in a separate airway kit, along with the portable oxygen cylinder.

Medication

- Oral glucose
- Naloxone
- Aspirin
- Nitro
- Epinephrine 1:1000 (Pen, Ampule or Vial)
- Other medications allowed by local protocol

Miscellaneous

- CPAP
- OB Kit
- C-Collars (variety of sizes)
- Backboard

v.8.23

- KED
- Patient securing resources to secure patient on backboard, Torso and Head

INDIVIDUAL SKILL SHEETS

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BANDAGING	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Identifies the injured area	
3	Assesses for pulse, motor and sensation distal to the injury	
4.	Cleans/irrigates the area as needed	
5.	Bandages area appropriate for injury	
6.	Assesses for pulse, motor and sensation distal to the injury	
7.	Exhibits calm professional demeanor with all persons involved	
8.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BLEEDING CONTROL	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Rapidly identifies significant hemorrhage	
3.	Immediately applies direct pressure and ensures reduction of bleeding	
4.	Selects and applies correct bandage technique (tourniquet or wound packing)	
5.	Places selected bandage in less than 30 seconds once application is initiated	
6.	Assesses effectiveness of bandage (corrects if deficiency is identified)	
7.	Assesses for pulse, motor and sensation distal to the injury as appropriate for hemorrhage control technique.	
8.	Exhibits calm professional demeanor with all persons involved	
9.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BLS MEDICAL ASSESSMENT	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Determines the scene/situation is safe	
3.	Initial Assessment (Ensures the following are evaluated regardless of mentation) • Mental Status • Evaluates Airway (Open/Patent) • Evaluates Breathing Status (Fast, Slow, Agonal, Apneic, Breathing Quality) • Evaluates Circulation Status (Fast, Slow, Absent, Pulse Quality, Skin Condition) • Evaluates for Major Bleeding • Completes prior to Focused or Secondary Assessment	
4.	States interventions necessary for any problem identified during the initial assessment.	
5.	Determines Chief Complaint	
6.	States General Impression (Sick/Not Sick; Urgent/Not Urgent)	
7.	Focused Assessment (Ensures the following are evaluated) • OPQRST • SAMPLE • Assesses affected body part(s) or system(s) • Obtains vitals (Minimum: P, R, BP) • Utilizes other diagnostic tools as necessary • Completes prior to Secondary Assessment	
8.	States accurate differential diagnosis	
9.	States interventions necessary for any problem identified during focused assessment.	
10.	Determines transport priority	
11.	Secondary Assessment: Completes full head to toe exam	
12.	States additional interventions as necessary	
13.	Reassessments • Reassess for changes in airway, breathing or circulation • Reassess interventions for effectiveness • Reassess vitals for improvement or deterioration. • Reassess for changes in mental status.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BLS TRAUMA ASSESSMENT	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Scene Size up: MOI, Number of Patients, Additional Resources Needed, Maintains Situation Awareness	
3.	Initial Assessment (Ensures the following are evaluated regardless of mentation) • Mental Status (AVPU) • Evaluates Airway (Open/Patent) • Evaluates Breathing Status (Fast, Slow, Agonal, Apneic, Breathing Quality) • Evaluates Circulation Status (Fast, Slow, Absent, Pulse Quality, Skin Condition) • Evaluates for Major Bleeding • Completes prior to Focused or Secondary Assessment	
4.	States interventions necessary for any problem identified during the initial assessment.	
5.	Determines Chief Complaint	
6.	States General Impression (Sick/Not Sick; Urgent/Not Urgent)	
7.	Focused Assessment (Ensures the following are evaluated) • OPQRST • Assesses affected body part(s) or system(s) • Utilizes other diagnostic tools as necessary • SAMPLE • Obtains vitals (Minimum: P, R, BP) • Completes prior to Secondary Assessment	
8.	States accurate differential diagnosis	
9.	States interventions necessary for any problem identified during focused assessment.	
10.	Determines transport priority	
11.	Secondary Assessment: Completes full head to toe exam consisting of inspection and palpation of • Head, facial bones, eyes, ears, nose mouth • Neck, anterior/posterior, trachea, jugular veins • Chest including auscultation • Abdomen • Lower extremities including PMS • Upper extremities including PMS • Back, thoracic, lumbar, sacral	
12.	States additional interventions as necessary	
13.	Reassessments • Reassess for changes in airway, breathing or circulation • Reassess interventions for effectiveness • Reassess vitals for improvement or deterioration. • Reassess for changes in mental status.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) Signature

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

CARDIAC ARREST / AED Usage	Start Time			End Time	

	CPR Feedback devices are recommended for testing.	Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Determines the scene/situation is safe	
3.	Assessment: Ensures the following • Responsiveness • Breathing • Pulse (Can be checked concurrently with breathing)	
4.	Chest Compressions: Ensures the following • Hand placement on lower half of sternum • 100-120 Compression per minute • Compression depth is appropriate for patient size • Allows for recoil	
5.	Breathing: Ensures the following • Ventilates appropriately • Provides each breath over 1 second • Visible chest rise	
6.	Completes 4 cycles of CPR with proper compression and breathing meeting above criteria	
7.	Steps 1-6 in Sequence	
	AED ARRIVES. 2nd Rescuer brings AED and states "I am taking over compressions." While 1st rescuer deploys AED	
8.	AED Placement: Ensures the following • Turns on AED • Places AED Pads on patient • Ensures pads are connected to AED • Clears to Analyze & Shock (May perform CPR during AED Charging)	
9.	Resumes CPR within 10 seconds.	
10.	ALL hands-off-chest time <10 seconds	
11.	Exhibits calm professional demeanor with all persons involved	
12.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

v.8.23

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BLS MEDICAL ASSESSMENT	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Determines the scene/situation is safe	
3.	Initial Assessment (Ensures the following are evaluated regardless of mentation) • Mental Status • Evaluates Airway (Open/Patent) • Evaluates Breathing Status (Fast, Slow, Agonal, Apneic, Breathing Quality) • Evaluates Circulation Status (Fast, Slow, Absent, Pulse Quality, Skin Condition) • Evaluates for Major Bleeding • Completes prior to Focused or Secondary Assessment	
4.	States interventions necessary for any problem identified during the initial assessment.	
5.	Determines Chief Complaint	
6.	States General Impression (Sick/Not Sick; Urgent/Not Urgent)	
7.	Focused Assessment (Ensures the following are evaluated) • OPQRST • SAMPLE • Assesses affected body part(s) or system(s) • Obtains vitals (Minimum: P, R, BP) • Utilizes other diagnostic tools as necessary • Completes prior to Secondary Assessment	
8.	States accurate differential diagnosis	
9.	States interventions necessary for any problem identified during focused assessment.	
10.	Determines transport priority	
11.	Secondary Assessment: Completes full head to toe exam	
12.	States additional interventions as necessary	
13.	Reassessments • Reassess for changes in airway, breathing or circulation • Reassess interventions for effectiveness • Reassess vitals for improvement or deterioration. • Reassess for changes in mental status.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

PROPOSED TDSHS SKILL SHEET (2021): SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

BLS TRAUMA ASSESSMENT	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Scene Size up: MOI, Number of Patients, Additional Resources Needed, Maintains Situation Awareness	
3.	Initial Assessment (Ensures the following are evaluated regardless of mentation) • Mental Status (AVPU) • Evaluates Airway (Open/Patent) • Evaluates Breathing Status (Fast, Slow, Agonal, Apneic, Breathing Quality) • Evaluates Circulation Status (Fast, Slow, Absent, Pulse Quality, Skin Condition) • Evaluates for Major Bleeding • Completes prior to Focused or Secondary Assessment	
4.	States interventions necessary for any problem identified during the initial assessment.	
5.	Determines Chief Complaint	
6.	States General Impression (Sick/Not Sick; Urgent/Not Urgent)	
7.	Rapid Trauma Exam or Focused Assessment (Ensures the following are evaluated) • OPQRST • Assesses affected body part(s) or system(s) • Utilizes other diagnostic tools as necessary • SAMPLE • Obtains vitals (Minimum: P, R, BP) • Completes prior to Secondary Assessment	
8.	States accurate differential diagnosis	
9.	States interventions necessary for any problem identified during focused assessment.	
10.	Determines transport priority	
11.	Secondary Assessment: Completes full head to toe exam consisting of inspection and palpation of • Head, facial bones, eyes, ears, nose mouth • Neck, anterior/posterior, trachea, jugular veins • Chest including auscultation • Abdomen • Lower extremities including PMS • Upper extremities including PMS • Back, thoracic, lumbar, sacral	
12.	States additional interventions as necessary	
13.	Reassessments • Reassess for changes in airway, breathing or circulation • Reassess interventions for effectiveness • Reassess vitals for improvement or deterioration. • Reassess for changes in mental status.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) Signature

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

CARDIAC ARREST / AED Usage	Start Time		End Time	

	CPR Feedback devices are recommended for testing.	Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Determines the scene/situation is safe	
3.	Assessment: Ensures the following • Responsiveness • Breathing • Pulse (Can be checked concurrently with breathing)	
4.	Chest Compressions: Ensures the following • Hand placement on lower half of sternum • 100-120 Compression per minute • Compression depth is appropriate for patient size • Allows for recoil	
5.	Breathing: Ensures the following • Ventilates appropriately • Provides each breath over 1 second • Visible chest rise	
6.	Completes 4 cycles of CPR with proper compression and breathing meeting above criteria	
7.	Steps 1-6 in Sequence	
	AED ARRIVES. 2nd Rescuer brings AED and states "I am taking over compressions." While 1st rescuer deploys AED	
8.	AED Placement: Ensures the following • Turns on AED • Places AED Pads on patient • Ensures pads are connected to AED • Clears to Analyze & Shock (May perform CPR during AED Charging)	
9.	Resumes CPR within 10 seconds.	
10.	ALL hands-off-chest time <10 seconds	
11.	Exhibits calm professional demeanor with all persons involved	
12.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

v.8.23

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐

Late Renewal ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

Continuous Positive Airway Pressure (CPAP)	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
Patient exhibits respiratory insufficiency requiring CPAP use		
2.	Appropriately determines the patient's need for the medication	
3.	Assesses patient to identify indications for CPAP • Respiratory distress with spontaneous respirations • Conscious patient with ability to protect their airway • Inquiries about Vitals	
4.	Identifying contraindication(s) for CPAP • Unresponsive • Inability to sit up • Inability to protect airway • Vomiting • Hypotension (systolic blood pressure < 90 mmHg)	
5.	Prepares patient • Explains procedure • Positions patient (Full Fowler's or sitting position of comfort)	
6.	Selects, checks, and assembles supplies. Ensures the following (minimum) • Assembles mask and tubing according to manufacturer instructions • Connects CPAP unit to suitable O2 supply and/or ventilator as necessary • Turn on power/oxygen • Coaches patient how to breathe through the mask	
7.	Adjusts CPAP Pressure to one of the following: • Titrates CPAP pressure (based on local protocols/device dependent). • Sets device parameters to correspond to 6-10 cm of H20 CPAP pressure.	
8.	Verbalizes reassessment of the patient including the following: • Mental Status • Respiratory Status • Circulatory Status	
9.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐

Late Renewal ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

Epinephrine Auto-Injector Administration	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
Patient exhibits anaphylactic reaction including shock and/or respiratory insufficiency		
2.	Appropriately determines the need for an epinephrine auto-injector	
3.	Checks medication. Ensures the following • Expiration date • Cloudiness • Discoloration	
4.	Explains procedure to the patient	
5.	Reconfirms medication. Ensures the following • Right medication • Right reason • Right patient • Right route • Right dose • Right administration method • Right administration site • Right response	
6	Selects appropriate injection site (middle of outer thigh)	
7.	Pushes injector firmly against site at 90^{o} angle to the leg	
8.	Holds injector against site for a minimum of three (3) seconds	
9.	Properly discards auto-injector in appropriate container	
10.	Verbalizes reassessment of the patient including the following: • Mental Status • Respiratory Status • Circulatory Status	
11.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐

Late Renewal ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

Epinephrine IM Medication Administration	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
Patient exhibits anaphylactic reaction including shock and/or respiratory insufficiency		
2.	Appropriately determines the patient's need for the medication	
3.	Inquiries about patient allergies to medications	
4.	Selects, checks, and assembles supplies. Ensures the following (minimum) • Medication and proper concentration • Syringe • Needle(s) • Sharps container • Alcohol preps • Band-Aid/sterile gauze	
5.	Checks medication. Ensures the following • Expiration date • Cloudiness • Discoloration	
7.	Draws up the correct amount of medication, and dispels air while maintaining sterility	
8.	Explains procedure to the patient	
9.	Reconfirms medication. Ensures the following • Right medication • Right reason • Right patient • Right route • Right dose • Right administration method • Right administration site • Right response	
10.	Selects and cleans the appropriate injection site	
11.	Inserts needle at a 90-degree angle (Intramuscular)	
12.	Injects medication appropriately	
13.	Properly discards needle in appropriate container	
14.	Covers puncture site	
15.	Verbalizes reassessment of the patient including the following: • Mental Status • Respiratory Status • Circulatory Status	
16.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

MECHANICAL AIDS TO BREATHING	Start Time		End Time	

	Patient is semi-conscious with O2 saturations less than 94%	Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Assembles	
3.	Gathers and assembles oxygen equipment (Ensures the following are evaluated) • Cracks valve on the oxygen tank pointing away • Assembles the regulator to the oxygen tank • Opens the oxygen tank valve with regulator gauge facing away • Checks oxygen tank pressure • Checks and corrects leaks • Completes all steps above in order • Never leaves bottle standing upright unattended	
4.	Ensures non-rebreather bag is filled with oxygen prior to placing on patient	
5.	Attaches mask to patient's face and adjusts flow to 10LPM	
	Patient goes unconscious and respirations drop to 6 per minute.	
6.	Selects and sizes either OPA, NPA(s) or both	
7.	Places OPA or NPA(s)	
	Patient accepts airway adjunct.	
8.	Ventilates patient for 1 minute with bag-valve-mask device (Ensures the following are evaluated) • Connects bag-valve-mask to oxygen at 10-15 LPM • Ensures chest rise • Ventilates once every 6 seconds • Ensures each ventilation is over 1 second • Ensures correct ventilation volume (until chest rise occurs) • Monitors and corrects ineffective mask seal	
	After ventilation, patient remains unconscious but vomits.	
8.	Turns patient head to side	
9.	Removes OPA/NPA(s) as necessary	
10.	Prepares suction device	
11.	Suctions oral pharynx for no longer than 15 seconds	
12.	Replaces OPA/NPA(s)	
13.	Resumes ventilating patient.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

Supraglottic Airway	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Ensures that CPR is continuing	
3	Selects Proper sized SGA device	
4.	Checks and lubricates distal tip of SGA with appropriate lubricant (can verbalize)	
CANDIDATE STATES: "I am ready to place the iGel."		
5.	Removes or directs removal of BLS adjunct(s). **If no adjunct give credit**	
6.	Places SGA: Ensures the following: • Positions head in neutral position • Performs tongue-jaw lift • Inserts device to proper depth	
7.	Directs partner to ventilate SGA with BVM: Ensures the following: • Confirms placement • Observes for Chest Rise/Fall • Observes Colorimetric EtCO2 for color change (purple to yellow/tan) • Directs auscultation of breath sounds	
8.	Secures device or confirms that device remains properly secured	
9.	Directs ventilation of patient at appropriate rate (1 breath every 6 seconds)	
10.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐ Late Renewal ☐

Initial RETEST ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

Small Volume Nebulizer	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
2.	Appropriately determines the patient's need for the medication	
3.	Selects appropriate device to administer medication and prepares equipment.	
4.	Inquiries about patient allergies to medications	
5.	Selects, checks, and assembles supplies. Ensures the following (minimum) • Medication and proper concentration • Nebulizer System • Oxygen tubing	
6.	Checks medication. Ensures the following • Expiration date • Cloudiness • Discoloration	
7.	Explains procedure to patient	
8.	Reconfirms medication. Ensures the following • Right medication • Right reason • Right patient • Right route • Right dose • Right administration method • Right administration site • Right response	
9.	Has oxygen connected and running at 6-8 liters/minute.	
10.	Instructs patient or properly applies device	
11.	Verbalizes reassessment of the patient including the following: • Mental Status • Respiratory Status • Circulatory Status	
12.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

VIITAL SIGNS	Start Time		End Time	

					Performed
1.	Takes/Verbalizes appropriate PPE				
2.	Reports pulse within 10% of evaluator. Includes Rhythm and Quality				
	Candidate Value		Evaluator Value		
3.	Reports respiration within 10% of evaluator. Includes Rhythm and Quality				
	Candidate Value		Evaluator Value		
4.	Reports Palpated Blood Pressure within 10% of evaluator				
	Candidate Value		Evaluator Value		
5.	Reports Blood Pressure				
	Diastolic within 10% of evaluator				
	Candidate Value		Evaluator Value		
	Systolic within 10% of evaluator				
	Candidate Value		Evaluator Value		
6.	Completes Skill within 5 minutes				
7	Exhibits calm professional demeanor with all persons involved				
8.	Exhibits leadership and teamwork				

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

BLS Integrated Out-of-Hospital Scenario	Start Time		End Time	

Scenario Name/Number:	***Circle Points Awarded***
Leadership and Scene Management	
Thoroughly assessed and took deliberate actions to control the scene, encouraged feedback from Team Members (if present)	2
Delayed OR incompletely assessed the scene; not to the detriment of patient care	1
Incompletely assessed or managed the scene **OR** did not assess or manage the scene	0
Patient Assessment	
Completed an organized assessment and integrated findings to expand further assessment while maintaining situational awareness	2
Completed incomplete or disorganized assessment that did not impact patient outcome	1
Omitted assessment components that were detrimental to patient outcome **OR** did not reassess	0
Patient Management	
Appropriately managed the patient's presenting condition with appropriate timeliness, prioritization/ sequence, adapted treatment plan as information became available	2
Provided incomplete or disorganized management	1
Did not manage life-threatening conditions	0
Interpersonal Relations	
Encouraged feedback, took responsibility for the team, established rapport and interacted in an organized, therapeutic manner	2
Interacted and responded appropriately with patient, crew, and bystanders using closed loop communication and appreciative inquiry	1
Used inappropriate communication techniques **OR** demonstrated unprofessional demeanor	0
Integration (Differential Diagnosis and Transport Decision)	
Appropriate differential diagnosis and management. Transport decision appropriate for area, capability and resources.	2
Provides plausible differential diagnosis, may be described as symptoms. Transport decision does not pose a threat to patient but may be delayed or unsure.	1
Inappropriate differential diagnosis, patient acuity or transport destination	0
TOTAL POINTS	

Failure: "0" score in any category OR <=6
Passing: No "0" scores AND >=7

PASS ☐ FAILED ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES. DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

MECHANICAL AIDS TO BREATHING	Start Time		End Time	

	Patient is semi-conscious with O2 saturations less than 94%	Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Assembles	
3.	Gathers and assembles oxygen equipment (Ensures the following are evaluated) • Cracks valve on the oxygen tank pointing away • Assembles the regulator to the oxygen tank • Opens the oxygen tank valve with regulator gauge facing away • Checks oxygen tank pressure • Checks and corrects leaks • Completes all steps above in order • Never leaves bottle standing upright unattended	
4.	Ensures non-rebreather bag is filled with oxygen prior to placing on patient	
5.	Attaches mask to patient's face and adjusts flow to 10LPM	
	Patient goes unconscious and respirations drop to 6 per minute.	
6.	Selects and sizes either OPA, NPA(s) or both	
7.	Places OPA or NPA(s)	
	Patient accepts airway adjunct.	
8.	Ventilates patient for 1 minute with bag-valve-mask device (Ensures the following are evaluated) • Connects bag-valve-mask to oxygen at 10-15 LPM • Ensures chest rise • Ventilates once every 6 seconds • Ensures each ventilation is over 1 second • Ensures correct ventilation volume (until chest rise occurs) • Monitors and corrects ineffective mask seal	
	After ventilation, patient remains unconscious but vomits.	
8.	Turns patient head to side	
9.	Removes OPA/NPA(s) as necessary	
10.	Prepares suction device	
11.	Suctions oral pharynx for no longer than 15 seconds	
12.	Replaces OPA/NPA(s)	
13.	Resumes ventilating patient.	
14.	Exhibits calm professional demeanor with all persons involved	
15.	Exhibits leadership and teamwork	

STATUS PASS (ALL COMPONENTS PERFORMED) ☐ FAILED (1 or MORE COMPONENTS NOT PERFORMED) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS (Required for any failure):

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

SPLINTING	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Instructs/assists with stabilization of the injured extremity	
3	Assesses for pulse, motor and sensation distal to the injury	
4.	Selects the proper splinting device	
5.	Prepares the patient for application of the splint	
6.	Applies the splint without significant movement/displacement of the injury	
7.	Assesses for adequate stabilization	
8.	Assesses for pulse, motor and sensation distal to the injury	
10.	Exhibits calm professional demeanor with all persons involved	
11.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐

Late Renewal ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT OF SEQUENCE UNLESS SPECIFICALLY INDICATED.

Spinal Immobilization (Seated Patient)	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
2.	Directs assistant to maintain manual stabilization/immobilization of the head	
3.	Reassesses motor, sensory and circulatory function in each extremity	
4	Applies appropriately sized extrication collar	
5.	Positions the immobilization device appropriately	
6.	Secures the device to the patient's torso	
7.	Evaluates torso fixation and adjusts as necessary	
8.	Evaluates and pads behind the patient's head as necessary	
9.	Secures the patient's head to the device	
10.	Reassesses motor, sensory and circulatory functions in each extremity	
11.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

PROPOSED TDSHS SKILL SHEET TEMPLATE

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Testing ☐ Initial Retest ☐

Late Renewal ☐ If Late Renewal, TDSHS EMS Number _____

Testing Location _____

Note: All components are ABSOLUTES. ALL components must be achieved.
DO NOT DEDUCT FOR OUT OF SEQUENCE UNLESS SPECIFICALLY INDICATED.

Spinal Immobilization (Supine Patient)	Start Time		End Time	

		Performed
1.	Takes or verbalizes appropriate PPE precautions	
2.	Directs assistant to maintain manual stabilization/immobilization of the head	
3.	Reassesses motor, sensory and circulatory function in each extremity	
4	Applies appropriately sized extrication collar	
5.	Positions the immobilization device appropriately	
6.	Directs movement of the patient onto the device without compromising the integrity of the spine	
7.	Applies padding to voids between the torso and the device as necessary	
8.	Secures the patient's torso to the device before HEAD	
9.	Secures the patient's head to the device	
10.	Secures the patient's legs to the device	
11.	Secures the patient's arms to the device	
12.	Reassesses motor, sensory and circulatory function in each extremity	
13.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

SKILL SHEETS SHOULD BE APPROVED BY INDIVIDUAL EDUCATION PROGRAM

Candidate Name _____ Date _____

TDSHS Level: ECA (EMR) ☐ EMT ☐ AEMT ☐ Paramedic ☐

Type of Test: Initial Course Number _____ Initial Testing ☐ Initial Retest ☐

LATE RENEWAL ☐ TDSHS EMS Personnel Number _____

Testing Location _____

All components are ABSOLUTES.
DO NOT DEDUCT FOR OUT-OF-SEQUENCE UNLESS SPECIFICALLY INDICATED.

SPLINTING	Start Time		End Time	

		Performed
1.	Takes/Verbalizes appropriate PPE	
2.	Instructs/assists with stabilization of the injured extremity	
3	Assesses for pulse, motor and sensation distal to the injury	
4.	Selects the proper splinting device	
5.	Prepares the patient for application of the splint	
6.	Applies the splint without significant movement/displacement of the injury	
7.	Assesses for adequate stabilization	
8.	Assesses for pulse, motor and sensation distal to the injury	
10.	Exhibits calm professional demeanor with all persons involved	
11.	Exhibits leadership and teamwork	

STATUS PASS (All steps performed above) ☐ FAILED (NOT all steps performed above) ☐

Evaluator Name (PRINTED) _____ Signature _____

COMMENTS:

OOH Integrated Scenario TEMPLATE

v.8.23

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario (Place a Check for the Skills)

- ☐ BLS Medical Assessment
- ☐ BLS Trauma Assessment
- ☐ Vital Signs
- ☐ Mechanical Aids to Breathing
- ☐ Cardiac Arrest-AED
- ☐ Bleeding Control
- ☐ Bandaging
- ☐ Splinting
- ☐ SI Seated
- ☐ SI Supine
- ☐ SVN
- ☐ Epi-Auto Injector
- ☐ Epi-IM
- ☐ SGA (OPTIONAL)
- ☐ CPAP (OPTIONAL)

MINIMUM EQUIPMENT	
EMS equipment and supplies	
Props	
Medical Identification jewelry	
SETUP INSTRUCTIONS	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle, you are the primary care giver with one EMT assistant
Other personnel needed (define personnel and identify who can serve in each role)	
MOULAGE INFORMATION	
Integumentary	
Head	
Chest	
Abdomen	
Pelvis	
Back	
Extremities	
Age	
Weight	

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	
Location	
Nature of the call	
Weather	
Personnel on the scene	

READ TO TEAM LEADER: DISPATCH INFORMATION GOES HERE

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	
Patient location	
Visual appearance	
Age, sex, weight	
Immediate surroundings (bystanders, significant others present)	
Mechanism of injury/Nature of illness	

PRIMARY ASSESSMENT	
General impression	
Baseline mental status	
Airway	
Ventilation	
Circulation	
HISTORY (if applicable)	
Chief complaint	
History of present illness	
Patient responses, associated symptoms, pertinent negatives	
PAST MEDICAL HISTORY	
Illnesses/Injuries	
Medications and allergies	
Current health status/Immunizations (Consider past travel)	
Social/Family concerns	
Medical identification jewelry	
EXAMINATION FINDINGS	
Initial Vital Signs	
HEENT	
Respiratory/Chest	
Cardiovascular	
Gastrointestinal/Abdomen	
Genitourinary	
Musculoskeletal/Extremities	
Neurologic	
Integumentary	
Hematologic	
Immunologic	
Endocrine	
Psychiatric	
Additional diagnostic test as necessary	
PRIMARY ASSESSMENT	
General impression	
Baseline mental status	
Airway	
Ventilation	
Circulation	
HISTORY (if applicable)	
Chief complaint	
History of present illness	
Patient responses, associated symptoms, pertinent negatives	

PAST MEDICAL HISTORY	
Illnesses/Injuries	
Medications and allergies	
Current health status/Immunizations (Consider past travel)	
Social/Family concerns	
Medical identification jewelry	
EXAMINATION FINDINGS	
Initial Vital Signs	
HEENT	
Respiratory/Chest	
Cardiovascular	
Gastrointestinal/Abdomen	
Genitourinary	
Musculoskeletal/Extremities	
Neurologic	
Integumentary	
Hematologic	
Immunologic	
Endocrine	
Psychiatric	
Additional diagnostic test as necessary	

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	
Additional Resources	
Patient response to interventions	
EVENT	
REASSESSMENT	
Appropriate management	List skills performed here and appropriate care
Inappropriate management	List inappropriate care here

TRANSPORT DECISION:

MANDATORY ACTIONS:
•
•
•
POTENTIALLY HARMFUL/DANGEROUS ACTIONS:
•
•
•

OOH Integrated PATIENT SCENARIOS

v.8.23

Out-Of-Hospital BLS Scenario
Adult Chest Pain

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Medical Assessment
- Vital Signs
- Mechanical Aids to Breathing

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	Table, Chair, Small TV
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Patient will be sitting in a chair at the table watching TV with his spouse. • TV, chairs, and table are in the room	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle, you are the primary care giver with one EMT assistant
Other personnel needed (define personnel and identify who can serve in each role)	Patient Spouse, Fire Department First Responders
MOULAGE INFORMATION	
Integumentary	Patient will be pale, cool, and clammy
Head	---
Chest	---
Abdomen	---
Pelvis	---
Back	---
Extremities	---
Age	60 years old
Weight	190 pounds

Out-Of-Hospital BLS Scenario
Adult Chest Pain

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	1530 hours
Location	123 Anywhere Street, My Town – single family residence
Nature of the call	Chest pain
Weather	Temperature of 68 degrees F, Clear and Mild
Personnel on the scene	Fire Department First Responders

READ TO TEAM LEADER: Medic 15 respond to 123 Anywhere Street for a 60-year-old male complaining of chest pain. Fire Department First Responder has been dispatched as well.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Noise from the TV and Spouse answering questions during patient interview
Patient location	Sitting on a chair at the kitchen table watching TV and drinking coffee
Visual appearance	Patient appears to look pale, right hand over left side of chest and moving hand toward the left shoulder showing signs of pain
Age, sex, weight	60-year-old male, 190 pounds
Immediate surroundings (bystanders, significant others present)	Spouse standing next to patient, First Responders relaying information to Medic 15 that they just arrived, and no information has been obtained
Mechanism of injury/Nature of illness	Sharp chest pain in the center of the chest radiating to left arm

Out-Of-Hospital BLS Scenario
Adult Chest Pain

PRIMARY ASSESSMENT	
General impression	Patient appears uncomfortable, grabbing his chest as in pain
Baseline mental status	Alert and oriented to person, place, time, and events leading to the chief complaint
Airway	Open
Ventilation	Equal rise and fall of the chest, spontaneous
Circulation	Strong pulse, no obvious external bleeding noted
HISTORY (if applicable)	
Chief complaint	Mid sternal chest pain radiating to the left shoulder
History of present illness	• After breakfast this morning, had a mild case of chest pain. Because of the discomfort, took one Nitro tab. Pain went away and felt better. • After lunch, decided to mow the lawn. While cutting the grass, chest pain reappeared. Was mild at the time and decided to finish before the basketball game on TV. • Pain became worse as the chore was finished. Took a Nitro tab to take away the pain when finished at 1500 hours. • While watching TV, the pain returned. 911 call made by spouse • Pain was different from last two events. Sharp and at center of chest moving to left shoulder. • Pt. states no trouble breathing now.
Patient responses, associated symptoms, pertinent negatives	• Feels somewhat nauseated, negative vomiting. Has not taken Viagra ® today. • Pain radiates left arm, nowhere else. Last time nitro was taken he became very lightheaded and felt like he was going to pass out. • Mild discomfort when breathing
PAST MEDICAL HISTORY	
Illnesses/Injuries	Had a mild heart attack a year ago, knee replacement 6 months ago.
Medications and allergies	Nitro tabs, Aspirin 81 mg, Lovastatin 40 mg, Warfarin 2 mg, **Viagra ® 50 mg**, Vitamin D, Vitamin C, Allergic to Penicillin
Current health status/Immunizations (Consider past travel)	Went to the doctor for annual physical. Nothing out of the ordinary.
Social/Family concerns	Cardiac history in the family. Father died of a heart attack at the age of 60.
Medical identification jewelry	---

Out-Of-Hospital BLS Scenario
Adult Chest Pain

EXAMINATION FINDINGS	
Initial Vital Signs	BP: 118/84 P: 80 R: 18 Pain: 8 out of 10 Temperature: 98.6 F SpO2: 93% on room air GCS: (E) Eyes open spontaneously, (V) Alert and Oriented x 4, (M) Obeys all commands. Total = 15
HEENT	---
Respiratory/Chest	Lung sounds = Clear, shallow, tachypneic
Cardiovascular	Sharp chest pain which radiates to the left shoulder down the left arm
Gastrointestinal/Abdomen	Nauseated
Genitourinary	---
Musculoskeletal/Extremities	---
Neurologic	---
Integumentary	Pale, cool and diaphoretic
Hematologic	---
Immunologic	---
Endocrine	---
Psychiatric	---
Additional diagnostic test as necessary	SpO_2 93% on room air, BGL of 90

Out-Of-Hospital BLS Scenario
Adult Chest Pain

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	Place patient in a comfortable position to help relieve pain. Give oxygen Administer aspirin 160 - 325 mg. Nitro tab to relieve chest pain (per local protocol)
Additional Resources	---
Patient response to interventions	No relief when Nitro administered.
EVENT	
TV is on and his spouse keeps answering questions about his heart problems and medication. Team leader must correct problem.	
REASSESSMENT	
Appropriate management	BP: 110/80 P: 80 R: 14 Pain: 2 out of 10 Lung sounds are clear bilaterally, chest pain reduced
Inappropriate management	BP: 86/40 P: 110 R: 26 Pain: 10 out of 10 Increase in respiratory distress

TRANSPORT DECISION: Team Leader should verbalize transport decision, reason for choosing the facility, and describe the appropriate transportation mode.
Recognize this is a cardiac emergency requiring transport to a cardiac care facility

MANDATORY ACTIONS:
• Full patient assessment • Obtains OPQRST History • Obtains SAMPLE History • Obtains Vitals • Inquiries about allergies prior to giving medications (this can be obtained during SAMPLE)
POTENTIALLY HARMFUL/DANGEROUS ACTIONS:
• Allows patient to refuse transport • Failure to obtain SAMPLE History • Failure to assess patient with a minimum of a FOCUSED assessment of chief complaint. • Fails to provide Oxygen • Gives Nitro

Out-Of-Hospital BLS Scenario
Adult or Pediatric Allergic Reaction

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Medical Assessment
- Vital Signs
- Mechanical Aids to Breathing
- SVN
- Epi-Auto Injector
- Epi-IM

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	Table
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Patient sitting outside at a picnic table • Ensure full ambulance equipment	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle
Other personnel needed (define personnel and identify who can serve in each role)	Law enforcement officer Fire department first responder
MOULAGE INFORMATION	
Integumentary	Pale, cyanotic face, swollen lips
Head	Swollen lips, hoarse raspy speech; stridor and wheezing
Chest	---
Abdomen	---
Pelvis	---
Back	---
Extremities	Insect sting on right hand
Age	Adult: 48 yo / Child: 6 yo
Weight	Adult: 195 lbs. / Child: 50 lbs.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Allergic Reaction

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	Day and time of testing
Location	Our Park on Jones St.
Nature of the call	Medical Call
Weather	Summer day, 95 F
Personnel on the scene	PD on scene

READ TO TEAM LEADER: Medic 14 respond to Our Park at the corner of Jones St and Murphy St., for a breathing problem.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Outside, rocky terrain and broken sidewalk to maneuver stretcher
Patient location	May use a photo of such street with pothole evident
Visual appearance	City Park
Age, sex, weight	Adult: 48yo; 195# M/F / 6yo; 50#; M/F
Immediate surroundings (bystanders, significant others present)	Family present
Mechanism of injury/Nature of illness	Was playing catch with a family member and chased the ball into a shrub. Was stung on the hand.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Allergic Reaction

PRIMARY ASSESSMENT		
General impression	Obvious stridor when breathing, pallor, swollen lips and right hand.	
Baseline mental status	Patient answers all questions. Is alert and oriented.	
Airway	Stridor and wheezing	
Ventilation	Rapid (40)	
Circulation	Rapid (120)	
HISTORY (if applicable)		
Chief complaint	"Something bit me. It's hard for me to breath."	
History of present illness	Was playing catch with a family member and chased the ball into a shrub. Was stung on the hand.	
Patient responses, associated symptoms, pertinent negatives	---	
PAST MEDICAL HISTORY		
Illnesses/Injuries	Allergy to wasps and bees	
Medications and allergies	Benadryl as needed for allergies	
Current health status/Immunizations (Consider past travel)	Up to date	
Social/Family concerns	---	
Medical identification jewelry	---	
EXAMINATION FINDINGS		
Initial Vital Signs	BP: 90/60 R: 40, shallow Temperature: normal (98.4) SpO2: 90% GCS: Total (E:4; V: 5, M:6) 15 BGL: 120 mg/dL	P: 120 Pain: 2/10 ETCO2: 44 mm Hg
HEENT	Swollen lips, tongue; Stridor	
Respiratory/Chest	Expiratory wheezing all lung fields	
Cardiovascular	Tachycardia	
Gastrointestinal/Abdomen	---	
Genitourinary	---	
Musculoskeletal/Extremities	General pallor	
Neurologic	Tired	
Integumentary	General pallor	
Hematologic	---	
Immunologic	---	
Endocrine	---	
Psychiatric	---	
Additional diagnostic tests as necessary	BGL 110 mg/dL	

Out-Of-Hospital BLS Scenario
Adult or Pediatric Allergic Reaction

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	• Focused assessment • O2 NC/NRB or Neb • Albuterol by Neb • Epi IM or Epi-Pen
Additional Resources	---
Patient response to interventions	Improved oxygenation; improved O2 Sats; improved respiratory and pulse rate
EVENT	

REASSESSMENT	
Appropriate management – Albuterol by Neb; Epi IM or Epi-Pen; O2 best method	Mentation: Alert BP: 108/72 P: 90 R: 24 SpO2: 98% EtCO2: 40 Stridor and Wheezing Resolves
Inappropriate management – > 5min to give patient Epi.	Mentation: Unconscious/Unresponsive BP: 60/P P: 140 (carotid only) R: 0 (airway completely swollen)

TRANSPORT DECISION: Urgent, to Hospital

MANDATORY ACTIONS:

- Focused assessment of medical condition
- Administration of Epi IM or Epi-Pen
- Obtains Vitals
-

POTENTIALLY HARMFUL/DANGEROUS ACTIONS:

- Failure to give Epi IM or Epi-Pen
- Failure to transport patient

Out-Of-Hospital BLS Scenario
Adult or Pediatric Blunt Trauma

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Trauma Assessment
- Vital Signs
- Mechanical Aids to Breathing
- Bleeding Control
- Bandaging
- Splinting
- SI Supine

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	Bicycle, bicycle helmet, shorts and t-shirt
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• You are on a suburban tree lined street; the bicycle is described as having a bent front wheel and the leader is told that there is a pothole by the fallen bike on the road. Police have closed the road at both ends. The helmet is off, broken and near the bike. The rider is no longer on the roadway and is found on the stretch of lawn between the road and sidewalk. He is apparently in good shape and a fit daily rider in a bike outfit. • Ensure full ambulance equipment	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle
Other personnel needed (define personnel and identify who can serve in each role)	Law enforcement officer
MOULAGE INFORMATION	
Integumentary	Road rash down left side of body
Head	Bump and abrasion on occiput
Chest	Road rash an L lateral side of chest
Abdomen	Road rash L lateral side,
Pelvis	Road rash on L upper hip
Back	Bruising to L scapula area
Extremities	Open fracture of anterior left lower leg
Age	19-year-old ***(Can adjust age as necessary)***
Weight	---

Out-Of-Hospital BLS Scenario
Adult or Pediatric Blunt Trauma

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	2:30 pm on Saturday afternoon
Location	23 Main Street (suburban setting)
Nature of the call	Trauma call
Weather	Clear fall day, 74 F
Personnel on the scene	PD on scene

READ TO TEAM LEADER: Medic 51 respond to 23 Main Street for bicycle accident, time out 1435 hours.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Is road closed and is passing traffic a concern?
Patient location	May use a photo of such street with pothole evident
Visual appearance	Bike appears to have deformed front wheel and is scratched. Pt has road rash and no major arterial bleeding
Age, sex, weight	He is young adult, in good health, in pain
Immediate surroundings (bystanders, significant others present)	No bystanders or relatives present
Mechanism of injury/Nature of illness	Bicycling accident (To be discovered – When bike hit pothole, bike stopped as wheel collapsed, and rider thrown in a near somersault over the handlebars and landed on left side (hip and shoulder, then back of head struck) sliding on blacktop. He does not remember the accident or how he got off the road onto lawn

Out-Of-Hospital BLS Scenario
Adult or Pediatric Blunt Trauma

PRIMARY ASSESSMENT	
General impression	Moderate localized injuries, lots of left sided road rash, with open anterior fracture of left lower leg
Baseline mental status	The patient seems dazed and oriented to person, and place, but disoriented to time and unable to recall event. Upon questioning – doesn't remember accident or how he got where he is found. Keeps repeating same question (e.g., "What happened?" or "How's my bike?")
Airway	Clear
Ventilation	Tachypnea at 24 BPM, shallow and regular
Circulation	Pulse is 110; skin is pale, cool, and clammy; dark oozing blood at left lower leg
HISTORY (if applicable)	
Chief complaint	"My leg!"
History of present illness	---
Patient responses, associated symptoms, pertinent negatives	Whole left side hurts, patient confused
PAST MEDICAL HISTORY	
Illnesses/Injuries	---
Medications and allergies	Vitamins and herbal supplements
Current health status/Immunizations (Consider past travel)	Up to date
Social/Family concerns	---
Medical identification jewelry	---
EXAMINATION FINDINGS	
Initial Vital Signs	BP: 130/84 P: 110 R: 24, regular, shallow guarded Pain: 8/10 Temperature: normal (99) SpO2: 99% ETCO2: 40 mm Hg GCS: Total (E:4; V: 4, M:6) 14 BGL: 120 mg/dL
HEENT	Pupils appear a little sluggish, but equal; ENT normal
Respiratory/Chest	Lung sounds bilaterally equal and clear – guarding and splinting L side resulting in shallow rapid breaths
Cardiovascular	Normal heart sounds
Gastrointestinal/Abdomen	Abdomen is soft and non-tender
Genitourinary	---
Musculoskeletal/Extremities	Open fracture of L lower Leg (Distracting complaint)
Neurologic	Initially confused, upon questioning find he has retrograde amnesia
Integumentary	Road rash down entire left side
Hematologic	Mild bleeding from road rash, skin pale and diaphoretic; wound sites minimal venous bleeding
Immunologic	----
Endocrine	---
Psychiatric	----
Additional diagnostic tests as necessary	SpO_2 is 99% on RA, $EtCO_2$ =40, BGL 120 mg/dL

Out-Of-Hospital BLS Scenario
Adult or Pediatric Blunt Trauma

PATIENT MANAGEMENT		
Initial stabilization/ Interventions/ Treatments	• Should take immediate manual immobilization of head. Supplemental 02 by nasal cannula • C-collar and backboard • Initiate transport rapidly	
Additional Resources	---	
Patient response to interventions	The patient will deteriorate in 5 minutes despite being appropriately treated due to expanding intracranial mass (subdural hematoma)	
EVENT		
The patient deteriorates in 5 minutes, becoming more confused and less respondent and eventually lapses into a period of silence/unconsciousness		
REASSESSMENT		
Appropriate management – notes shock and head trauma rapidly boards and initiates oxygen therapy and trans to trauma center	BP: 200/100 R: 30, shallow and irregular(Cheyne-Stokes)	P: 64 Pain: Pt. lapses unconscious
Inappropriate management – doesn't rec need to assist vent and/or urgency. Patient becomes unconscious and shows signs consistent with Cushing's triad	BP: 200/100 R: 30, shallow and irregular(Cheyne-Stokes)	P: 64 Pain: Pt. lapses unconscious

TRANSPORT DECISION: Urgent, to Trauma Center

MANDATORY ACTIONS:

- Full patient assessment
- Obtains OPQRST History
- Obtains SAMPLE History
- Obtains Vitals
- Inquires about allergies prior to giving medications (this can be obtained during SAMPLE)

POTENTIALLY HARMFUL/DANGEROUS ACTIONS:

- Allows patient to refuse transport
- Failure to obtain SAMPLE History
- Failure to assess patient with a minimum of a FOCUSED assessment of chief complaint.
- Failure to transport patient
-

Out-Of-Hospital BLS Scenario
Adult/Pediatric Cardiac Arrest

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario (Place a Check for the Skills)

- BLS Medical Assessment
- SKILL Vital Signs
- Mechanical Aids to Breathing
- Cardiac Arrest-AED
- SGA (OPTIONAL)

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	Table, chair or bed
Medical Identification jewelry	--
SETUP INSTRUCTIONS	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle, you are the primary care giver with one EMT assistant
Other personnel needed (define personnel and identify who can serve in each role)	Patient spouse (or parent if patient is child). Fire Department First Responders Law enforcement
MOULAGE INFORMATION	
Integumentary	Pale
Head	--
Chest	--
Abdomen	--
Pelvis	--
Back	--
Extremities	--
Age	ADULT: 46yo / Child: 3yo
Weight	ADULT: 180 lbs. / Child: 30 lbs.

Out-Of-Hospital BLS Scenario
Adult/Pediatric Cardiac Arrest

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	06:20
Location	154 1st St.
Nature of the call	9E1 (unconscious, not breathing, no pulse)
Weather	As is on day of scenario
Personnel on the scene	2 on EMS; 1 LE; 3 FF

READ TO TEAM LEADER: DISPATCH INFORMATION GOES HERE

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Family is panicked, scared, worried and crying.
Patient location	In bedroom on floor
Visual appearance	Prone, lifeless
Age, sex, weight	As noted, (sex no important)
Immediate surroundings (bystanders, significant others present)	Front door unlocked. Spouse/parent attempting to perform CPR. On phone with dispatcher/call taker. CPR is not effective
Mechanism of injury/Nature of illness	Found on the floor when family member went to wake patient up.

Out-Of-Hospital BLS Scenario
Adult/Pediatric Cardiac Arrest

PRIMARY ASSESSMENT	
General impression	Pale, unconscious, unresponsive
Baseline mental status	Unresponsive (AVPU)
Airway	Open
Ventilation	None
Circulation	None
HISTORY (if applicable)	
Chief complaint	None, unconscious, unresponsive
History of present illness	Found lying on floor around 6:15. Family member immediately called 911. Call taker/Dispatcher coached family member in performing CPR.
Patient responses, associated symptoms, pertinent negatives	---
PAST MEDICAL HISTORY	
Illnesses/Injuries	Asthma
Medications and allergies	Albuterol
Current health status/Immunizations (Consider past travel)	Annual doctor visit 3 months ago. Unremarkable. Re-prescribed albuterol PRN for seasonal allergy asthma.
Social/Family concerns	1 dog; 2 cats in house
Medical identification jewelry	--
EXAMINATION FINDINGS	
Initial Vital Signs	0/0; Pulse Absent; Respirations Absent
HEENT	Pale, pupils dilated
Respiratory/Chest	--
Cardiovascular	No pulse
Gastrointestinal/Abdomen	--
Genitourinary	--
Musculoskeletal/Extremities	Mottled, pale, cool
Neurologic	Unresponsive
Integumentary	Mottled, pale, cool
Hematologic	--
Immunologic	--
Endocrine	--
Psychiatric	--
Additional diagnostic test as necessary	Blood Glucose: 112

Out-Of-Hospital BLS Scenario
Adult/Pediatric Cardiac Arrest

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	• CPR, Hands off chest time less than 10 seconds (average) • Effective ventilation • Use of OPA/NPA or Both and BVM • AED Advised shock • Rotating compressors every 1-2 minutes • Effective 2 person BVM if no SGA/iGel
Additional Resources	--
Patient response to interventions	Pulse regained after 10 minutes of CPR AED advises at least 1 shock
EVENT	
Family member is wanting to get in the way; hysterical and crying. Team leader must direct someone to correct this problem.	
REASSESSMENT	
Appropriate management	Patient regains pulse after 10 minutes of CPR BP: 90/60 P: 110 R: 2-6 occasional. Assisted with BVM No gagging on OPA/NPA
Inappropriate management	Patient does not regain a pulse

TRANSPORT DECISION: Team leader should verbalize transport after 10 minutes of High-Quality CPR; Regardless of patient recovery.

Out-Of-Hospital BLS Scenario
Adult/Pediatric Cardiac Arrest

MANDATORY ACTIONS:
• CPR, Average Hands-off-chest <=10 seconds • Rotate Compressors every 1-2 minutes • OPA/NPA or both • AED usage • Clear to shock • Placement of SGA/iGel if indicated • Effective ventilations with BVM as evidenced by rise and fall of chest
POTENTIALLY HARMFUL/DANGEROUS ACTIONS:
• Fails to identify need for CPR within 10 seconds of identifying pulselessness • Fails to begin CPR within 10 seconds of identifying pulselessness • Fails to properly perform CPR • Fails to properly use AED • Fails to clear patient prior to delivering AED Shock • Fails to ventilate properly with BVM

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Bleeding

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Trauma Assessment
- Vital Signs
- Mechanical Aids to Breathing
- Bleeding Control
- Bandaging

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	---
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Residential or apartment house. Patient tripped and fell onto plate-glass window with arm outstretched, • Ensure full ambulance equipment	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle
Other personnel needed (define personnel and identify who can serve in each role)	Law enforcement officer Fire department first responder
MOULAGE INFORMATION	
Integumentary	Deep 4" laceration on right forearm actively bleeding
Head	---
Chest	---
Abdomen	---
Pelvis	---
Back	---
Extremities	---
Age	Adult: 24 yo / Child: 10 yo
Weight	Adult: 150 lbs. / Child: 75 lbs.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Bleeding

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	2:30 pm on Saturday afternoon
Location	1624 Jeff Str.
Nature of the call	Trauma call
Weather	Clear fall day, 74 F
Personnel on the scene	PD on scene

READ TO TEAM LEADER: Medic 601 respond to 1624 Jeff St, cross street Bodark, for the Injured Person.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Parking on narrow residential street. Barking dog in residence
Patient location	May use a photo of such street with pothole evident
Visual appearance	Broken glass front door
Age, sex, weight	Adult: 24yo; 150# M/F / 10yo; 75#; M/F
Immediate surroundings (bystanders, significant others present)	No family present
Mechanism of injury/Nature of illness	Walking from the living room to front to door to get the mail. Dog ran to the door. Patient tripped over dog; Patient tripped and fell into plate-glass window. Window broke; lacerating right forearm.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Bleeding

PRIMARY ASSESSMENT		
General impression	Moderate to severe injury. Lots of blood loss. Patient is holding a towel over laceration. Patient appears pale and diaphoretic.	
Baseline mental status	Patient answers all questions. Is alert and oriented.	
Airway	Clear	
Ventilation	Rapid (28)	
Circulation	Rapid (110) Skin is pale	
HISTORY (if applicable)		
Chief complaint	"I fell and cut my arm"	
History of present illness	---	
Patient responses, associated symptoms, pertinent negatives	Right arm bleeding profusely.	
PAST MEDICAL HISTORY		
Illnesses/Injuries	---	
Medications and allergies	None	
Current health status/Immunizations (Consider past travel)	Up to date	
Social/Family concerns	---	
Medical identification jewelry	---	
EXAMINATION FINDINGS		
Initial Vital Signs	BP: 90/60 R: 28, regular Temperature: normal (98.4) SpO2: 92% GCS: Total (E:4; V: 5, M:6) 15 BGL: 120 mg/dL	P: 110 Pain: 8/10 ETCO2: 40 mm Hg
HEENT	---	
Respiratory/Chest	---	
Cardiovascular	---	
Gastrointestinal/Abdomen	---	
Genitourinary	---	
Musculoskeletal/Extremities	3-4" laceration on right forearm, bleeding profusely	
Neurologic	---	
Integumentary	---	
Hematologic	Bleeding from laceration	
Immunologic	----	
Endocrine	---	
Psychiatric	----	
Additional diagnostic tests as necessary	BGL 120 mg/dL	

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Bleeding

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	• Immediate TQ use on Right Arm • O2 by NC • Initiate transport rapidly
Additional Resources	---
Patient response to interventions	BP improves; Pulse rate decreases.
EVENT	
Time greater than 5min to place a TQ, patient becomes unconscious	
REASSESSMENT	
Appropriate management – TQ Usage; O2, shock management; and trans to trauma center	Mentation: Alert BP: 94/62 P: 110 R: 24 Bleeding controlled
Inappropriate management – >5 min to apply TQ patient becomes unconscious/unresponsive with absent radial pulse, present carotid pulse.	Mentation: Unconscious/Unresponsive BP: 70/P P: 140 R: 8 shallow

TRANSPORT DECISION: Urgent, to Trauma Center

MANDATORY ACTIONS:

- Focused assessment of injury
- TQ placement
- Full patient assessment
- Obtains Vitals
-

POTENTIALLY HARMFUL/DANGEROUS ACTIONS:

- >5 min to apply TQ
- If uses QuikClot, this does not stop bleeding and candidate fails to address or apply TQ
- Failure to assess patient with a minimum of a FOCUSED assessment of chief complaint.
- Failure to transport patient

Out-Of-Hospital BLS Scenario
Adult/Pedi Respiratory Distress

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Medical Assessment
- Vital Signs
- Mechanical Aids to Breathing
- SVN
- CPAP (OPTIONAL)

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies, AED,
Props	
Sound clips	
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Identify the level of the detail of the scene that we expect • Minimum expectation of how props and sound clips will be used	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle and Equipment
Other personnel needed (define personnel and identify who can serve in each role)	Mother and sister play in front yard
MOULAGE INFORMATION	
Integumentary	Pale, Cool, and Diaphoretic
Head	---
Chest	Wheezing
Abdomen	---
Pelvis	---
Back	---
Extremities	---
Age	Adult: 23yo / Child: 8 yo
Sex	M
Weight	Adult: 105 lbs. / Child: 70 lbs.

Out-Of-Hospital BLS Scenario
Adult/Pedi Respiratory Distress

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	1026
Location	5621 Peanut Street
Nature of the call	Medical call; Adult
Weather	Road condition Clear
Personnel on the scene	Patient, Mother and child in the front yard

READ TO TEAM LEADER: EMS 10 respond to 5621 peanut street for a 23-year-old male who is complaining of wheezing and tightness in chest. Time out 1028

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Patient lives with his mother and sister. The home is need of repair
Patient location	Patient is sitting on the front porch
Visual appearance	Font yard has trash all over it and a doghouse
Age, sex, weight	Adult: 23, M, 105 / Child: 8, M, 70
Immediate surroundings (bystanders, significant others present)	Patient's mother and sister
Mechanism of injury/Nature of illness	Respiratory (Asthma)

Out-Of-Hospital BLS Scenario
Adult/Pedi Respiratory Distress

PRIMARY ASSESSMENT	
General impression	Audible wheezing
Baseline mental status	Alert
Airway	open
Ventilation	Tachypneic, and Wheezing
Circulation	No major bleeding, Tachycardic
HISTORY (if applicable)	
Chief complaint	Increasing respiratory distress and wheezing
History of present illness	The patient has had asthma since he was 10-year-old and has taken different types of asthma medication
Patient responses, associated symptoms, pertinent negatives	The patient is having sudden dyspnea, Wheezing, tightness in the chest
PAST MEDICAL HISTORY	
Illnesses/Injuries	Asthma
Medications and allergies	Albuterol, Vitamin, NKDA
Current health status/Immunizations (Consider past travel)	No travel in the past 4 weeks. Asthma attack
Social/Family concerns	---
Medical identification jewelry	---
EXAMINATION FINDINGS	
Initial Vital Signs	BP: 140/90 P: 130 R: 32 shallow w/wheezing Pain: 0 Temperature: 98.2 GCS: Total (E:4; V:5; M:6)
HEENT	---
Respiratory/Chest	Diminished breath sounds
Cardiovascular	Tachycardia
Gastrointestinal/Abdomen	---
Genitourinary	---
Musculoskeletal/Extremities	---
Neurologic	---
Integumentary	Pale, Cool, and Diaphoretic
Hematologic	---
Immunologic	---
Endocrine	---
Psychiatric	
Additional diagnostic tests as necessary	SpO_2: 94% $EtCO_2$: 40 ECG: Sinus Tach BGL determination: 90

Out-Of-Hospital BLS Scenario
Adult/Pedi Respiratory Distress

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	Vitals, History E Fowler position, Small Volume Nebulizer w/Albuterol Oxygen, Fowler position
Additional Resources	Considers CPAP (ADULT ONLY)
Patient response to interventions	Wheezing is reduced, vital signs are getting better
EVENT	
At a predetermined time in the scenario, an event should occur. This could be a scene safety concern, rapid change in patient condition, or an issue with equipment, bystanders, or other personnel. The Team Leader and Team Members will need to address this issue while continuing to manage the patient.	
REASSESSMENT	
Appropriate management	BP: 128/80 P: 100 R: 18 Pain: List improving vital signs and reassessment findings
Inappropriate management	BP: 130/100 P: 150 R: 30 Pain: List deteriorating vital signs and reassessment findings

TRANSPORT DECISION: Team Leader should verbalize transport decision, reason for choosing the facility, and describe the appropriate transportation mode.

MANDATORY ACTIONS:
• Fowler position, Oxygen, Small Volume nebulizer w/Albuterol
POTENTIALLY HARMFUL/DANGEROUS ACTIONS:
• Failed to give oxygen and small nebulizer w/Albuterol

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Fracture

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Trauma Assessment
- Vital Signs
- Mechanical Aids to Breathing
- Bleeding Control
- Bandaging
- Splinting

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st in bag, oxygen cylinder and supplies
Props	Chair or table
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Residential or apartment house. Patient was using a chair to get something out of a tall cabinet in kitchen • Ensure full ambulance equipment	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle
Other personnel needed (define personnel and identify who can serve in each role)	Law enforcement officer Fire department first responder
MOULAGE INFORMATION	
Integumentary	Laceration on left mid-shaft tibia and fibula
Head	---
Chest	---
Abdomen	---
Pelvis	---
Back	---
Extremities	Open fracture of left mid-shaft tibia and fibula
Age	Adult: 54 yo / Child: 8 yo
Weight	Adult: 195 lbs. / Child: 60 lbs.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Fracture

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	Day and time of testing
Location	911 Murphy St.
Nature of the call	Trauma call
Weather	Heavy rain. 74 F
Personnel on the scene	PD on scene

READ TO TEAM LEADER: Medic 34 respond to 911 Murphy St., cross street Law, for the Injured Person.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Parking on narrow residential street. Heavy rain outside creating slip hazards
Patient location	May use a photo of such street with pothole evident
Visual appearance	Residential house or apartment
Age, sex, weight	Adult: 54yo; 195# M/F / 8yo; 60#; M/F
Immediate surroundings (bystanders, significant others present)	Adult: No family present / Child: Father present
Mechanism of injury/Nature of illness	Attempted to get something out of a top cabinet in kitchen. Patient stood on a chair to reach. The chair become wobbly; and tipped; Patient's leg with through the back of the chair and as the patient came down, the chair tip against the lower leg and cause the lower leg to break.

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Fracture

PRIMARY ASSESSMENT		
General impression	Moderate to severe injury. Minimal bleeding. Patient is holding a towel over the opened wound.	
Baseline mental status	Patient answers all questions. Is alert and oriented.	
Airway	Clear	
Ventilation	Rapid (24)	
Circulation	Rapid (100)	
HISTORY (if applicable)		
Chief complaint	"I fell and I think my leg is broke"	
History of present illness	---	
Patient responses, associated symptoms, pertinent negatives	---	
PAST MEDICAL HISTORY		
Illnesses/Injuries	---	
Medications and allergies	None	
Current health status/Immunizations (Consider past travel)	Up to date	
Social/Family concerns	---	
Medical identification jewelry	---	
EXAMINATION FINDINGS		
Initial Vital Signs	BP: 100/80 R: 24, regular Temperature: normal (98.4) SpO2: 96% GCS: Total (E:4; V: 5, M:6) 15 BGL: 120 mg/dL	P: 100 Pain: 8/10 ETCO2: 40 mm Hg
HEENT	---	
Respiratory/Chest	---	
Cardiovascular	---	
Gastrointestinal/Abdomen	---	
Genitourinary	---	
Musculoskeletal/Extremities	1-2" laceration on left lower leg; leg is unstable; and appears angulated	
Neurologic	---	
Integumentary	---	
Hematologic	Minimal bleeding from left leg laceration	
Immunologic	----	
Endocrine	---	
Psychiatric	----	
Additional diagnostic tests as necessary	BGL 120 mg/dL	

Out-Of-Hospital BLS Scenario
Adult or Pediatric Injury with Fracture

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	• Focused assessment • Bandage open fracture • Splint fracture site • No indication for spinal management
Additional Resources	---
Patient response to interventions	Unchanged
EVENT	

REASSESSMENT	
Appropriate management – Bandaging, splinting and transport	Mentation: Alert No changes in vitals
Inappropriate management – Use of traction splint; neither bandaging nor splinting.	Mentation: Unconscious/Unresponsive BP: 104/84 P: 120 R: 24

TRANSPORT DECISION: Urgent, to Trauma Center

MANDATORY ACTIONS:

- Focused assessment of injury
- Bandaging open fracture
- Splinting fracture
- Obtains Vitals
-

POTENTIALLY HARMFUL/DANGEROUS ACTIONS:

- Failure to Bandage open fracture
- Failure to Splint fracture site and joint's above and below
- Failure to assess patient with a minimum of a FOCUSED assessment of chief complaint.
- Failure to transport patient

Out-Of-Hospital BLS Scenario
MVC

Program:	
Scenario Number:	
Approval Date:	
Medical Director Approval (Name & Signature):	
Program Director Approval (Name & Signature):	

Potential Skills Interlinked with Scenario

- BLS Trauma Assessment
- Vital Signs
- Mechanical Aids to Breathing
- Bleeding Control
- Bandaging
- Splinting
- Sl Supine

MINIMUM EQUIPMENT	
EMS equipment and supplies	1st bag in and ambulance with equipment
Props	
Sound clips	
Medical Identification jewelry	---
SETUP INSTRUCTIONS	
• Identify the level of the detail of the scene that we expect • Minimum expectation of how props and sound clips will be used	
BACKGROUND INFORMATION	
EMS System description	BLS vehicle (adjusts as needed for individual scenarios)
Other personnel needed (define personnel and identify who can serve in each role)	law enforcement officers, fire fighters.
MOULAGE INFORMATION	
Integumentary	Description of the injuries that need to be moulage
Head	Cut on the left side of head
Chest	Bruising
Abdomen	Bruising from the seat belt
Pelvis	---
Back	---
Extremities	Left arm broken
Age	23-year-old
Sex	Female
Weight	105 lbs.

Out-Of-Hospital BLS Scenario
MVC

DISPATCH INFORMATION (Specific script for each scenario; Must be read over radio, telephone or in such a way that the candidate cannot look at the Examiner as he/she reads the dispatch information)	
Dispatch time	18:40
Location	Cherry lane and Bet Street
Nature of the call	Medical or Trauma call; Adult, Pediatric, or Geriatric
Weather	Cool and rain
Personnel on the scene	Patients law enforcement, fire department personnel

READ TO TEAM LEADER: Medic 12 respond to Cherry Lane and Bet Street on a traffic accident.

SCENE SURVEY INFORMATION	
A scene or safety consideration that must be addressed	Gas, oil
Patient location	May use a photo: (car crash, etc.)
Visual appearance	The patient vehicle has a two-foot intrusion
Age, sex, weight	23-year-old Female 105 lbs.
Immediate surroundings (bystanders, significant others present)	
Mechanism of injury/Nature of illness	Traffic accident two vehicles patient vehicle is T-bone

Out-Of-Hospital BLS Scenario
MVC

PRIMARY ASSESSMENT	
General impression	Two vehicle accident
Baseline mental status	Alert
Airway	open
Ventilation	Normal
Circulation	tachycardia
HISTORY (if applicable)	
Chief complaint	Cut to head, broken arm, bruising to the chest and abdominal area
History of present illness	The patient has
Patient responses, associated symptoms, pertinent negatives	---
PAST MEDICAL HISTORY	
Illnesses/Injuries	None
Medications and allergies	Asthma medication Morphine
Current health status/Immunizations (Consider past travel)	No travel in the last year
Social/Family concerns	---
Medical identification jewelry	---
EXAMINATION FINDINGS	
Initial Vital Signs	BP: 150/90 P: 130 R: 20 Pain: 8 Temperature: GCS: Total (E: V: M:)individual findings 4,5,5
HEENT	---
Respiratory/Chest	Diminished lung sounds
Cardiovascular	---
Gastrointestinal/Abdomen	Bruising to the abdomen
Genitourinary	---
Musculoskeletal/Extremities	Broken left arm
Neurologic	---
Integumentary	---
Hematologic	---
Immunologic	---
Endocrine	---
Psychiatric	Upset
Additional diagnostic tests as necessary	Pulse oximetry, capnography, cardiac monitoring, blood glucose level determination

Out-Of-Hospital BLS Scenario
MVC

PATIENT MANAGEMENT	
Initial stabilization/ Interventions/ Treatments	• C-spine control • Control bleeding, oxygen, • splint to arm
Additional Resources	---
Patient response to interventions	---
EVENT	
The vehicle catches on fire.	
REASSESSMENT	
Appropriate management	BP: 130/90 P: 110 R: 16 Pain:8 List improving vital signs and reassessment findings
Inappropriate management	BP: 150/100 P: 130 R: 24 Pain:10 List deteriorating vital signs and reassessment findings

TRANSPORT DECISION: Team Leader should verbalize transport decision, reason for choosing the facility, and describe the appropriate transportation mode.

MANDATORY ACTIONS: List all actions that need to be completed by the Team during the Assessment and Management of the patient.
• C-spine, oxygen, splinting the arm
POTENTIALLY HARMFUL/DANGEROUS ACTIONS:
• did not splint the arm