



Southern Fox Valley EMS System
Paramedic System Entry

General Instructions

Welcome to Southern Fox Valley EMS System and our Paramedic System Entry process. Once you have been hired by a system department these are the steps you need to follow:

1. System entry sessions are held at the EMS office on the third Tuesday of every month (*dates are subject to change*) at 9 a.m. Be sure that your EMS Coordinator or Chief has scheduled you for one of these sessions. Please be on time. Plan on being at the testing for at least 2 hours. Appropriate attire must be worn (uniform preferred).
2. Enclosed in your packet is a Prescreen Check-Off Sheet. It is the responsibility of the applicant to assure that all of the information is in the office prior to the prescreen date. You will not be allowed to complete your system entry testing if any items are missing.
3. The prescreen process consists of the following:
 - a. Practical testing of the skills listed on pages 3-4: *Completed and signed off by your department EMS Coordinator prior to prescreen*
 - b. Written cardiac rhythm test on SFVEMSS Protocols.
 - c. Written entrance exam on SFVEMSS policies and protocols.
4. If you have any questions at all about system entry, please contact:
Deb Ward at debra.ward@nm.org 630-938-8464
or
Dustin Roop at dustin.roop@nm.org 630-938-8461



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Prescreen Check-off Sheet

Name: _____ Department: _____

*The following items **must** be submitted to the EMS office **PRIOR** to scheduling of prescreen:*

- Copy of current state EMT-Paramedic license
 - Copy of current AHA Health Care Provider CPR card
 - Copy of valid Driver's License
 - Letter of Good Standing from current system (if applicable)
 - Verification of current continuing education
 - Copies of any other certifications that you currently hold (ACLS, PALS, PHTLS, ITLS)
 - Skills sign off sheet, signed by department EMS Coordinator or designee
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Correspondence and items being mailed to the office should be addressed to:

Southern Fox Valley EMS System
System Entry Testing
300 Randall Road
Geneva, IL 60134

Forms may also be faxed to (630) 208-3496, or e-mailed to debra.ward@nm.org or dustin.roop@nm.org

Letters and certificates must be on system letterhead to be considered valid.



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**Southern Fox Valley
 Emergency Medical Services System
 Paramedic System Prescreen
 Skills Check Off Sheet**

This form is to be completed and signed by the Department EMS Coordinator or Chief.
 By signing this form you are stating that the Paramedic listed below has reviewed all of the items listed, is proficient in these skills and ready to be tested into SFV EMS System.

Paramedic Name: _____

Department: _____

Prescreen Date: _____

Chief / EMS Coordinator Signature: _____

| ITEM | COMPLETED /DATE |
|-------------|------------------------|
|-------------|------------------------|

POLICY AND PROTOCOL REVIEW COMPLETE

Including but not limited to the following

- a. Drug Assisted Intubation
- b. Allergic Reaction / Anaphylactic Shock
- c. Asthma / COPD
- d. Acute Coronary Syndrome
- e. Bradycardia with a pulse
- f. Supraventricular Tachycardia
- g. Ventricular Tachycardia with a pulse
- h. Ventricular Fibrillation and pulseless V-Tach
- i. Traumatic Arrest
- j. Dialysis / Chronic Renal Failure
- k. Heart Failure and Pulmonary Edema
- l. PEA and Asystole
- m. Refusals
- n. School Bus Policy
- o. Multiple Patient Release
- p. C- Spine Clearance

Please complete items on page 2



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COMPETANT IN THE FOLLOWING SKILLS:

- a. Blood sampling _____
- b. Capnography _____
- c. Endotracheal intubation (non-trauma patient) _____
 - a. Adult _____
 - b. Child _____
 - c. Infant _____

- d. IO infusion _____

- e. King LT-D airway _____
- f. Monitoring OG/NG tubes _____
- g. Stoma suctioning _____
- h. Surgical cricothyrotomy _____
- i. Tourniquet application _____
- j. Use of hemostatic agents _____
- k. Vaccine administration _____



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Personal Information Sheet

This form needs to be faxed to SFVEMSS or emailed to debra.ward@nm.org as soon as you begin processing a new provider and prior to allowing an employee to have patient contact. Fax number: 630-208-3496. Please submit a copy of Illinois license and CPR card along with this sheet.

Social Security Number _____ Drivers License Number _____

Name _____ Date of Birth _____
last first initial

Address _____
street city county state zip

Phone number: _____

E-mail _____

Agency Employed by: _____

Agency start date: _____

State of Illinois License Number: _____ License Level: _____

Licensure date: _____ License expiration date: _____

Other System Affiliations: _____

Will SFVEMSS be your Primary or Secondary system? _____

The above information is correct to the best of my knowledge. If any of this information changes in the future, it is my responsibility to inform the EMS Office in accordance with the policies and procedures within the SFV/EMS System and IDPH.

Signature _____ Date _____

For EMS office use only"
EMS System Number: _____

Entered into ESO: _____

Entered into Load-n-go: _____



Skills Study Sheet: Surgical Cricothyrotomy

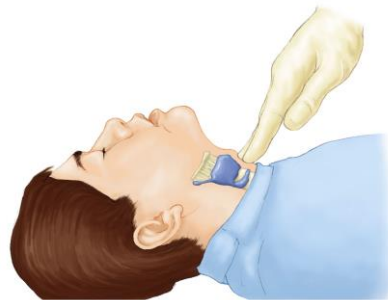
Indications

Indicated only when airway control is impossible by other available methods. These "difficult airway" situations are caused by:

- Upper airway obstruction by trauma
- Allergic reactions with swelling and angioedema
- Foreign bodies
- Anatomic variations
- Bleeding

Technique

1. Locate the thyroid cartilage and the cricoid cartilage. Find the cricothyroid membrane between the two cartilages.



2. Clean the area with iodine-containing solution if time permits, while your partner sets up suction, pulse oximetry, and cardiac monitor.

3. Stabilize the cartilages with one hand, while using a scalpel in the other hand to make a 1 to 2 cm vertical skin incision over the membrane.



4. Find the cricothyroid membrane again and make a 1 cm incision in the horizontal plane through the membrane, avoiding nearby veins and arteries.

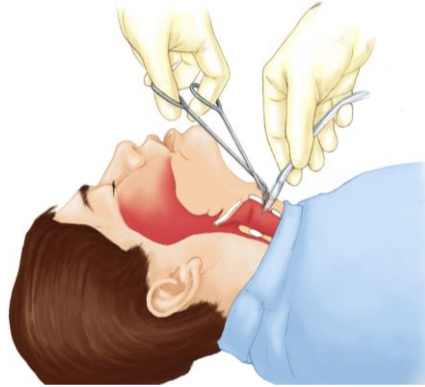
5. Insert a curved hemostat or Kelly forceps into the membrane incision and spread it open.





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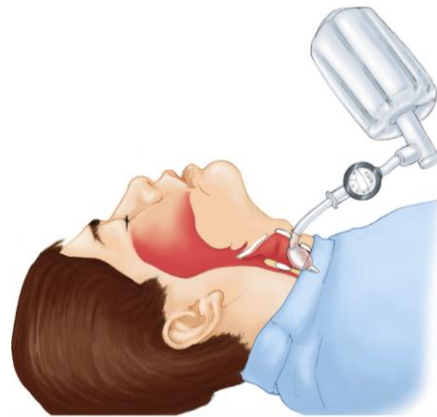
6. Insert a cuffed endotracheal tube (7.0 mm), directing the tube into the trachea.



7. Inflate the cuff and ventilate.



8. Confirm placement with auscultation, end-tidal CO₂ detector, and chest rise.
9. Secure the tube in place.



Complications

- Incorrect tube placement into false passage
- Cricoid and/or thyroid cartilage damage
- Thyroid gland damage
- Severe bleeding
- Laryngeal nerve damage
- Subcutaneous emphysema
- Vocal cord damage
- Infection



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Skills Study Sheet: Endotracheal Intubation

Indications for Endotracheal Intubation

- Respiratory or cardiac arrest
- Unconsciousness or obtunded without gag reflex
- Risk of aspiration
- Obstruction due to foreign bodies, trauma, burns or anaphylaxis
- Respiratory *extremis* due to disease
- Pneumothorax, hemothorax, or hemopneumothorax with respiratory difficulty

Advantages of Endotracheal Intubation

- It isolates the trachea and permits complete airway control of the airway
- It impedes gastric distention by channeling air directly into the trachea
- It eliminates the need to maintain a mask seal
- It offers a direct route for suctioning of the respiratory passages
- It permits administration of medication **Lidocaine**, **Epinephrine**, **Atropine**, and **Narcan**

Disadvantages of Endotracheal Intubation

- The technique requires considerable training and experience
- It requires specialized equipment
- It requires direct visualization of the vocal cords
- It bypasses the upper airway's function of warming, filtering, and humidifying the inhaled air

Complications

- *Equipment malfunction*
- *Teeth breakage and soft-tissue lacerations*
- *Hypoxia*
- *Esophageal intubation*
- *Endobronchial intubation*
- *Tension pneumothorax*



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Adult Orotracheal Intubation (NON-Trauma Patient)

1. Place the patient supine.
2. Have your partner open the airway and hyperventilate the patient with 100 percent oxygen.
3. While your partner is ventilating the patient, prepare your equipment.
4. Position the patient's head
 - a. remove dentures
 - b. place head in sniffing position
 - c. placing towel or sheet under the patient's shoulders may help
5. Have your partner apply Sellick's maneuver
6. Hold laryngoscope in your left hand and insert it gently into the right side of the patient's mouth. With a gentle sweeping action, displace the tongue to the left.
7. Move the blade toward midline.
 - a. Macintosh (curved) blade: distal end placed in vallecula
 - b. Miller (straight) blade: distal end under the epiglottis
8. Lift the laryngoscope handle slightly upward and toward the feet to displace the jaw. Be careful to not put pressure on the teeth. Suction if needed.
9. Adjust laryngoscope until you can visual the vocal cords. If you cannot see the landmarks, gently withdraw the blade, slowly and slightly, to see if the cords come into view. If not, you made need to gently advance the blade further into the hypopharynx.
10. Keep your left wrist straight and use your left shoulder and arm to continue lifting the mandible and tongue until the glottis is exposed.
11. Advance the ET tube through the right corner of the patient's mouth and gently pass it through the glottic opening until the distal cuff disappears beyond the vocal cords; then advance it another 1 to 2 cm.
12. Hold the tube in place with your hand to prevent displacement; do NOT let it go until it is taped or tied securely in place.
13. Check placement by applying Positube
 - a. If the plunger pulls out easily and stays out, you are in the trachea
 - b. If the plunger is difficult to pull and is 'sucked' back down the barrel, you are in the esophagus
– remove the ET tube, hyperventilate and try again.
14. Inflate the distal cuff.



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15. Check for proper tube placement
 - a. listen for equal, bilateral breath sounds
 - b. watch for chest rise and fall
 - c. listen over the epigastrium to assure no gastric sounds heard
 - d. look for moisture condensation in exhaled breath in the tube
16. Hyperventilate with 100% oxygen.
17. Secure ETT with commercial tube-holding device. If not available, use tape and be sure to insert an oropharyngeal airway to serve as a bite block.
18. Periodically confirm proper ETT placement.

Pediatric Intubation

While the indications, procedures, and precautions for airway management in children are fundamentally the same as in adults, be sure to remember several significant differences.

- the structures are proportionally smaller and more flexible than an adult's
- the tongue is larger in relation to the oropharynx
- the epiglottis is floppy and round
- the glottic opening is higher and more anterior in the neck
- the vocal cords slant upward, toward the back of the head, and are closer to the base of the tongue
- the narrowest part of the airway is the cricoid cartilage, not the glottic opening as in adults

Other points:

- straight laryngoscope blade is preferred for most pediatric patients
- be sure to select an appropriate sized tube – too large a tube can cause tracheal edema and/or damage to the vocal cords
- tubes are uncuffed
- depth of insertion should be 2 to 3 cm below the vocal cords
- infants and small children have greater vagal tone than adults – more likely to participate a vagal response in a pediatric patient; monitor the heart rate and consider atropine 0.02 mg/kg



Skills Study Sheet: King LT Device

Equipment Needed:

- King LT-D Airway
- water-based lubricant
- 100 ml syringe
- tape or commercial securing device



Procedure:

1. Test cuff and inflation system for leaks by injecting 80 mL of air into the cuffs.
2. Apply lubricant to the beveled distal tip and posterior aspect of the tube, taking care to avoid introduction of lubricant in or near the ventilatory openings.
3. Pre-oxygenate the patient.
4. Position the head. Ideal position is the sniffing position. In the trauma patient, maintain neutral alignment.
5. Hold the King LT-D at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.
6. With the King LT-D rotated laterally 45-90° so that the blue orientation line is touching the corner of the mouth, introduce the tip into the mouth and advance behind the base of the tongue.
7. As the tube tip passes under the tongue, rotate the tube back to midline (the blue orientation line facing the chin).
8. Without exerting excessive force, advance the tube until the base of the connector is aligned with the teeth or gums.
9. Using the syringe provided, inflate the cuffs of the King LT-D with 70 mL of air.
10. Attach BVM device to the connector. While gently bagging the patient to assess ventilation, simultaneously withdraw the King LT-D until ventilation is easy and free flowing (large tidal volume with minimal airway pressure.)
11. Confirm proper position by auscultation, chest movement, and verification of CO₂ by capnography if available.
12. Readjust cuff inflation to just seal volume (cuffs inflated with minimum volume necessary to seal the airway at the peak ventilatory pressure employed).
13. Secure King LT-D to patient using tape or commercial device.



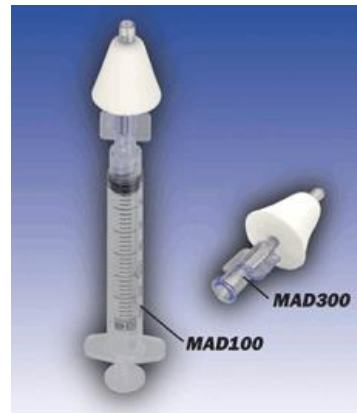
Intranasal Drug Administration

Equipment Needed:

- Syringe with leur lock
- Needle
- Mucosal Atomizer Device (MAD)
- Medication
- Towel

Procedure:

1. Inspect the patient's nostrils for mucus, blood, or other problems that might inhibit absorption.
2. Load the syringe with the appropriate dose of medication.
3. Expel the air from the syringe and attach the MAD.
4. Place the atomizer within the nostril.
5. Briskly compress the syringe to administer the $\frac{1}{2}$ the correct drug dose, no more than 0.5 – 1 mL per nostril. Have a towel available to catch any secretions.
6. Remove the atomizer and repeat the process in the other nostril, if indicated, until the full therapeutic dose is administered.
7. Continue assuring the patient is ventilated and secure the airway as needed.
8. Assess the patient's response to the medication and document the following:
 - drug
 - dose given, including how much in each nostril
 - time administered
 - patient response (vitals, signs of improvement/decompensation)





INTRANASAL (IN) NALOXONE (NARCAN) PROTOCOL

1. Inspect nostrils for mucus, blood or other problems that might inhibit absorption
2. Load syringe with 0.4 mg of naloxone (narcan) (1mg/ml IV solution)
3. Expel air from the syringe
4. Attach the MAD device via luer lock
5. Briskly compress the syringe plunger to administer 0.4 mg naloxone via rapid intranasal mist spray (**no more than 0.5 – 1 ml per nostril at one time**)
6. Secure airway as needed
7. If patient does not respond to IN Narcan within the time limit it takes to establish venous access and an airway is necessary, give Narcan 0.4 mg IVP as soon as the IV is started or Narcan 0.8 mg ET up to a total of 2 mg IVP or 4 mg ET.
8. Successful awakening eliminates the need for IV or further ALS care
9. Gradual awakening with adequate respiratory efforts: Continue to monitor for 3-5 minutes
10. Reassess the need for second dose of IN Narcan



INTRANASAL (IN) MIDAZOLAM (Versed) PROTOCOL

1. Inspect nostrils for mucus, blood or other problems that might inhibit absorption
2. Load syringe with 0.2 mg/kg up to 10 mg of midazolam (Versed) (10mg/2ml IV solution)
3. Expel the air from the syringe
4. Attach the MAD device via luer lock
5. Briskly compress the syringe plunger to administer $\frac{1}{2}$ of the volume (**no more than 0.5 – 1 ml per nostril**)
6. Secure airway as needed
7. If patient does not respond to IN Versed (midazolam) in 5 minutes give IV or IM Versed dose per SOP.