Welcome to the Austin/Travis County EMS System Clinical Operating Guidelines Study Guide for System First Responders. The Study Guide is designed to walk/drag you through the COGs. The questions are sometimes very open ended so the correct answer may be a concept that is answered by a combination of areas i.e. Standards and Protocols in with some Procedures thrown in for good measure. We feel confident that if you use the Study Guide in preparation for recentialing/recredentialing you will be successful (hint, hint).

A few helpful thoughts: with multiple sections this document may seem overwhelming at first. Please remember that many of the items have not changed from the last COGs and should be review. For new members to the system most things are not terribly different than the national standards that you learned in school or practiced elsewhere so they should at least seem familiar. That said please don’t cram all your studying in at the last minute. Break the document down into sections and then break those down into a few pages at a time. You will find it much easier to digest and remember little chunks than a big document. Also realize that this is the first big revamp of the COGs we’ve had in some time so future changes should be limited and much less painful.

The practice of medicine is dynamic. “Lifelong learning” is not a trite phrase in EMS; it is a fact of life. There is always new evidence emerging which allows our practice to evolve and provide better care for the community we serve. The COG documents were not developed in a vacuum. We worked with almost all the organizations in the System as well as hospitals, physicians and other specialists in the field (not to mention reading hundreds of scientific studies) to put this document together. It is in place for the safety of the community we serve as well as to guide you as you operate in our community under our Medical Director’s license.

Contact us with any questions at: cogs@ci.austin.tx.us
Exam Goal and Objectives

Goal:
The goal of the System First Responder credentialing exam is to insure that providers in the Austin/Travis County Emergency Medical System (ATCEMS) are able to provide competent care at the System Provider level to patients requiring their services.

More specifically, this exam is designed to test the System First Responder candidate’s basic knowledge as well as his or her ability to apply the A/TCEMS Systems COGs.

Objective:
From memory, the candidate will be able to answer questions related to the A/TCEMS COGs (version 01.0.6.11) with at least 80% accuracy.

System First Responder Exam Description
The System First Responder COG Exam is a 25-question multiple-choice exam in Scantron format. There is a two-hour time limit for the System First Responder exam. It may be hand-scored or scored using a Scantron reader.
Exam Blueprint

About the Written Exam Blueprint

The purpose of an exam blueprint is to provide information and a “map” of the exam content to help better target study for the exam.

This blueprint includes:

- A list of the test question domains/cognitive levels and the number of each type for exam content
- A description of the types of exam questions

Cognitive Levels

**Knowledge Level:** this is general recall, low-level thinking required, considered “easy”

**Comprehension Level:** the test taker must infer causes and predict consequences, relatively low-level cognition, generally considered “easy”

**Application Level:** requires the test taker to use information provided to solve problems, considered “moderate” in difficulty.

**Analysis Level:** the test taker must use multiple concepts to critically think through a situation, generally considered “difficult”.
# System First Responder Exam Blueprint

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Under normal circumstances could a 17-year-old refuse care? Under what circumstances could he/she refuse care?

You respond to an automobile accident where two cars have collided in an intersection. There is considerable damage to both vehicles and both airbags have deployed. One driver is still in the car and the other is out of the car and insists that he is not injured although he has bruising to his face and small lacerations to his left arm. There were no passengers in either car. How many patients do you have on scene? Explain.

Describe the definition of a patient?

Who can refuse transport? Could a patient obviously working to breathe with significant signs and symptoms of hypoxia refuse treatment? What about a patient with a significant head injury? What if they are showing signs and symptoms of impairment because of alcohol or drug abuse?

If a patient tells you that they only want a nebulizer treatment for their asthma but do not want to go to the hospital would they still get treatment?

What is YOUR responsibility if a patient wants to refuse care? Can you give them a probable diagnosis?

If they refuse care what things must you include in your documentation?

Can you list the required items in your first responder kit that are required to be IMMEDIATELY at a patient’s side? Could you explain WHY each of the items is important to have immediately available?

Are you familiar with what to do if a piece of equipment fails while managing a patient?

Under what circumstances would a physician on scene not need to provide his/her Texas Medical Board License?

What would you do if a patient’s personal physician wants you to do something outside the System COGs?

What options does an intervener physician have if he or she wants to provide care for the patient? What if he/she disagrees with the online medical control? What responsibilities does this individual have if they do decide to provide care?

What is a “qualification”? How are qualifications different than credentials?

How are credentials different from certification or licensure? What, exactly, is credentialing? This will be revisited when we get to the “Appendix” section.

Can a non-credentialed, non-certified/licensed individual perform CPR and defibrillate a patient?

Who, on-scene, would have “credential seniority” to you? What would you do if you disagreed with a decision made on-scene by someone with more credential seniority than you? Who should you report to if you believe that the on-scene conflict negatively impacted patient care?
Under what circumstances might transfer of care from a higher credentialing level to a lower credentialing level? What things need to be considered before this happens? What kind(s) of patients at your level could you not care for?

You have a patient who doesn’t fit any of the protocols listed. What do you do?

What does that mysterious “Office of the Medical Director” do, anyway? Is it regulated by anyone else? What are the basic responsibilities of the OMD? You do not need to memorize these things, but be familiar with them.

What is a minimum score for successful passing of the protocol exam? What happens if you don’t pass the first time? Are you familiar with the process if you are not successful?

Once you are successful in your credentialing process you will be issued a badge. In addition to the OMD, what other organization requires a Provider to be “properly identified”?

What happens if a Provider within the System performs a procedure without being credentialed to do so?

What actions are listed that could/will cause credentials to be permanently revoked?

What would happen if your TDSHS certification or licensure were to lapse? What is your responsibility to the System if TDSHS were to take action against you for some reason?

What is a Medical Directive? Other than the OMD, who is responsible for disseminating Medical Directives?

What are the objectives of the Clinical Event Review Process? Are you familiar with what will happen during a Clinical Event Review? What is a Clinical Event? What items would be considered a “Level 1 Event” at your level? What about a “Level 2 Event”? How would you handle a Level 1 event? What is the primary difference between the handling of a Level 1 and a Level 2 event?

What can you do if you have a great idea for a clinical change in the System?

What conditions must be present in order to honor a DNR request and withhold CPR and ALS therapy? How may a DNR request be overridden?

Under what circumstances can you cease CPR/resuscitation efforts at your credential level?

Other than a DNR under what circumstances can a provider withhold CPR and ALS treatment?

If you arrive on scene and law enforcement prevents entry/access to the patient what should you do next? What do you do if you need to move/remove a weapon from a scene? If a patient is obviously deceased and a law enforcement officer asks you to cover the body what will you do? What else in the protocols do you think might be important for the general management of a crime scene?

Can you modify or cancel providers not already on-scene? If you are cancelled prior to arrival by another responder can you continue to the scene? Should you continue to the scene?

Are you a member of a Tier 1 or a Tier 2 organization? What’s the difference?

If a patient cannot afford an ambulance ride will an ambulance still transport them to a hospital?
Is it okay to package a pediatric patient for transport in their child seat if it was involved in a collision? If Mom wants to hold her baby in her lap on the way to the hospital is this okay? Although you may not be the person making transport decisions you are responsible (as is everyone in the system) for basic patient safety and packaging.

Under what circumstances could a patient be restrained? What documentation needs to be done for a patient being restrained? Can the spitting patient be restrained face-down? How often do extremities need to be checked if restrained? Can a handcuffed patient be transported without an officer in the back of the ambulance?

To whom do you report suspected child abuse or neglect? What assessment principles do you need to follow when evaluating your suspected child abuse patient? What procedures will you follow? What specifics do you need to document? Why would you not want to talk to law enforcement in front of the child’s caregiver? Should you confront the parent or caregiver with your suspicions? For bonus points what kinds of things would make you suspicious that your patient is being abused?

What is domestic violence? Specifically, what constitutes elder abuse? What assessment principles do you need to follow when evaluating the suspected abuse/violence patient? What “clues” would you look for to indicate abuse/violence/neglect towards the patient? What are some of the psychological characteristics of abuse? Who do you report your findings to?

An infant is left at the door of the station. Now what?

How would/should you contact the Poison Control Center (PCC)? Are you allowed to share patient information with PCC or is it a privacy violation?

Under what circumstances could you be downgraded from Code 3 to Code 1? Under what circumstances could you be upgraded from Code 1 to Code 3? Can an ambulance be diverted from a call? Under what circumstances? What happens if a provider comes across what appears to be a higher priority call on the way to another call (say going to a Priority 4 call you come upon an MVC with significant mechanism of injury)?

Is the expectation to take a complete set of vital signs on EVERY patient? What is the purpose of taking manual vs. mechanical vital signs? What do you do if the manual set is different from the mechanical set? What is included in a complete set of vital signs? When are palpated blood pressures acceptable? What do you do if a patient flat refuses to allow you to take their vital signs?

What does #1 under the “Documentation of the Patient Care Report Policy” state? Can you use abbreviations that you came up with on your own? What does “contain a detailed assessment of the nature of the patient’s complaints and the rationale for that assessment” mean? What do you document if you find something abnormal? What must you document before and after spinal motion restriction? Why? What must you document before and after splinting/limb immobilization? Why? Why is it important to list events in chronological order? What are you trying to do for the reader of your documentation? Why is this important?

Under what circumstances are alcohol-based hand cleaners and acceptable alternative to soap and water for hand washing? How long do you need to actually “wash” your hands for it to be effective? Do you need to cover scrapes and other wounds? Do you have to wear gloves for every patient? Under what circumstances would you add a mask and/or eye-shield? When should you wear a gown? Given a scenario
could you recognize when different types of PPE would be appropriate? What will an N95 mask protect you against? How about the mask and eye shield? If you have an exposure do you know what you need to do next? For example, what would you do if you were stuck by a needle on-scene?

**Protocols**

What are the minimum pieces of information that you need to get while gathering a patient history (for most patients)? What are the pieces of a “Primary Assessment”? “Secondary Assessment”? What differential topics do you need to consider? What is meant by the term “differential”? When given a scenario could you identify what you would need to do first? Under what circumstances would you assess the patient’s temperature? How often should you reassess a patient’s vital signs? What is the minimum exam for every patient?

Do you have to document the presence of equipment at the beginning of each shift? Do you have to have your OMD credentials on your person? What do you do if there is equipment failure while on scene? What do you do if there is an error, clinical misadventure or other adverse patient outcome on a call? Given a scenario would you know what the minimum amount of equipment would be needed at the patient’s bedside?

What would consist of “serious mechanism” in the SMR protocol? Given a scenario could you identify a patient who does/does not need SMR? Are you really familiar with the acronym to remember the steps for this protocol? For example, what does “A” stand for in this protocol? Is a “normal” exam sufficient to rule out spinal injury in all patient groups? Under what circumstances would you not assess range of motion?

What history do you need to acquire prior to pronouncement? What differentials do you need to consider with a deceased person (as there might be other protocols you will have to consider)? What are the criteria for withholding resuscitation? If you feel like you need law enforcement on scene how would you request them? When could/should you request victim services? If the patient meets criteria for “obvious death” or has a DNR can you cancel additional first responders?

What history should you acquire for a patient in cardiac arrest? What additional signs and symptoms would you look for? What things would you consider in your differential? Given a scenario could you pick what happens “next”?

Given a patient scenario where the patient has had a syncopal episode, what history/information should you gather? What signs and symptoms should you look for? What should you consider in your differential? What additional assessment procedures should you perform? Given a scenario could you determine whether or not to check for s/s of trauma as well?

What history should you acquire for a patient complaining of back pain? What additional signs and symptoms would you look for? What things would you consider in your differential? What is the recommended exam for this patient? What do you have to consider for patients over the age of 50?

What history do you need to gather for a patient complaining of abdominal pain (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? If your patient is a female of childbearing age what do you have to consider until proven otherwise? What do you have to consider for all patients over the age of 50 with abdominal pain?
What history do you need to gather for a patient complaining of nausea and/or vomiting (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What else do you need to check?

What history do you need to gather for a patient complaining of chest pain (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What medication(s) can you give? Do all patients with cardiac problems present with chest pain? If your patient has chest pain and a heart rate over 120 and HTN what else do you need to consider?

What, exactly, is considered: “Excited Delirium”? What history do you need to gather for a patient with excited delirium (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Who should assist you with restraints if at all possible? Can restrained patients be transported either supine or prone?

What history do you need to gather for a patient you think might be having a stroke (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential other than a stroke? Do you know the three steps to the Cincinnati Pre-Hospital Stroke Screen? Define “onset of symptoms” for the potential stroke patient. What other protocols should you consider with the potential stroke patient? Can you declare a “stroke alert” at your credentialing level? What is a stroke alert?

Given a scenario could you differentiate between an allergic reaction and anaphylaxis? What history do you need to gather for a patient with an allergic reaction (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? If the allergic reaction is from a bite or sting what else can you do for the site?

What history do you need to gather for a patient with an eye injury (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? If there is no obvious trauma what assessments do you need to do? If the eye is out of the socket how do you treat it? What if it is injured and still in the socket? Do you remove contact lenses? Why do you cover both eyes when only one is injured? Do you remove impaled objects?

What history do you need to gather for a patient with respiratory distress (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What do you do if their respiratory/ventilatory rate is insufficient? What do you do if you find rales or other s/s of CHF during your assessment? What do you know if you listen to lung sounds and don’t hear much of anything even though the patient is clearly working to breathe (silent chest)?

What is the minimum adult airway assessment? If the patient’s respiratory effort is insufficient what maneuvers/treatments will you try before an advanced airway? Given a scenario could you select the correct airway adjunct/treatment?

What history do you need to gather for a patient with an altered mental status (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Under what circumstances could you give oral glucose? How often can you repeat it? What are your patients on oral diabetic medication at risk for? Alcoholics frequently develop what? If the hypoglycemic patient returns to baseline and wants to refuse what do you do next? How would your treatment change if your patient was pediatric?
What history do you need to gather for a patient with a behavioral emergency (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What basic things could you do to help de-escalate these patients? See the same questions asked for your excited delirium patient.

What history do you need to gather for a patient with pulmonary edema (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What treatment options do you have for this patient?

What history do you need to gather for a patient with a seizure (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Why would you need to consider SMR? How would this treatment change if your patient was a pediatric patient?

What history do you need to gather for a patient with a bite/sting (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? If it is a snakebite do you have to bring the snake to the ED with you? How does insect bite/sting treatment differ from snakebite treatment? Are cat bites more infectious than other bites? Why is it good to know this? What is the number for poison control?

What history do you need to gather for a patient with fever (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What additional PPE do you need to consider? Given a scenario could you select the correct type of PPE? Would any of your differentials change if you were treating a pediatric patient? Any treatment changes?

What history do you need to gather for a patient with hyperthermia (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What is the difference between heat cramps, heat exhaustion and heat stroke? Are all patients equally susceptible to the heat? Which populations/conditions make them more likely to have heat-related problems? Given a scenario could you select the appropriate treatment plan? If you decide to cool the patient should you use cold water?

What history do you need to gather for a patient with hypothermia (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Why do you need to handle these patients very gently? How do you treat patients if you are unsure what their exact temperature is? How can you reheat the patient (based on your credential level)?

What history do you need to gather for a patient with hypotension (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? How would you position this patient? What is the definition of hypotension? Would your differential change if you were treating a pediatric patient? Would your treatment change if your patient was a pediatric patient?

What history do you need to gather for a patient with an organophosphate or nerve agent exposure (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Can you treat these patients before they have been decontaminated? If you have it, what can you give these patients via autoinjector? How many times can you administer this medication for a severe exposure?

What history do you need to gather for a patient with an overdose or toxic ingestion (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential?
differential? If the patient intentionally overdosed can you trust their account of what happened? What is the poison control number? Does your treatment change if you have a pediatric patient?

What history do you need to gather for a patient with a burn (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Given a scenario would you know how to treat a chemical burn vs. a thermal burn? Which burn patients also receive 100% oxygen? What other “issues” do you need to consider with your burn patient (complications, etc.)? Are their any other treatment plans or concerns if you are treating a pediatric patient?

What history do you need to gather for a patient with a constant crush injury (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Given a scenario could you determine which patients would be safe to approach and which would have to be rescued?

What history do you need to gather for a patient who has had a submersion event (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? At what point does a rescue turn into a recovery? Given a scenario would you be able to determine when to implement SMR? Why is it important for these patients to be transported?

What history do you need to gather for a patient who has had an extremity injury (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Would you know how to manage an amputation? What do you need to do before and after splinting? If the patient is pulseless in an angulated extremity what do you do? How quickly does a laceration need to be evaluated for repair (aka stitches)?

What history do you need to gather for an adult patient who has had an extremity injury (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? If the adult patient has evidence of brain herniation what rate should you ventilate at? How does this differ for a pediatric patient? What is included in a rapid trauma assessment? What things can you do to stabilize the patient? Given a scenario could you determine what patients should get extensive immobilization and bandaging and other interventions vs. immediate transport? What is permissive hypotension? Can you declare a trauma activation at your credential level? What else do you have to consider with geriatric and pediatric multiple trauma patients?

What history do you need to gather for an adult patient who has had multiple trauma (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What is included in a rapid trauma assessment? What things can you do to stabilize the patient? Given a scenario could you determine what patients should get extensive immobilization and bandaging and other interventions vs. immediate transport? What is permissive hypotension? Can you declare a trauma activation at your credential level? What else do you have to consider with geriatric and pediatric multiple trauma patients?

What history do you need to gather for an adult patient who has had a traumatic arrest (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Under what circumstances would you start CPR? Under what circumstances wouldn’t you start CPR?

Given a scenario could you appropriately rank patients using the START/Jump START Triage Algorithm?

What history do you need to gather for a neonate (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? Given a scenario
could you determine what should happen next? Which of the "pearls" would you think are really important to know? Which do you suction first, the mouth or nose? At what point to you begin CPR?

What history do you need to gather for a patient who has just given birth (in addition to the usual)? What other signs and symptoms do you need to consider? What things would you consider in your differential? What do you do if there is significant post-partum hemorrhage? What are the initial credentialing requirements for your credentialing level? What must you do to maintain your credentials?

What skills can you do at your credentialing level? What medications can you give and under what circumstances? These are covered in the "Protocols" section and this last statement is just a reminder that you are definitely responsible for information on the medications that you are allowed to give at your level.

Procedures

What is the universal sign of choking? How can you tell the difference between a mild and severe airway obstruction? How do you address a mild obstruction? How do you clear a severe obstruction for an infant? Child? Adult? What do you do if they suddenly become unresponsive?

What is included in the initial adult assessment? Who is considered an "adult" for assessment purposes (not refusal purposes)? What needs to be included in a secondary exam? How do you decide what you will assess for the focused assessment? What kinds of things would you check during an on-going assessment? What needs to be documented?

For assessment purposes, who is considered a "pediatric" patient? What is included in the Pediatric Assessment Triangle? Be specific. What is a Broselow-Luten Tape? Pediatric patients become __________ more quickly than adult patients. This needs to be remembered as pediatric patients cannot verbalize their own complaint so they should be _________________. What is the most common sign of compensated shock in children? How can you assess pediatric perfusion if it is not possible to obtain a BP?

How often do you need to do quality assurance checks on glucometers? What are the clinical indications to do a glucose assessment? What patients do you need to be cautious with when performing a glucose assessment? Where should you acquire a blood sample on a neonate or infant? What if your results don’t match the clinical presentation you’re seeing? What is a common cause of erroneous readings?

What are the clinical indications for the use of cricoid pressure? What are the contraindications? How do you perform this maneuver? What cautions do you need to be aware of before you perform this maneuver?

The call went out as an abdominal pain but you arrive and your patient is clearly getting ready to deliver a baby. Why do you need to try to slow the delivery of the infant if at all possible (and the answer is not to delay until the transport unit arrives…). What do you do if the umbilical cord is around the patient’s neck? How do you suction the infant’s airway (you may need to reference an old textbook for this one)? How do you manipulate the infant to facilitate delivery of the shoulders? What is the procedure for cutting the cord? When do you record the APGAR score? What do you do with the placenta when it delivers?

Why do you perform the Cincinnati Prehospital Stroke Scale? What are the three assessment techniques for the Cincinnati Prehospital Stroke Screen (CPSS)? What else do you need to check if you think that the patient is having a stroke? Do you have to do all three parts of the Screen? What factors need to be in place to declare a Stroke Alert?
When should initial triage of patients who have been contaminated happen? How do patients contaminated with liquids and some solids get decontaminated? Why doesn't this work for patients contaminated with gasses, vapors and powders? Why is harsh scrubbing not indicated?

If possible, who should assist you with restraining a patient? What five things do you need to consider when determining a patient’s capacity to make an informed decision (not including physical findings)? What physical findings could indicate a decreased capacity to make a good decision? What is our responsibility with this process?

What are the clinical indications for the use of an Impedance Threshold Device (ITD)? How do you use the ITD for a BLS airway? What about for an ALS airway? What is the light for? The use of the ITD should not interfere with what?

Use of the Kendrick Traction Device (KTD) should be limited to what kind of patients? What are the contraindications to the use of the KTD? What should you check before and after application of the KTD?

What are the clinical indications for performing orthostatic blood pressure measurement? How long do you wait between having a patient lying and sitting and checking the blood pressure and pulse? What changes are you looking for? When might you forego a formal orthostatic examination?

What is pain? How and when do you assess for and document pain? What three scales do we use and under what circumstances would you use each one?

What are the clinical indications for using a Pelvic Binder (also known as the SAM Sling ® or “Sling” here)? What are the contraindications for the Sling’s use? Under what circumstances can the Sling be removed?

What are the clinical indications for the use of pulse oximetry? Are there any contraindications to the use of pulse oximetry? What is considered a “normal” reading? If possible, how much oxygen should the patient be on for the initial reading? What circumstances/conditions could result in an inaccurate reading? If the patient is breathing fast is in obvious distress but the pulse ox reads 100% what do you do?

Who should receive a spinal examination? When you tell the patient what you are going to do what should you coach them to do? Where does the spinal exam begin (on the patient)? What are you checking for during your assessment? If the patient is totally pain free during the palpated assessment what do you ask them to do next? Which patients might you not be immobilizing using “standard” immobilization techniques?

Under what circumstances would you splint an extremity? What do you need to check before and after you splint? Why do you remove clothing and jewelry from the affected extremity? What do you do if there are no pulses when you check prior to splinting?

What are standard precautions? Under what circumstances do you wear gloves? When would you change your gloves? When would you wear a gown? What about mouth, nose and eye protection?

Who can apply a tourniquet? What kind of patient/injury would you place a tourniquet on? What contraindications are there to the use of a tourniquet? How do you know when the tourniquet is tight enough?

How can most bleeding be controlled? Under what circumstances would you not irrigate contaminated wounds? What do you need to check before and after bandaging?
Clinical Reference

There is no “study guide” for the clinical reference section. These things are designed for you to refer to while you are on scene. Be familiar with the tools that are available to you.

Appendices (not covered elsewhere)

Appendix 1 is a list of approved abbreviations. We’re not going to ask you dozens of questions on abbreviations here in a study guide. One of the best ways to learn abbreviations or definitions is using flash-cards. Common abbreviations are fair game for use in test questions on credentialing exams so be familiar with them. That said the exam will not be peppered with obscure abbreviations just to trick you.

You absolutely, positively need to be aware of the information in Appendix 6 which is the clinical event review process. Why? Because everyone is terrified of these and they’re simply designed to look at problems that have occurred, figure out why they occurred and make sure they do not happen again. It is necessary for us to grow and improve as a system. It is required so that we have a better legal leg to stand on if a problem arises. It is not punitive except under a few, rare circumstances. You should know exactly what those are and think, “Gee, I’d never do that” and so be reassured that you’ll be okay. Errors will happen. What we do with them afterwards helps define us as a system and improve from those mistakes.

Appendix 7 is a reference for suspected child abuse and is more thorough than the information back in Procedures Read through this and be familiar with it but the specifics you have to know were covered back in Procedures.

Appendix 8 is dedicated to vital signs and terminology. Yes, you need to know this.

Formulary

For every drug that you can give, or assist with, at your level you need to know:

1. How it works (generally)
2. Given a scenario be able to identify whether or not use of that drug is appropriate
3. Contraindications to the use of the drug.
4. Doses
5. Any other “pearls” regarding the medication such as end points for administration, when you would use one vs. another if they basically do the same thing (like acetaminophen vs. ibuprofen).