

Ventilatory Management

(Adult, Supraglottic Airway Device, and Pediatric)

Essay to Skill Examiners

Thank you for serving as a Skill Examiner at today's examination. Before you read this essay for the skill you will be evaluating today, please review your general responsibilities as a Skill Examiner below:

- Conducting examination-related activities on an equal basis for all candidates, paying particular attention to eliminate actual or perceived discrimination based on race, color, national origin, religion, gender, age, disability, position within the local EMS system, or any other potential discriminating factors. The Skill Examiner must help ensure that the EMT Assistant and/or Simulated Patient conduct himself/herself in a similar manner throughout the examination.
- Objectively observing and recording each candidate's performance
- Acting in a professional, unbiased, non-discriminating manner, being cautious to avoid any perceived harassment of any candidate
- Providing consistent and specific instructions to each candidate by reading the "Instructions to the Psychomotor Skills Candidate" exactly as printed in the material provided by the National Registry. Skill Examiners must limit conversation with candidates to the communication of instructions and answering of questions. All Skill Examiners must avoid social conversation with candidates or making comments on a candidate's performance.
- Recording, totaling, and documenting all performances as required on all skill evaluation forms
- Thoroughly reading the specific essay for the assigned skill before actual evaluation begins
- Checking all equipment, props, and moulage prior to and during the examination
- Briefing any Simulated Patient and EMT Assistant for the assigned skill
- Assuring professional conduct of all personnel involved with the particular skill throughout the examination
- Maintaining the security of all issued examination material during the examination and ensuring the return of all material to the National Registry Representative

These sequential skills are designed to evaluate a candidate's ability to provide ventilatory assistance to an apneic patient with a palpable central pulse and no other associated injuries. Today you could be evaluating candidates who were trained over several different education standards and have different scopes of practice. You must determine the level at which each candidate is testing before beginning his/her actual evaluation so that you do not mistakenly evaluate a candidate over a skill that he/she may not have been trained. The instructions you read to the candidate will assist you in determining his/her level of training and which skills to evaluate today. The evaluations you conduct today may include:

1. **Advanced EMT (AEMT) candidates** only complete one adult scenario and are only authorized to place a supraglottic airway device.
2. **Intermediate/99 candidates** must complete two separate adult scenarios:
 - a. Endotracheal intubation of the apneic adult patient
 - b. Insertion of a supraglottic airway device into an apneic adult patient
3. **Advanced EMT (AEMT) candidates** also complete a Pediatric Respiratory Compromise scenario that the Examination Coordinator may or may not have chosen to set up in your room today.
4. **Intermediate/99 candidates** also complete a Pediatric Ventilatory Management scenario which also includes endotracheal intubation that the Examination Coordinator may or may not have chosen to set up in your room today.

For the purposes of this evaluation, the cervical spine is intact and cervical precautions are **not** necessary. These skills were developed to simulate a realistic situation where an apneic patient with a palpable

pulse is found supine on the floor. **The adult manikin must be placed and left on the floor for these skills.** Bystander ventilations have not been initiated. A two minute time period is provided for the candidate to check and prepare any equipment he/she feels necessary before the actual timed evaluation begins.

When the actual timed evaluation begins, the candidate must immediately open the patient's airway and initiate ventilation using a BVM device unattached to supplemental oxygen. The candidate may choose to set up the reservoir and attach supplemental oxygen to the BVM device prior to establishing a patent airway and ventilating the patient. **Regardless of the candidate's initial ventilatory assistance (either with room air or supplemental oxygen attached), ventilation must be initiated within the 30 seconds after taking appropriate PPE precautions or the candidate has failed to ventilate an apneic patient.**

It is acceptable to insert a simple airway adjunct prior to ventilating the patient with either room air or supplemental oxygen. You must inform the candidate that no gag reflex is present when he/she inserts the oropharyngeal airway.

After the candidate ventilates the patient for a minimum of 30 seconds, you must inform the candidate that ventilation is being performed without difficulty. The candidate should call for integration of supplemental oxygen at this point in the procedure (if it was not attached to the BVM initially). After supplemental oxygen has been attached, the candidate must ventilate the patient at a rate of 10 – 12 ventilations/minute (1 ventilation every 5 – 6 seconds) with adequate volumes of oxygen-enriched air. It is required that an oxygen reservoir (or collector) be attached. Should the candidate connect the oxygen without such a reservoir or in such a way as to bypass its function, he/she will have failed to provide a high percentage (at least 85%) of supplemental oxygen. You must mark the related statement under "Critical Criteria" and document his/her actions. Determination of ventilation volumes is dependent on your observations of technique and the manikin's response to ventilation attempts. Ideally, these volumes range between 500 – 600 mL (6 – 7 mL/kg), but specific and accurate measurements of these volumes are quite difficult with the intubation manikins currently available. If two or more rooms are set up and one is using a disposable BVM, be sure to leave the mask and reservoir attached to all the non-disposable BVMs throughout the examination. To assist in containing costs of the practical examination, the oxygen tank used may be empty. The candidate must be advised to act as if the oxygen tank were full. However, the supplemental oxygen tubing, regulator, BVM, and reservoir should be in working order.

After the candidate ventilates the patient with supplemental oxygen for at least 30 seconds, you must automatically auscultate breath sounds. Inform the candidate that breath sounds are present and equal bilaterally and medical control has ordered:

1. Placement of a supraglottic airway device of the candidate's choosing
2. Endotracheal intubation

Therefore, each Intermediate/99 candidate will complete the adult scenario twice as if treating two separate patients, once using a supraglottic airway device of the candidate's choosing and the second time performing endotracheal intubation (ET). Advanced EMT candidates will only complete the adult scenario once using a supraglottic airway device of the candidate's choosing. Be sure to document the supraglottic airway utilized by noting the specific device the candidate chooses on the evaluation form. This will also help clarify any performance documentation at a later time if necessary.

You must then take over ventilation while the candidate prepares all intubation or other supraglottic airway device equipment. When the candidate is prepared to insert the airway and instructs you to move, you must also remove the oropharyngeal airway (nasopharyngeal airways may be left in place). The candidate has only three attempts to successfully intubate the patient (ET) or place the supraglottic airway device. An "attempt" for this examination is defined as introduction of the laryngoscope blade or the supraglottic airway device into the manikin's mouth regardless of trying to pass the tube or not. Throughout these attempts, ventilation may **not** be interrupted for more than 30 seconds.

Verification of endotracheal tube placement must be performed immediately after the cuff is inflated and the syringe is removed from the pilot bulb. The supraglottic airway devices will be discussed later in this essay. As soon as the candidate verifies tube placement, you must verify his/her knowledge of proper tube placement by asking, "How would you confirm that the tube has been correctly placed?" The candidate's response must include chest rise and auscultation over both the epigastrium and lungs bilaterally. Ask what the candidate should expect to hear over each if placement is correct. The candidate should also state that he/she would be checking for condensation to periodically collect inside of the endotracheal tube. Other secondary methods of confirming proper endotracheal tube placement, such as capnometry, esophageal detection device (EDD), or a colorimetric device may also be utilized. However, continuous quantitative waveform capnography is now recommended for intubated patients as it serves as the most reliable method of confirming and monitoring correct placement of an endotracheal tube. It is clearly superior to all other secondary means of endotracheal tube placement confirmation. Any omitted or inappropriate response to the related questions concerning endotracheal tube placement verification must be documented under "Critical Criteria" and the point for verifying proper placement must be deducted.

To assist in controlling costs of the practical examination, it is acceptable to have the candidate explain how he/she would secure the ET tube rather than actually taping and securing the tube to the manikin. You must also ask the candidate, "How would you know if you are delivering appropriate volumes with each ventilation?" If not already accomplished, at that point the candidate should attach waveform capnography and verbalize what he/she would observe to verify proper tube placement and adequate ventilation. If the candidate attaches a colorimetric device, ask him/her to describe the color changes of the indicator that would represent proper tube placement and adequate ventilation.

Each candidate who places an endotracheal tube will also have to demonstrate tracheal suctioning. After the endotracheal tube has been secured and its placement confirmed, you should state, "You see secretions in the tube and hear gurgling sounds with the patient's exhalation." The candidate should then prepare the suction equipment. The candidate should estimate and mark the maximum insertion length of the catheter and direct you to stop ventilation of the patient. The candidate should insert the catheter to the correct depth with the whistle stop port open and suction not being applied. The port should then be occluded, and the catheter withdrawn slowly as suction is applied. The patient should not be excessively suctioned and should be immediately ventilated after being suctioned. Before suctioning the patient again, the catheter should be flushed with sterile water or saline. Please recall that endotracheal suctioning should be a sterile technique and the candidate should state that as he/she performs the skill. If the candidate excessively suctioned the patient, you should state, "The patient's SpO₂ has dropped to 92%." If the candidate continues to suction the patient, mark the appropriate statement under "Critical Criteria" and document the candidate's actions as required. To help contain costs of the examination, the use of sterile gloves and performance of the skill in a sterile field are not required. A container of tap water may be used to simulate the use of sterile water or saline during this procedure.

Throughout these skills, the candidate should take or verbalize appropriate PPE precautions. At a minimum, examination gloves must be provided as part of the equipment available in the room. Masks, gowns, and eyewear may be added to the equipment for these skills but are not required for evaluation purposes. If the candidate does not protect himself/herself with at least gloves or attempts direct mouth-to-mouth ventilation, appropriate PPE precautions have not been taken. Should this occur, mark the appropriate statement under "Critical Criteria" and document the candidate's actions as required.

Key Information on Supraglottic Airway Devices

Proper evaluation requires that the Skill Examiner be fluent in the proper use of each piece of equipment that could be used in these skills. Be sure that you review all related information for these devices before you begin evaluation of the candidates and insert each device to help ensure that all equipment is in proper working order, the manikin is compatible with insertion of each device, and you are familiar with the appropriate use of each device.

The device selected must be properly inserted, secured and placement appropriately verified.

Pediatric Ventilatory Management

Only Intermediate/99 candidates complete this skill. These sequential skills are designed to test a candidate's ability to provide ventilatory assistance to an apneic infant with a palpable brachial pulse and no other associated injuries. For the purposes of these testing skills, the cervical spine is intact and cervical precautions are **not** necessary. This skill was developed to simulate a realistic situation where an apneic infant with a palpable pulse is found. Bystander ventilations have not been initiated. A two minute time period is provided for the candidate to check and prepare any equipment he/she feels necessary before the actual timed evaluation begins. An array of appropriate equipment is essential for these skills. You must ensure that pediatric (BVM) devices, oropharyngeal and nasopharyngeal airways, laryngoscope blades, and uncuffed endotracheal tubes (sizes 3.0 – 5.0) are available and work adequately throughout the examination. The choice of appropriate equipment is essential when assisting ventilation in the infant. Using an oropharyngeal airway that is too large may obstruct the airway or displace the tongue in the pharynx, resulting in obstruction. The BVM device must be of appropriate size to provide an adequate mask seal and not over-inflate the lungs.

When the actual timed evaluation begins, the candidate must immediately open the patient's airway and initiate ventilations using a BVM unattached to supplemental oxygen. The candidate may set up the reservoir and attach supplemental oxygen to the BVM device prior to establishing a patent airway and ventilating the patient. **Regardless of the candidate's initial ventilatory assistance (either with room air or supplemental oxygen attached), ventilation must be initiated within 30 seconds after taking appropriate PPE precautions or the candidate has failed to ventilate an apneic patient.**

In children less than two years of age, padding may need to be placed under the scapulae to properly position the head in a neutral or sniffing position. If you are using a manikin where it is not possible to demonstrate elevation of the upper torso, **simply ask the candidate to describe how he/she would place a live infant in a neutral or sniffing position.**

It is acceptable to insert a simple airway adjunct prior to ventilating the patient with either room air or supplemental oxygen. [It is currently acceptable to insert the oropharyngeal airway using a tongue blade and following the natural curvature of the oropharynx. If a tongue blade is not available, it is acceptable to insert the oropharyngeal airway with the tip toward the roof of the mouth and curve of the adjunct pressing on the tongue, then rotating the adjunct 180° into the correct position. The adjunct should not scrape the palate (**see PEPP**).] You must inform the candidate that no gag reflex is present when he/she inserts the oropharyngeal airway.

After the candidate ventilates the patient for a minimum of 30 seconds, you must inform the candidate that ventilation is being performed without difficulty. The candidate should call for integration of supplemental oxygen at this point in the procedure (if it was not attached to the BVM initially). After supplemental oxygen has been attached, the candidate must ventilate the patient at a rate of 12 – 20 ventilations/minute (1 ventilation every 3 – 5 seconds) with adequate volumes of oxygen-enriched air. It is required that an oxygen reservoir (or collector) be attached. Should the candidate connect the oxygen without such a reservoir or in such a way as to bypass its function, he/she will have failed to provide a high percentage (at least 85%) of supplemental oxygen. You must mark the related statement under "Critical Criteria" and document his/her

actions. Determination of ventilation volumes is dependent on your observations of technique and the manikin's response to ventilation attempts. Ideally, these volumes should be sufficient to cause visible chest expansion and air movement in and out of the lungs. Specific and accurate measurements of these volumes are quite difficult with the intubation manikins currently available. If two or more rooms are set up and one is using a disposable BVM, be sure to leave the mask and reservoir attached to all the non-disposable BVMs throughout the examination. To assist in containing costs of the practical examination, the oxygen tank used may be empty. The candidate must be advised to act as if the oxygen tank were full. However, the supplemental oxygen tubing, regulator, BVM, and reservoir should be in working order.

After the candidate ventilates the patient with supplemental oxygen for at least 30 seconds, you must automatically auscultate breath sounds. Inform the candidate that breath sounds are present and equal bilaterally and medical control has ordered endotracheal intubation. You must then take over ventilation while the candidate prepares all intubation equipment. When the candidate is prepared to insert the airway and instructs you to move, you must also remove the oropharyngeal airway (nasopharyngeal airways may be left in place). The candidate has only three attempts to successfully intubate the infant. An "attempt" for this examination is defined as introduction of the laryngoscope blade into the manikin's mouth regardless of trying to pass the tube or not. Throughout these attempts, ventilation may **not** be interrupted for more than 30 seconds. The candidate must recognize the need for re-oxygenation of the patient and order you to re-oxygenate the patient. At this point, you may only ventilate the patient upon the candidate's command and must document any interruption in ventilation for more than 30 seconds under "Critical Criteria" on the evaluation form. Do not stop the candidate's performance if he/she exceeds this 30 second maximum time-limit on any attempt but document the ventilation delay as required.

The infant's head should not be excessively flexed during intubation, but rather placed in a neutral or sniffing position by placing padding under the scapulae. The straight (Miller) laryngoscope blade may be preferred for infant intubation over the curved (Macintosh) blade. Uncuffed endotracheal tubes must be used in the infant. Once inserted, the uncuffed tube seals in the narrowing trachea just distal to the cricoid cartilage.

It is essential that tube placement be confirmed immediately after the tube is inserted. As soon as the candidate verifies tube placement, you must verify his/her knowledge of proper tube placement by asking, "How would you confirm that the tube has been correctly placed?" The candidate's response must include visualizing chest rise and auscultation over both the epigastrium and lungs bilaterally. Breath sounds should be assessed in the upper and lower fields as well as auscultation over the epigastrium. The candidate should also observe the rise and fall of the chest with each ventilation and look for condensation in the tube. Any omitted or inappropriate response to these questions must be documented under "Critical Criteria" and the point for confirming proper placement must be deducted. The use of an end-tidal CO₂ detection device is not required in the infant portion of these skills. To assist in controlling costs of the practical examination, it is acceptable to have the candidate explain how he/she would secure the ET tube rather than actually taping and securing the tube to the manikin.

Throughout these skills, the candidate should take or verbalize appropriate PPE precautions. At a minimum, examination gloves must be provided as part of the equipment available in these skills. If the candidate does not protect himself/herself with at least gloves or attempts direct mouth-to-mouth ventilation, appropriate PPE precautions have not been taken. Should this occur, mark the appropriate statement under "Critical Criteria" and document the candidate's actions as required.

Pediatric Respiratory Compromise

Only Advanced EMT candidates complete this skill. This skill may be set up and tested in a separate Pediatric Skills area or incorporated into the other Ventilatory Management skills as the Examination Coordinator chooses. These sequential skills are designed to test a candidate's ability to provide ventilatory assistance to a one year old child who progresses from respiratory distress to respiratory failure. For the purposes of these testing skills, no spinal injury is suspected, and spinal immobilization precautions are **not** necessary. This skill was developed to simulate a realistic situation where a one year old child in respiratory distress is found sitting in his mother's lap. No bystander interventions have been initiated. An array of appropriate equipment is essential for these skills. You must ensure that an appropriate volume/size pediatric BVM device, oropharyngeal and nasopharyngeal airways, pediatric oxygen adjuncts (simple face mask, non-rebreather face mask), pulse oximeter, and capnography/capnometry (waveform or colorimetric) are available and work adequately throughout the examination. The choice of appropriate equipment is essential when assisting ventilation in the pediatric patient who is experiencing respiratory distress or failure. Using an oropharyngeal airway that is too large may obstruct the airway or displace the tongue in the pharynx, resulting in obstruction. The BVM device must be of appropriate size to provide an adequate mask seal and not over-inflate the lungs. If two or more rooms are set up and one is using a disposable BVM, be sure to leave the mask and reservoir attached to all the non-disposable BVMs throughout the examination. To assist in containing costs of the practical examination, the oxygen tank used may be empty. The candidate must be advised to act as if the oxygen tank were full. However, the supplemental oxygen tubing, regulator, BVM, and reservoir should be in working order.

When the actual timed evaluation begins, the candidate must begin to assess the patient who initially presents sitting upright in his mother's lap with signs of respiratory distress. The candidate should form a general impression of the patient's condition by observing the patient and his interaction with the mother and the environment. These assessments should be accomplished without approaching or touching the patient to avoid upsetting the child which could worsen respiratory distress and hasten the progression to respiratory failure. You should inform the candidate that the child is alert but anxious and is being consoled by his mother. The child should present with a 2 – 3 day history of recent upper respiratory infection and low-grade fever. The symptoms have worsened over the past four hours which caused the parents to call 9-1-1. The candidate should continue to assess the child from a distance, looking for secretions, drooling, and signs of foreign body airway obstruction as well as listening for audible noises. The candidate should be informed that he/she observes increased work of breathing with retractions and hears audible grunting. The initial respiratory rate is 60 breaths/minute.

As the candidate begins his/her primary survey and initial treatment with supplemental oxygen, you should report that the initial SpO₂ is 82% on room air. The candidate should leave the child in his mother's lap while coaching the mother to assist with administration of blow-by oxygen for her child. At this point, you should provide signs of a patient who is progressing from respiratory distress to respiratory failure. The child should become drowsy and the head should begin bobbing. Despite a few minutes of supplemental oxygen administration, the hemoglobin saturation does not increase appreciably. The candidate should observe see-saw respirations and the pulse rate begins to decrease. You should also describe signs of a decreasing level of responsiveness, such as drowsiness, lethargy and eventually unresponsiveness.

It is imperative that the candidate recognizes the signs of a worsening patient and immediately begins effective ventilation of the child. Supplemental oxygen delivery should be discontinued at this point and the patient should be removed from his mother's lap and placed in the supine position. Padding must be placed under the scapulae to properly position the head in a neutral or sniffing position in children less than two years of age. If you are using a manikin where it is not possible to demonstrate elevation of the upper torso, simply ask the candidate to describe how he/she would place a one year old child in a neutral or sniffing position. The candidate should assess the child's airway and consider insertion of a nasopharyngeal or oropharyngeal airway.

[It is currently acceptable to insert the oropharyngeal airway using a tongue blade and following the natural curvature of the oropharynx. If a tongue blade is not available, it is acceptable to insert the oropharyngeal airway with the tip toward the roof of the mouth and curve of the adjunct pressing on the tongue, then rotating the adjunct 180° into the correct position. The adjunct should not scrape the palate (see PEPP).] After advising the candidate that the adjunct was accepted without difficulty, you should inform the candidate that the patient is breathing at a rate of 20/minute. An appropriately sized BVM device should be chosen and immediately attached to the oxygen regulator flowing at 12 – 15 L/minute. While maintaining the head in a neutral or sniffing position, a tight mask seal should be obtained, and assisted ventilations should be initiated. Be sure to time the candidate for at least 1 minute and count the ventilations delivered. If the candidate does not ventilate the manikin at a rate of 12 – 20/minute (1 ventilation every 3 – 5 seconds), be sure to mark the related "Critical Criteria" and document the exact rate that you observed. Determination of ventilation volumes is dependent on your observations of technique and the manikin's response to ventilation attempts. Remember that each ventilation should be sufficient to cause visible chest rise in a real patient. If the candidate does not explain how he/she would assess the effectiveness of ventilations, you should ask him/her, "How would you know if you are ventilating the patient properly?" No more than two ventilatory volume errors in a one minute time period are acceptable. You should document any incorrect responses concerning the ventilatory rate and/or tidal volume and check any related "Critical Criteria" statements if necessary.

Throughout these skills, the candidate should take or verbalize appropriate PPE precautions. At a minimum, examination gloves must be provided as part of the equipment available in these skills. If the candidate does not protect himself/herself with at least gloves or attempts direct mouth-to-mouth ventilation, appropriate PPE precautions have not been taken. Should this occur, mark the appropriate statement under "Critical Criteria" and document the candidate's actions as required.

Equipment List

Do not open these skills for testing until the following equipment is available. If the Pediatric Ventilatory Management skill is being evaluated in a separate Pediatric Skills area, disregard all pediatric equipment in the following list. You must ensure that all equipment is working adequately throughout the examination. All equipment must be disassembled (reservoir disconnected, and oxygen supply tubing disconnected when using only non-disposable equipment, regulator turned off, laryngoscope disassembled, cuffs deflated with syringes disconnected, etc.) before accepting a candidate for evaluation:

- Examination gloves (may also add masks, gowns, and eyewear)
- Intubation manikins (infant and adult)
- Pediatric/Infant manikin (approximate size of a one year old child)
- Laryngoscope handle and blades (straight and curved – infant and adult)
- Endotracheal tubes (3.0 – 8.5 mm)
- End-tidal CO₂ detector and/or esophageal detector device (EDD)
- Syringes (10 mL, 20 mL, 35 mL, etc.)
- Stylette
- Bag-valve-mask device with reservoir (infant and adult)
- Oxygen cylinder with regulator (may be empty)
- Oxygen connecting tubing
- Selection of oropharyngeal airways (infant and adult)
- Selection of nasopharyngeal airways (infant and adult)
- Various supplemental oxygen devices (nasal cannula, non-rebreather mask with reservoir, etc. for infant and adult)
- Suction device with rigid and flexible catheters and appropriate suction tubing
- Sterile water or saline
- Supraglottic airway
- Stethoscope
- Lubricant
- 1/2" tape
- Spare batteries
- Tongue blade
- Towel or other appropriate padding

The Skill Examiner reads the following instructions to all Intermediate/99 candidates:

Instructions to the Psychomotor Skills Candidate Ventilatory Management – Adult

Welcome to the Ventilatory Management skills. These progressive skills are designed to evaluate your ability to provide immediate and aggressive ventilatory assistance to an apneic adult patient who has no other associated injuries. This is a non-trauma situation and cervical precautions are not necessary. You are required to demonstrate sequentially all procedures you would perform, from simple maneuvers and adjuncts to endotracheal intubation. You will have three attempts to successfully intubate the manikin. You must actually ventilate the manikin for at least 30 seconds with each adjunct and procedure utilized. I will serve as your trained assistant and will be interacting with you throughout these skills. I will correctly carry-out your orders upon your direction. Do you have any questions?

At this time, please take two minutes to check your equipment and prepare whatever you feel is necessary.

[After two minutes or sooner if the candidate states, "I'm prepared," the Skill Examiner continues reading the following:]

-Upon your arrival to the scene, you observe the patient as he/she goes into respiratory arrest and becomes unresponsive. A palpable carotid pulse is still present. Bystander ventilations have **not** been initiated. The scene is safe, and no hemorrhage or other immediate problem is found.

The Skill Examiner reads the following instructions to all Advanced EMT and Intermediate/99 candidates who must also complete the Supraglottic Airway Device Skill:

Instructions to the psychomotor skills candidate. Ventilatory management – supraglottic airway device.

These progressive skills are designed to evaluate your ability to provide immediate and aggressive ventilatory assistance to an apneic adult patient who has no other associated injuries. This is a non-trauma situation and cervical precautions are not necessary. You are required to demonstrate sequentially all procedures you would perform, from simple maneuvers and adjuncts to placement of a supraglottic airway device of your choosing.

Note: skill examiner now begins to fill out appropriate form and documents which supraglottic airway device the candidate chooses.

You will have three attempts to successfully place the supraglottic airway device. You must actually ventilate the manikin for at least 30 seconds with each adjunct and procedure utilized. I will serve as your trained assistant and will be interacting with you throughout these skills. I will correctly carry-out your orders upon your direction. Do you have any questions?

At this time, please take two minutes to check your equipment and prepare whatever you feel is necessary.

[After two minutes or sooner if the candidate states, "I'm prepared," the Skill Examiner continues reading the following:]

-Upon your arrival to the scene, you observe the patient as he/she goes into respiratory arrest and becomes unresponsive. A palpable carotid pulse is still present. Bystander ventilations have **not** been initiated. The scene is safe, and no hemorrhage or other immediate problem is found.

The Skill Examiner reads the following instructions to all Intermediate/99 candidates who must complete the Pediatric Ventilatory Management Skill if it has been set up in your room and not in a separate Pediatric Skills area:

Instructions to the Psychomotor Skills Candidate Pediatric Ventilatory Management

Since you are testing at the [Intermediate/99] level today, these progressive skills are designed to evaluate your ability to provide immediate and aggressive ventilatory assistance to an apneic infant who has no other associated injuries. This is a non-trauma situation and cervical precautions are not necessary. You are required to demonstrate sequentially all procedures you would perform, from simple maneuvers and adjuncts to endotracheal intubation. You will have three attempts to successfully intubate the manikin. You must actually ventilate the manikin for at least 30 seconds with each adjunct and procedure utilized. I will serve as your trained assistant and will be interacting with you throughout these skills. I will correctly carryout your orders upon your direction. Do you have any questions?

At this time, please take two minutes to check your equipment and prepare whatever you feel is necessary.

[After two minutes or sooner if the candidate states, "I'm prepared," the Skill Examiner continues reading the following:]

-Upon your arrival to the scene, you observe the infant as he/she goes into respiratory arrest and becomes unresponsive. A palpable brachial pulse of 106 is still present. Bystander ventilations have **not** been initiated. The scene is safe, and no hemorrhage or other immediate problem is found.

The Skill Examiner reads the following instructions to all Advanced EMT candidates who must also complete the Pediatric Respiratory Compromise Skill if it has been set up in your room and not in a separate Pediatric Skills area:

Instructions to the Psychomotor Skills Candidate Pediatric Respiratory Compromise

Since you are testing at the Advanced EMT level today, these progressive skills are designed to evaluate your ability to provide immediate and aggressive ventilatory assistance to a one year old child in respiratory distress. No other associated injuries are present. This is a non-trauma situation and cervical precautions are not necessary. You must actually perform all assessments and interventions that you feel are necessary. If you choose to ventilate the manikin with a bag-valve-mask (BVM) device, you must do so for at least one minute. I will serve as your trained assistant and will be interacting with you throughout these skills. I will correctly carryout your orders upon your direction. Do you have any questions?

At this time, please take two minutes to check your equipment and prepare whatever you feel is necessary.

[After two minutes or sooner if the candidate states, "I'm prepared," the Skill Examiner continues reading the following:]

You respond to a residence for a sick child who is having difficulty breathing. The scene is safe, and no hemorrhage or other immediate problem is found. As you enter the residence, you see a one year old child sitting on his mother's lap.