Ladder Up: 10 Rungs For Successful EMS Basic Training

By S. CHRISTOPHER SUPRUN

The new guy just graduated paramedic school a month ago, took his test and has his brand new shiny patch. He also just got assigned to you for field training so he can be cleared to practice in your jurisdiction. What are your responsibilities to help bridge the gap between the book and the street? How are you going to do it? Here are 10 thoughts to create a ladder of success for your new partner and to make you a better field training officer.

Note that most of these apply predominantly to department members who have finished their training but are still being evaluated to determine if they have the skills, knowledge and decision-making tools to practice at a given level. They can, however, also be applied to EMS students who are doing ride-outs or field evaluations to obtain street experience.

The First Steps

As in our everyday patient care, **Rung One** of being a successful field training officer means emphasizing that we will do the right thing for the patient. While it sounds elementary enough, it is easy to let our protocols, trucks and fancy equipment distract us from this basic mission.

It cannot be overemphasized that the patient must be taken care of both physically, with our vast array of monitors, medicines, and widgets, and emotionally. Starting your student off with an early reminder of this important point may save you from problems later.

In his article about mentoring the gamer generation (*fireEMS*, March 2005), Darryl Cleveland noted that he had to sit down with one of his students not because he was providing poor care, but because his student did not seem to connect with his patients. He was not able to empathize with them or care for their nonmedical issues. Although this working-with-people approach is taught very little in any EMS school, the field training process is an important place to bridge this gap.

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It also leads to **Rung Two**. Early on in the evaluation process, you and your trainee should have a basic conversation about expectations, roles and responsibilities. It is important for students to know what standard they are being judged against, where they will fit in on your established team and what they are expected to do. In most situations, new squad members are not expected to run an entire call by themselves but work up to it. Your situation might differ, though, and students should know what and where they fit in.

Rung Three: Set a positive example. One FTO recently told me that he likes having students because it means he gets out of doing documentation and cleaning the ambulance in the afternoon. Being a FTO, however, means that you don't lose responsibility, you gain it.

Perhaps my best FTO started every shift not only by checking out her bags but also scrubbing the ambulance interior with disinfectant. It seems pretty straightforward now to provide this protection to the patient, but no other crew I know of was nearly as consistent. Without question, the reason I have a bottle of spray disinfectant and a rag in my hand when I start my shift is because of my FTO Tina, when I was a volunteer paramedic in North Central Virginia.

Her example transcended cleaning the ambulance. Her detail to the rig was nothing compared to her patient care, but one leads to the other. If you want to dodge work and would rather watch the soaps or play Xbox, you should probably skip being a field training officer.

Rung Four is a warning about war stories. War stories certainly have their place in EMS, but use them carefully. Entertaining as they are, those tales usually involve extraordinary things that don't reflect the day-to-day job. It is important for the FTO to remember that students who come out of EMS programs, no matter how well they do on their certification test, still need reinforcement on the basics. War stories themselves should be used after calls to reinforce basics, not cause confusion.

The other problem with war stories is their overuse. One EMS instructor told so many war stories in class and labs that almost nothing else ever happened. This instructor was a former medic from the streets of Pittsburgh and certainly had some great experiences from a premier EMS system. However, he used so many stories that many of his students knew where to eat in Pittsburgh. While this is useful for medics in Pittsburgh, it didn't help medics learn good patient-assessment skills.

Rung Five: Know what you need to know. It is safe to say medic school has changed greatly in the last decade or two. If you are an older EMS provider, especially helping more recent students, make sure you know what you need to know.

When I was grading a recent evaluation test I gave a group of medics, one of the cardiac rhythms I included was a second-degree heart block. I know that AV blocks can give medics difficulty, but one of the students in the class, an FTO, returned his answer sheet with the answer "Junctional SVT." Needless to say, blocks were not nearly as important to me as trying to figure out why any medic, much less a FTO, did not understand impulse transmission and pathways.

The important issue here for the FTO is to know basic EMS from both a textbook and street perspective forward, backward, right, left, and upside down. The answer "junctional SVT" to a student not only would cause confusion but also would lead to credibility issues later. Correct your educational issues before this comes up. Take a refresher class, sit in on some initial education classes on topics you feel weak or attend a conference such as the Fire Department Instructor's Conference in Indianapolis.

Dealing with mistakes

Mistakes happen and are a huge issue. They are so important that they require two rungs to discuss.

As an FTO, you will need to determine your own comfort level for students caring for your patients. Without becoming lazy or uninvolved, it is important for the new bird to venture out a bit and learn to become a medic. For this to happen, the FTO often needs to take a hands-off approach, except to get the student involved in care through expectation and sometimes cajolement. That's **Rung Six**.

We all have seen the time when a student will do something either outright wrong or might just not know the next step to take. It is important to have a code word or phrase to tell the student that the preceptor is taking over the call. This can happen without the patient becoming overly aware that mistakes are, were or about to become happen. Patients should always have full knowledge that they are getting the best care in your community they can.

I always told my students that it was their call until I said "I think we should..." This phrase was to indicate to my student that the direction they were headed was either not right or they weren't moving along quickly enough for the severity of the patient. For me this phrase was always followed by Rung Seven.

Rung Seven is realizing the value of mistakes. There can be many opportunities to improve the knowledge, skill set and decision-making issues that any given student has. Very few of us came out of school as perfect medics, so let mistakes be teaching opportunities. This is the time to let students know that we all need some polish coming out of school.

Rung Eight follows along with the idea of feedback and learning. I strongly encourage you and your system to consider a graded system that uses a wide range of numbers to evaluate care. A scale of 1 to 10 works pretty well; I find three- or five-point scales too limiting.

Develop criteria for your students to pass through their internship. While often we put skills on such as synchronized cardioversion and needle decompression, those are skills most of us need only rarely. While appropriate, they may need to be simulated. Make sure you include enough time for students to achieve your goals for them and build in remediation time into the schedule.

Also, be fair to your student: no scoring inflation.

Visiting an East Coast department recently, one student received a score of 5 out of 5 for initiating an intravenous line. The criteria for the score read something along the line of "achieves the skill or knowledge objective in adverse circumstances or situations, or in extreme difficulty." With all respect to the FTO and student, was a score of 5 deserved on a 21-year-old typical male experiencing flank pain and other symptoms of a kidney stone? Maybe. Maybe not.

Just remember to develop a grading system that lets students accomplish a successful internship without scores that make them look like they should be teaching you. If your scale is 1 to 5 with 3 as average, and a student gets an IV when he is supposed to, give him a 3. On the other hand, if everyone on the crew misses an IV attempt on an elderly patient with poor circulatory status, and your student is successful, a 4 or 5 is obviously warranted.

Rung Nine: Help your students use critical thinking skills. When EMS trainees read from a cookbook, it should be to cook lunch or dinner, not to care for a patient. We are all governed by protocols, but every set of protocols I have ever seen lists them as a guide. Most, in fact, refer back to Rung One and doing the most appropriate thing for the patient.

I am not suggesting you skip over your protocols but rather to teach your students discernment. It is easy to say that chest pain is not always a heart attack; it is much harder to teach the variables that lead to caring for all the separate conditions that cause chest pain.

Finally, **Rung Ten**: focus on the basics. Although some departments try to be cute with slogans about "100 percent of the basics 100 percent of the time" make it mean something.

If your department interprets 12-leads, that's great; however, if your department interprets 12-leads and answers cardiac evaluations with answers like "junctional SVT," it might be time to get into a more consistent continuing education program for some of your providers. Similarly, your students should feel as if they can pass the skills section of their certification test at any time without a great deal of study. Whether it be immobilizing a patient to a short spinal immobilization device such as a KED, basic ECG rhythm knowledge or airway skills, we need to maintain these basic skills before we move forward with new technology, medicines and devices.

Ten rungs to the top. These suggestions will lead to greater success for your EMS providers who are climbing the ladder from the classroom into the street. You'll like the view from up there. So will your medics, your department and your patients. ●

speaking the language

By J.P. Martin

Many of the people who emigrate to the United States never get more than a couple of miles before they establish residency. As a result, the city of New York can boast dozens of different languages spoken within its boundaries. Add to those immigrants all the diplomats and members of United Nations consulate staff, and you have an even larger number and a significant challenge for EMS crews: How do you communicate with patients who speak one of more than 100 languages, but might not speak English?

Imagine a crew is on the scene with only the patient and no one else. Let's start with "do it yourself" solutions:

1. Émigrés who don't speak any English (if you allow what is most commonly spoken in New York City to be called "English") gravitate to places in the city where others speak the same native tongue. Veteran New York City EMS personnel who work in areas with concentrations of certain ethnic groups will, by necessity, pick up enough of a language to communicate with their patients. In the Coney Island area, for example, many medics learn enough key words and phrases in Russian to establish a chief complaint and perform an assessment. The department picked up on the idea and distributed…

2. Pocket-size plastic laminated language cards, with the idea that they would facilitate the communication process with non-English-speaking patients. A medic needs only to read off the phonetically spelled words to elicit a response. Unfortunately, a response in a foreign language might not be particularly helpful, but could be supplemented with…

3. Sign language. When a patient nods that he is experiencing pain, the medic would then have the patient point to the exact location and maybe even to a time on the clock or a date on the calendar. Surgical scars are also findings that can be dated by writing years down on a piece of paper. Speaking of writing….

4. Drawing pictures describing mechanisms of injury or organs can also be helpful.

Often, there are other resources on the scene or nearby.

1. Bilingual police officers are frequently assigned to an area where they speak the local tongue. They can be an invaluable resource for interpretive services. If they're not on the assignment, the cops who are there can request them to respond to assist. This might also be true of other EMS personnel who may be in the area and able to help.

2. School-age children frequently act as translators as they have learned their parents' language at home and English in school or from neighborhood friends. Even without any medical vocabulary (like the cops) they can be a great resource.

3. Relatives of the patient might speak some English or a common language other than English. Let's say a patient speaks Portugese and the medic speaks Spanish. If there's a relative who understands Spanish, a connection is made.

4. Related languages: Many Italians can understand Spanish, which is quite similar in structure and vocabulary. Warning: Do not use someone who speaks Cantonese to translate for a patient who speaks only Mandarin; they are as similar as Greek and Gaelic.

If all these other resources fail, try these formal solutions, which will undoubtedly yield the best results:

1. AT&T long provided a service called LanguageLine to assist public service agencies in crisis situations though it is not clear—given AT&T's recent business reverses—if the company still offers the service. The company LanguageLine Services (www.languageline.com) provides a similar service. LanguageLine can help identify the language and provide a translator who facilitates a three-way conversation among the medic, the patient and the translator. You should establish a relationship with these companies and their services well before your need for them is acute.

2. *Multilingual Patient Assessment Manual*, written by Kelland/Jordan and published by Elsevier is an excellent, easy-to-use spiral-bound book that provides common phrases to facilitate patient assessment in 20 languages, from Arabic to Yiddish. An EMS provider need only point to a phrase or question in the patient's language opposite the English translation. The patient selects an answer in his own language and points to it, adjacent to the English translation.

3. Another innovative solution was provided by one of our medical control physicians. Several years ago, Dr. Dario Gonzalez, (the current FDNY EMS medical director), gave his paramedics a course in medical Spanish. A pamphlet was distributed (produced by the NYC Health and Hospitals Corporation) to reinforce the lecture content, and the paramedics received CME credits. Because Spanish is so prevalent in New York City, the paramedics put the lessons to use immediately, which helped reinforce the lessons.

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