KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

Emergency Medical Services Division

PARAMEDIC SKILLS VERIFICATION POLICIES AND PROCEDURES

July 1, 2014

Edward Hill
EMS Director

Robert Barnes, M.D.
Medical Director

TABLE OF CONTENTS

Revision Log

2/6/2014 – Presented at EMS System Collaborative
2/13/2014 – EMCAB Approval
7/1/2014 – Policy Implementation

I. AUTHORITY

A. Health and Safety Code Division 2.5, Chapter 4, Article 1, 1797.214,

B. California Code of Regulations Title 22, Division 9, Article 7, § 100168.5

II. DEFINITIONS

A. ALS Provider (Provider) – Any Kern County EMS Division approved provider of ALS services, including transporting and non-transporting agencies.

B. EMS Division (Division) – The Kern County Emergency Medical Services Division

C. Paramedic – Any person accredited by the Division as a paramedic and providing ALS care for an approved ALS Provider

III. GENERAL PROVISIONS

A. The policy establishes the policies and procedures for the Paramedic Skills Verification program.

B. These policies shall apply to all Kern County paramedics and all Kern County ALS providers.

C. The Division reserves the right to change or update these policies and procedures as deemed necessary in accordance with Health and Safety Code, California Code of Regulations Title 22, and Kern County Ordinance.

IV. REQUIRED SKILLS VERIFICATION

A. All Paramedics shall be certified in CPR, PALS, ACLS, and PHTLS.

i. Paramedics shall present copies of their cards at time of re-accreditation.

ii. An instructor in PALS, ACLS, and PHTLS may verify a skill during the course if a manipulative station is part of the normal course material.

B. The following skills require verification:
    i. Cricothyrotomy
    ii. Thoracic Decompression
    iii. Endotracheal Intubation
        1. Adult
        2. Pediatric
    iv. Interosseous needle placement

C. Skills that are successfully completed in the field may be used as verification.

D. The following information must be provided for verification:
    i. Run Number
    ii. Date of Procedure
    iii. Indications
    iv. Complications
    v. Attempt

E. The Paramedic must turn in the skills verification sheets at the time of re-accreditation.

F. Two verifications sheets shall be presented for reaccreditation.
    i. One verification must be completed within twelve months of accreditation.
    ii. One verification must be completed greater than twelve months after accreditation.
    iii. Verifications must be more than six months apart.

G. Skills may be verified through a refresher course that provides hands-on manipulation.

H. The refresher course must include the following:
    i. Review of indications and contraindications
    ii. Paramedic must be able to physically identify landmarks
    iii. Paramedic must be able to practice the procedure and have positive feedback indicating success
    iv. Division approved devices shall be reviewed and practiced.

V. PROVIDER RESPONSIBILITIES

A. The ALS Provider shall be responsible to provide skills verification for each Paramedic affiliated with their respective program.

B. Skills shall be verified annually by the Provider.

C. The ALS Provider shall maintain documentation of the verification which shall be available upon request by the Division.

D. Documentation shall include the following:
    i. Roster
        1. Date
        2. Record of Participant Performance
    ii. Course Outline
        1. Brief Overview
        2. Objectives
        3. Comprehensive Outline
        4. Method of Evaluation
    iii. Copy of the Skills Verification Sheet
    iv. Program Evaluation
    v. Approved Instructor
        a. Resume to the Division
        b. Approval by the Division

VI. APPENDIX A – PARAMEDIC SKILLS VERIFICATION FORM

Kern County
Emergency Medical Services Division
Paramedic Skills Verification

Cricothyrotomy:
Date: _____ Run #:_____ # Attempts:_____
Complications:_____
Indications:_____
If Verified by Refresher Provide the following:
Date_____ Verifying Instructor:_____ Signature:_____

Thoracic Decompression:
Date: _____ Run #:_____ # Attempts:_____
Complications:_____
Indications:_____
If Verified by Refresher Provide the following:
Date_____ Verifying Instructor:_____ Signature:_____

Endotracheal Intubation - Pediatric
Date: _____ Run #:_____ # Attempts:_____
Complications:_____
Indications:_____
If Verified by Refresher Provide the following:
Date_____ Verifying Instructor:_____ Signature:_____

Endotracheal Intubation - Adult
Date: _____ Run #:_____ # Attempts:_____
Complications:_____
Indications:_____
If Verified by Refresher Provide the following:
Date_____ Verifying Instructor:_____ Signature:_____

Interosseous Needle Placement:
Date: _____ Run #:_____ # Attempts:_____
Complications:_____
Indications:_____
If Verified by Refresher Provide the following:
Date_____ Verifying Instructor:_____ Signature:_____

Paramedic Name (Print):_____
Paramedic Signature:_____
Paramedic License #:_____ Date:_____

EMS Coordinator Name:_____
EMS Coordinator Signature:_____
Date of Approval:_____