CASAC Meeting

Minutes – November 15th, 2023

Meeting called to order by Jimmy Pixton.

Approval of minutes – the minutes from the September meeting were sent out by SOCALR.

Are there any additions or corrections to the minutes? None

Motion to approve – Jim Pixton

No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Chizmar

For your information:
Franklin Square Medical Center has recently become designated as a Comprehensive Stroke Center. At the same time John Hopkins Bayview Medical Center is going to be a Thrombectomy-Capable Stroke Center.

Protocol Review Committee meeting was held a week ago and it is the last PRC meeting of this year. They discussed a variety of topics, but the most relevant to private ambulance services would be the IV Maintenance Therapy for EMT.

IV Maintenance Therapy for EMT: The protocol has been a little unclear to several of the services and the PRC committee so they are going to try to clarify this protocol. It is written so that the EMT is authorized to transport a patient that has IV maintenance KVO for LR, dextrose solutions, and NS. Basically fluids not on a pump. Currently the protocols have Potassium chloride on the list and this is a medication that is double and triple checked in the hospital. Usually these patients are on a monitor. If potassium chloride is in an IV maintenance solution, EMTs can transport that patient. But, if on a pump, this patient must be transported ALS. The PRC is going to clean up this protocol so that it is clearer.

The other topic today is the procedure list. These usually involve new products on the market and available to use.

PureWick Catheter: PureWick Catheter is an externally placed catheter. They make both male and female versions. Most commonly seen and used with females. It helps keep the patient from having to wear a Depends / Adult diaper. As far as the maintenance of the PureWick Catheter, it a sponge-like material that is placed in the groin and attached to suction. The level of care for this device should be able to go BLS, but Dr. Chizmar wanted to get input from the services because in some cases it does require suction and he does not want to overly impose on the BLS services. He asked the group to respond. There was no input, concerns, or worries express by the group of services. With no comments, Dr. Chizmar advised he will plan to put this procedure in the protocols for EMT level and up. Dr. Chizmar did advise that some EMTs may need a little introduction and training on these catheters.

TR Band: TR Band which is an inflatable wrist band for patients who are fresh out of cardiac cauterization procedures. Many times in the past the access was through the groin and there were various procedures to stem the bleeding. With the TR Band, it is inflatable, and there are protocols in the hospital for the nurse to gradually deflate it and monitor it for bleeding. Several services have questioned if this device needs to be ALS level or SCT level transports. The services have been mixed about how this transport goes. Dr. Chizmar asked for some feedback from the services. Mark Buchholtz, ProCare, asked Dr. Chizmar if he received Justin Gebhardt-Kram's feedback. Dr. Chizmar advised Justin feels this patient can be transported ALS, feels this is basically a dressing and a tourniquet. Mark agreed this patient with this device could go ALS. Dr. Chizmar clarified that his questions is… should this patient be transported ALS or SCT? Tyler Stroh, Med-Care, agreed that if this patient is just being transported, with no changes to the device, this patient could go ALS. If this goes ALS, this is not something in the Paramedic's core curriculum so it is something that they are not expected to know about. They will need some education on this device. Jimmy Pixton suggested putting together a "cheat sheet" or a little information about it and then the services can take it back and put it out to their paramedics. Jimmy suggested Dr. Chizmar give the services a "starting point" for the training of this device since it is something new out there. Dr. Chizmar agreed that this is a good idea. He might ask Justin to work with him on that information piece. Justin chimed in and agreed with helping out with this information. Dr. Chizmar advised we will list this device as ALS if no manipulations, manipulations expected or anticipated will go SCT.

Ketamine: We are due to submit the annual Ketamine report to the General Assemby. No surprises there. Most of the Ketamine we give is for pain management, not for agitation.

Vaccines: Pat Gainer is not on this call. We are aiming to extend vaccinations, both Covid and flu vaccinations. Right now they are scheduled to sunset on January 1st, 2025. Pat asked that we hold off on sending any letters anywhere, but be ready with letters of support in early January if you do support continued vaccinations for EMS.

Dr. Chizmar finished up and asked if there were any questions or items to discuss.

Abby Butler spoke up. She had a couple of comments on the PureWick Catheter having used them in the past. She wanted to share that clinicians will need to know what suction settings they will need to use for that device so there is no damage. Increased suction can cause tissue damage. It is also recommended that these devices are changed every 8 to 12 hours. That should not be an issue with the commercial ambulance transports. She advised they have good success with those devices. Dr. Chizmar thanked Abby for her insight on these devices and will get together with her to work on the teaching information for the services. Jimmy asked for the training information sooner than later as their service completes their annual training in January of each year. Dr. Chizmar said he would welcome any volunteer help with keeping this training moving forward.

SOCALR Report – Scott Legore

Inspection/License Update – Scott Legore stated that he was going to start this update and Marty Johnson will join in.

SOCALR closed out the 2024 licensure renewal cycle. SOCALR inspectors conducted 58 renewal inspections totaling 443 units. In November, we have already conducted several make up inspections for units that were not available during the planned renewal. With that being said, I would like to bring up some issues that we encountered during the license renewal cycle.

- Two services did not submit their license renewal paperwork until the week before the licensure expiration date and expected us to turn around and inspect their units before their expiration date.
- One service requested that we arrive at 0530 to inspect their units. We did not do that.
- One large service said there would be 18 units at the inspection. Only eight were available when we arrived. The number of inspectors we schedule is based on the number of units.
- Several services requested to bring their unit to the office for an inspection, only to arrive late or not at all. One service requested our inspector to stay late – saying "I don't know what time I will be there, how late can you stay?" Completely unacceptable.
- Several services had units that were not ready for inspection upon our arrival. These units need to have all required equipment at all times, not just at the renewal inspection. This is very concerning and makes us wonder how you are running your units on a daily basis.
- One service changed their Accounts Payable system and did not set up SOCALR in their new system. It took almost 10 weeks and jumping through a bunch of hoops for SOCALR to receive payment. SOCALR is not just another vendor; it is the service's responsibility to ensure payment of your invoices.
- Multiple services have requested inspection dates for new units before submitting the required paperwork. In several cases, the inspection date came up with no paperwork submitted, and the inspection was cancelled.

In my opinion, this is taking advantage of the flexibility offered by SOCALR. For next year, we will be a little stricter on our side. Example: No inspections will be scheduled without the corresponding paperwork. Services that fail to submit their license renewal application within 14 days of their expiration (as spelled out in the regulations) will not be guaranteed an inspection prior to their expiration. None of this is a surprise. You know when your license will expire. We send out your renewal license information 60 days in advance. It is an "open book" inspection and you should know what we are coming to look at during the inspection.

Marty Johnson had a few things to add:

- Several services had equipment that wasn't maintained properly. They didn't get their preventative maintenance done. Your preventative maintenance should come with a sticker or they should give you a date with it expires and needs to be inspected again.
- We had several units fail at the ALS level this year, which is a first for Marty to see. Usually we just outright fail the unit, but this year, instead we went ahead and certified the unit as BLS level so they could continue to move patients within Maryland. Note that, besides a little tidying up, the unit should be ready at all times.

- We have found that most services wait until the end of the month to get their inspections done. Since we moved every services around to be inspected throughout the year, most of the time it is not an issue to inspect at the end of the month. But, sometimes it is. That last two weeks at the end of a month can get really busy for us. If you can, try to line up some inspections a little earlier in your inspection month.
- One other item, that doesn't have to do with inspections, is that when any information you submitted with your original application changes, you are to notify our office. You are to fill out a new form and get that updated information into our office. Examples would be: address changes or officer changes. We usually find out that someone has left the service because their email bounces back to us. Please stay on top of those changes and keeping SOCALR informed.

Jimmy Pixton said that he would like to make a comment. Jimmy stated that some of this information is irritating to hear and he doesn't think a lot of newer services understand how this all works, how we fund this program, and when it costs money to do things outside (like doing extra inspections), it will eventually raise all of our costs. Jimmy stated he was really taken back by what Scott shared and that it is a shame that we have to deal with these extra tasks. Jimmy stated that this all needs to improve. We fund this program, that was created many years ago, and it is disrespectful. Jimmy was upset and said "From AAA, please accept our apologies that our industry has been that harsh." Jimmy said the "rules are the rules" and Maryland is more relaxed than other states and we should appreciate what we have here. Scott appreciated hearing Jimmy's comments.

QA Review/Data Imports: Scott Barquin

NEMSIS 3.5 is going to take place effective December 1st, 2023.
We are a NEMSIS state and it has always been NEMSIS compliant. The big thing that we are requiring is 100% complaint with the destination facility name / code list. It is located on the MIEMSS website under EMS Clinicians. That is the most updated list we have. It is also on the NEMSIS' website as well. Your third party software vendors can access the code list off there and they can directly import it into their software. Scott is in current talks with Zoll to try and get them to send over test reports. Traumasoft… I have all of the services that were required by DC standards to switch over to 3.5 are now fully compliant. Butler, Lifestar, ProCare, and Keystone are fully compliant and switched over. Traumasoft does have the capability to make this happen. We are asking that you send over the test results by November 28th as this goes live on December 1st. The cutoff date for 3.4 is January 1st. So the State of Maryland will not accept any NEMSIS 3.4 reports after January 1st. There's not much time to get this done so if I can be of assistance to you, please reach out to me. Right now I have a lot of "crickets" when it comes to this project.

Equipment Update: Scott Legore

We don't have anything right now. We are going to wait for the protocol changes and see if there is any impact on our required equipment lists. We did notice that we have glucometer listed twice, on the BLS checklist and ALS checklist. You are only required to carry one as an ALS unit or BLS unit.

Website: Scott Legore

Just to keep you informed, internally our media services group is working on a new MIEMSS website. My ask from the group, and you can send me an email, is what information would you like to see on the SOCALR page of the new website? What features are you currently using? Share what you use on the website and what you never use so we can get the new website working for all of us.

Reminder… After the meeting, within the next couple of days, Donna will be sending out an email asking for 2024 CASAC representatives. We have to identify them per the by-laws. Look for that email so we can update the CASAC representatives for 2024.

Clinician Services – Bev Witmer

Online Training Center is back up and running normally.

Just released our first volume / issue of "Educator News" and what we are doing with that news is that it goes out in an email to education programs (some of you may have received it) and it highlights patterns of pass and fail that we are seeing. These are things that may need to be restated or meshed up with protocols so we may be able to go back and correct the curriculum, make it harder in certain areas, or clarify equipment that the students may not have access to. Copy of "Educator News" has been attached to the minutes.

We are also sending out an annual report to all the education programs this week. Those will be due by December 31st, 2023.

She shared a link in the chat. They did post the Educational Manager position and it closes on Monday. If you know of anybody who would be interested or would be a good fit for that job, please share the link. It is also on the DBM website.

We do have an "EMT Skills Minimum Competency Workgroup" that we created. There are 5 educational programs represented. What we are working on is to create a minimum number of skills required for educational programs to put their student through in an EMT course in order for them to be competent and ready to go out for exams and out to be a clinician in the field. We are currently working on what evidence these particular 5 programs are doing and where they do these skills. Such as, do they do these skills during lecture or lab session, or do they expect the students to put them up during their internship? So we are collecting that evidence now. We will meet again next week and we will discuss the next step in that group.

The new EMT psychomotor exam pilot will be ending the last day of December. I will have a report for you in January. So far, the objectives we set internally have been met with positive feedback. There are some patterns of fails that they have been seeing that she mentioned earlier about in the Educator News. Those patterns are shared directly with the educational program immediately on the day of the exams so they can make immediate changes in their curriculum and in their remediation. We want to be transparent. We want the students to be prepared.

SEMSAC – Danny Platt was not present, but he forwarded information to Jimmy Paxton.

They did pass the Specialty Paramedic CCT regulation changes.

PEMAC – Jill Dannenfelser

Jill advised she did not have any new to report. We have already talked about protocol changes and the King Airway. There has been a lot of education going on and they have had several presentations of research articles but there is currently no action needed under new business.

MIH – Mark Buchhotlz - No report.

SCT – Will Rosenberg was not present.

Scott Legore advised they did not meet but the regulation changes not only passed SEMSAC, but EMS Board has approved them. They will go to AELR. We have to submit our same business impact statement and then they will go out for public comment. Hopefully they will go through the regulatory process and be in place with the July protocols. That is the change that a patient with one SCT skills needed can be transported by one SCT. It has been approved and it is just moving through the process.

Old Business – Scott Legore

Non-EMS Drivers: Scott Legore shared information on the screen. Copies of the documents shared on the screen have been attached to the minutes. The "ask" of the committee last time was to look at revisions to the Non-EMS Driver regulations, specifically looking at allowing the Non-EMS Driver to drive an ALS unit as long as the crew consisted of an additional EMT as an extra with the paramedic in the back. There was a couple of other "asks". One was on our side of the house to allow some additional control for disciplinarily action over the Non-EMS Drivers since they are not a licensed EMS clinician and don't really fall under our regulations. The other "ask" was to let MIEMSS have its own licensing and eliminate the Public Service Commission. Let me jump on that one first. In reviewing the regulations and the language, we don't feel MIEMSS has the ability to license Non-EMS clinicians. We don't feel the statue gives us that permission so we are going to stay with the Public Service Commission since they have already established oversight over "for hire" drivers. The other ones are in this portion here, shown on the screen.

I tried to make it readable. The first part we changed some language, but it really doesn't change anything. It gives SOCALR the ability to issue a waiver for a licensed driver. Part 2 adds ALS licensed ground ambulance. As you move down to Section G, covers the ALS licensed ground ambulance and says that it has to be staffed with at least two individuals who are an CRT or higher and an EMT or higher as your additional crew. Then Section H gives us the ability that the person that is designated as the Non-EMS driver is not subject to current suspension or revocation of EMS licensure and has not been determined to be a threat to the health and safety of the patients or the public. It just gives us the prohibited conduct cause that applies to all of the EMS clinicians. Down at the bottom, this is where it states that if a service decides to continue to

use a driver that we have determined to be a threat to the health and safety of the patients or the public, SOCALR can suspensed their waiver. That is the proposed changes right now. We are in a period where we have some time because the General Assembly won't consider the regulation changes at this time. Scott will send out this information to everyone, get some comments, and we can move it forward to the EMS Board and SEMSAC to get their weigh in on these changes as well.

Jimmy Paxton asked a question. If someone continues using somebody they are not supposed to, why would you only suspend the waiver? Why wouldn't you suspend their license? Scott replied that we technically could, but that is being really heavy handed. We were just going to take their waiver away. Claire Pierson commented that the ability to suspend their license would be there, but suspending their waiver would be a first step.

Scott asked if there were any additional comments and there were none at this time.

Scott had one other thing to discuss under old business. Back in early spring Scott called all of the services and one of the things Scott asked was for them to send SOCALR some photos of your units, personnel, something we could put together in a photo collage. We only got a response from about half a dozen services. You will probably see a reminder, if you haven't sent anything in, from Donna within the next couple of days asking you for some photos. We are going to try to put something together that highlights all of the commercial services in Maryland in one photo collage or something. Still working through how we will present/set this up. It will probably go on our website.

New Business –

Ferno INX Stretcher – Scott Legore

EMSC has sent out (approximately 10 years ago) what was a safe transport of kids. It was a set of cards that showed how to properly secure pediatrics in the various devices. They have updated pages for both Ferno and Stryker. Scott showed both of them on the screen. The question is: does every service want new pages to update the old version of the transport guide or should we just download the pdf to our website where you can download it and print it? Are you even carrying these? We currently don't have enough to give everybody, but we can certainly get them printed, if that is what you want. Would you carry them if we printed them off? Do you just want the individual pages for those devices that you carry or is it something you wouldn't be carrying at all? Matt posted in chat "pdf". Scott said we can make them available printed or pdf, just get back to him and let him know. Cyndy clarified what they have available and reworded Scott's question. Plus she mentioned that they a lot of other information available on other transport devices: Pedimate, Safeguard, How to Use a Traditional Car seat, or one of the special car beds that you may be more likely to use to transport an infant. And, if you want any additional information, in what format would you like that information? Jimmy mentioned "pdf" and website would be good. Is there a need for the laminated cards they just made up on How to Use the Shoulder Harnesses on the stretchers? Cyndy determined that the answer was "pdf" versions. Scott said we will make the information available on our website or EMSC's website and if a service wants laminated one, just reach out to our office.

Cyndy had another question for the group. As EMSC is going around training, they are finding that the shoulder harnesses are not readily available and if they are, they are tied behind or they are balled up and put in a pocket. This has been a soapbox of hers for well over 20 years. There now new information from the Society of Automobile Engineering Truck Division, that sets the standards for stretchers, that this situation has lead in other states some major injuries. We are writing the standards for how to secure car seats and other devices to stretchers, so the subject has come back up. How do your companies encourage or insist that all parts of the stretcher strap system are to be used for transporting patients? Jimmy spoke up and stated that they have supervisors that spot check and that is actually one of the top things they look for. He advised most companies have not had a tip over and really see the value in them. He said it's the crews. They hate using them and we just have to keep reinforcing it. Jimmy also mentioned that his maintenance people also see the stretchers and the straps, making note if the straps are not in place. He stated that the straps are never removed from the stretchers. They see them tucked behind the back. Mark, ProCare, said they do the same. They do a lot of new hire orientation, preaching on the proper safety of the stretchers. Then we have the supervisors do spot inspection checks. Jimmy said one of the new things they have been doing is have videos to train it. Most of the services involved with wheelchair transports really need to have this training as we see more incidents with the wheelchairs. Jimmy said they now have video training, then have the drivers demonstrate how to properly do it. We upload the video file in their personnel files so it is on file that they have been trained.
Ferno iNX Stryker Stretcher Guide has been attached to the minutes.

On a positive note, Cyndy said in the new year (since we are already going into December with the holidays) we would like to do a short training video on why it is important and what would happen to the clinician if an adult patient is not secured with the shoulder harness and arrives in their lap at a sudden stop or crash. Questions that they have: Length of time? The value for your service? And would you also want something in a closed social media message? Closed social media message… means that there would be a message on social media, but they would have to click on a link and go through EMS to see the video. What we don't want to do is put the video out there for everyone to see. We don't want to scare kids. We tend not to put graphic stuff on the social media page. Jimmy asked if the video would be something they could show their employees? Cyndy said yes. Jimmy feels it could be something they could show during orientation. Mark, ProCare, agreed with Jimmy. Anything they can add to their training video or otherwise is appreciated. Both agreed the youth of today like to watch the videos. Susanne said there has been some suggestions to have it as a humerous message. Do you think that has value or making it real? It was agreed that the real message would be better.

Operations Manager Training – Scott Legore

Quick blurb, we have had a request from one service to create an Operations Manager Program. He feels we are going to look to put together something similar to what we have for the Medical Director Orientation. The question he is asking the group is: What are some things you would like to see in there if you brought in a new manager? Would you like this posted on the online training center similar to what we have for the QA Officer or would you like this to be more formalized where we would schedule a meeting and go over the training one-to-one? Just start

thinking about that. We have already started working on a base outline but we would like to hear from you to see if there are things we have left off. Think about it. Feel free to email Scott with any thoughts on that training.

For the Good of the Committee – Scott Legore

Some training has come up recently and he would like to share it with everyone.

EMSC has a Pediatric Readiness Forum on November 29th at Noon. It's a virtual program. If you think your Medical Director would be interested in it, let Scott know and he could forward the registration information.

For the folks out west, there is a Fall Trauma Conference at Meritus Medical Center on December 1st that runs from 8 am until 1:30 pm.

There is a "Best Practices in Trauma Care" half day EMS Conference at Shock Trauma on December 16th from 8 am until noon.

Mid-Atlantic Transport Conference is coming next February 26th-27th and they just put out the agenda, one day pre-conference and one day conference.

Motion to adjourn by Jim Pixton, seconded by Mark Buchholtz. Meeting adjourned.

Attendance:

In Person: Jim Pixton, Scott Legore, Donna Geisel, Marty Johnson, Claire Pierson, Jill Dannenfelser, Cyndy Wright-Johnson, Susanne Ogaitis-Jones

Virtual: Dr. Tim Chizmar, Abby Butler, Bev Witmer, Kelly Hammond, Mark Buchholtz, Scott Barquin, Tyler Stroh, Bobby Harsh, Jimmy Harsch, Brad Borkowski, Brian Fletcher, Cody Winniford, Jeffrey Huggins, Justin Webster, Matt Larrabee, Mike Moreitti, Rob Weiss, Timothy Gargana, Teddy Baldwin

Jonathan Siegel, Bobby Harsh, Jimmy Harsh, Claire Pierson, Teddy Baldwin, Justin Webster, Jeff Kreimer, Zach Risoldi, Mark Buchholtz, Mike Moretti, Tyler Stroh, Bev Witmer, Kelly Hammond.

Callers: #1 – Matt Larrabee
#2 – Justin Gebhardt-Kram, ProCare

Commercial Ambulance Service Advisory Committee

2024 CASAC Meeting Schedule

January 17, 2024	1 PM – 3 PM
March 20, 2024	1 PM – 3 PM
May 15, 2024	1 PM – 3 PM
July 17, 2024	1 PM – 3 PM
September 18, 2024	1 PM – 3 PM
November 20, 2024	1 PM – 3 PM

All meetings will be held at:

MIEMSS HQ
Room #212
653 West Pratt Street
Baltimore, MD 21202

Join the meeting virtually at:

https://global.gotomeeting.com/join/690488141

You can also dial in using your phone.
United States: +1 (872) 240-3212
Access Code: 690-488-141

Ferno iNX Stretcher

Securing the Patient

1. Unbuckle all straps in preparation for the patient.
2. Position patient in center of stretcher with patient's back flat, and buttocks at the joint of the stretcher.
3. Lay shoulder straps on the patient's chest with the red webbing and metal links extended to the patient's waist.
4. Take the pelvis strap buckle (male part) and guide it through the slots in the shoulder strap links. Buckle the pelvis strap to connect all red parts.
5. Adjust the shoulder and pelvis straps to be snug on the patient.
6. Fasten the black chest strap across the patient's rib cage.
7. Fasten the black leg restraint over the patient's legs and snug.

* Some older Ferno stretchers may use a different shoulder restraint. Refer to the appropriate Ferno manual and videos for complete instructions and information on product storage and maintenance.

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Stryker Power Pro XT Stretcher (With XPR restraints*)

Securing the Patient

1. Unbuckle all straps in preparation for the patient.
2. Position patient in center of stretcher with patient's back flat, and buttocks at the joint of the stretcher.
3. Lay one shoulder strap diagonally across the patient's chest, buckle, and snug the harness. Repeat with other shoulder strap crossing the chest.
4. Position the waist restraint over the patient's pelvic bones. Buckle it and snug the strap.
5. Place the leg restraint over the upper legs. Buckle and snug the straps.
6. Fasten the second leg restraint over the patient's lower legs. Buckle and snug the strap.

* Some older Stryker stretchers may use a different shoulder restraint. Refer to the appropriate Stryker manual and videos for complete instructions and information on product storage and maintenance.

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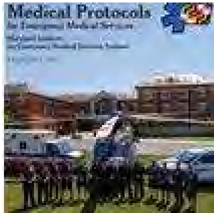
Published September 2023

EDUCATOR NEWS

A monthly insight into the BLS Psychomotor Exam
by Office of Clinician Services and Office of State EMS Medical Director

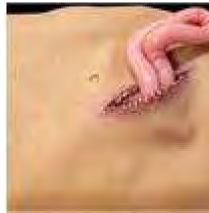
Top stories in this newsletter

November 13, 2023 Volume 1 Issue 1



Maryland Medical Protocols

Pelvic Binder



Evisceration

Medication Admin

BLS Psychomotor Exam Highlights

On July 1, 2023, MIEMSS began the pilot of the new BLS Psychomotor Exam that moved the focus away from a check sheet style of testing to a rubric method. The new exam is designed to assess a student's ability to perform as an entry level EMT while working through a medical and trauma scenario through a lens of the protocols.

Scenarios based on *Maryland Medical Protocols for EMS* (MMP)

The exam scenarios are based upon best practices and the *Maryland Medical Protocols for EMS*. The psychomotor cases were re-evaluated and redesigned with the new rubric method applied. There have been some new scenarios created, which will be gradually introduced to allow the MIEMSS scenario review committee an opportunity to review the pass/fail rate and adjust scenarios as needed. This is a primary reason that results given on the day of the exam are marked as "unofficial." Every failed attempt is reviewed by the exam coordinator and reviewed by the State EMS Medical Director if needed.

The results of each scenario are analyzed by the MIEMSS scenario review committee and State EMS Medical Director. The goal of this process is to identify patterns of success and failure throughout the state.

Pelvic Binder

One pattern that has emerged is that not all programs are teaching how to stabilize a fractured pelvis. According to MMP (page 147), a pelvic binder should be used if available. A cravat or sheet method is also acceptable to stabilize a pelvis fracture. Students should receive instruction in at least one of these methods.

Evisceration

Treatment for Evisceration

According to the MMP (page 162), an abdominal evisceration, is a life threatening emergency. This injury meets Trauma Decision Tree Category Bravo (a penetrating injury to the torso). There are two treatment options: application of a moist dressing on the injury with occlusive layer applied over it, or application of an occlusive layer directly on the injury with the final layer of dressing and cravats to hold the dressing in place. The cravats should be secured to the edges of the dressing, so they do not exert direct pressure on eviscerated bowel. The knees should be flexed to release the abdominal muscles to prevent exsanguination.

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5 Rights of Medication Administration

In the medical scenario, the "5 Rights of Medication administration" are not consistently being expressed by students. It is important that the testing candidate clearly addresses the "5 Rights" during the scenario. We teach the "5 Rights" to ensure patient safety when receiving medications. We also want to ensure that students will carry this training forward into real patient care encounters.