BASTROP COUNTY
EMERGENCY SERVICES DISTRICT NO. 3

BLS Shotgun Scenarios

Airway management, Z Vent preflight, and sick or not sick decisions

Audience	EMT credential and above; BLS skills every credential is expected to own
Facilitation	Trainer-led, under one minute per card, two stages
Source	BCEMS Patient Care Guidelines v58 (08/18/2026)
Cards	37 (12 Airway, 8 Z Vent preflight, 17 Sick / Not Sick)
Prepared	September 2026

How to run a card

Read the front of the card aloud: patient, complaint, presentation, vitals, then the Stage 1 task. Stop talking. The crew acts.

The back of the card is the trainer's. It holds the expected answer for both stages, the must-haves, the common misses, cues for when the crew stalls, and the guideline to cite in the wrap-up.

Airway cards run on the manikin with the real adjuncts, suction, BVM, CPAP, and iGel. Preflight cards run on the Z Vent itself with the circuit packages, oxygen hose, and power cable at hand; the crew stops at 'ready to connect' and the medic's settings stay on the ALS cards. Sick or not sick cards are read fast and answered fast: the decision, the finding that made it, and what happens next.

Every skill on these cards sits at the EMT credential in PCG v58, including iGel insertion, direct-connect CPAP, oral glucose, intranasal naloxone, intramuscular epinephrine for anaphylaxis, nebulized albuterol, and activation of stroke, trauma, and sepsis alerts. Paramedics are expected to be fast at all of it.

Two preflight cards carry IBW math (Devine: women 45.5 + 2.3 per inch over 5 ft; men 50 + 2.3 per inch over 5 ft; Vt 6 mL/kg; Mv 100 mL/kg; rate = Mv / Vt). Entering those values is a paramedic task. Knowing them is the ramp-up for BLS providers.

Accept an answer inside the stated range. Coach the must-haves. Name the common miss if it happens. Close with the PCG reference so the crew knows where to look it up in the MCP app.

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Airway management

BLS 01 | Airway | Snoring respirations, NPA

Patient: 52 M, about 100 kg

Complaint: Found on the couch after drinking, family cannot wake him.

Presentation: Snoring, drooling, responds to pain by moaning. Gags when you touch the tongue depressor to the back of the tongue.

Vitals: HR 92, BP 134/80, SpO2 89% RA, RR 10.

Stage 1: Manage the airway with an adjunct. Which one and why?

Stage 2: He starts to bleed from the nostril during insertion and the airway will not advance. What now?

EXPECTED ANSWER

Stage 1: Gag reflex present, so an OPA is contraindicated. NPA: size from the tip of the nose to the tragus, lubricate, bevel toward the septum, insert parallel to the floor of the nose in the wider nostril, flange at the nostril. Position: sniffing, ear to sternal notch. Oxygen to SpO2 94 to 99% (nasal cannula 1 to 6 L or NRB by distress). Suction ready.

Stage 2: Rotate slightly and re-advance; if it still will not pass, try the other nostril. Bleeding comes from the bevel scraping the septum, so check the orientation. Suction the oropharynx. Reassess ventilations once it is in.

Must-haves: Gag check before choosing. Correct measurement. Bevel to the septum. Oxygen with a target, not a habit.

Common misses: OPA on a patient with a gag. Measuring the NPA to the earlobe. Forcing the same nostril.

Trainer cues: Ask which adjunct and wait for the reason before they pick one up.

Wrap-up: PCG 8.3 Airway Adjunct (NPA) Insertion; PCG 1.2 General Management of Airway and Breathing Emergencies; PCG 8.32 Oxygen Administration

BLS 02 | Airway | Unresponsive, no gag, OPA and BVM

Patient: 34 F, about 60 kg

Complaint: Opioid overdose, bystander gave one dose of intranasal naloxone with no effect.

Presentation: Unresponsive, no gag, pinpoint pupils, cyanotic lips.

Vitals: HR 58, BP 96/60, SpO2 78% RA, RR 4 and shallow.

Stage 1: Airway and ventilate. Two of you.

Stage 2: Your partner is squeezing the bag with both hands every three seconds and the stomach is getting bigger. Fix it.

EXPECTED ANSWER

Stage 1: Open the airway (head-tilt chin-lift, no trauma), suction if needed, OPA sized corner of mouth to angle of the jaw, inserted tip to the palate and rotated 180 degrees, flange at the lips. Two-person BVM: one provider two-handed thumbs-down seal, the other squeezes. Oxygen on the bag at 15 L, reservoir filled. One breath over one second every 5 to 6 seconds for an adult, chest rise as the volume guide. Naloxone 2 to 4 mg IN once BVM ventilation has the SpO2 above 93%, repeat every 4 minutes to effective ventilations.

Stage 2: Over-ventilation and gastric insufflation. One hand on the bag, thumb and three fingers for an adult, volume to visible chest rise only, rate 10 to 12. Reseat the mask seal and recheck the OPA. Prepare suction for emesis.

Must-haves: Ventilation before naloxone. Two-person seal. One hand on the bag. Rate by age.

Common misses: Naloxone first while the patient stays apneic. One-person C-E clamp when a partner is free. Squeezing to the bag's full volume.

Trainer cues: Count the partner's rate out loud. Watch the hand on the bag.

Wrap-up: PCG 8.4 Airway Adjunct (OPA) Insertion; PCG 8.7 BVM Ventilations; PCG 5.13.1 Overdose/Toxins: Opioid

BLS 03 | Airway | Trauma, jaw thrust and suction

Patient: 27 M, about 85 kg

Complaint: Motorcycle versus car, no helmet, unresponsive on the roadway.

Presentation: Blood and teeth in the mouth, gurgling with each breath, deformity to the right side of the face.

Vitals: HR 120, BP 100/60, SpO2 84% RA, RR 22 gurgling.

Stage 1: Airway.

Stage 2: After suction he is breathing 8 times a minute with poor chest rise. What next, and what adjunct can you not use?

EXPECTED ANSWER

Stage 1: Jaw thrust, cervical spine held. Rigid catheter suction of the oropharynx, remove loose teeth and debris you can see, suction only what you can see, then reassess. NRB at 15 L while he is breathing adequately. Oxygen target for head trauma 95 to 99%.

Stage 2: Inadequate respirations: BVM with jaw thrust, two-person seal, one breath every 5 to 6 seconds. OPA is acceptable if no gag. NPA is contraindicated with a suspected basilar skull fracture and significant facial trauma. Request ALS for an advanced airway. Trauma Red criteria met (skull deformity, room air SpO2 under 90%): closest Level I or II.

Must-haves: Jaw thrust, not head-tilt. Suction before ventilating. NPA contraindication named. Trauma Red called.

Common misses: Head-tilt chin-lift on a trauma patient. Bagging through blood. Placing an NPA.

Trainer cues: Ask what adjunct they are reaching for and why it is safe here.

Wrap-up: PCG 1.2 General Management of Airway and Breathing Emergencies; PCG 8.36 Suctioning; PCG 8.3 Airway Adjunct (NPA) Insertion; PCG 7.18 Trauma Alert Criteria

BLS 04 | Airway | Cardiac arrest, iGel

Patient: 66 M, about 90 kg

Complaint: Collapsed at home, CPR in progress by fire first responders, AED has delivered one shock.

Presentation: Pulseless, apneic. OPA in place, BVM ventilations hard to seal because of a beard.

Vitals: Pulseless.

Stage 1: Place an iGel.

Stage 2: After placement you hear gurgling over the stomach and the chest is not rising. Go.

EXPECTED ANSWER

Stage 1: RODS check: restricted mouth opening, obstruction, distorted airway, stiff lungs or C-spine. Size by weight (size 4 for most adults 50 to 90 kg, size 5 above 90 kg; check the package). Lubricate, suction the mouth, sniffing position, cuff outlet toward the chin, glide along the hard palate until definitive resistance, incisors on the bite block. Confirm: chest rise, lung sounds present, epigastric sounds absent, EtCO2 capnoline attached and a waveform on the monitor. Secure. Continuous compressions with a breath every 6 seconds once the airway is in.

Stage 2: Displaced or malpositioned. Remove, reoxygenate with BVM, suction, reinsert with a jaw thrust and slight rotation, or go up or down one size. Reconfirm with EtCO2 and auscultation. If it fails twice, go back to two-person BVM with the OPA and let ALS manage the airway.

Must-haves: RODS aloud. EtCO2 for confirmation. Gastric sounds checked. Secured before moving.

Common misses: Forcing the device. Confirming by chest rise alone. Continuing to bag a misplaced device.

Trainer cues: Ask what RODS stands for. On stage 2, let them decide to pull it.

Wrap-up: PCG 8.37 Supraglottic Airway Insertion - iGel; PCG 3.1 Cardiac Arrest (Non-Traumatic); PCG 8.8 Capnography / Capnometry Monitoring

BLS 05 | Airway | iGel contraindication

Patient: 44 F, about 70 kg

Complaint: Seizure at a bus stop, now postictal with snoring respirations.

Presentation: Responds to pain, teeth clenched, gags on the OPA attempt, vomit around the mouth.

Vitals: HR 110, BP 140/88, SpO2 88% RA, RR 12.

Stage 1: Your partner hands you the iGel. Do you place it?

Stage 2: Her SpO2 is 91% on an NPA and NRB. She vomits again. What is your sequence?

EXPECTED ANSWER

Stage 1: No. Intact gag reflex and trismus are contraindications, and she is breathing. Suction the oropharynx, recovery position or lateral, NPA (measure and lubricate), NRB 15 L. Reassess. Request ALS.

Stage 2: Roll to the side, rigid suction, clear the airway, reassess breathing, replace oxygen. Suction first, then ventilate if respirations become inadequate. Keep the NPA. Time and result of suction documented.

Must-haves: Names both contraindications. Suctions before oxygen. Positions the patient.

Common misses: Forcing an iGel past clenched teeth. Bagging over vomit. Supine with a full mouth.

Trainer cues: Hand over the iGel yourself and say nothing.

Wrap-up: PCG 8.37 Supraglottic Airway Insertion - iGel; PCG 8.36 Suctioning; PCG 8.3 Airway Adjunct (NPA) Insertion; PCG 5.11 Seizure / Convulsions

BLS 06 | Airway | Pediatric BVM

Patient: 3 y/o F, about 14 kg

Complaint: Near-drowning in a bathtub, pulled out by a parent, gasping.

Presentation: Limp, cyanotic, gasping 6 times a minute.

Vitals: HR 70, SpO2 70%, RR 6.

Stage 1: Ventilate this child.

Stage 2: Her heart rate falls to 50 while you bag her. What do you do?

EXPECTED ANSWER

Stage 1: Pediatric BVM, correct mask size (bridge of nose to cleft of chin), OPA sized corner of mouth to angle of jaw if no gag, neutral to sniffing position with padding under the shoulders. Thumb and two fingers on the bag, one breath every 2 to 3 seconds (20 to 30 per minute) with chest rise. Oxygen 15 L with reservoir. Suction ready.

Stage 2: Infant and child bradycardia under 60 with poor perfusion despite oxygenation and ventilation: start compressions at 15:2 with two rescuers, AED on. Request ALS. Recheck the airway and seal first, because the most common cause of a falling pediatric heart rate is inadequate ventilation.

Must-haves: Pediatric rate. Two fingers on the bag. Compressions at HR under 60 with poor perfusion.

Common misses: Adult rate of 10 to 12. Adult bag on a toddler. Waiting for a pulse to disappear before compressing.

Trainer cues: Count their breaths per minute out loud.

Wrap-up: PCG 8.7 BVM Ventilations; PCG 3.3 Dysrhythmia (Symptomatic Bradycardia); PCG 7.11 Pediatric Vital Signs

BLS 07 | Airway | Choking adult, then unresponsive

Patient: 58 M, about 110 kg

Complaint: Choked on steak at a restaurant.

Presentation: Standing, hands at the throat, cannot speak or cough, turning blue.

Vitals: Unable to obtain.

Stage 1: Act.

Stage 2: He goes limp. Go.

EXPECTED ANSWER

Stage 1: Severe obstruction: abdominal thrusts, repeated until the obstruction clears or he loses consciousness. Chest thrusts for pregnant or obese patients where abdominal thrusts cannot be performed. Request ALS now.

Stage 2: Lower him to the ground, start CPR. Each time the airway is opened for breaths, look in the mouth and remove anything visible. No blind finger sweeps. A supraglottic airway is contraindicated with an obstruction. ALS will use laryngoscopy and Magill forceps.

Must-haves: Recognizes the silent cough as severe. Transitions to CPR on collapse. Looks before each breath. Does not place an iGel.

Common misses: Back blows on an adult. Blind finger sweep. Placing an iGel because ventilations are failing.

Trainer cues: Ask what device is off the table for this patient and why.

Wrap-up: PCG 8.16 Foreign Body Airway Obstruction Removal; PCG 3.1 Cardiac Arrest (Non-Traumatic)

BLS 08 | Airway | Infant obstruction

Patient: 8-month-old M, about 9 kg

Complaint: Was eating grapes, now silent with no chest movement.

Presentation: Held by a parent, wide-eyed, no cry, no air movement, going dusky.

Vitals: Unable to obtain.

Stage 1: Act.

Stage 2: After two cycles he is limp. Go.

EXPECTED ANSWER

Stage 1: Under one year: five back blows, five chest thrusts, repeat until the obstruction clears or he loses consciousness. Support the head and neck through the whole sequence.

Stage 2: CPR with a 15:2 ratio (two rescuers), look in the mouth before each breath, remove what you can see, no blind sweeps. Request ALS for laryngoscopy and Magill forceps. AED on with pediatric pads.

Must-haves: Back blows and chest thrusts, not abdominal thrusts. Head supported. CPR on collapse.

Common misses: Abdominal thrusts on an infant. Shaking the child. Finger sweeps.

Trainer cues: Use the infant manikin. Watch the head support.

Wrap-up: PCG 8.16 Foreign Body Airway Obstruction Removal; PCG 3.1 Cardiac Arrest (Non-Traumatic)

BLS 09 | Airway | CHF, direct-connect CPAP

Patient: 70 F, about 80 kg

Complaint: Woke up drowning, cannot lie flat.

Presentation: Awake, oriented, tripoding, rales halfway up, speaking two words at a time.

Vitals: HR 112, BP 176/98, SpO2 85% RA, RR 30.

Stage 1: Put her on CPAP.

Stage 2: After five minutes she says the mask is 'suffocating' her and tries to pull it off. SpO2 is 90%. What do you do?

EXPECTED ANSWER

Stage 1: Meets criteria: awake, A&O x4, SBP over 90, no vomiting, fits the mask. Size the mask to the bridge of the nose and cover the mouth, forehead strap with one to two finger widths, lower straps, tubing connected, PEEP valve at 5 cmH2O, oxygen on. Coach her through the first breaths before tightening. Reassess ventilation and comfort, titrate PEEP as needed to a maximum of 20. Notify the receiving hospital.

Stage 2: Coach and reassure. Hold the mask by hand for a minute before restrapping. Check the seal and flow. Do not sedate at the EMT level. If she cannot tolerate it, remove it, NRB 15 L, and hand off to ALS for BiPAP or further options. Vomiting or a drop in mental status ends CPAP immediately.

Must-haves: Contraindication screen spoken. PEEP 5 to start. Coaching before straps. Knows when to stop.

Common misses: Starting at PEEP 10. Strapping first and coaching after. Leaving CPAP on an altered patient.

Trainer cues: Play the patient. Pull at the mask if they strap it before coaching.

Wrap-up: PCG 8.10 CPAP (Direct Connect); PCG 2.8 Non-Invasive Positive Pressure Ventilation; PCG 3.9 Pulmonary Edema and Acute Decompensated Heart Failure

BLS 10 | Airway | CPAP contraindication trap

Patient: 61 M, about 95 kg

Complaint: COPD, short of breath for two days.

Presentation: Drowsy, answers only his name, wet cough with blood-streaked sputum, vomited once in the truck.

Vitals: HR 118, BP 88/50, SpO2 84% on 2 L home O2, RR 30 shallow.

Stage 1: Your partner is setting up CPAP. Stop them or help them. Explain.

Stage 2: He becomes unresponsive with agonal breathing. What is your airway plan?

EXPECTED ANSWER

Stage 1: Stop. Three contraindications: hemodynamic instability (SBP 88), vomiting, and obtundation (A&O under 4, GCS under 15). NRB 15 L now, suction ready, position of comfort, request ALS, prepare the BVM.

Stage 2: BVM with OPA if no gag, two-person seal, one breath every 5 to 6 seconds. Suction as needed. iGel if BVM is inadequate and there is no gag. CPR if pulseless. Hand off to ALS for intubation and pressors.

Must-haves: Names at least two contraindications. Has the BVM out before it is needed.

Common misses: CPAP on a hypotensive, altered, vomiting patient. Reaching for the iGel before trying two-person BVM.

Trainer cues: Set the CPAP up yourself as the partner and see if they stop you.

Wrap-up: PCG 8.10 CPAP (Direct Connect); PCG 8.7 BVM Ventilations; PCG 8.37 Supraglottic Airway Insertion - iGel

BLS 11 | Airway | Oxygen device selection

Patient: 82 F, about 55 kg

Complaint: Weak and tired for a week, mild shortness of breath walking to the bathroom.

Presentation: Alert, speaking full sentences, mild pallor, no accessory muscle use.

Vitals: HR 96, BP 128/76, SpO2 90% RA, RR 20, Temp 100.9 F.

Stage 1: Pick an oxygen device and flow. Say the target.

Stage 2: SpO2 is 96% on your device. Your partner turns it up to 15 L NRB 'to be safe.' Respond.

EXPECTED ANSWER

Stage 1: Medical target SpO2 94 to 99%. Nasal cannula 1 to 6 L for a patient with adequate tidal volume and minimal distress. Start at 2 L, titrate to the target. Escalate to a simple mask at 8 to 10 L or NRB at 10 to 16 L if distress increases or the target is not met. This patient also meets two SIRS criteria (HR over 90, temp over 100.4), so flag possible sepsis.

Stage 2: Oxygen is a drug given when indicated. She is at target. More flow adds nothing, dries the mucosa, and burns the tank. Leave the cannula. Document the SpO2 and device.

Must-haves: Target stated. Device matched to tidal volume and distress. Titration, not maximum.

Common misses: NRB for everyone. Cannula above 6 L. Missing the SIRS flags.

Trainer cues: Ask what number they are aiming for before they pick a device.

Wrap-up: PCG 8.32 Oxygen Administration; PCG 1.2 General Management of Airway and Breathing Emergencies; PCG 5.5 Fever / SIRS / Sepsis

BLS 12 | Airway | Stridor, child

Patient: 2 y/o M, about 12 kg

Complaint: Barking cough since midnight, now noisy breathing at rest.

Presentation: Sitting on mom's lap, inspiratory stridor at rest, retractions, drooling a little, anxious.

Vitals: HR 150, SpO2 92% RA, RR 40, Temp 101.8 F.

Stage 1: What is your airway plan for this child?

Stage 2: Your partner wants to look in the mouth with a tongue depressor and put him supine for a better look. Respond.

EXPECTED ANSWER

Stage 1: Upper airway (stridor, barking cough): croup or epiglottitis. Keep him on the parent's lap, position of comfort, no agitation. Humidified blow-by or mask oxygen as tolerated. No adjuncts in a breathing child with an upper airway problem. Request ALS. Note whether stridor is at rest or only when agitated.

Stage 2: No. Do not examine the oropharynx or force him supine; agitation and a tongue depressor can convert partial obstruction to complete. Leave him upright with the parent. If he obstructs, BVM with a jaw thrust and request ALS immediately. Pediatric SBP floor 70 + (2 x 2) = 74.

Must-haves: Recognizes stridor as upper airway. Minimal handling. No oral exam. Parent holds the child.

Common misses: OPA or NPA attempt. Laying him flat. Separating him from the parent for vitals.

Trainer cues: Play the partner and reach for the tongue depressor.

Wrap-up: PCG 1.2 General Management of Airway and Breathing Emergencies; PCG 2.2 Croup / Epiglottitis; PCG 7.11 Pediatric Vital Signs

Zoll Z Vent preflight

BLS 13 | Z Vent preflight | **Shift check preflight**

Patient: No patient. Start of shift, the Z Vent is in its bag on the truck.

Complaint: Daily equipment check.

Presentation: Vent powered off, circuit sealed in its package, oxygen hose coiled.

Vitals: N/A

Stage 1: Run the preflight and tell me when it is ready to hand to a medic.

Stage 2: The self-check fails with an alarm you do not recognize. What do you do with this ventilator?

EXPECTED ANSWER

Stage 1: Power source: plug into the truck's DC outlet or confirm battery charge (10 hours at defaults on a full battery). Inspect the fresh gas and emergency air intake filter for debris and never block it. Attach the high-pressure oxygen hose to the oxygen input and open the cylinder or wall supply. Attach a circuit: corrugated hose to the gas output after removing the red cap, green pressure line to the transducer, clear exhalation valve line to the exhalation valve fitting. Power switch to I. Watch the self-check complete. Confirm the start menu appears (Adult, Pediatric, Mask CPAP). Power down, cap, restow.

Stage 2: A ventilator with a failed self-check and unresolved alarms does not go on a patient. Refer to the operator's guide (PCG 7.19 User Manuals), tag it out of service, notify the supervisor, and swap to a spare. Document the alarm text.

Must-haves: All three circuit connections. Intake filter checked. Power source stated. Knows a failed self-check pulls the unit.

Common misses: Skipping the filter. Forgetting the pressure line or exhalation line. Using a unit that failed self-check 'because it turned on.'

Trainer cues: Cover the intake port with a piece of tape before they start and see if they find it.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 7.19 User Manuals

BLS 14 | Z Vent preflight | Circuit selection, adult

Patient: 60 M, 5 ft 11 in

Complaint: The medic is intubating. 'Get the vent ready for him.'

Presentation: Two circuit packages on the shelf: Pediatric/Adult and Infant/Pediatric.

Vitals: N/A

Stage 1: Pick the circuit, connect it, power up, and select the start default. Stop at 'ready to connect.'

Stage 2: The medic asks what tidal volume range your circuit is rated for and whether it fits this patient.

EXPECTED ANSWER

Stage 1: Pediatric/Adult circuit (tidal volume 200 mL or more). Connect the three lines, oxygen hose on and supply open, power on, self-check passes, select Adult default. FiO2 to 100%. Perform the circuit check and flow test with the medic. Hand off with the settings screen visible.

Stage 2: Pediatric/Adult: 200 mL and up. Infant/Pediatric: 50 to 300 mL. A 5 ft 11 in man has an IBW near 75 kg and a tidal volume near 450 mL, so the adult circuit is correct. (Ramp-up: IBW 50 + 2.3 per inch over 5 ft = 75 kg; Vt 6 mL/kg = 450 mL.)

Must-haves: Correct circuit by tidal volume range. Adult default. Oxygen attached before handoff.

Common misses: Grabbing the infant circuit for a small adult. Leaving FiO2 at 21%. Handing over with the start menu still up.

Trainer cues: Ask what the two circuit packages say on the label.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 2.6 Mechanical Ventilation

BLS 15 | Z Vent preflight | Circuit selection, pediatric

Patient: 4 y/o F, 40 in tall (White zone)

Complaint: Drowning, ROSC, the medic is placing the tube.

Presentation: Two circuit packages available.

Vitals: N/A

Stage 1: Pick the circuit, set up, select the start default. Ready to connect.

Stage 2: The medic asks for the IBW and tidal volume from the pediatric reference so she can confirm your circuit.

EXPECTED ANSWER

Stage 1: Infant/Pediatric circuit (50 to 300 mL). Three connections, oxygen on, self-check, Pediatric default. FiO2 100%. Circuit check and flow test.

Stage 2: Pediatric Mechanical Ventilation Reference, White (4 to 6 years, 34 to 39 in): IBW 17 kg, Vt 108 mL, Mv 1.7 L, rate 30. 108 mL sits inside the infant/pediatric circuit range. PEEP 3 to 5 is the pediatric setting the medic will use.

Must-haves: Infant/pediatric circuit. Pediatric default. Finds the color zone on the reference.

Common misses: Adult circuit and adult default. Devine math on a child.

Trainer cues: Have the color reference on the table. Ask what zone.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 2.6 Mechanical Ventilation (Pediatric); Pediatric Mechanical Ventilation Reference

BLS 16 | Z Vent preflight | Mask CPAP start default

Patient: 72 F, 5 ft 4 in

Complaint: Pulmonary edema, the medic wants ventilator CPAP instead of direct connect.

Presentation: Patient awake, tripoding, SBP 170.

Vitals: N/A

Stage 1: Set up the Z Vent for mask CPAP and hand it over ready to connect.

Stage 2: While you set up, the patient becomes drowsy and her breathing slows to 8. Do you still hand over a CPAP setup?

EXPECTED ANSWER

Stage 1: Adult circuit with the appropriately sized facemask attached. Three connections, oxygen on, self-check, select Mask CPAP (CPAP or BL). Adult CPAP defaults per PCG 2.8: PEEP 5, rate 2, FiO2 to keep SpO2 over 90%. Alarms and extended menu the medic will set: low peak pressure 0, low minute volume 0, rise time 1, flow termination 40%.

Stage 2: No. Never use CPAP or BL mode on a patient who is not spontaneously breathing or who may stop. Tell the medic, switch the start default to Adult, and begin BVM ventilations with an adjunct until the medic takes over.

Must-haves: Mask CPAP default. Knows CPAP and BL are for support, not ventilation. Says it out loud when the patient changes.

Common misses: Adult default with a mask. Handing over a CPAP setup on a patient with agonal breathing.

Trainer cues: Announce the change in the patient quietly and see if the setup changes.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 2.8 Non-Invasive Positive Pressure Ventilation

BLS 17 | Z Vent preflight | Oxygen supply for transport

Patient: 55 M, intubated, on the Z Vent at FiO2 100%

Complaint: Forty-minute transport to Austin.

Presentation: Vent running on a portable D cylinder that reads 1,000 psi. The truck's onboard K cylinder reads 1,800 psi.

Vitals: N/A

Stage 1: Is the D cylinder enough for the trip? Show the check, then set up the supply you will actually use.

Stage 2: The oxygen input alarm sounds on the highway. What do you do in the first 30 seconds?

EXPECTED ANSWER

Stage 1: D cylinder: constant 0.16 x (psi minus 200 safe residual) divided by liters per minute. At a minute volume near 8 L on FiO2 100%: 0.16 x 800 / 8 = 16 minutes. Not enough. Switch to the onboard K cylinder before leaving: constant 3.14 x 1,600 / 8 = 628 minutes. Connect the vent's oxygen hose to the onboard outlet, confirm the K valve is fully open, and keep the D cylinder at the head as the backup for the move into the hospital.

Stage 2: Check the supply: gauge, valve open, hose seated at the oxygen input and at the wall outlet. Swap to the D cylinder if the onboard line is the problem. The Z Vent's internal compressor keeps ventilating on room air (21%) through the emergency air intake, so the patient is ventilated but not oxygenated; a BVM on a separate oxygen source is the fallback if the fix takes longer than a minute.

Must-haves: Does the math or at least knows a D at 1,000 psi will not last 40 minutes at high flow. Moves to the K. Knows the compressor fallback.

Common misses: Leaving on the D tank. Disconnecting the patient from a vent that is still ventilating. Forgetting the D for the walk into the ED.

Trainer cues: Ask how long the tank lasts before they answer yes or no.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 8.32 Oxygen Administration

Note: Cylinder duration constants (D 0.16, K 3.14) are standard reference values, not PCG content.

BLS 18 | Z Vent preflight | Power fault on the road

Patient: 48 F, intubated, on the Z Vent

Complaint: Interfacility transport, 90 minutes.

Presentation: Vent plugged into the module's DC outlet. Ten minutes into the trip the External Power Fault alarm sounds.

Vitals: N/A

Stage 1: What just happened to the patient and what do you do?

Stage 2: The battery indicator now shows 20 percent and you are 60 minutes out. Options?

EXPECTED ANSWER

Stage 1: Nothing changed for the patient: the ventilator switched to its internal battery with no interruption and no loss of alarms. Check the DC cable at both ends (pinch and slide the latch, do not twist), check the outlet, reseat. When external power returns, it switches back and charges.

Stage 2: Try a different outlet or the AC power supply from the inverter. If no external power can be restored, tell the medic the remaining battery time, have the BVM and oxygen ready at the head, and consider diverting to the closest appropriate facility. Do not let the battery run to zero without a plan.

Must-haves: Knows the alarm means a source change, not a vent failure. Handles the cable correctly. Escalates the battery to the medic.

Common misses: Panicking and bagging a working vent. Twisting the power plug. Silencing the alarm and forgetting it.

Trainer cues: Ask what the patient felt when the alarm sounded.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup

BLS 19 | Z Vent preflight | Intake filter blocked

Patient: No patient. Vent check after a wildland standby.

Complaint: Vent was run on a dusty scene last shift.

Presentation: Fresh gas and emergency air intake visibly caked with dust. The unit powered on fine.

Vitals: N/A

Stage 1: Is this vent ready for a patient? What does that port do?

Stage 2: The medic says 'it passed self-check, we are fine.' Respond.

EXPECTED ANSWER

Stage 1: Not ready. The fresh gas and emergency air intake feeds the internal compressor and acts as the anti-asphyxia port if the vent fails. Its disk filter protects the compressor and the patient. Never block it; free airflow is required during compressor operation. Replace the filter per the operator's guide, then power on and confirm self-check.

Stage 2: The self-check does not prove airflow through a fouled filter under load. A blocked intake means the compressor can starve when the oxygen supply drops and the patient's spontaneous breathing through the port is restricted. Replace the filter or swap units.

Must-haves: Names both functions of the port. Refuses to deploy with a fouled filter.

Common misses: Blowing it out and calling it good. Trusting the self-check alone.

Trainer cues: Ask what happens to a patient breathing spontaneously if the vent dies and that port is blocked.

Wrap-up: PCG 7.22 Zoll Z-Vent: Setup; PCG 7.19 User Manuals

BLS 20 | Z Vent preflight | Handoff after preflight, IBW ramp-up

Patient: 35 M, 6 ft 2 in

Complaint: Overdose, the medic is intubating. 'Have the numbers ready.'

Presentation: Vent preflighted, Adult default selected.

Vitals: N/A

Stage 1: Give the medic the IBW, tidal volume, and minute volume so she can enter them.

Stage 2: The medic asks what rate that gives and what the alarm limits should be.

EXPECTED ANSWER

Stage 1: Devine, men: 50 + (2.3 x inches over 60). 74 in: 50 + (2.3 x 14) = 82 kg. Vt 82 x 6 = 490 mL. Mv 82 x 100 = 8.2 L. The MCP Patient Metrics screen gives the same numbers from height.

Stage 2: Rate = Mv / Vt = 8,200 / 490 = 17 (range 16 to 20). Alarms within 10%: Vt 440 to 540, Mv 7.4 to 9.0 L. PEEP 5. FiO2 100%. Entering them on the vent is the medic's call; knowing them is the EMT's.

Must-haves: Uses height, not weight. Correct sex constant. Shows the arithmetic.

Common misses: Guessing a 'normal' 500 mL. Using the women's constant. Confusing mL and L on minute volume.

Trainer cues: Give the height only. If they ask for weight, ask why they need it.

Wrap-up: PCG 2.6 Mechanical Ventilation; PCG 7.22 Zoll Z-Vent: Setup

Note: Ramp-up card. IBW calculation is not an EMT task in the PCG; this card builds the habit ahead of a future expectation.

Sick or not sick

BLS 21 | Sick / Not Sick | Chest pain, doorway

Patient: 56 M

Complaint: Chest pressure for 30 minutes.

Presentation: Sitting on the edge of the bed, pale, sweating through his shirt, hand on his chest, nauseated.

Vitals: HR 96, BP 146/92, SpO2 96% RA, RR 20.

Stage 1: Sick or not sick? What decides it and what do you do first?

Stage 2: Aspirin given. He says he took two of his wife's nitro tablets before you arrived and now feels dizzy. BP is 92/60.

EXPECTED ANSWER

Stage 1: Sick. Diaphoresis with chest pressure at rest decides it before the vitals do. Aspirin 324 mg chewed (four 81 mg tablets) unless he took the full dose within the hour. Oxygen only if SpO2 under 94%. Request ALS for a 12-lead within 5 minutes of contact. Move toward the truck now, no walking.

Stage 2: Nitro in a patient who may be preload dependent. Lay him flat with legs raised, recheck BP, no more nitro (P-2 only, after a 12-lead, and withheld below SBP 100). Report the home nitro and the pressure to ALS. Pads within reach.

Must-haves: Calls sick on presentation. Aspirin. ALS requested early. No walking.

Common misses: Waiting for vitals to decide. Oxygen at 96%. Letting him walk to the truck.

Trainer cues: Give the vitals only if they ask. The picture should be enough.

Wrap-up: PCG 3.7 Acute Coronary Syndrome; PCG 1.3 General Management of Cardiovascular Emergencies

BLS 22 | Sick / Not Sick | Stroke, last known well

Patient: 74 F

Complaint: Daughter says 'she is not making sense.'

Presentation: Sitting in a recliner, right facial droop, right arm drifts, slurred speech. Daughter last saw her normal at breakfast, 2 hours ago.

Vitals: HR 88, BP 188/100, SpO2 95% RA, RR 16, glucose 112.

Stage 1: Sick or not sick? Which alert, and what three things does the hospital need from you?

Stage 2: On the way to the truck she vomits and her speech gets worse. What changes?

EXPECTED ANSWER

Stage 1: Sick. Cincinnati stroke scale positive on all three, so complete a VAN assessment for large vessel occlusion. Glucose checked (112, not the cause). Stroke alert to the receiving facility: last known well time (breakfast, get the clock time), deficits, anticoagulant use. Transport to a stroke center appropriate to the VAN result. Nothing by mouth.

Stage 2: Airway: lateral position, suction, oxygen to 94 to 99%. Worsening deficit is possible hemorrhage or extension; do not delay transport. Reassess the stroke scale and report the change. Request ALS intercept if not already en route.

Must-haves: Stroke scale done and named. Last known well as a clock time. Glucose. Alert made early.

Common misses: Skipping glucose. Reporting 'two hours ago' without the actual time. Missing the VAN step.

Trainer cues: If they say 'a couple of hours,' ask what time that was.

Wrap-up: PCG 5.12 Stroke / CVA; PCG 7.15 Stroke Scales; PCG 5.2 Blood Glucose Management

BLS 23 | Sick / Not Sick | Sepsis in the nursing facility

Patient: 83 M

Complaint: Staff say 'he is just not himself today.'

Presentation: Lying in bed, confused (baseline oriented per staff), warm and flushed, foul urine in the catheter bag.

Vitals: HR 108, BP 104/60, SpO2 93% RA, RR 24, Temp 101.6 F.

Stage 1: Sick or not sick? Name the criteria you are using.

Stage 2: BP on repeat is 84/48. What alert and what destination?

EXPECTED ANSWER

Stage 1: Sick. SIRS two or more: HR over 90, RR over 20, temp over 100.4 F, plus a suspected source (urine) and new confusion. Oxygen to 94 to 99%. Request ALS. Document the temperature and the baseline mental status from staff.

Stage 2: Sepsis with hypotension. Sepsis alert to the receiving facility (EMT-level task). Closest appropriate emergency department; ALS for fluids and pressors. Move now, reassess every 5 minutes.

Must-haves: Two SIRS criteria named. Source identified. Alert made. Baseline mental status obtained.

Common misses: Calling it 'a UTI' and going non-emergent. Missing the temperature. No baseline from staff.

Trainer cues: Ask what the criteria are before they say sepsis.

Wrap-up: PCG 5.5 Fever / SIRS / Sepsis; PCG 1.5 General Management of Medical Emergencies

BLS 24 | Sick / Not Sick | Anaphylaxis at a picnic

Patient: 29 F

Complaint: Ate a cookie, now itchy and 'her throat feels tight.'

Presentation: Hives on the neck and chest, lip swelling, hoarse voice, anxious.

Vitals: HR 122, BP 96/58, SpO2 94% RA, RR 26.

Stage 1: Sick or not sick? What is the first drug and who gives it?

Stage 2: After the first dose she improves for ten minutes, then the stridor returns. What now?

EXPECTED ANSWER

Stage 1: Sick. Airway involvement plus hypotension is anaphylaxis. Epinephrine 1:1,000, 0.5 mg IM in the lateral thigh (EMT level), repeat every 5 minutes as needed. Albuterol 2.5 to 5 mg nebulized for the respiratory component. Oxygen. Request ALS. Position supine with legs raised if hypotensive, sitting if she cannot breathe lying down.

Stage 2: Biphasic or persistent reaction: repeat epinephrine 0.5 mg IM at the 5-minute interval. After two doses without improvement ALS considers push-dose or an infusion. Prepare for airway compromise: BVM ready, no adjuncts forced past swelling, ALS for advanced airway. Do not let her walk. Transport now.

Must-haves: Epinephrine before anything else. IM lateral thigh. ALS requested. Recognizes recurrence.

Common misses: Diphenhydramine first. Waiting for ALS to give epinephrine. Sitting her up when she is hypotensive.

Trainer cues: Ask what drug, then what route, then where.

Wrap-up: PCG 5.1 Allergic Reaction / Anaphylaxis; PCG 1.2 General Management of Airway and Breathing Emergencies

BLS 25 | Sick / Not Sick | Hypoglycemia, awake

Patient: 44 M

Complaint: Wife found him confused and sweaty. Type 1 diabetic.

Presentation: Awake, slurred, combative when touched, diaphoretic. Can swallow on command.

Vitals: HR 110, BP 138/84, SpO2 98% RA, RR 18, glucose 38.

Stage 1: Sick or not sick? What can you do at the EMT level?

Stage 2: He improves to alert and oriented, glucose 118, and wants to refuse. Your partner says fine. Respond.

EXPECTED ANSWER

Stage 1: Sick until the glucose is corrected, then reassess. Oral glucose per PCG 5.2 since he can swallow and protect his airway. Recheck glucose in 15 minutes. Request ALS if he cannot take oral glucose or does not improve. Look for the cause: missed meal, extra insulin, illness.

Stage 2: Refusal after hypoglycemia is high risk. Capacity has to be assessed after the correction, he needs to eat a full meal, someone must stay with him, and the cause has to make sense (a long-acting insulin dose makes recurrence likely). Consult the P-3 or OLMC on the refusal per PCG 1.8. Document the repeat glucose.

Must-haves: Glucose checked and treated at the EMT level. Recheck. Refusal handled as high risk.

Common misses: Waiting for ALS to treat. No recheck. Signing him off without a meal plan or a capacity assessment.

Trainer cues: Play the partner and push the easy refusal.

Wrap-up: PCG 5.2 Blood Glucose Management; PCG 1.8 Consent and Refusal

BLS 26 | Sick / Not Sick | Pediatric fever, looks fine

Patient: 18-month-old F, about 11 kg

Complaint: Fever and fussy since yesterday, mom is worried.

Presentation: Sitting up on mom's lap, crying but consolable, making eye contact, drinking from a bottle, pink skin, good tone.

Vitals: HR 140, SpO2 98% RA, RR 32, Temp 102.2 F, cap refill under 2 seconds.

Stage 1: Sick or not sick? What is the pediatric assessment triangle telling you?

Stage 2: Mom says she had a brief 'shaking spell' an hour ago that stopped on its own. Does that change your answer?

EXPECTED ANSWER

Stage 1: Not sick. Appearance (alert, consolable, eye contact, tone), work of breathing (normal), circulation to skin (pink, cap refill under 2) are all normal. HR 140 and RR 32 sit inside the 1 to 3 year range. Acetaminophen 15 mg/kg = 165 mg PO or ibuprofen 10 mg/kg = 110 mg PO per PCG 5.5 (confirm the last dose given at home). Transport for evaluation.

Stage 2: Likely a simple febrile seizure and she is back to baseline, so still not sick right now, with a lower threshold to reassess. Document the event, duration, and recovery. Keep her monitored, glucose check, transport. A second seizure, a focal seizure, or one over 5 minutes changes the answer to sick and calls for ALS.

Must-haves: Uses the triangle. Knows the age-range vitals. Weight-based dose. Documents the seizure history.

Common misses: Calling sick on the fever number alone. Adult dose. Ignoring the seizure history.

Trainer cues: Ask what normal HR and RR are for an 18-month-old.

Wrap-up: PCG 5.5 Fever / SIRS / Sepsis; PCG 7.11 Pediatric Vital Signs; PCG 5.11 Seizure / Convulsions

BLS 27 | Sick / Not Sick | Pediatric, looks fine then does not

Patient: 5 y/o M, about 19 kg

Complaint: Vomiting and diarrhea for two days, 'sleepy today.'

Presentation: Lying on the couch, opens eyes to voice, dry lips, sunken eyes, cool hands, cap refill 4 seconds.

Vitals: HR 150, BP 84/50, SpO2 97% RA, RR 30.

Stage 1: Sick or not sick? Which finding decides it?

Stage 2: He becomes hard to wake on the way to the truck. What now?

EXPECTED ANSWER

Stage 1: Sick. Cap refill 4 seconds and cool hands mean poor perfusion, and a 5-year-old who opens eyes only to voice is not normal. HR 150 is above the 3 to 6 year range (70 to 120). SBP floor 70 + (2 x 5) = 80, so 84 is barely above it: compensated shock. Oxygen, keep him warm, request ALS for IV or IO fluids, glucose check, transport now.

Stage 2: Decompensating. Airway first: position, suction ready, BVM if respirations become inadequate. Glucose. Rapid transport, ALS intercept. Report the change in mental status with the time.

Must-haves: Cap refill and skin as the deciding findings. Age-range vitals. Glucose. Early ALS.

Common misses: Reassured by the normal SpO2. Missing the BP floor math. Waiting on scene for ALS.

Trainer cues: Ask what the SBP floor is for a 5-year-old.

Wrap-up: PCG 7.11 Pediatric Vital Signs; PCG 3.10.3 Hypovolemic Shock; PCG 5.2 Blood Glucose Management

BLS 28 | Sick / Not Sick | Trauma, quiet and pale

Patient: 31 M

Complaint: Fell 12 feet from a ladder onto concrete.

Presentation: Lying supine, quiet, answers slowly, pale, abdomen tender, left thigh deformed.

Vitals: HR 118, BP 100/68, SpO2 97% RA, RR 22, GCS 14.

Stage 1: Sick or not sick? Red, Yellow, or neither, and where does he go?

Stage 2: Second set: HR 130, BP 88/60. What changed and what do you do?

EXPECTED ANSWER

Stage 1: Sick. Trauma Red: GCS 14 alone does not meet Red (Red is 13 or under), and one femur is one proximal long bone, so look at Yellow mechanism (fall over 10 feet). With HR 118 against SBP 100 he is close to Red vitals (HR greater than SBP). Treat as Red-level urgency: spinal precautions, splint the femur (traction splint if isolated mid-shaft), oxygen, warm, request ALS, transport to a Level I or II trauma center. Trauma alert.

Stage 2: HR 130 above SBP 88: Red criteria met (SBP under 90 and HR greater than SBP). Hemorrhagic shock, likely abdomen and femur. Do not wait on scene for anything. Keep him warm, legs level, no fluid at the EMT level, ALS intercept for blood or fluid en route. Update the trauma alert.

Must-haves: Uses the Red and Yellow criteria by name. Compares HR to SBP. Moves fast.

Common misses: Reassured by SBP 100. Calling GCS 14 a Red criterion. Spending scene time on a perfect splint.

Trainer cues: Ask what the HR to SBP comparison tells them.

Wrap-up: PCG 7.18 Trauma Alert Criteria; PCG 1.4 General Management of Trauma Emergencies; PCG 8.41 Traction Splinting

BLS 29 | Sick / Not Sick | Overdose, breathing slow

Patient: 26 F

Complaint: Friend found her 'passed out' after a party, pills on the nightstand.

Presentation: Responds to sternal rub only, pupils pinpoint, snoring, lips dusky.

Vitals: HR 64, BP 102/64, SpO2 86% RA, RR 8.

Stage 1: Sick or not sick? First action?

Stage 2: After naloxone she is awake, angry, and wants to leave. Respond.

EXPECTED ANSWER

Stage 1: Sick. Airway and breathing first: jaw thrust, NPA, BVM assist at 10 to 12 with oxygen. Naloxone 2 to 4 mg IN (EMT level) once BVM ventilation has the SpO2 above 93%, repeat every 4 minutes to effective ventilations. Request ALS. Glucose.

Stage 2: Naloxone wears off before many opioids do. She has capacity to refuse only after assessment, and the risk of recurrent respiratory depression is high, especially with long-acting or unknown pills. Explain, involve the friend, consult the P-3 or OLMC per PCG 1.8 if she still refuses, leave naloxone if the District's leave-behind program applies.

Must-haves: Ventilate before naloxone. Ventilation quality checked. Refusal treated as high risk.

Common misses: Naloxone first, then watching her stay apneic. Letting her walk away without a capacity assessment.

Trainer cues: Play the patient. Be irritable.

Wrap-up: PCG 5.13.1 Overdose/Toxins: Opioid; PCG 8.7 BVM Ventilations; PCG 1.8 Consent and Refusal

BLS 30 | Sick / Not Sick | Back pain, not what it looks like

Patient: 68 M

Complaint: 'Threw out his back' lifting a cooler an hour ago.

Presentation: Pale, sweaty, restless on the couch, tearing pain to the low back, legs feel 'heavy.'

Vitals: HR 104, BP 168/92 right arm, 132/80 left arm, SpO2 96% RA, RR 20.

Stage 1: Sick or not sick? What finding should stop you from treating this as a strain?

Stage 2: He wants to walk to the truck. Do you let him, and where does he go?

EXPECTED ANSWER

Stage 1: Sick. Tearing pain with diaphoresis, an arm-to-arm blood pressure difference over 20 mmHg, and leg symptoms in a 68-year-old suggest aortic dissection or aneurysm. No walking, no nitro, no aspirin until ALS evaluates. Oxygen to 94 to 99%. Request ALS. Palpate distal pulses and compare.

Stage 2: No. Stair chair or stretcher, minimal exertion. Destination is a facility with cardiothoracic and vascular surgery, so bypass a facility that cannot handle it if time allows; coordinate with ALS and OLMC. Repeat both-arm pressures and report them.

Must-haves: Two-arm blood pressure. Names the arm difference as the red flag. Withholds aspirin.

Common misses: One-arm BP and 'musculoskeletal.' Aspirin for 'chest or back pain.' Letting him walk.

Trainer cues: Give the second-arm pressure only if they take it.

Wrap-up: PCG 1.3 General Management of Cardiovascular Emergencies; PCG 1.5 General Management of Medical Emergencies

BLS 31 | Sick / Not Sick | Syncope in a young adult, not sick, still transport

Patient: 22 F

Complaint: Fainted in line at a food truck on a hot afternoon.

Presentation: Sitting on the curb, embarrassed, alert and oriented, warm and sweaty, drank nothing since morning. Prodrome of nausea and tunnel vision. Recovered in under a minute.

Vitals: HR 88, BP 108/70 sitting, SpO2 99% RA, RR 16, glucose 96.

Stage 1: Sick or not sick? What separates this from the syncope that scares you?

Stage 2: Orthostatics: standing HR 116, BP 90/58, and she feels dizzy again. Change your answer?

EXPECTED ANSWER

Stage 1: Not sick on this picture: prodrome, heat, dehydration, rapid full recovery, normal glucose. Red flags absent: no exertional onset, no chest pain, no palpitations, no family history of sudden death, no head injury. Still obtain a 12-lead through ALS or at the ED, orthostatic vitals, and transport for evaluation. Shade, cool, oral fluids if not nauseated.

Stage 2: Orthostatic with a HR rise over 20 and SBP drop: volume depleted. Still not 'sick' in the doorway sense, and now a clear reason to transport supine instead of accepting a refusal. Request ALS for fluids if she remains symptomatic. Keep her from standing.

Must-haves: Names at least three red flags they are checking for. Orthostatics. Glucose.

Common misses: Clearing her without orthostatics. Letting her stand and walk off.

Trainer cues: Ask what would make this sick.

Wrap-up: PCG 1.5 General Management of Medical Emergencies; PCG 1.8 Consent and Refusal; PCG 5.2 Blood Glucose Management

BLS 32 | Sick / Not Sick | Seizure, still seizing

Patient: 37 M

Complaint: Coworkers saw him 'shaking' at his desk.

Presentation: On the floor, generalized tonic-clonic activity ongoing, cyanotic around the mouth, incontinent. Coworkers say it started 6 minutes ago.

Vitals: Unable to obtain during activity. SpO2 82% on the finger probe.

Stage 1: Sick or not sick? What do you do in the first minute?

Stage 2: Activity stops. He is snoring, drooling, and does not respond. Glucose 92. Now what?

EXPECTED ANSWER

Stage 1: Sick. Over 5 minutes is status. Protect from injury, nothing in the mouth, NPA if it will pass, oxygen NRB or BVM assist if not ventilating, suction ready, request ALS for midazolam. Time the seizure. Glucose as soon as you can.

Stage 2: Postictal airway: lateral position, suction, NPA, oxygen to 94 to 99%, monitor breathing. Look for a cause: medication history, head trauma, fever, pregnancy, alcohol. Reassess for recurrence. Transport with ALS.

Must-haves: Recognizes status by time. Airway without forcing anything into the mouth. Glucose. Times the event.

Common misses: OPA during the seizure. Restraining the limbs. Forgetting glucose.

Trainer cues: Say 'still seizing' every 30 seconds until they act on the airway.

Wrap-up: PCG 5.11 Seizure / Convulsions; PCG 1.2 General Management of Airway and Breathing Emergencies; PCG 5.2 Blood Glucose Management

BLS 33 | Sick / Not Sick | Asthma, talking in words

Patient: 19 M

Complaint: Asthma attack for an hour, two inhaler puffs did nothing.

Presentation: Sitting forward, speaking one word at a time, retractions, wheezing you can hear from the door, then quieter breath sounds when you listen.

Vitals: HR 130, BP 138/86, SpO2 88% RA, RR 32.

Stage 1: Sick or not sick? What does the quiet chest mean?

Stage 2: After a nebulizer he is speaking in short phrases, SpO2 93%. Then he becomes drowsy and RR falls to 12. Sick or not sick now?

EXPECTED ANSWER

Stage 1: Sick. One-word dyspnea and a quiet chest mean air movement is failing; the wheeze got quieter because less air moves, not because he improved. Albuterol by nebulizer per PCG 2.1 (EMT level), oxygen, position of comfort, request ALS (epinephrine and CPAP are ALS decisions here). Transport now.

Stage 2: Sicker. Drowsiness and a falling rate in a severe asthmatic is exhaustion and rising CO2, not improvement. Prepare BVM assist, ALS for epinephrine and airway. Do not let the 93% reassure you.

Must-haves: Interprets the quiet chest correctly. Nebulizer started. Recognizes fatigue as deterioration.

Common misses: Calling improvement when the wheeze quiets. Reassured by SpO2 after the neb.

Trainer cues: Say 'the wheezing is quieter now' with a neutral face.

Wrap-up: PCG 2.1 Asthma / COPD; PCG 1.2 General Management of Airway and Breathing Emergencies

BLS 34 | Sick / Not Sick | Abdominal pain, elderly, not sick at the door

Patient: 79 F

Complaint: 'Stomach ache' since yesterday, no appetite.

Presentation: Sitting in a chair, alert, pleasant, minimizing. Abdomen distended, quiet, diffusely tender, she flinches when the cot bumps the wall.

Vitals: HR 98, BP 118/70, SpO2 96% RA, RR 20, Temp 99.9 F.

Stage 1: Sick or not sick? What is the finding the doorway picture hides?

Stage 2: On the cot her BP is 92/58 and HR 112. Change anything?

EXPECTED ANSWER

Stage 1: Sick, despite the pleasant presentation. Pain with movement and a distended quiet abdomen in an elderly patient suggests peritonitis, obstruction, or ischemia. Elderly patients under-report and under-respond. Position of comfort, nothing by mouth, oxygen to 94 to 99%, glucose, request ALS for pain control and fluids, transport.

Stage 2: Now she meets the definition on vitals too. Trauma-style urgency without the trauma: warm, supine if tolerated, rapid transport, ALS intercept, notify the ED. Reassess every 5 minutes.

Must-haves: Palpates and moves the patient before deciding. Does not accept 'she looks fine.'

Common misses: Non-emergent transport on the first set of vitals. Skipping the abdominal exam.

Trainer cues: Bump the cot. Say she winced.

Wrap-up: PCG 1.5 General Management of Medical Emergencies; PCG 5.7 Pain Control

BLS 35 | Sick / Not Sick | Carbon monoxide, whole family

Patient: Family of four, ages 6 to 41

Complaint: Headache and nausea in everyone this morning. Generator running in the attached garage overnight.

Presentation: Adults dizzy and irritable, 6-year-old vomiting and drowsy, dog lethargic.

Vitals: Adults SpO2 98% RA (pulse oximeter), child HR 130, RR 26.

Stage 1: Sick or not sick, and what about the SpO2?

Stage 2: The father says he feels fine now that he is outside and wants to go back in for the dog. Respond.

EXPECTED ANSWER

Stage 1: Sick, all four. Everyone in the house with the same symptoms and a combustion source is carbon monoxide until proven otherwise. Standard pulse oximetry reads carboxyhemoglobin as oxygenated, so 98% means nothing. Get everyone out, request fire for monitoring and ventilation, NRB 15 L on everyone, request ALS, and multiple patients means a second unit. The drowsy child is the sickest.

Stage 2: No one goes back in. Symptom relief outdoors is expected and does not clear the exposure. All four go to the hospital on oxygen. Fire retrieves the dog once the atmosphere is monitored.

Must-haves: Identifies CO from the pattern. Does not trust the SpO2. NRB for all. Calls fire and a second unit.

Common misses: Clearing the adults on their SpO2. Letting anyone re-enter. Treating the child last.

Trainer cues: Ask why the SpO2 is normal.

Wrap-up: PCG 5.13.9 Overdose/Toxins: Other (Carbon Monoxide); PCG 8.32 Oxygen Administration; PCG 1.1 Standard Patient Care

BLS 36 | Sick / Not Sick | GI bleed, does he meet blood criteria

Patient: 63 M, about 85 kg

Complaint: Vomiting blood since this morning, black stools for two days. Heavy drinker.

Presentation: Pale, diaphoretic, coffee-ground emesis in a bucket, dizzy sitting up.

Vitals: HR 128 sustained, BP 86/64, SpO2 94% RA, RR 24.

Stage 1: Sick or not sick? Run the adult blood criteria you can score without EtCO2 and tell me who you are calling.

Stage 2: The supervisor unit with blood is 12 minutes out and the hospital is 15. Your partner says just go. What do you do in the truck?

EXPECTED ANSWER

Stage 1: Sick. Adult Blood Product Inclusion Criteria: SBP 86 (90 or under, +1), pulse pressure 22 (0), HR 128 (125 or more, +1), shock index 128/86 = 1.49 (+1). Score 3 without EtCO2. GI bleeding needs 2 to 5: meets criteria. Blood is a P-2 order carried on the supervisor unit, so request it now and give them the numbers. EMT tasks: position of comfort, oxygen to 94 to 99%, suction ready, nothing by mouth, warm, vitals every 5 minutes, get a saline bag and blood tubing out of the cabinet so the medic is not hunting for them.

Stage 2: Both. Start toward the hospital and set up an intercept on the route; a 12-minute wait on scene is worse than a rolling meet. Radio the ED with the score and the estimated arrival. Repeat vitals every 5 minutes and be ready to report the trend. If he vomits, lateral and suction. If the supervisor cannot meet you, the hospital gets the same score in the report so they can have blood at the door.

Must-haves: Scores the four criteria available. Names the 2 to 5 threshold. Calls for the blood unit early. Keeps moving.

Common misses: Waiting on scene. Not calling for the supervisor because 'we cannot give blood.' Fluids by mouth.

Trainer cues: Ask what the shock index is. If they do not know it, hand them the criteria card.

Wrap-up: PCG 3.10.6 Blood Product Administration; Adult Blood Product Inclusion Criteria; PCG 3.10.2 Hemorrhagic Shock; PCG 1.5 General Management of Medical Emergencies

BLS 37 | Sick / Not Sick | Pediatric blood criteria, two children

Patient: 4 y/o M (about 16 kg) and his 18-month-old sister (about 11 kg)

Complaint: Both thrown from an ATV that rolled. Neither restrained.

Presentation: The 4-year-old: pale, mottled legs, cap refill 4 seconds, opens eyes to voice only, tender swollen abdomen. The 18-month-old: crying, pink, cap refill under 2, scalp laceration bleeding controlled with pressure.

Vitals: 4 y/o: HR 160, BP 72/50, RR 34. 18-month-old: HR 140, BP 88/56, RR 32.

Stage 1: Sick or not sick for each. Score both on the Pediatric Blood Product Inclusion Criteria and tell me which child the supervisor's blood is for.

Stage 2: The medic asks how much blood the 4-year-old gets, and whether the sister's score changes anything.

EXPECTED ANSWER

Stage 1: 4-year-old: sick. SBP floor 70 + (2 x 4) = 78; he is at 72 (+1). Poor perfusion (+1). Altered mental status (+1). Age 2 or over (0). Score 3, blunt trauma needs 2 to 5: meets criteria. 18-month-old: not sick on this picture, but age under 2 alone scores +6, so any blood decision for her is an OLMC call before it starts. SBP floor for her is 73, she is at 88 (0), perfusion normal (0), mental status normal (0). Request the supervisor unit with blood for the 4-year-old, pediatric trauma Red (SBP under 70 + 2 x age), Pediatric Level I trauma center. EMT: oxygen, keep both warm, direct pressure on the scalp, spinal precautions, vitals every 5 minutes on both.

Stage 2: Pediatric LTOWB 5 to 20 mL/kg: 16 kg gives 80 to 320 mL, OLMC for anything beyond 20 mL/kg. Calcium gluconate 100 mg/kg (1.6 g) after the first unit. The sister's +6 does not mean she gets blood; it means that at her age the criteria cannot be met without OLMC approval and their criteria for initiation. Reassess her every 5 minutes because a toddler compensates until she does not.

Must-haves: Two SBP floors computed. Recognizes the under-2 rule as an OLMC trigger, not an indication. Blood goes to the child who meets criteria.

Common misses: Scoring both children the same. Reading the +6 as 'meets criteria.' Missing the abdomen on the quiet child.

Trainer cues: Ask for the SBP floor for each child before anything else.

Wrap-up: PCG 3.10.6 Blood Product Administration; Pediatric Blood Product Inclusion Criteria; PCG 7.18 Trauma Alert Criteria; PCG 7.11 Pediatric Vital Signs