



EMT Handbook

PSE Guide

Rev. 4/2026

PATIENT ASSESSMENT MEDICAL

Practical Skills Evaluation (PSE) Station 1

SCENE SIZE-UP

"Is the scene safe?"

"Am I wearing enough BSI/PPE?"

"What is the **Nature of Illness (NOI)**?"

"How many patients do I have?"

Request additional resources (PD, ALS, Fire, etc.)

L.I.S.A.

L - Identify LIFE THREATS (arterial bleed, open chest wound, cardiac arrest, burning, choking etc.)

I - General IMPRESSION (age, gender, chief complaint, position found, and the apparent mental status)

S - SPINAL precaution (ask if they have neck / back pain or if they have recently fallen)

A - A.V.P.U. (Ask for person, Place, and Time)

PRIMARY ASSESSMENT – ABC'S

AIRWAY

Self-maintained if they are speaking to you, *however be mindful of potential airway compromise*

BREATHING

LOOK - Inspect the chest for equal chest rise, labored breathing, and accessory muscle use

LISTEN - Auscultate lungs **mid-clavicular and mid-axillary** for *air movement*

FEEL - Palpate the chest (if appropriate and consent is given)

GAS - Give high concentration oxygen via N.R.B. at 10 - 15 LPM if patient is **conscious**

CIRCULATION

V - Voids **Ask the patient if they are bleeding anywhere** to assess the bleeding you cannot see

C – Carotid *No need to check the carotid pulse for patient's that are awake*

R – Radial Radial pulses (check BOTH wrists for presence and quality)

S – Skin Assess Color, Temperature, and Condition **at the neck**

S – Shock Treat for shock *if needed*. Provide **O2**, keep them **comfortable**, keep them **warm**

IDENTIFY PRIORITY PATIENTS

Identify if this patient is **high** or **low** priority

Update the dispatcher with a report; Include your general impression and findings from the primary assessment

SECONDARY ASSESSMENT

S	Signs/Symptoms	"Is there anything else bothering you?"
A	Allergies	"Are you allergic to any medications/food/environment?"
M	Medications	"Are you taking any medications?"
P	Past History	"Do you have any medical conditions?"
L	Last Oral Intake	"What was the last thing you ate or drank?"
E	Events Leading Up	"What were you doing before this all started?"

O	Onset	"What were you doing when this problem began?"
P	Provocation	"What makes it worse and/or better?"
Q	Quality	"In your own words, how does this episode or problem feel?"
R.	Radiate	"Does this pain/discomfort radiate anywhere else in your body?"
S	Severity	"On a scale of 1-10, how would you rate this episode?"
T	Time	"What time did this start? Has it gotten better/worse/stayed the same?"
I	Interventions	"Have you done or taken anything before we got here to help your situation?"

VITAL SIGNS

Blood Pressure, Eyes, Respirations (rate/quality), Pulse (rate/quality), Skin Condition, SPO2, and BGL if appropriate.

ASSESS APPROPRIATE BODY SYSTEM

Cardiovascular • Respiratory • Neurological • Musculoskeletal • GI/GU • Reproductive • Psychological

For **cardiovascular** emergencies, assess the following:

Conjunctiva • Lips • JVD • Lung Sounds x6 • Ascites • Radial Pulses • Carpal Edema • Pedal Edema

For **respiratory** emergencies, assess the following:

Conjunctiva • Lips • Accessory Muscle Use • Lung Sounds x6 • Barrel Chest

For **neurological** emergencies, assess the following:

SPO2 • BGL • Pupils • Stroke Scale • Mental Acuity Questions

INTERVENTIONS

Assist or administer appropriate medications and dosage **according to New York State protocol**.

Ensure the six rights are in order for medication administration. (Time, Patient, Route, Dose, Medication, Documentation)

REASSESSMENT

Every 5 (unstable) or 15 (stable) minutes, you should reassess:

- A** A.V.P.U.
- V** Vital Signs
- I** Interventions (OPA, amount of O2 in cylinder, occlusive dressing, etc.)
- P** Primary Assessment (the ABC's)

Report - Present emergency department nurse with full story of patient's illness along with your findings.

10 MINUTE TIME LIMIT

PATIENT ASSESSMENT TRAUMA

Practical Skills Evaluation (PSE) Station 2

SCENE SIZE-UP

“Is the scene safe?”

“Am I wearing enough BSI/PPE?”

“What is the **Mechanism of Injury (MOI)**?”

“How many patients do I have?”

Request additional resources (PD, ALS, Fire, etc.)

L.I.S.A.

L - Identify LIFE THREATS (arterial bleed, open chest wound, cardiac arrest, etc.)

I - General IMPRESSION (age, gender, chief complaint, position found, apparent mental status)

S – SPINAL precaution (have a partner maintain c-spine stabilization)

A – Check A.V.P.U. (if unresponsive, check carotid pulse for presence)

PRIMARY ASSESSMENT – ABC’S

AIRWAY

OPEN JAW THRUST to open the airway

SUCTION Suction if necessary

MAINTAIN Secure airway with OPA / NPA

BREATHING

LOOK - Inspect the chest for equal chest rise, labored breathing, and injuries. Treat life threats.

LISTEN - Auscultate lungs **mid-clavicular and mid-axillary** for *air movement*

FEEL - Palpate the chest (if appropriate and consent is given)

Oxygen - Provide O2 via B.V.M. at 15 LPM, or, if appropriate, a N.R.B. at 10-15 LPM.

CIRCULATION

V - Voids Check for pooling blood, behind the: *neck, back, knees, ankles*

C - Carotid Check carotid pulse

R - Radial Check both radial pulses to compare

S - Skin Skin Color, Temperature, and Condition **at the neck**

S - Shock Treat for shock *if necessary*. Provide O2 and keep them warm and lay the patient down.

IDENTIFY PRIORITY PATIENTS

Identify if this patient is **high (rapid transport)** or **low (slow transport)** priority

Update the dispatcher with a report; Include your general impression and findings from the primary assessment

SECONDARY ASSESSMENT

Attempt to obtain a **SAMPLE** history by asking family or bystanders if they know the patient, what happened, etc.

HEAD TO TOE EXAMINATION

Head –	Scalp, pupil reaction, facial area, ears, nose, mouth
Neck –	Jugular vein distension, tracheal deviation, palpate cervical spine, <i>put a c-collar on</i>
Back -	<i>Log roll the patient on the backboard or scoop.</i> Inspect/palpate the back and buttocks
Chest –	Inspect, palpate, auscultate six lung sounds
Abdomen -	Inspect and palpate four quadrants
Pelvis -	Palpate the pelvis in and down for stability
Groin -	Visually inspect the groin for incontinence / bleeding / priapism
Extremities -	Palpate arms/legs together and individually , check for pulse + (motor / sensory)

VITAL SIGNS

Blood Pressure, Eyes, Respirations (rate/quality), Pulse (rate/quality), Skin Condition, SPO2, and BGL if appropriate.

REASSESSMENT

Every 5 (unstable) or 15 (stable) minutes, you should reassess:

A	A.V.P.U.
V	Vital Signs
I	Interventions (OPA, amount of O2 in cylinder, occlusive dressing, etc.)
P	Primary Assessment (the ABC's)

Present emergency department nurse with full story of patient's injuries along with your findings

10 MINUTE TIME LIMIT

CARDIAC ARREST / A.E.D. MANAGEMENT

Practical Skills Evaluation (PSE) Station 3

1. **Verbalize or wear B.S.I. / P.P.E.**
2. Assess A.V.P.U. and confirms **no pulse**
3. Instruct partner to perform **Single Rescuer CPR** assuring they perform adequate non-stop CPR while you set up the A.E.D.
4. **Turn on A.E.D.** and place pads in the right location
5. Connect A.E.D. pads to device
6. **Clear patient** while A.E.D. analyzes heart rhythm.
7. Instruct partner to continue CPR while A.E.D. is charging.
8. **Clear patient**, and deliver shock to patient when prompted by A.E.D.
9. Directs partner to begin CPR
10. Insert OPA, connect oxygen, and ventilate when your partner reaches 30 compressions. Continue compressions and ventilations.
11. **Clear patient**, and deliver shock to patient when prompted by A.E.D. (second shock)
12. Verbalizes rotation with partner and transport of patient after shock.

15 MINUTE TIME LIMIT

APENIC PATIENT WITH A PULSE (BVM)

Practical Skills Evaluation (PSE) Station 4

1. **Verbalize or wear B.S.I. / P.P.E.**
2. Open airway with a head tilt chin lift
3. Insert OPA
4. Select appropriate size mask and attach to BVM
5. Make a seal and ventilate with BVM without Oxygen (1 breath every 5-6 seconds) for 30-45 seconds

Your partner will arrive at the direction of the instructor and assist you

6. Instruct your partner to connect the O2 tubing to the regulator and **set the liter flow to 15LPM**
7. Hold the seal with two hands and *have your partner* squeeze the bag **at your command** every 5-6 seconds for 30-45 seconds
8. Ensure chest rise is visible

5 MINUTE TIME LIMIT

UPPER AIRWAY ADJUNCTS AND SUCTIONING

Practical Skills Evaluation (PSE) Station 5A

1. **Verbalize or wear B.S.I. / P.P.E.**
2. Select appropriate size OPA measuring from the tip of the earlobe to the corner of the mouth or middle of mouth to angle of jaw
3. Insert using cross finger method and rotate 180° until the OPA is fully inserted
-You will be informed that your patient begins to gag-
4. Remove anatomically (straight forward)
5. Assemble suction tubing and **set suction device to -300mmHg.**
6. Insert rigid catheter as far as you can see in the airway and suction in a circular motion on the way out for **≤15 seconds.**
7. Once airway is clear, select appropriate size NPA by measuring from the tip of nose to earlobe
8. Lubricate NPA with a **water-soluble** lubricant.
9. Insert with the beveled side toward septum, **into the patient's right nostril.**
10. If resistance is met, remove and **relubricate**, inserting into the patient's **left** nostril with the bevel facing the septum and rotate 180°.
11. Do not insert if facial or head trauma are presenting.

5 MINUTE TIME LIMIT

SUPPLEMENTAL OXYGEN ADMINISTRATION

Practical Skills Evaluation (PSE) Station 5B

1. **Verbalize or wear B.S.I. / P.P.E.**
2. Identify cylinder is medical oxygen – Green, ‘PISS’, “Oxygen and USP” on label, and hydrostatic test date.
3. *Crack or burp* cylinder open to blow dust or dirt from discharge.
4. Assemble regulator to cylinder by matching regulator pins to tank inlets using the *Pin Index Safety System*.
5. Open and close cylinder, listening and looking for leaks. Identify amount of PSI in cylinder. **Open cylinder again fully.**
6. **Attach NRB to regulator set at 15LPM. Pre-fill reservoir** and apply to patient.
7. Remove NRB from patient *with oxygen flowing* and connect a nasal cannula to regulator, **setting at 6 LPM**. Apply to patient.
8. Remove nasal cannula, disconnect the device from the regulator.
9. Close cylinder fully and bleed air out using the regular once the cylinder is closed.
10. Disassemble the regulator from the cylinder.

5 MINUTE TIME LIMIT

BLEEDING CONTROL

Practical Skills Evaluation (PSE) Station 5C

1. Verbalize or wear B.S.I. / P.P.E.
2. Apply direct pressure to wound with a 4x4 dressing
3. If patient continues to bleed, apply pressure bandage to wound.
4. If severe bleeding persists from a limb, apply a tourniquet 3” proximal to the bleeding site, but never over a joint. If severe bleeding persists, a second tourniquet may be applied proximal to the first tourniquet.
5. Record the time tourniquet was secured and document near the tourniquet site.
6. Patient may experience signs and symptoms of *hypoperfusion* (shock). Lay the patient down, cover with blanket and apply oxygen (NRB@15lpm) and verbalize immediately transport.

Radius / Ulna Long Bone Fracture

Practical Skills Evaluation (PSE) Station 6A

1. Verbalize or wear B.S.I. / P.P.E.
2. Hold manual stabilization of injury – lower arm.
3. Direct partner to take stabilization and check pulse, motor, and sensory function.
4. Apply short board splint to anterior forearm, *place padding in hand to maintain hand in position of function.*
5. Apply (3) triangular bandages: below elbow, near wrist, and over knuckles, thread through the thumb. Tie knots on board splint.
6. Sling injured arm high across patient's chest, tying knot on the side of neck.
7. Swathe under the wrist and tie off on the patient's ribs, *place padding for comfort.*
8. Check pulse, motor, and sensory function.

10 MINUTE TIME LIMIT

Tibula / Fibula Long Bone Fracture

Practical Skills Evaluation (PSE) Station 6A

1. Verbalize or wear B.S.I. / P.P.E.
2. Hold manual stabilization of injury – lower leg.
3. Direct partner to take stabilization and check pulse, motor, and sensory function.
4. Apply triangular bandages along leg, to the upper thigh, above the knee, below the knee, and at the ankle. Tie knots to board splint.
5. Place another triangular bandage around foot to maintain the foot in a position of function.
6. Check pulse, motor, and sensory function.

10 MINUTE TIME LIMIT

Joint Immobilization

Practical Skills Evaluation (PSE) Station 6B

1. Verbalize or wear B.S.I. / P.P.E.
2. Hold manual stabilization of injury
3. Direct partner to take stabilization and check pulse, motor, and sensory function
4. Apply triangular bandage to sling arm low. *Place padding for comfort*
5. Swathe under the wrist and tie off on the patient's ribs, *place padding for comfort*
6. Check pulse, motor, and sensory function

10 MINUTE TIME LIMIT

Traction Splint - Slishman

Practical Skills Evaluation (PSE) Station 6C

- 1. Verbalize or wear B.S.I. / P.P.E.**
- 2. Hold manual stabilization of injury – femur.**
- 3. Direct partner to take stabilization and check pulse, motor, and sensory function.**
- 4. Place ankle hitch on ankle, with cup opening placed on the outer part of the leg facing up toward the patient.**
- 5. Pull manual traction and hand leg to partner.**
- 6. Place ischial strap around upper thigh.**
- 7. Using the black knob, extend splint and connect into ankle hitch.**
- 8. Pull outward in both directions until you feel resistance and tighten black knob to keep in place. (Coarse traction).**
- 9. Loosen red knob and pull back toward patient on the string with the red handle. Tighten when patient feels relief. (Fine traction).**
- 10. Place both legs together and place red Velcro of leg strap to the red label on the splint. Wrap around both legs.**
- 11. Check pulse, motor, and sensory function.**

10 MINUTE TIME LIMIT