Washington/Oregon
Dental Anesthesia Assistant Program
Catalog

The Resuscitation Group
901 West Evergreen Boulevard
Vancouver, Washington USA 98660
+1-855-739-2257
http://resuscitationgroup.com/

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Admission Requirements

All documentation must be submitted to the office staff at the time of admissions and final payment.

Pre-requisites:

1. 18 years or older by start date of program.
2. High School diploma or GED
3. Copy of USA State Driver's License or Copy of Current Passport Photo Page.
4. Must have the following current certifications to be awarded a certificate:
    a. American Heart Association Basic Life Support (BLS)
    b. American Heart Association Advanced Cardiac Life Support (ACLS)

Insurance Requirements:

None required

Immunizations Required:

1. MMR immunization at least twice during lifetime, or within the last ten years;
2. Hepatitis B immunization
3. Current influenza vaccine shot
4. Tetanus/Diphtheria
5. Polio

Tests Required:

1. Tuberculosis test within the past six months.

INTRODUCTION

OVERVIEW OF ANESTHESIA ASSISTANT PROGRAM

The 40 hour Anesthesia Assistant Certificate Program is approved by the Washington State Dental Commission specifically for Dental Anesthesia Assistants who assist a Dentist, Oral Surgeon, Maxillofacial Surgeon, or other provider with anesthesia during procedural or surgical events.

An anesthesiologist assistant is a non-physician qualified to assist a licensed provider with preoperative, operative, and postoperative anesthesia, monitoring, and interventional care. The anesthesia assistant works under the direct medical direction of a licensed provider as an assistant in the care team. Anesthesia assistants obtain pre-anesthetic health history, perform vascular access, establish non-invasive monitors, assist with the preparation and administration of medications, assist in the treatment of life-threatening situations, and execute techniques, as directed by licensed provider.

OUR VISION

The Resuscitation Group seeks to showcase the exceptional healthcare system in Washington State, improve healthcare systems in the region, increase the effectiveness of the healthcare system, enhance the education of healthcare practitioners, and provide a model for other regions and countries.

OUR PHILOSOPHY

The Resuscitation Group (TRG) is committed to a philosophy of educational excellence and attention to detail both in our programs and in our students. We accept responsibility for preparing students who are knowledgeable in the field, responsive to service in the community and dedicated to continued expansion of human understanding through study.
To this end, we hold to the following philosophy:

- To promote high ethical codes of conduct and professional standards and foster participation in professional organizations and activities.
- To prepare students to assume responsibility for management of critical care patients in a wide range of environments, utilizing the principles of critical care medicine.
- Academically educating students for successful completion of international, national, and state certification examinations.
- Assuring student competencies in critical care medicine prior to allowing patient contact and then assuring high standards of compliance with competencies during patient care.

GOALS AND PROGRAM OBJECTIVES

TRG holds that learning is a lifelong process through which an individual modifies his/her behavior in order to accommodate changing healthcare needs. We also believe that learning is

facilitated when student participation is actively encouraged, instructional and educational goals are well defined and communicated, and student goals and objectives are clear and supported by the faculty.

It is understood that, ultimately, the full responsibility for learning rests with the student and his/her commitment to the learning process.

The 40 hour, Anesthesia Assistant Program has the distinction of being among the highest level of training programs in the world today and incorporates the 2017 International Liaison Committee on Resuscitation (ILCOR) Education and Science Recommendations, The 2013 IHCA AHA Conesus Recommendations, The Emergency Cardiovascular Care Update Anesthesia Assistant objectives; while blending in the objectives required for the unique environment and challenges of the Pacific Northwest and Pacific Rim environments, with additional objectives incorporated to meet the highest level of clinical expectation under the current United States CMMS guidelines.

Specific Program Objectives can be found at the start of each learning module in the program curriculum (Appendix 1).

CONTACT TELEPHONE NUMBERS

Rod Rowan	Director of School Operations	+1-855-739-2257
Michael Christie	Director - Critical Care Program	+1-855-739-2257
Dr. Luke Parr	Medical Director	+1-855-739-2257
Maria Sagolili	CME Administer	+1-855-739-2257

PROGRAM STAFF & DUTIES

Rod Rowen - Director of School Operations:
The DOSO manages the day to day operations of the entire school environment, as well as assures compliance with equipment, support services, and legal documents.

Michael Christie - CC Program Director
The CCPD will review and approve the educational content of the program curriculum to certify its ongoing appropriateness and medical accuracy against current regional, national, and international guidelines. The CCPD will review and approve the quality of medical instruction, supervision, and evaluation of the students in all area of the program. The CCPD will assure and attest to the competence of each graduate in the cognitive, psychomotor, and affective domains.

Dr. Luke Parr - Medical Director

The Medical Director is responsible for all adherence to medical science in the curriculum, supervision of the CCPD, issuance of medical privileges, and final approval of all patient contact protocols and treatment processes.

CME Manager
The CME Manager is responsible for operating The Resuscitation Group continuing medical education accreditation processes.

FACULTY

The TRG faculty is comprised of a numerous healthcare practitioners at a variety of levels from Critical Care Paramedic to Physician.

The Resuscitation Group practices non-discriminatory faculty recruitment with regard to disability, race, color, creed, gender, sexual preference, affectional preference, veteran status, and national origin; but The Resuscitation Group does seek the highest qualified educational staff in the United States and abroad.

ACCREDITION

There is no accreditation process for the educational component of critical care medicine at the non-physician level in the United States; the process in the United States as revolved around outcome testing through third party boards or registry.

FACILITIES

We are located in Southwest Washington in the Portland Metro area at 901 West Evergreen Boulevard, Suite 100, in Vancouver, Washington. Business hours are from 9:00am until 5:00pm Monday through Friday and we can be reached at 855-739-2257 or by email at info@resuscitationgroup.com

STUDENT/TEACHER RATIO

While no standard exists for this type of educational process, The Resuscitation Group intends to hold to the international standard of not more than 24:1 ratio during didactic sessions, a student/teacher ratio of not greater than 8:1 in the laboratory setting, and a ratio not to exceed 8:1 in the clinical setting under an assigned educator.

ACADEMIC CALENDAR AND HOURS OF OPERATION

The Resuscitation Group will observe the following holidays and classes will not be held on the following United States Holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day

- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Eve
- Christmas Day

Enrollment is ongoing throughout the year. The Program runs 600 hours in duration over a 3-6 month period. Class hours are scheduled for ease of the student population in the program cohort.

TUITION, FEES AND DEPOSITS

Tuitions, fees, and deposits are paid to The Resuscitation Group.

1. Tuition and Fees for domestic or international students:

Application Fee:	$100
Tuition:	$550
Lab Fee:	$100
Total Charges:	$750 usd

Notation as to Textbooks:
Students are required to obtain the text book, Basics of Anesthesia 7th Edition
by Manuel Pardo MD (Author), for the course per the course syllabus and complete reading of Anesthesia 101 at https://www.asahq.org/whensecondscount/anesthesia-101/

REFUND POLICY

All refunds will be made within thirty (30) calendar days from the time of cancelation from the program; provided cancellation was made at least 30 days prior to program start date.

The official date of termination or withdrawal for a student shall be determined in the following manner:

1. The date on which the school recorded the student's last day of attendance; or,
2. The date on which the student is terminated for a violation of a published school policy which provides for termination.

No student shall be continued on an inactive status in violation of school policy without written consent of the student. Inactive students must be terminated within thirty days of the next available start date and refunded appropriate prepaid tuition and fees at that time.

Refunds must be calculated using the official date of termination or withdrawal and the date designated on the current enrollment agreement executed with the student. Refunds must be paid within thirty calendar days of the student's official date of withdrawal or termination.

Application/registration fees may be collected in advance of a student signing an enrollment agreement; however, all monies paid by the student shall be refunded if the student does not sign an enrollment agreement and does not commence participation in the program.

The school must refund all money paid if the applicant is not accepted; this includes instances where a starting class is canceled by the school.

The school must refund all money paid if the applicant cancels within five business days (excluding Sundays and holidays) after the day the contract is signed or an initial payment is made, as long as the applicant has not begun training; the applicant may request cancellation in any manner, in the event of a dispute over timely notice. The burden of proof rests on the applicant.

The school may retain an established registration fee equal to ten percent of the total tuition cost, or one hundred dollars, whichever is less, if the applicant cancels after the fifth business day after signing the contract or making an initial payment. A "registration fee" is any fee charged by a school to process student applications and establish a student records system.

If training is terminated after the student enters classes, the school may retain the registration fee established under (c) of this subsection, plus a percentage of the total tuition as described in the following table:

If the student completes this amount of training:	The school may keep this % of the tuition cost:
One week or up to 10%, whichever is less	10%

If the student completes this amount of training:	The school may keep this % of the tuition cost:
More than one week or 10% whichever is less but less than 25%	35%
25% through 50%	50%
More than 50%	100%

Should The Resuscitation Group (TRG) cancel the program after a student has paid the full tuition, TRG will refund all monies paid by the student, including the application fee.

COURSES AND PROGRAMS OFFERED AT TRG

- Advanced Cardiac Life Support (ACLS)
- Advanced Cardiac Life Support – Experienced Provider (ACLS EP)
- Pediatric Advanced Life Support (PALS)
- Cardiopulmonary Resuscitation (CPR)
- AHA Blended learning programs (All disciplines)
- Trauma Life Support courses
- 12 Lead ECG and Capnography workshops
- Advanced Airway management workshops
- Advanced scope of practice, transport, wilderness, and SAR medicine courses
- Emergency Medical Responder (EMR) – NREMT and Washington State
- Emergency Medical Technician (EMT) Program – NREMT and Washington State
- Anesthesia Assistant Programs
    - Anesthesia Assistant (CCP)
    - Critical Care Transport (CCT)
    - Flight Paramedic and Flight Nurse
- Ultrasound Program
    - Basic Ultrasound
    - Emergency Ultrasound
    - Ultrasonography
- Tactical Medicine Program
- Search and Rescue (SAR) Medicine Program
- Disaster Medicine Program
- Crew Resource Management (CRM)
- Immersive simulation for healthcare staff drills
- Safety and disaster response drills
- Managing large scale events
- All terrain discipline rescue programs

POLICIES & PROCEDURES

ATTENDANCE

The education program is a rigorous program of study where any absences are detrimental to a student's chances of passing all required phases. Attendance is required for all classes. Excused absences will be granted for emergency situations only. Students are required to attest to attendance for each day of class. Absences, tardiness and/or early exits, and operational policies are as follows:

Absences:
A student will be allowed only three (3) absences with notification. Absences above this limit may result in expulsion from the program with any reimbursement provided in accordance with TRG scheduled refund policy.
An absence with prior notification means that the student has contacted the TRG staff more than one hour prior to the scheduled start of class.
After one (1) absence without prior notification or two (2) absences with notification, the student shall meet with the Program Director to create a remediation plan and the student will be placed on probation. In addition, if a student is absent for three (3) or more consecutive days, he or she will be expelled from the program with no reimbursement for tuition already paid.

During the clinical phase of a program, absence without prior notification to the educator or preceptor in charge is not acceptable and is cause for dismissal from the program.

Tardiness and Early Exits:
A student will be allowed only three (3) unexcused tardy or early exits. A tardy is defined as arriving to class more than 5 minutes after the scheduled start time. An early exit is defined as leaving class more than 30 minutes prior to the end of scheduled class time. Tardy arrivals or early exits above this limit will be cause for expulsion from the program with any reimbursement provided in accordance with TRG scheduled refund policy.

During the clinical phase of a program, tardiness without prior notification to the educator or preceptor in charge is not acceptable and is cause for dismissal from the program.

Make-up Work:
Students who miss assignments, exams, or any other work due to absences, tardiness, or early exits must make-up any missed assignments. Missed exams must be taken before the next day class can be attended.

During the clinical phase of a program, make up sessions or shifts are at the discretion of the educator or preceptor in charge.

Inclement Weather:
During inclement weather, TRG will hold class according to the Vancouver School District weather condition policy. Students should use added discretion when traveling from more rural areas. If class is in session, and the student deems it unsafe to travel to class, the Program Director should be contacted immediately.

Cell Phones and Pagers:
All cell phones, pagers, or other such electronic communication devices will be turned to vibrate during class and will not be utilized except for emergency or clinical contact during class.

Dress Code:
During didactic and laboratory sessions, students may wear any form of clothing they feel is appropriate, keeping in mind that The Resuscitation Group does not, under any circumstances, take responsibility for clothing which becomes soiled, stained, torn, or ruined during didactic or laboratory sessions.

Clinical Phase Behavior
All students are expected to follow the instructions of his or her educator/preceptor exactly and present a professional attitude/presence at all times.

CONFIDENTIALITY OF SUTDENT RECORDS (FERPA)

Student records are released only for legitimate educational reasons or pursuant to a student's express written consent. Students may provide written consent to the TRG staff by filling out and submitting the **Consent to Release Student Information** form.

A copy of this document is available at the back of this handbook, the form may not be sent electronically.

TRG adheres to the guidelines set forth in the federal Family Educational Rights and Privacy Act (FERPA).

Family Educational Rights and Privacy Act (FERPA)
The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S Department of Education.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1-800-877-8339. Or you may contact the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington D.C. 20202-5920

STUDENT EVALUATIONS

Students will be evaluated relative to the cognitive, psychomotor, and affective educational domains. Evaluation of students shall be conducted on a recurring basis and with sufficient frequency to provide both the student and program faculty with valid and timely indicators of the student's progress toward and achievement of entry level competencies stated in the curriculum.

STUDENT CONDUCT

Representation of the TRG Education Program:

Through their professional conduct, students represent TRG. The quality of medical care, abilities to explain and/or justify the care provided and even personal appearance all reflects the educational and professional philosophies of TRG.

We have an excellent reputation in the healthcare community because our faculty and students take pride in the TRG Education Program. Students should not make statements on behalf of TRG, or represent TRG in administrative, financial, educational, or policy matters without the express written authorization of TRG staff.

Honor Code:

Students are responsible for conducting themselves in a manner that is above reproach at all times. The TRG staff maintains that above all, ethical conduct, especially honesty, is one of the most important attributes of a competent healthcare professional. Having adopted the high ethical standard of the healthcare profession, the student is charged with the responsibility for the behavior of his or her colleagues as well as his/her own.

Violations of this honor code can be cause for dismissal from the program. Students with knowledge of an infraction of this honor code are obligated to provide this information to the TRG staff immediately. If a student fails to notify TRG staff immediately, the student could face disciplinary action up to and including expulsion.

Prohibited Conduct:

The following is a list of prohibited conduct. This list is not meant to be exhaustive, nor should it be inferred that items not expressly listed are acceptable. Students are required to abide by all rules, policies, and procedures dictated by TRG staff, whether indicated herein or communicated at a later date.

- Submitting material in assignments, examinations, or other academic work which is based upon sources prohibited by the instructor or the furnishing of materials to another person for the purposes of aiding another person to cheat
- Submitting material in assignments, examinations, and other academic work which is not the work of the student in question
- Knowingly producing false evidence or false statements, making charges in bad faith against any other person, or making false statements about one's own behavior related to educational or professional matters
- Falsification or misuse of TRG records, permits, or documents.
- Exhibiting behavior which is disruptive to the learning process or to the academic or community environment.
- Conviction of a crime, either:
    - Before becoming a student under circumstances bearing on the suitability of a student to practice a health or related profession, or
    - While a student at the program.
- Disregard for the ethical standards appropriate to the practice of a health or related profession while a student
- Attending any TRG Program while under the influence of alcohol, drugs, or medication that may impair one's ability to perform required functions is prohibited. It is inappropriate to be under the influence or have consumed within the last eight (8) hours any substance that would alter your state of mind, or jeopardize patient care (e.g. alcohol, drugs, or medications). Students should be aware that tolerances may vary and the eight (8) hour minimum may not be sufficient time for some individuals.
- If a student is suspected of being under the influence of alcohol, drugs, or impairing medication, he/she will be dismissed immediately from class, lab, or clinical placement. In such an instance, the student will fall under the procedures outlined in the Academic Discipline/Dismissal Procedure.
- Obstruction or disruption of teaching, research, administration, disciplinary procedures, or other institutional activities including the TRG public service functions or other authorized activities on institutionally owned or controlled property.
- Obstruction, disruption, and/or interfering with freedom of movement, either pedestrian or vehicular, on TRG owned or controlled property.
- Possession or use of firearms, explosives, dangerous chemicals, or other dangerous weapons or instruments on institutionally owned, TRG controlled property, or Clinical placement, unless the student is a law enforcement officer or active duty military personnel on specific assignment requiring armed capability.
- Detention or physical abuse of any person or conduct intended to threaten imminent bodily harm or endanger the health of any person on any TRG owned, TRG controlled property, or Clinical site.

- Malicious damage, misuse, or theft of TRG property, or the property of any other person where such property is located on TRG owned or controlled property or regardless of location, is in the care, custody, or control of TRG or a clinical site.
- Refusal by any person while on TRG owned or controlled property (or clinical site) to comply with TRG staff orders or an appropriate authorized official to leave such premises because of conduct proscribed by this rule when such conduct constitutes a danger to personal safety, property, or educational or other appropriate institutional activities on such premises.
- Unauthorized entry to or use of TRG facilities, including buildings and grounds.
- Use of TRG or clinical site computers for any activities involving (a) buying or selling of items not required for program use, (b) downloading programs off the Internet, including music or video files, (c) accessing Internet sites containing pornography or gambling.
- Inciting others to engage in any of the conduct or to perform any of the acts prohibited herein. Inciting means that advocacy of prescribed conduct which calls upon a person or persons addressed for imminent action and is coupled with a reasonable apprehension of imminent danger to the functions and purposes of the TRG including the safety of persons and the protection of its property.

Knowledge of Misconduct:
Any person who witnesses or has firsthand knowledge of misconduct as described in the section above is obligated to send a written report of the infraction to TRG Staff. Failure to do so may result in disciplinary action up to and including dismissal from the program.

DRUG AND ALCOHOL AWARENESS

TRG recognizes the obligation of the administration, faculty, staff, and students to support and maintain a community atmosphere that emphasizes the development of healthy lifestyles and the making of responsible, informed decisions concerning drug and alcohol use. Efforts to provide this atmosphere will include: education through curriculum infusion, intervention, treatment referral, and especially the support of healthy lifestyle alternatives.

The goal of these efforts is to provide factual information about use and abuse and to increase awareness of indicators of harmful involvement; to educate students, faculty, and staff concerning options for dealing with excessive consumption by self and/or others; and to educate concerning possible interventions to prevent further abuse.

Whenever a person is concerned about another's abuse of chemicals. The concerned individual is encouraged to speak privately with the abuser. Students needing assistance should consult with TRG staff for counseling and/or referral.

DISCIPLINE PROCEDURE

Academic Discipline/Dismissal Procedure:
Any student for whom a recommendation for discipline/dismissal is considered will have received ample notification of unsatisfactory work. The student will be notified in writing, either by email, personal delivery or posted letter, of the following:

1. Factors the TRG Program intends to consider in the discipline/dismissal proceedings.
2. The time and place for a meeting with members of the program staff.

From the time of written notification to the time in which the proceeding is held and a final decision rendered, the student loses all attendance privileges. This time period will not exceed three (3) business days.

A meeting will be convened, attended by members of the program staff and the student. During this meeting, the following will be reviewed:

- Policies and Procedures relevant to the disciplinary proceeding.
- Student's signed statement, agreeing to be bound by the TRG Education Program policies.
- TRG Education Program documentation regarding student's deficient performance.
- Student rebuttal.

Within five (5) business days of this meeting TRG Staff shall provide the student with a written decision. The student has the right to appeal the Instructors decision based on the Appeal Process outlined below.

APPEAL PROCESS

A student who has been dismissed from TRG program or disciplined in any way that the student feels is unfair may appeal the decision of the staff.

- **Step 1:**
  Within five (5) working days of receiving the Instructor's decision, the student shall provide to the Director staff (or his or her designee) a written request for an appeals hearing. The request should outline the alleged behavior that led to discipline and why the student does not believe this is a fair outcome.
- **Step 2:**
  Within five (5) working days of receiving the request for an appeals hearing, the Director staff (or his or her designee) shall meet with the student. During this meeting the student will present his or her case as to why he or she believes the discipline to be unfair.
- **Step 3:**
  Within five (5) working days of this meeting, the Director staff (or his or her designee) shall provide a written response to the student regarding this matter. The decision of the Director staff (or his or her designee) is final and may not be appealed.

DISCRIMINATION AND HARASSMENT

In addition to the prohibited behaviors listed above, TRG prohibits any type of discrimination or harassment against any person based on the following:

- Race
- National Origin
- Sex
- Age
- Creed
- Presence of physical, sensory, or mental disability
- Religion
- Color
- Disabled veteran status
- Sexual Orientation
- Affectional Preference
- U.S. Military Veteran status
- Marital Status

The responsibility for, and the protection of this commitment extends to students, faculty, administration, staff, contractors, and those who develop or participate in TRG programs. It encompasses every aspect of employment and every student and community.

Trainees are seeking to assume a vital position of trust in the community and taking on the responsibility of serving everyone in need of their services, regardless of gender, race, age, national origin, sexual orientation, economic or educational background, religion, or any other factor. This is the responsibility that goes with having access to people's private homes and lives in times of their great stress. It is your obligation to treat every patient and their families with equal respect. Everyone in the community must be approached and served with equal respect, care, and professionalism.

Persons who believe they have been discriminated against or harassed by TRG or its employee(s) or agent(s) on the basis of any status listed above, may request informal assistance and/or lodge a formal complaint.

COMPLAINT PROCESS

The process for filing a complaint for alleged discrimination or harassment is as follows:

- **Step 1:**
  The student shall provide TRG with a written summary of the alleged behavior which led to the complaint. If the complaint involves the Instructor, the student shall provide the complaint to the Director staff.
- **Step 2:**
  Having received the complaint, TRG shall review the facts with the Director staff and determine the appropriate course of action. Many situations can be resolved by the Instructor mediating a meeting between the complainant and the alleged offender. If that is not a viable option, or if it is not successful in resolving the matter, TRG shall initiate an investigation.
- **Step 3:**
  The investigation shall include interviews with the complainant and the alleged offender(s). This investigation may be conducted by TRG staff or outside investigators. This investigation will be completed within 45 days of the original complaint. Once the investigation is complete, the Instructor shall provide the complainant with a written summary of the findings and the action to be taken by TRG
  - No one shall be singled out, penalized, or retaliated against in any way by a member of the agency for initiating or participating in the complaint process. Retaliation may be grounds for disciplinary action.

If desired, inquiries or appeals beyond TRG level may be directed to:

Equal Employment Opportunity Commission
909 First Avenue, Suite 400
Seattle, WA 98104
(206) 220-6883

Washington State Human Rights Commission
711 South Capitol Way, Suite 402
PO BOX 42490
Olympia, WA 98504
(360) 753-6770

Workforce Training and Education Coordinating Board
128 10th Avenue, SW
PO BOX 43105
Olympia, WA 98504-3105
(360) 753-5673

BLOODBORNE/AIRBORNE PRECAUTIONS

In the laboratory and clinical settings students are at risk for exposure to blood borne pathogens and infectious diseases. All bodily substances should be considered potentially infectious. Personal protective equipment (PPE) is readily available in the laboratory, clinical, and field internship settings and should be used at any time where there is a possibility of exposure to blood borne pathogens. The minimum recommended PPE includes:

- **Gloves:** Disposable gloves should be worn BEFORE initiating patient care when there is any risk of exposure to bodily substances.
- **Masks and Protective Eyewear:** Masks and protective eyewear should be worn when there is any risk of blood or other bodily fluids splashing or spattering.
- **Gowns:** Gowns should be worn when there is any risk of blood or other bodily fluids splashing or spattering.
- **Hand Washing:** Hand washing is mandatory before and after any patient contact. All students must wash their hands after eating or using the restroom facilities.
- Any student who is exposed to a patient's bodily fluids should immediately decontaminate themselves and report the incident to their instructor or preceptor. Failure to adhere to precautions will result in disciplinary action.

PATIENT CARE & CONFIDENTIALITY

Students should expect to participate in the care of patients with infectious diseases during their educational activities. Students will follow Bloodborne/Airborne Precautions to avoid transmission of or infection from infectious diseases. The procedures deemed necessary should be those recommended by the Centers for Disease Control (CDC).

1) It shall be the responsibility of TRG or clinical placement site to provide adequate protective materials (e.g. disposable gloves, masks, eye protection), or to ensure that the student is not put in a position where unprotected exposure is likely. Some facilities may require the student to supply his/her own HEPA-filter masks as protection against airborne pathogens.
2) It shall be the responsibility of TRG or clinical site to instruct the student about accepted infection control procedures applicable to the student's activities.
3) It shall be the responsibility of the student to use the protective barriers provided, and to follow the instructions given, to minimize the risk of being infected by or transmitting any infectious diseases.

Student Illness or Injury:

Students are expected to exercise prudence in attending mandatory class or clinical sessions when ill. Healthcare professionals at clinical sites are empowered to restrict the activities of, or prohibit a student from completing a clinical shift.

Patient Confidentiality:

The following guidelines should be followed to protect the patient's right to privacy:

1. Students, staff, and faculty of TRG will comply with the patient confidentiality guidelines established in the Health Insurance Portability & Accountability Act (HIPAA) of 1996.
2. TRG Patient Charting Forms and the clinical logs submitted for review should not have patients name, social security number, address, phone number, hospital identification number, or any other uniquely distinguishing information noted on them.
3. Patient condition and/or therapy will not be discussed with anyone not directly involved in that patient's care. Cases may be discussed as part of the educational process of the TRG Program. During these case presentations, every effort will be made to protect the patient's confidentiality. Any discussion regarding patient condition or care will be undertaken in an area and under circumstances which prevent dissemination of information to others not directly involved in the patient care conference.
4. If patient care assessment or management problems are perceived, or questions arise regarding the care, the case may be discussed in private with the Program Director.

Students should understand that when at international clinical placements, the standards of patient confidentiality and behavioral values may differ from the United States. Students must show respect for and compliance with local customs and regulations.

RECORD KEEPING

The TRG maintains all training records in electronic format. All records will be made available to students and to authorized agencies upon request. All hard copy format student files, during the program instruction, are maintained in a locked office within TRG, only the Instructor, Executive Assistant, and the Director staff are permitted access to these records. Each student shall be permitted to review their file upon request. In addition, TRG conforms with all laws under the Family Education Rights and Privacy Act (FERPA) regarding any records released to outside sources. Student records will be maintained for a minimum of ten (10) years.

TRG Program Files:

TRG Program files will contain for each course: summary of student attendance, summary of all written exams and all practical exams, copies of all written exams with answer keys, copy of practical exam plan to include evaluators utilized. Also included for each course is a detailed syllabus, copy of applicable handbook(s), and records pertaining to clinical and field internship experiences.

Student Files:

Student files will contain the student application and any applicable documentation for prerequisites, waivers, signed code of conduct agreements, attendance record, skill competency record, exams, counseling forms, clinical evaluations, incident reports (as needed), clinical and field internship records, and copies of certifications earned.

Access to Student Files:

Any student shall have access to their personal class records upon request. This request should be made to the Instructor or the Director staff. The Instructor and student issuing the request will then review the student's file.

GRADING

The program is a preparatory program for exam process, such as the BCCTPC, BCEN, AREMT, HSI, and PHECC, as well as preparation to care for patients. It is important for all students to know at least 85% of the course content to successfully complete the program. This is ensured through homework, skills competency examination, authentic assessment, and exams.

Self-Paced Student Assignments:
Assignments are graded as pass/fail; and are due according to the course syllabus. Any assignments not turned in on time will be entered into the grade book as failed and successful completion of the course will not occur.

Exams:
Each student must pass exams to successfully complete the program. A minimum score of 85% on all exams is required. If an exam is failed, the student will be allowed one retest, after meeting with the director of the program. The exam must be retested within five (5) days of failing the exam. If the exam is not tested within five (5) days the student will be dismissed from the program.

If the student fails, the retest they will be dismissed from the program. If a second exam is failed, the student will meet with the director to discuss continuing in the program. It is the responsibility of the student to arrange to meet with the director and schedule a retest.

If a student misses an exam due to an absence, they must take the exam before their next class day.

If a retest is passed the maximum score the student will receive for that exam will be 85%.

Exam Grading Scale:
Grades during the didactic phase will be determined on the basis of the following:

A	95% - 100%	Exceeds Expectations
B	86% - 94%	Exceeds Standard
C	85%	Satisfactory
F	0% - 84%	Failing

Method to report Student Grades:
Student's grades will be posted and accessible via electronic record.

Academic Probation / Remediation:

Failure of a student to meet academic or skill performance standards will result in remedial action to address educational strategies. Such corrective action may include additional course work in the form of oral presentations, written assignments, additional examinations, and/or one-on-one coaching by peers or staff. Remediation may be initiated by the student or the Director staff. All remedial sessions will be documented and recorded in the student's personal file. Inability to resolve academic or skill performance deficiencies with remedial course work is grounds for dismissal. A student may discuss academic or skill performance difficulties at any time by making an appointment directly with the Director staff.

GRADUATION

REQUIRMENTS

1. Payment in full of all TRG Program tuition and fees.
2. Meet minimum attendance requirements.
3. Satisfactory completion of all didactic requirements with grade scores of at least 85%.
4. Satisfactory completion of all skills competency examinations with a “meets standard” rating.
5. Satisfactory completion of clinical placement and submission of supporting documentation.
6. Submission of all assigned writing assignments

CERTIFICATE AND PERMANENT RECORD

Students successfully completing the program will receive a certificate in Resuscitation Officer. An example of the certificate is below:

The Resuscitation Group
901 West Evergreen Blvd
Vancouver, Washington USA 98660
+1-855-739-2257
http://resuscitationgroup.com/

After 40 hours (2.5 credits) of program study

(INSERT NAME)

Has successful completed the required course of study delivered by The Resuscitation Group (Vocational/Technical School licensed under Chapter 28C.10RCW.), and is therefore awarded this

Certificate - Dental Anesthesia Assistant

School Director

Course Director

Date

The student’s academic records will be kept on file at TRG for a minimum of fifty (50) +1 years using secured cloud capabilities as required per state law WAC 490-105-200.

PLACEMENT SERVICES

None

EDUCATIONAL CREDENTIAL UPON GRADUATING

Upon graduation from the program student will be prepared to potentially successfully complete national or international exams.

The Resuscitation Group

Consent to Release Student Information

The TRG philosophy regarding student information is that students are adults and we generally will not share their academic and/or financial records with third parties, including parents, without consent. At the same time, we will share a student's education records where the student has given consent and in other cases permitted by federal law. The Family Educational Rights and Privacy Act of 1974 (FERPA) and the TRG policy on the confidentiality of student records protect the privacy of student education records and generally limit access to the information contained in those records by third parties. FERPA and TRG policy, however, do provide for situations in which TRG may, at its discretion, and sometimes must, disclose information without a student's consent. For example, we may disclose education records to a parent without the consent of the student of the student is listed as a financial dependent on the parent's federal tax submission (financial aid applicants) when we determine such disclosure is merited. **You may choose to grant TRG the right to disclose education records to certain individuals in accordance with FERPA and TRG policy by filling out and signing this consent form.**
You have the right to revoke the permissions granted here at any time by submitting your written revocation to the office maintaining this consent form. Such revocation will not affect disclosure made by the TRG relying on your consent prior to receipt of such notice of revocation. **Note: this form does not pertain to Medical inquiries.**

Student's Name: _____

Last four digits of your SSN: _____

I have listed below the individual(s) to whom TRG may release information from my education records:
Name: _____
Relationship to Student: _____
Address & Telephone #: _____
Name: _____
Relationship to Student: _____
Address & Telephone #: _____

The above named individual(s) may have access to the following information (examples: all academic information, all financial information):

_____
_____
_____
_____

Student Signature_____ Date_____

ACADEMIC GUIDELINES

1. Reading assignments are to be completed prior to class.
2. Attendance is required for all classes. Excused absences will be granted for emergency situations only.
3. You will be responsible and accountable for all equipment assigned to you during skill stations and patient care scenarios. You are expected to assist in the cleaning and proper storage of equipment after each class.
4. Tests will include the material from the resource texts, online resources, and classroom work.
5. Any student may withdraw from the program at any time; refunds will be made according to the policy.
6. Any student may be dismissed if they do not meet the course standards; this will include skills, clinical rotation, and written grades (after review by the Director staff and the individual).
7. Passing score for this program is 85% or greater on exams and "meets standard" on skills competencies and clinical evaluations.
8. If the student does not successfully pass any practical portion of the class, they will not receive a passing grade or a course completion certificate.

GENERAL RELEASE

I understand that the education and work of a Resuscitation Officer, including lab work and clinical rotations within hospitals or other healthcare facilities with which I may be associated, are inherently dangerous and could expose me to accident and injury, including but not limited to blood borne and airborne pathogens, needle sticks, and many other dangerous and hazardous situations and environments, and I hereby release and hold harmless The Resuscitation Group and any other their employees, instructors and volunteers from any liability associated with these risks.

All students have the understanding that taking and successfully completing the required written and practical material does not guarantee the student will obtain certification and/or practice as a Anesthesia Assistant in the state of Washington or any other state.

I, (Print Student Name)_____, understand the Student Code of Conduct from this handbook and agree to follow these policies and procedures of TRG.

I, (Print Student Name)_____, understand this activity will fundamentally place me in an environment that has risks, dangerous situations, and exposure to potentially deadly diseases and accept this potential risk as my own, holding all organizations and staff associated with this program harmless from liability.

_____ _____

Student Signature Date

NOTICE OF LICENSURE

This school is licensed under Chapter 28C.10RCW.

Inquiries or complaints regarding this private vocational school may be made to the:

Workforce Board, 128 – 10th Ave., SW, Box 43105, Olympia, Washington 98504
Web: wtb.wa.gov
Phone: (360) 709-4600
E-Mail Address: pvsa@wtb.wa.gov

APPENDIX 1

Anesthesia Assistant Curriculum

Anesthesia Assistant Training Program

Course Description: This 40-hour course, instructor led and Physician oversighted, designed to provide the Anesthesia Assistant a program of learning to enhance the knowledge and skills of the

Course Contact:
The Resuscitation Group
+1-855-739-2257
info@resuscitationgroup.com
www.resuscitationgroup.com

Course Location:
The Resuscitation Group
901 West Evergreen Blvd, Vancouver, WA 98660

Prerequisites:

1. Washington State KNOW HIV Prevention Education for Health Care Facility Employees (7 hour course certificate)
2. Current AHA ACLS Provider Certification

Pre-Course Review Media:

Conscious Sedation for Minor Procedures in Adults NEJM
https://youtu.be/BSYYq01Y9xQ

Understanding IV Conscious Sedation
Gina L. Salatino DMD, FAGD
https://youtu.be/bZHzQsgovy8

Principles of Capnography Lesson 1
https://youtu.be/KLRPlvbw3M8

Principles of Capnography Lesson 2: Basic principles
https://youtu.be/rsd5C7FLXXo

Principles of Capnography Lesson 3: Capnography waveforms
https://youtu.be/GUV7BTlGLeM

Nitrous Oxide Oxygen Sedation
Royal College
https://youtu.be/1o35MoG3cc8

Intravenous line insertion, IV starting techniques, How to start an IV.
Eyad Ahmed MD. https://youtu.be/sGKZbKlSQSM

Reasons Why People Miss Veins When Starting an IV or Drawing Blood.
RegisteredNurseRN.com; https://youtu.be/jNf-8DwW224

How to start an IV : Antecubital Fossa. Med School Made Easy Inc. https://youtu.be/IxhXahrXLbQ

Instructional Format: Integrative lectures, practical skills lab, and supervised practice.

Participation Expectations: In order to successfully complete this course of instruction, a registered participant must be present for all scheduled hours and be engaged in the interactive discussions, case reviews and knowledge evaluation. Participants will successfully:

1. Complete a comprehensive written examination with a score of 86% or better.
2. Successfully manage three anesthesia emergencies in an immersive simulation environment, under the observation of instructor staff and scored against the NREMT scenario skills sheet.
3. Successfully complete five (5) intravenous catheter placements under the observation of the instructor staff, using the NREMT IV Access Skills Sheet Standard.
4. Successfully complete ten (10) intravenous catheter placements under the supervision of their Dental or Medical Provider.

Course completion: Having met the Participation Expectations listed above, a participant will receive a Course Completion indicating the respective course or module hours completed. It is recommended that the participant also retain this Syllabus and the attached module descriptions as further documentation to professional certification/licensure agencies or employers of content, objectives, outcomes, and assessments.

Course Certification: Having successfully completed the program of instruction and 10 independent vascular access initiations, the student will receive a *Certificate in Anesthesia Assistant* from the Resuscitation Group with approval from the Washington State Workforce Training - Vocational Education Board.

Objectives: Educational content covered in this course includes a review of current science and best practices, with the following objectives:

1. Orientation to the continuum of sedation.
2. Demonstration of pre-procedure patient evaluation and monitoring.
3. Recognition of respiratory and/or circulatory compromise.
4. Ability to describe patient safe monitoring procedures.
5. Recognize the role of pulse oximetry and quantitative waveform capnography in sedation.
6. Demonstrate the ability to interpret common waveform capnography waveforms.
7. Demonstrate familiarity with common anesthesia pharmacological agents; including, but not limited to: Ketamine, Midazolam, Lorazepam, Fentanyl, and Propofol.

8. Demonstrate the ability to respond with a systematic resuscitative approach to the following common anesthesia emergencies; including: hypoxia, hypotension, hypertension, bradycardia, cardiac arrest, respiratory conditions, angina, syncope, stroke, allergy, and hypoglycemia.
9. Recognize the role of IV Therapy and medication infusion.
10. List factors that affect flow rates of IV solutions.
11. Describe proper use of specific IV therapy equipment.
12. Initiate IV therapy utilizing nursing precautions or patient safety by:
    a. Preparing the patient psychologically
    b. Explaining the rationale for venipunctures
    c. Differentiating between the types of skin puncture, venipunctures and arterial devices and their appropriate uses
    d. Differentiating between skin puncture, arterial puncture, and venipunctures
    e. Distinguishing between types of intravenous solutions and their appropriateness
    f. Preparing equipment properly and aseptically
    g. Selecting and correctly preparing the most appropriate vein for venipuncture
    h. Preparing the site in a manner which reduces the chance of infection
    i. Performing venipuncture utilizing direct or indirect method
    j. Dressing site according to policy
    k. Securing and immobilizing device appropriately and safely
    l. Regulating flow rate and fluid accurately
    m. Documenting on medical record
13. Recognize complications related to venipunctures.
14. Recognize local and systemic reactions related to intravenous therapy and medications.
15. List the measures taken to reduce local and systemic reactions
16. List three reasons to discontinue and restart IV access.
17. List the cause and differentiate clinical symptoms of electrolyte imbalances.
18. Identify the role of IV therapy and pH balance.
19. Differentiate actions, dosages, side effects, and implications of specified intravenous solutions.
20. Correlate the IV fluid container label with the name of the solution as commonly ordered.
21. Examine the differences between techniques used in adult and pediatric IV therapy.
22. Discuss situations related to IV therapy and legal implications.
23. Describe appropriate ways of minimizing legal risks in IV therapy and blood withdrawal practice.
24. Identify the safety precautions in regards to administering IV fluids.
25. Properly calculate, draw up, and administer IV medications.
26. Successfully manage three anesthesia emergencies in an immersive simulation environment.

Outcomes: Participants who successful complete this course will be able to:

- Discuss the continuum of sedation.
- Explain the perimeters for patient safe monitoring during conscious sedation.
- Describe pharmacological agents for conscious sedation.
- Demonstrate proper administration of pharmacological agents.
- Discuss proper pre-procedure evaluation and physical exam processes.
- Demonstrate proper response to anesthesia emergencies in a simulation environment.
- Discuss the structure and function of veins.
- Identify the names and the locations of the veins most suitable for phlebotomy and cannulation/venipuncture.
- Assemble equipment and supplies needed to collect blood and for cannulation/venipuncture and discuss the correct use of each.
- Demonstrate the steps in performing blood collection and cannulation/venipuncture procedure.
- Assess techniques and equipment used to minimize biohazard exposure in blood collection and cannulation/venipuncture.
- Evaluate procedural errors in blood collection and cannulation/venipuncture and discuss remedies for each.
- Differentiate complications associated with blood collection and cannulation/venipuncture and their effect on the quality of laboratory results.

Assessments: Knowledge Evaluation Tool completion and skills testing completion.

Course Outline:

Day 1:

0800-0815	Course Introduction and Registration
0815-0900	Continuum of Sedation
0900-1030	Pharmacology
1030-1200	Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 1
1200-1300	Lunch
1300-1400	Physiologic monitoring (EtCO2, SpO2, ECG, NIBP) Part 2
1400-1700	Emergency Response Protocols for anesthesia emergencies

Day 2:

0800-1200	Intravenous Therapy Didactic
1200-1300	Lunch
1300-1700	Intravenous Therapy and Pharmacology Lab
1700-1715	Participants orientation to provider supervised activities

Day 3:

0800-1200	Immersive Simulation – Anesthesia Emergencies
1200-1300	Lunch
1300-1700	Immersive Simulation – Anesthesia Emergencies

Day 4:

0800-1700	Anesthesia Lab

Day 5:

0800-1200	Immersive Simulation – Anesthesia Emergencies
1200-1300	Lunch
1300-1700	Immersive Simulation – Anesthesia Emergencies

APPENDIX 2

Education, Competency Assurance, Privileges to Practice Considerations

Education, Competency Assurance, Privileges to Practice Considerations

What is the best way to determine if a provider is competent? This question is increasingly being asked by employers, regulators, certifying agencies, insurance companies, and professional associations. Currently in the majority of jurisdictions and courts, a practitioner is determined to be competent when initially licensed, able to show proof of skills competencies, and has the approval of medical oversight; thereafter unless proven otherwise, the issue of competency has been through this pathway, yet in the past decade, legal actions and media investigations have thrown a poor light on this pathway.

As a result, the simple fiscal impacts to the major carriers has resulted in a standard determination that the standard must change. Many organizations and regulatory authorities are exploring alternative approaches to assure continuing competence in today's environment where technology and practice are continually changing, new health care systems are evolving and consumers are pressing for providers who are competent, both privately, through legal action, and through social media processes.

The purpose of this discussion is to explore various approaches and views related to continuing competency and examine the difficult policy, development and implementation issues related to continuing competency.

Both the American Medical Association (AMA) and the American Nurses Association (ANA) have been asked this question by their membership, regulators, consumers and the public. Since competence of the provider has become a primary concern of the profession, Both the AMA and ANA have embarked on the development of policy addressing the continuing competence of practicing providers.

The American College of Emergency Physicians (ACEP) believes that:

1. The exercise of clinical privileges in the emergency department is governed by the rules and regulations of the department;
2. The medical director (or their designee) is responsible for periodic assessment of clinical privileges of emergency physicians against the national competency guidelines;
3. When a physician applies for reappointment to the medical staff and for clinical privileges, including renewal, addition, or rescission of privileges, the reappraisal process must include assessment of current competence by the medical director (or their designee);
4. The medical director (or their designee) will determine the means by which each emergency physician will maintain competence and skills and the mechanism by which the proficiency of each physician will be monitored.

(Revised and approved by the ACEP Board of Directors October 2014, June 2006 and June 2004)

Mechanisms for continuing competence include regulatory and private sector approaches, as well as approaches by national organizations, certifying entities, and state boards.

Regulatory Approaches to Continuing Competence:
Health care practitioners are regulated by state regulatory boards with the purpose of protecting the health, safety and welfare of the public. When a practitioner is initially licensed, they are deemed by the state to have met minimal competency standards. The challenge of licensure boards is to assure practitioners are competent throughout their practice career not just with initial licensure. As well as address the issues of post licensure inexperience during the first licensure period.

The ongoing demonstration of continuing competence is not a new regulatory issue.

According to a national commission on health manpower sponsored by the U.S. Department of Health, Education and Welfare recommended physicians undergo periodic reexaminations *(Schmitt Shimberg 1996)*. In 1971, a similar report recommended that requirements to ensure continued competence should be developed by professional associations and states. The alternative to periodic reexamination was deemed to be continuing education (CE) and states began requiring mandatory CE as a condition of licensure renewal for a variety of professions. The National Registry of Emergency Medical Technicians (NREMT) required both continuing medical education and skills competency evaluation in its very first year of establishment.

Continuing Education and Clinical Competence:
This approach to continuing competence proved to be controversial. Given the broad parameters of what continuing education consists of and the lack of formal research to support the correlation between participation in continuing education and continuing competence related to improved practice outcomes, this method has been called into question. However, several investigators are working to make this link by designing a longitudinal descriptive research study to determine the relationship between education sessions and practice.

The 2006 study, National Reregistration and the Continuing Competence of Paramedics, by Keith Holtermann and colleagues, found that NREMT Paramedics who reregistered 4 and 6 years after initial registration were twice as likely to pass the exam as their State-certified cohort counterparts who did not reregister with the NREMT. The registered group, compared to the nonregistered group, had significantly more Continuing Medical Education. The findings suggest that Paramedics who reregister with the NREMT are more knowledgeable than those who do not reregister.

In a 2011 study *(The Association Between Emergency Medical Services Field Performance Assessed by High-fidelity Simulation and the Cognitive Knowledge of Practicing Paramedics; Jonathan R. Studnek PhD, NREMT-P, Antonio R. Fernandez PhD, NREMT-P, Brian Shimberg NREMT-P, et Al)*, investigators simultaneously assessed cognitive knowledge and simulated field performance. Utilization of these measurement techniques allowed for the assessment and comparison of field performance and cognitive knowledge. Results demonstrated an association between a practicing paramedic's performance on a cognitive examination and field performance, assessed by a simulated EMS response.

Substantial research demonstrates that the stressors accompanying the profession of paramedicine can lead to mental health concerns. In contrast, little is known about the effects of stress on paramedics' ability to care for patients during stressful events. In this study, investigators examined paramedics' acute stress responses and performance during simulated high-stress scenarios. Advanced care paramedics participated in simulated low-stress and high-stress clinical scenarios. The paramedics

provided salivary cortisol samples and completed an anxiety questionnaire at baseline and following each scenario. Clinical performance was videotaped and scored on a checklist of specific actions and a global rating of performance. The paramedics also completed patient care documentation following each scenario. Results showed that clinical performance and documentation both appeared vulnerable to the impact of acute stress. Developing systems and training interventions aimed at supporting and preparing emergency workers who face acute stressors as part of their everyday work responsibilities is a vital avenue to successful patient outcomes. *(LeBlanc VR, Regehr C, Tavares W, Scott AK, MacDonald R, King K. The impact of stress on paramedic performance during simulated critical events. Prehosp Disaster Med. 2012)*

In a randomized controlled trial, simulation based learning was superior to problem based learning for the acquisition of critical assessment and management skills *(Simulation-based training is superior to problem-based learning for the acquisition of critical assessment and management skills; Steadman, Randolph H. MD; Coates, Wendy C. MD; et Al; Critical Care Medicine; January 2006 - Volume 34)*

The link between exposure to patients and improvement in performance has been established many times in literature, but perhaps most compelling of recent studies is from Australia, where patient survival after OHCA significantly increases with the number of OHCAs that paramedics have previously treated *(Paramedic Exposure to Out-of-Hospital Cardiac Arrest Resuscitation Is Associated With Patient Survival; Kylie Dyson, Janet E. Bray, et Al; Circulation: Cardiovascular Quality and Outcomes; January 26, 2016)*

In the past twenty years, state legislative action related to continuing competency has increased. In 1999, legislation was passed in Tennessee requiring the development of continuing competence requirements of providers. In the same year, legislation was passed in Vermont mandating continuing competency evaluations of physicians, chiropractors, and podiatrists. Currently, twenty-four states have introduced legislation relative to continuing competence of health professions. Most legislation would require licensees to demonstrate continuing competence to a licensure board upon re-licensure while some bills would require a provider to demonstrate competency in the workplace setting.

A bill in Massachusetts that would authorize the Board of Registration (Board of Nursing) to require periodic competency testing of all licensed and registered nursing including testing of current nursing practice and procedures. Failure to pass this test would result in automatic suspension of a nurses' license until competency was established. A bill introduced in Hawaii would require nurses in hospitals to demonstrate competence in providing care in order to be assigned to a nursing unit. Other continuing competence bills apply to chiropractors, podiatrists, dentists, dietitians, physicians, paramedics, pharmacists and speech-language pathologists.

As states regulate advanced practice, they are turning to certification as an indicator of entry-level competence. Certification in these instances is therefore not a voluntary process, but instead constitutes a regulatory requirement to ensure public safety and enhance public health. As a result, certifying bodies are expected to demonstrate that their initial certification exams truly reflect entry level and that their recertification process reflects continuing competence.

The underlying assumptions regarding the use of certification to ensure competence and its inherent value have been increasingly questioned since the late 1970's. There is a dearth of empirical data which substantiate the predictive power of certification and recertification exams, which has led to the assertion that certification does not have an impact on patient outcomes.

Private Sector Approaches to Continuing Competence:
The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requires hospitals to assess the competency of employees when hired and then regularly throughout employment. The competence assessment is defined as "the systematic collection of practitioner-specific data to determine an individual's capability to perform up to defined expectations." *(Joint Commission on Accreditation of Healthcare Organizations, 1998)*.

Pew Commission Reports on health professions licensure issues have been a catalyst in bringing the issue of continued competence to the public's attention. In its 1995 report, Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century, one of the proposed recommendations is: "States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals." Accompanying the recommendation was a series of policy options. In formal responses to the report from the public, this recommendation received the highest score for level of concern and one of the highest scores for level of support. There were 76 formal responses to the report; 45% were from the nursing community which included state and national organizations as well as nursing boards; 26% of the responses were from individuals; and 29% from other health care professions including occupational therapy, physical therapy, medicine, pharmacy and dentistry *(Gragnola, Stone, 1997)*. Identified barriers to reform included the complexity of the health care environment and the vast differences in practice. These differences make testing for competence difficult as areas of expertise may not fit into standardized testing.

A second Pew Report, Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation was released in October of 1998. One of the three priority issues included in the report was continuing competence. The report recommended that state regulatory boards should be held responsible to require health care practitioners to demonstrate competence throughout their careers. However, the report added that the "actual assessment of competence may best be left to the professional associations, private testing companies and specialty boards" *(Pew Health Professions Commission, 1998)*.

The Interprofessional Workgroup on Health Professions Regulation, which represents 17 health professions, received a Pew Foundation grant to sponsor a continuing competence Summit entitled, "Assessing the Issues, Methods and Realities for Health Care Professions," July 25 - 26, 1997 in Chicago, Illinois. The objective of the Summit was for participants to recognize the significance of ensuring continued competence for health care professionals. The Summit focused on analyzing the issues related to continuing competence and promoted discussion of various methods of assessing continuing competence.

Other measures to promote competence have been indirectly aimed at the prevention of potential problems through accreditation of educational institutions, background checks on licensees and the threat of disciplinary action if the licensee is reported to the board.

Whose role is it to assure continuing competence? Is it the role of the individual provider, professional association, employer, regulatory board, or certifying agency to assure continued competence? Should all of the stakeholders be involved, or just one or two?

Dennis Wentz, American Medical Association, points out that 90% of physicians take specialty board examinations and pass. There are continuing medical education requirements for recertification. Fourteen programs are now operational and moving toward maintenance of competence rather than testing at intervals.

The ANA sponsored Expert Panel appointed in 1999 has formulated the following assumptions regarding continuing competence:

1. The purpose of ensuring continuing competence is the protection of the public and advancement of the profession through the professional development of providers.
2. The public has a right to expect competence throughout provider's careers.
3. Any process of competency assurance must be shaped and guided by the profession of the provider.
4. Assurance of continuing competence is the shared responsibility of the profession, regulatory bodies, organizations/workplaces and individual providers.
5. Providers are individually responsible for maintaining continuing competence.
6. The employer's responsibility is to provide an environment conducive to competent practice.
7. Continuing competence is definable, measurable and can be evaluated.
8. Competence is considered in the context of level of expertise, responsibility, and domains of practice.

Building on existing regulatory models and the mission of its organizations, the National Council of State Boards of Nursing (NCSBN) has explored various approaches to determine continued competence. NCSBN has investigated the use of computer simulated testing (CST) for assessing nursing competence, reviewed and utilized mandated continuing education, and is now focusing on the licensee's responsibility for individual competence. NCSBN has also explored through the Continuing Competence Accountability Profile (CCAP), a self-assessment tool, which "provides a framework for nurses to track and document a synthesis of professional growth activities across a nurse's career." NCSBN recognizes that continued competence is a multifaceted issue that compels the profession, consumers and other to assist in comprehensive development of options to best assure ongoing nursing education and skill levels. (National Council of State Boards of Nursing, 1998).

In addition to competency assessment, the issue of clinical privileges is significant.

In its Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine, the American College of Emergency Physicians (ACEP) states the medical director (or designee) is responsible for setting competence criteria. The medical director is also ultimately responsible for determining the competence of individual department members.

The medical director must also be in compliance with established department proficiency and competence criteria. In the event of question or dispute over the medical director's competency, the matter may be referred to the medical staff's credentials committee or to the medical executive committee.

Establishing criteria for proficiency and the evaluation of proficiency may be problematic. For those medical specialties that perform major procedures (i.e.: surgery, emergency medicine, etc..), establishing numerical thresholds may be a valid methodology (ie, requiring that a minimal number of procedures be

performed during the privileging period under review). Lack of numerical compliance requires stress inoculation simulation performance appraisal.

However, for those specialties that are primarily "cognitive" in nature, which employ a wide armamentarium of "minor" procedural skills, establishing numerical thresholds for numerous procedures may be very difficult to track. Further, it is not clear whether such tracking of "minor" procedural skills is a valid component of proficiency assessment.

Many departments will choose to establish clinical privileges assessment methodologies that utilize a combination of procedure tracking (frequency), plus assessment based on sentinel events, training, assessment, and information forthcoming from the department's overall quality improvement plan.

Establishing frequency thresholds in emergency medicine may be problematic. Certain procedures may be performed very rarely (eg, cricothyrotomy). Yet, all emergency physicians must be capable of performing this and several other rarely-performed emergency procedures. In the event that a member does not meet or exceed numerical thresholds for procedures when such thresholds have been set, an option is to extend a providers procedure privileges through a "skills lab" (eg, educational review, demonstration, simulation and testing) is a recommended process.

In their work, Defining and Assessing Professional Competence, Epstein and Hundert *(JAMA 2002;287(2):226-235)* stated that in addition to assessments of basic skills, new formats that assess clinical reasoning, expert judgment, management of ambiguity, professionalism, time management, learning strategies, and teamwork promise a multidimensional assessment while maintaining adequate reliability and validity. Institutional support, reflection, and mentoring must accompany the development of assessment programs.

Summary:

Clinical competency, defined as, “The capability to perform acceptably those duties directly related to patient care. competence in professional activities directly related to patient care”, has been an issue for decades in healthcare. As early as 1967, a national commission on health manpower sponsored by the U.S. Department of Health, Education and Welfare recommended licensed physicians be re-examined periodically; this commission later recommended CE as an alternative to re-licensure. State legislatures continue to address continuing competence, as do the courts and private accreditation and certification agencies.

The reality of critical care medicine, especially as applied in the prehospital environment, requires that each and every provider have base licensure, recognized educational processes, regular competency assessment, and a formal process for clinical privilege granting.

Failure to have a defendable program that does not include skills demonstration, simulation, and supervised clinical practice as components of the process will not lead to improved patient outcomes, and most certainly will lead to professional or legal complications.

APPENDIX 4

Course Participant Assessment Documents and Tools

National Registry of Emergency Medical Technicians
Advanced Level Psychomotor Examination

INTRAVENOUS THERAPY

Candidate: _____ Examiner: _____
Date: _____ Signature: _____
Level of Testing: ❑ NREMT-Intermediate/85 ❑ NRAEMT ❑ NREMT-Intermediate/99 ❑ NR-Paramedic

Actual Time Started: _____

	Possible Points	Points Awarded
Checks selected IV fluid for: -Proper fluid (1 point) -Clarity (1 point) -Expiration date (1 point)	3	
Selects appropriate catheter	1	
Selects proper administration set	1	
Connects IV tubing to the IV bag	1	
Prepares administration set [fills drip chamber and flushes tubing]	1	
Cuts or tears tape [at any time before venipuncture]	1	
Takes or verbalizes body substance isolation precautions [prior to venipuncture]	1	
Applies tourniquet	1	
Palpates suitable vein	1	
Cleanses site appropriately	1	
Performs venipuncture -Inserts stylette (1 point) -Notes or verbalizes flashback (1 point) -Occludes vein proximal to catheter (1 point) -Removes stylette (1 point) -Connects IV tubing to catheter (1 point)	5	
Disposes/verbalizes proper disposal of needle in proper container	1	
Releases tourniquet	1	
Runs IV for a brief period to assure patent line	1	
Secures catheter [tapes securely or verbalizes]	1	
Adjusts flow rate as appropriate	1	

Actual Time Ended: _____ **TOTAL** **22** _____

NOTE: Check here ❑ if candidate did not establish a patent IV within 3 attempts in 6 minutes. Do <u>not</u> evaluate the candidate in IV Bolus Medications.

Critical Criteria
___ Failure to establish a patent and properly adjusted IV within 6 minute time limit
___ Failure to take or verbalize appropriate body substance isolation precautions prior to performing venipuncture
___ Contaminates equipment or site without appropriately correcting the situation
___ Performs any improper technique resulting in the potential for uncontrolled hemorrhage, catheter shear, or air embolism
___ Failure to successfully establish IV within 3 attempts during 6 minute time limit
___ Failure to dispose/verbalize disposal of blood-contaminated sharps immediately in proper container at the point of use
___ Failure to manage the patient as a competent EMT
___ Exhibits unacceptable affect with patient or other personnel
___ Uses or orders a dangerous or inappropriate intervention

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.

INTRAVENOUS BOLUS MEDICATIONS

Actual Time Started: _____

	Possible Points	Points Awarded
Asks patient for known allergies	1	
Selects correct medication	1	
Assures correct concentration of medication	1	
Assembles prefilled syringe correctly and dispels air	1	
Continues to take or verbalize body substance isolation precautions	1	
Identifies and cleanses injection site closest to the patient [Y-port or hub]	1	
Reaffirms medication	1	
Stops IV flow	1	
Administers correct dose at proper push rate	1	
Disposes/verbalizes proper disposal of syringe and needle in proper container	1	
Turns IV on and adjusts drip rate to TKO/KVO	1	
Verbalizes need to observe patient for desired effect and adverse side effects	1	

Actual Time Ended: _____ **TOTAL** **12** _____

Critical Criteria
___ Failure to continue to take or verbalize appropriate body substance isolation precautions
___ Failure to begin administration of medication within 3 minute time limit
___ Contaminates equipment or site without appropriately correcting the situation
___ Failure to adequately dispel air resulting in potential for air embolism
___ Injects improper medication or dosage [wrong medication, incorrect amount, or pushes at inappropriate rate]
___ Failure to turn-on IV after injecting medication
___ Recaps needle or failure to dispose/verbalize disposal of syringe and other material in proper container
___ Failure to manage the patient as a competent EMT
___ Exhibits unacceptable affect with patient or other personnel
___ Uses or orders a dangerous or inappropriate intervention

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.

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National Registry of Emergency Medical Technicians
Advanced Level Psychomotor Examination

ORAL STATION

Candidate:_____ **Examiner:**_____

Date:_____ **Signature:**_____

Scenario:_____

Actual Time Started: _____

	Possible Points	Points Awarded
Scene Management		
Thoroughly assessed and took deliberate actions to control the scene	3	
Assessed the scene, identified potential hazards, did not put anyone in danger	2	
Incompletely assessed or managed the scene	1	
Did not assess or manage the scene	0	
Patient Assessment		
Completed an organized assessment and integrated findings to expand further assessment	3	
Completed primary survey and secondary assessment	2	
Performed an incomplete or disorganized assessment	1	
Did not complete a primary survey	0	
Patient Management		
Managed all aspects of the patient's condition and anticipated further needs	3	
Appropriately managed the patient's presenting condition	2	
Performed an incomplete or disorganized management	1	
Did not manage life-threatening conditions	0	
Interpersonal relations		
Established rapport and interacted in an organized, therapeutic manner	3	
Interacted and responded appropriately with patient, crew, and bystanders	2	
Used inappropriate communication techniques	1	
Demonstrated intolerance for patient, bystanders, and crew	0	
Integration (verbal report, field impression, and transport decision)		
Stated correct field impression and pathophysiological basis, provided succinct and accurate verbal report including social/psychological concerns, and considered alternate transport destinations	3	
Stated correct field impression, provided succinct and accurate verbal report, and appropriately stated transport decision	2	
Stated correct field impression, provided inappropriate verbal report or transport decision	1	
Stated incorrect field impression or did not provide verbal report	0	

Actual Time Ended: _____ **TOTAL** **15**

Critical Criteria

____ Failure to appropriately address any of the scenario's "Mandatory Actions"
____ Failure to manage the patient as a competent EMT
____ Exhibits unacceptable affect with patient or other personnel
____ Uses or orders a dangerous or inappropriate intervention

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.

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