

# Orientation for Preceptors

Connie J. Mattera  
EMS Administrative Director, NWC EMSS

Worth 1000.com

*Introducing your new mentees!*  
“You are now our partners in ...  
education & practice excellence!”




Northwest Community Healthcare (NCH) PARAMEDIC PROGRAM

## Squad and Agency Assignments 2018-2019

Squad 1	Squad 2	Squad 3	Squad 4	Squad 5
Nicholas Berghaus BLFPD	Matthew Bakke PAL	Daniel Awisha SCH	Rebecca Gaare HEFD	Nicholas Czerniak EGTWDFD
Jim Bollenbacher BGFD	Matthew Bohnen SCH	Ryan Brueckert WDFD	Samuel Garcia SCH	Robert Loverher SCH
Kristian Kalev LZFD	Tyler Brendle RMFD	Nick Chiam BCFPD	Alexander Gard EGV	Jacob Thornton MPFD
Kevin Leska SCH	Brian Repple AHFD	Trevor Korinek BLFPD	William Lehnert AHFD	Jack Trujillo SCH
Ana Rosales (Tallon) HEFD	William Shanahan EGV	Ashley Kuffner BAFD	John Meyer DFFD	Kelsey Wittmann DFFD
Adam Schallmoser PAL	Shannon Walters PAL	John McDermott MPFD		

**Hospital EMS Coordinator/Educator assignments:**  
**Alexian Brothers Medical Center (Georgene Fabrizi):** Nicholas Berghaus (BLFPD); Ryan Brueckert (WDFD); Nicholas Czerniak (EGTWDFD); Alexander Gard (EGV); Trevor Korinek (BLFPD); William Shanahan (EGV);  
**Advocate Good Shepherd Hospital (Beth Keane):** Nick Chiam (BCFPD); Kristian Kalev (LZFD); Ashley Kuffner (BAFD);  
**NCH (Noreen Untz):** Matthew Bakke (PAL); Jim Bollenbacher (BGFD); Tyler Brendle (RMFD); William Lehnert (AHFD); Brian Repple (AHFD); Adam Schallmoser (PAL); Shannon Walters (PAL);  
**NCH (Connie Mattera):** John Meyer (DFFD); Kelsey Wittman (DFFD);  
**NCH (Susan Wood):** John McDermott (MPFD); Jacob Thornton (MPFD);  
**St Alexius Medical Center (Karin Buchanan):** Daniel Awisha (SCH); Matthew Bohnen (SCH); Rebecca Gaare (HEFD); Samuel Garcia (SCH); Kevin Leska (SCH); Robert Loverher (SCH); Ana Rosales (Tallon) (HEFD); Jack Trujillo (SCH)

# Environment driving change in education & practice





## The Future Starts Now

People-centered vision for EMS

After more than two years of stakeholder and public input, the Office of EMS at the National Highway Traffic Safety Administration and its federal partners today released “[EMS Agenda 2050: A People-Centered Vision for the Future of Emergency Medical Services](#).” The document describes a vision for evidence-based, data-driven EMS that is integrated with the rest of the nation’s healthcare system.

“The release of EMS Agenda 2050 marks a beginning, not an end. It is now up to all of us to work together to make this vision a reality,” said Jon Krohmer, MD, director of the NHTSA Office of EMS. “NHTSA and our federal partners appreciate the work of the Technical Expert Panel, project team, and everyone who contributed to this effort. They have provided an inspiring framework on which to build.”

## EMS AGENDA 2050

### A People-Centered Vision

In 2050, EMS systems are designed to provide the best possible outcomes for patients and communities—every day and during major disasters. They collaborate with community partners and are integral to regional systems of care that are data-driven, evidence-based and safe. EMS clinicians have access to the resources they need, including up-to-date technology and training. To achieve this vision, EMS systems in 2050 will be designed around six guiding principles.

#### ADAPTABLE AND INNOVATIVE

Technological system design, educational programs and other aspects of EMS systems are continuously evaluated in order to meet the evolving needs of public and communities. Innovations, individual and organizational, are encouraged to meet them in safe and effective ways and to implement effective new programs.

#### INHERENTLY SAFE AND EFFECTIVE

EMS systems are designed to be inherently safe and to minimize regions of greatest injury risk. EMS systems are designed to be safe for patients, their families, clinicians and the public as a priority. Clinical care and operations are based on the best available evidence, based on continuous development by the entire community, including the professional nursing team.

#### SUSTAINABLE AND EFFICIENT

EMS systems ensure the resources have the capacity they require to provide care to a diverse population. EMS systems are designed to be sustainable, efficient and to operate with transparency and accountability.

#### INTEGRATED AND SEAMLESS

EMS systems are designed to be integrated with the rest of the nation’s healthcare system, including public health, social services and public works. Community plans and coordination ensure the care continuum is seamless, from prevention to delivery of care, including end-of-life care, including the care of the dying and their families.

#### SOCIALLY EQUITABLE

Access to care, quality of care and outcomes are not determined by race, ethnicity, gender, age, disability, geographic or other social determinants. Consistent high standards and protocols ensure every patient, regardless of their background, receives the same high-quality care. All patients who speak different languages, persons with disabilities or other populations that face barriers to care are supported.

#### RELIABLE AND PREPARED

EMS is a consistent, comprehensive and guided by evidence for the community during public health emergencies. The EMS system is prepared for anything that happens in public and after hours, including disasters to day-to-day demands, as well as major events, both planned and unplanned.

### THE FUTURE STARTS NOW

Visit [ems.gov](#) to learn more about EMS Agenda 2050 and help make the vision a reality.







Will drive changes to SOPs

## Guidelines Review & Discussion

Education and Professional Standards Council

March 7, 2017

The speed of technology expansion is exponential – moving faster than ever before in the history of mankind. Replacing generations of progress in months, weeks, and days.

[www.ems.gov](http://www.ems.gov)

# Beyond EMS Data Collection: Envisioning an Information-Driven Future for Emergency Medical Services



### v3.5.0 Revision Requests

### SOFTWARE DEVELOPERS

Follow the standard to implement new ePCR software products for local and state EMS systems.

**EMS EDUCATORS**

Promote the importance of data quality and performance evaluation through accurate documentation.

 GENERAL PUBLIC

Discover how EMS data can improve patient care nationwide.

7,907,829

4,016

## 7 Minutes

Emergency Triage, Treat and Transport (ET3) Model announced by HHS 2-14-19

"ET3 is an exciting opportunity for our country's great first responders to expand the care they provide. We're grateful for the work they do today and we appreciate how excited they are about this model. Together, this effort is going to save lives and improve the quality of care."

Health and Human Services Secretary Alex Azar  
presenting the ET3 model (NAEMT photo)

### ET3 – *What does it mean to us?*

*Medicare reimbursement will be available for certain non-transport ambulance services and for ambulance transports to alternate destinations*

"ET3 will make it possible for participating ambulance providers to partner with qualified healthcare practitioners to deliver treatment in place (on-scene or via telehealth) and with alternative destination sites (PCP offices or urgent care clinics) to provide care (and bill) Medicare beneficiaries following a medical emergency for which they have accessed 9-1-1 services."

### ET3 – Here's what we know now (PWW)

- CMS anticipates start date of early 2020
- Model applies only to 911 agencies
- Agencies currently enrolled as Medicare providers can *apply to participate beginning summer 2019*
- Voluntary program- reimbursement under standard ambulance fee schedule won't change for now
- Approved agencies must track quality metrics

**What's coming?** More details soon - how to apply and how to code for these services

## Paramedic roles evolving



Advances in technology, costs, reimbursement, value-based care, need for integration, trends in patient populations (increasing # elderly) are rapidly driving change

*What does this add up to?*



## Paramedics are key links to bridge hospital and out-of-hospital care transitions

**And  
here's  
our plan**



**NWC EMSS  
COMMUNITY  
PARAMEDIC**



Mobile Integrated Healthcare  
Using  
Community Paramedics  
Pilot PLAN – Phase 1  
2019

Prepared by:  
Cynthia J. Mallory, M.S., R.N., CNRN-IP  
HNRC Child Administrative Director

Approved by:  
Matthew T. Jordan, MD, FACP  
HNRC Child Medical Director

NDH

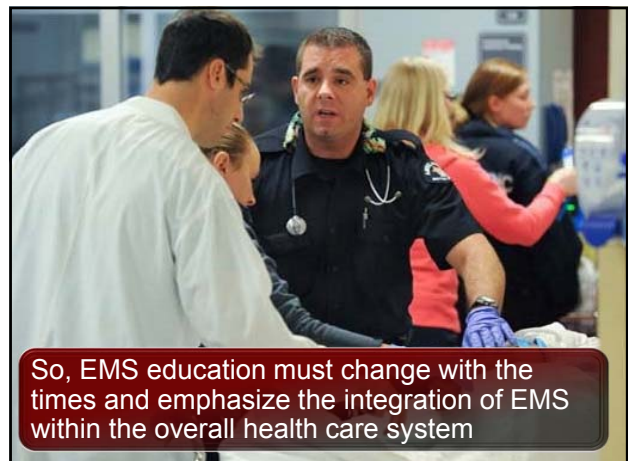
Steve Bergins, President and CEO  
Ellen Gilgore, CHS Acting Exec VP Patient Services & CHS  
Celia J. Gower, RN, MSN, MBA-BC, BC Director, Care Coord

CHS is a partner

Scott Anderson, Chief, Pediatric PG  
Korrie Van, Chief, Pediatric Rural PG  
Terry Laveland, Chief Nursing Operations PG



Off-duty Palatine paramedics will make house calls to check on certain patients released from Northwest Community Hospital in Arlington Heights as part of a new pilot program involving two other agencies. This Palatine ambulance arrived at the hospital late Monday afternoon.  
(Bob Sarsjara / Staff Photographer)



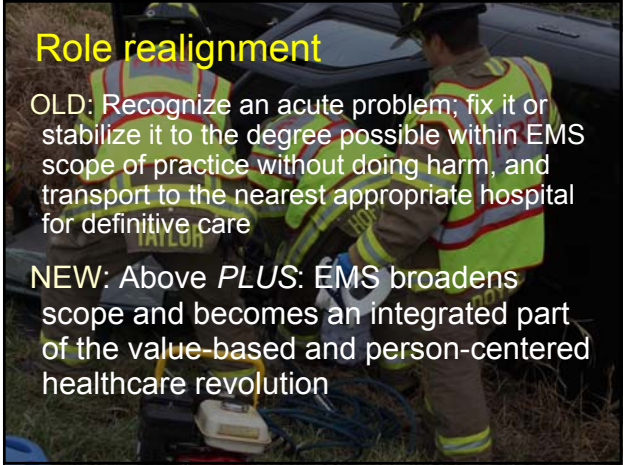
So, EMS education must change with the times and emphasize the integration of EMS within the overall health care system



### Role realignment

OLD: Recognize an acute problem; fix it or stabilize it to the degree possible within EMS scope of practice without doing harm, and transport to the nearest appropriate hospital for definitive care

NEW: Above *PLUS*: EMS broadens scope and becomes an integrated part of the value-based and person-centered healthcare revolution



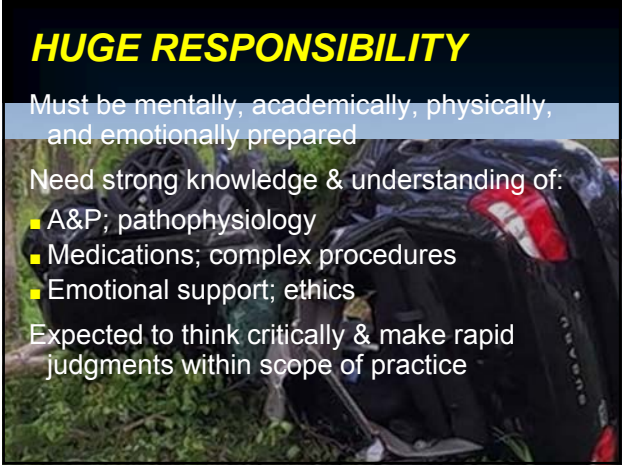
### HUGE RESPONSIBILITY

Must be mentally, academically, physically, and emotionally prepared

Need strong knowledge & understanding of:

- A&P; pathophysiology
- Medications; complex procedures
- Emotional support; ethics

Expected to think critically & make rapid judgments within scope of practice



Our program of instruction:  
core classes, schedule by weeks; accreditations, 3 domains of learning; expected competencies of professional education



### National Education Standards (2009)

Pre- or co-requisites

Guide program personnel in making decisions about material to cover

Provides minimal terminal objectives for each level

Clinical/field requirements

In process of revision now



NATIONAL EMERGENCY MEDICAL SERVICES  
EDUCATION STANDARDS



### Our relationship with Harper College

Dual enrollment; taught at NCH; Harper credits Certificate courses (38 credits); AAS degree



### Instructional design

		Credit hours
EMS 110	EMT Education	9
<u>Paramedic CERTIFICATE Program</u>		
EMS 210	Preparatory (fall)	10
EMS 211	Med. Emerg I (fall)	5
EMS 212	Med. Emerg II (spring)	7
EMS 213	Trauma, special populations	6
EMS 217 & 218	Hospital Internship	3
EMS 215	Field Internship (spring)	4
EMS 216	Seminar (summer)	3
Total PM Certificate hours		38

In addition to EMS 110 and PM certificate:  
Required courses for Assoc. in Applied Science (AAS)  
EMS Degree:

C or better for all letter grade courses and P (pass ) for EMS 215, 217, 218		
BIO 160	Human Anatomy	4
BIO 161	Human Physiology	4
Electives1		4
ENG 101	Composition	3
NUR 210	Physical Assessment	2
SOC 101+	Introduction to Sociology	3
SPE 101	Fund. of Speech Communication	3
<b>Total credit hours for AAS degree</b>		<b>70</b>

1Electives: BIO 130, CHM 100, HSC 104, or HSC 213  
+ This course meets World Cultures and Diversity graduation requirement.



# The Joint Commission





Emergency Medical Services - Paramedic  
Northwest Community Healthcare  
Arlington Heights, IL

Credible education is accredited



ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
**IDPH**  
PROTECTING HEALTH. IMPROVING LIVES

**Accreditation** evaluates programs relative to standards and guidelines developed by national communities of interest

Entry level competence assured by curricula standards, **national** accreditation, testing



**CoAEMSP** Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions

**Outcome points for EMS Education:**

Graduates have achieved the competency in all three domains of learning required for practice that ensures the delivery of **safe, timely, efficient, effective, equitable, compassionate and person-centered care** to serve the health care needs of the population.

**Higher order thinking skills**

**Create**

1. Use old ideas to create new ones.
2. Generalize information from given facts.
3. Combine knowledge from several areas into a cohesive new idea.
4. Use information to predict and draw conclusions.

**Evaluate**

1. Differentiate between and among ideas.
2. Assess the value of various theories.
3. Assess the logic in arguments and presentations.
4. Use logic to make decisions.
5. Verify & Value evidence in many forms.
6. Differentiate between objective & subjective.

**Analyze**

1. See the larger systems view.
2. Organize material into its various parts.
3. Recognize the underlying or hidden meaning in messages.
4. Identify and label important components of an object or idea.

**Apply**

1. Use information in a specific manner.
2. Use concepts, methods, and/or theories in new contexts.
3. Solve problems using specific sequences or skills.


**Understand**

1. Comprehend & interpret information.
2. Grasp basic meanings.
3. Translate information into a new context.
4. See causes and effects.
5. Predict outcomes.

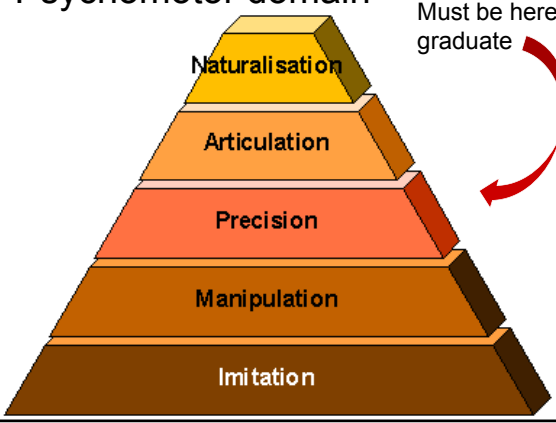
**Remember**

1. Observe and recall information & facts.
2. Recollect dates, events, & places.
3. List, describe, and recognize information & facts.

**Lower order thinking skills**



**Psychomotor domain**



Must be here to graduate

The pyramid levels from top to bottom are: Naturalisation, Articulation, Precision, Manipulation, and Imitation. A red arrow points to the top three levels (Naturalisation, Articulation, Precision).





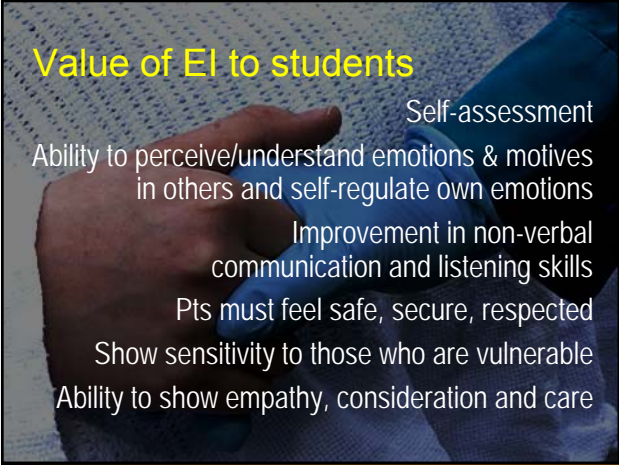
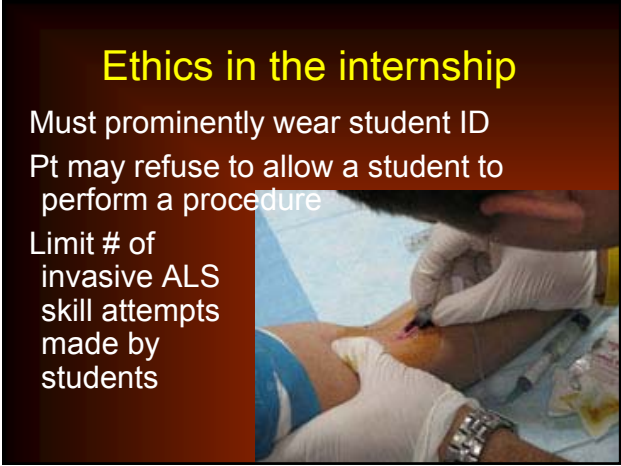
**PERFORMANCE APPRAISAL:** Indicate the general level of performance

Scale:

5	Exceptional	Clearly outstanding for a student at this level of training
4	Superior	Above average for a student at this level of training
3	Proficient	As expected for a student at this level of training
2	Marginal	Not quite up to expectations for a student at this level of training
1	Deficient	Poor performance for a student at this level of training

AFFECTIVE OBJECTIVES:	Rating
1. <b>INTEGRITY:</b> Consistently honest, is able to be trusted with the property of others and with confidential information.	
2. <b>EMPATHY/Report with patients:</b> Shows compassion for others; good listening skills, sensitivity and empathy.	
3. <b>SELF-MOTIVATION:</b> Self-disciplined, takes initiative and follows through on tasks without constant supervision, strives for excellence in all aspects of patient care and professional activities; accepts coaching in a positive manner; takes advantage of all learning opportunities.	
4. <b>APPEARANCE AND PERSONAL HYGIENE:</b> Always clean, neat, well-groomed, wearing clothing appropriate for a medical professional team member and presents a positive image of EMS within the hospital, good personal hygiene and grooming.	
5. <b>SELF-CONFIDENCE:</b> Is aware of own strengths and limitations; projects confidence to patients.	
6. <b>COMMUNICATIONS:</b> Speaks clearly; maintains appropriate interpersonal language even in difficult situations or when unmonitored; writes legibly; adjusts communication strategies to various situations.	
7. <b>TIME MANAGEMENT:</b> Demonstrates appropriate work habits, punctual, completes tasks and assignments on time.	
8. <b>TEAMWORK AND DIPLOMACY:</b> Interaction with peers, hospital personnel & others; Places success of team above self-interests, helps and supports other team members; communicates effectively to resolve problems.	
9. <b>ATTITUDE:</b> Refrains from complaining; demonstrates a positive attitude through verbal and non-verbal communication.	
10. <b>RESPECT:</b> Is polite to others, does not use derogatory or demeaning terms, behaves in a manner that brings credit to the profession.	
11. <b>PATIENT ADVOCACY:</b> Does not allow personal bias to interfere with patient care; places the needs of patients above self-interest; protects and respects patient confidentiality and dignity.	
12. <b>CAREFUL DELIVERY OF SERVICE:</b> Performs complete equipment checks; demonstrates safe ambulance operations; makes critical judgments supported by ethical, legal and moral standards as specified in System standards.	








Jen mentoring students carefully in clinical units

nch Northwest Community Healthcare		2018-2019 NCH Paramedic Program Clinical Documentation Evaluation		0 = expectations not met; see comments 1 = acceptable; see comments for suggestions, instructions 2 = meets or exceeds expectations	
Student:		Date:		Unit:	ED
History / Info gathering	Rating	Comments			
CC / S&S	2	Excellent - keep up the good work			
CC ORQUEST	2	Your histories are very good!			
AMPLE "1" (incl in S&S)	2	Good! Very thorough -			
Assessment: Primary	2	Great			
Airway	2	Great job!			
Breathing	2	Great job!			
Circulation	1	Great - keep it up. Also - any time you have a pt w/ S&S of anything that might impact their normal intake of food and fluids, you should include asmt of hydration = oral membrane moistness and skin turgor.			
Disability	2	Good!			
Assessment: Secondary as appropriate	2	Your secondary asmts are very good. Think you forgot to document your abd asmt on Pt #3.			
Vital Signs	2	Great - good job including temps on any pt whose S&S might possibly be due to infection			
FSDAP	2	All approp fields entered			
Substantiated by clin form	2	Yes. Awesome job.			
Accurate CC, impression	1	Changed your CC on #2 to abd pain (not just pain), and your imp. to Abd pain/problems instead of medical. (You have to have several abd pain complaints so important to check that specifically when that is their complaint).			
Narrative	2	Excellent. Concise, organized, "paints the picture".			
Clinical Form Documentation	Yes	Legible & organized			
Preceptor signature/ratings	Great				
Other Comments:	Just one impression unless there is a second, different one. You are off to a great start!!!!				



**Contextual competence**

Understand how EMS practice fits within greater whole of healthcare continuum

Ability to use conceptual and technical skills in right context, avoiding technical imperative

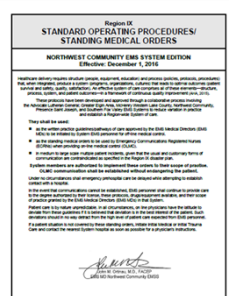
**Integrative competence**

Ability to take all other competencies and put them together to meld theory and practice



**Adaptive competence:** Ability to change with evolutions in EMS or in the care of one patient based on changing clinical presentations (move from 1 page of SOP to another)

Challenge for us all due to constant pace of change~



**Failure to adapt can have some serious consequences!**



**Teamwork and diplomacy**

EMS is a team sport!  
Must work well with others to achieve common goals  
Team leader role crucial part of internship  
Puts team success above own interest  
Respect for all team members





Field internship  
Goals & objectives;

WILLIAM RAINY HARPER COLLEGE				
HEALTH CAREERS DIVISION				
NORTHWEST COMMUNITY HEALTHCARE PARAMEDIC PROGRAM				
COURSE SYLLABUS				
EMS	215	PARAMEDIC: FIELD INTERNSHIP	(0 / 20)	4
Course	Number	Course Title	Course	Credit
		Connie J. Mattera, M.S., R.N., PM	(Lec-Lab)	Hours
		Program Director		
		Michael Gentile, BA, PM, Lead Instructor		
		Northwest Community Hospital (NCH)		
		800 W. Central Rd. EMS Offices in Behavioral Health/901 Kirchoff Center		
		Arlington Heights, IL 60005		
		Office hours: M-F 0800-1700		
		Phone: 847.618.4482 (Secretary) #4490 (Mr. Gentile)		
		<a href="mailto:cmattera@nch.org">cmattera@nch.org</a> or <a href="mailto:mgentile@nch.org">mgentile@nch.org</a>		
Dates: March 1- May 17, 2019 and/or until all objectives and patient care contacts are achieved; □				
No later than June 12, 2019 unless an extension is granted				
Time & location of classes: EMS agencies within the Northwest Community EMS System				
Class days: Dates and times variable depending on preceptor schedules and agency policies				
COURSE DESCRIPTION				
This course integrates the theoretical concepts and practical skills acquired during EMS 210, 211, 212, 213, 217, and 218 and requires students to use higher order thinking and critical reasoning to safely care for patients in the out of hospital environment under the direct supervision of an approved paramedic preceptor. The internship is divided into two phases of ascending mastery and accountability with each having a minimum number of patient care contacts and competencies. A full description of the objectives and expectations is contained in the NCH Paramedic Program Student Handbook and on the internship forms. (NOTE: This course has an additional fee of \$1500 to cover the cost of preceptor supervision.)				
Prerequisites for release to Field Internship:				
• Successful completion of EMS 213				
• All initial hospital clinical rotations (EMS 217 & 218) done except for the elective; paperwork approved by J. Dyer				
• *All Fisdap entries for labs and EMS 217 and 218 entered by student and approved by J. Dyer				
• All class-required simulated runs completed by student, submitted to and approved by J. Albert				
• Eligible preceptor(s) identified by agency, approved by hospital educator, & paperwork submitted to M. Gentile				
• Agency agreement to host students signed by authorized administrator and submitted to C. Mattera				
• Hold harmless statement signed by student and forwarded to agency				

General course objectives

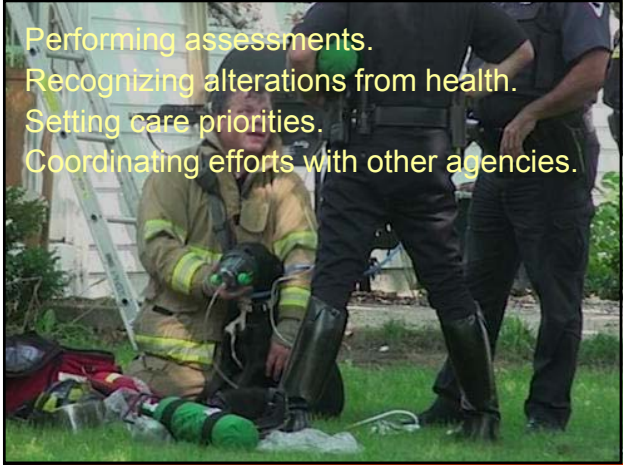


**Upon completion, graduates will demonstrate safe entry level competency in the following:**  
Assessing and observing appropriate safety precautions and triaging multiple patients.



Gaining patient access using a variety of tools and techniques.

Performing assessments.  
Recognizing alterations from health.  
Setting care priorities.  
Coordinating efforts with other agencies.



Establishing rapport to decrease anxiety and meet emotional and physical needs.





General course objectives cont.



Providing care as prescribed by EMS MD.  
Exercising critical judgment where OLMC has been delayed, interrupted or aborted.

© Larry Shapiro



Communicating effectively with the designated medical command authority



Giving interim reports as needed  
Interhospital transfers:  
    • Obtaining medical record & transfer form  
    • Obtaining verbal report  
Documenting **any** delays  
Effectively communicating with **all** involved

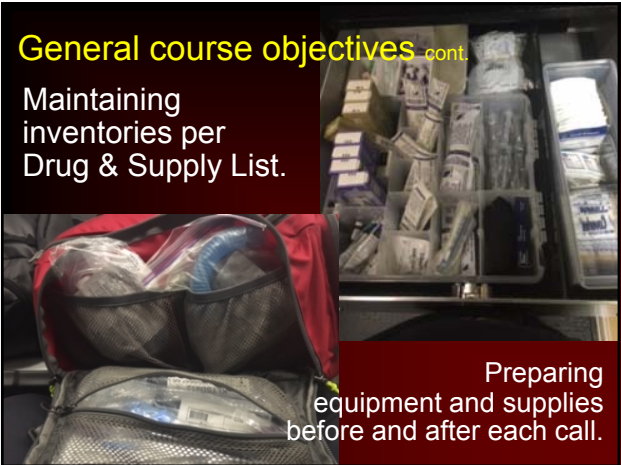
General course objectives cont.

Thoroughly documenting an ePCR using Image Trend software  
Appropriately executing a Refusal of Service

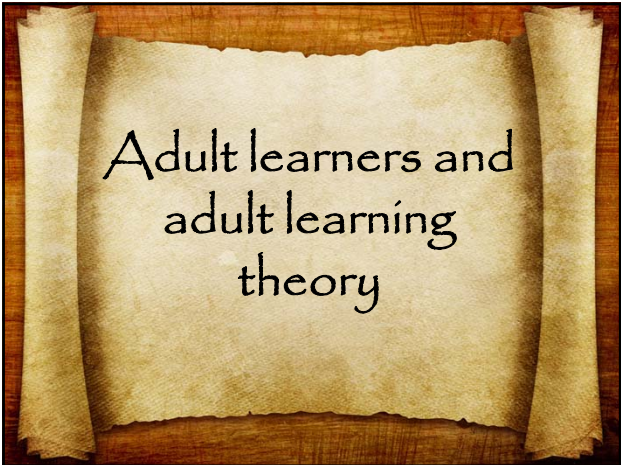
A screenshot of a medical form, likely an ePCR (Electronic Patient Care Report). It contains various fields for patient information, vital signs, and medical history, organized in a structured layout with multiple sections and checkboxes.

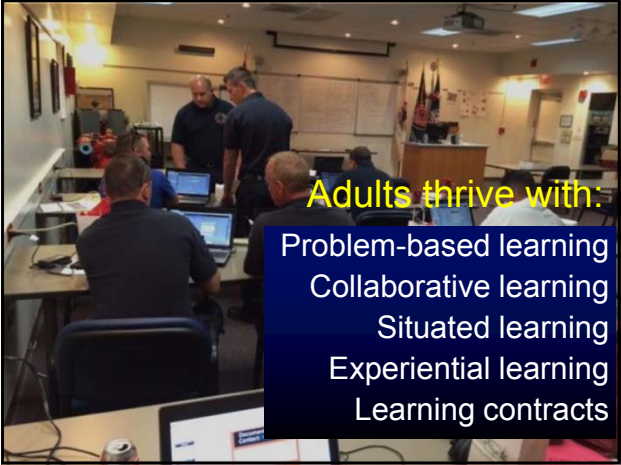
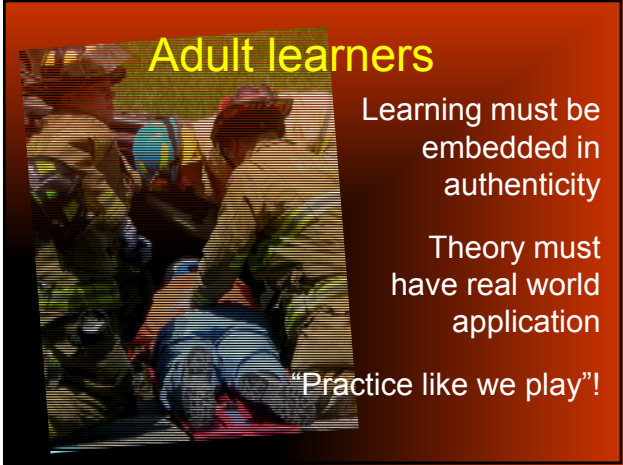
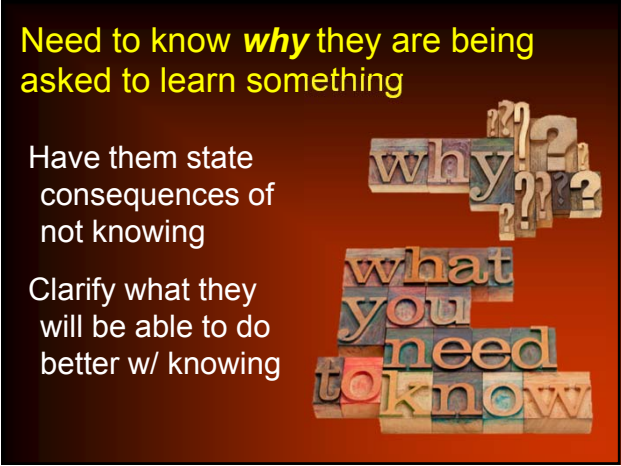
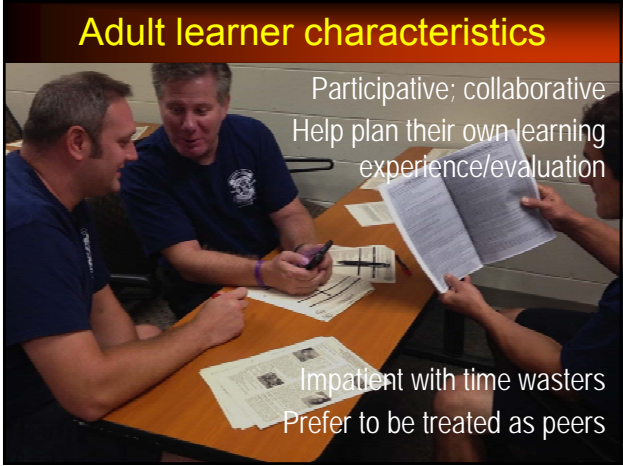
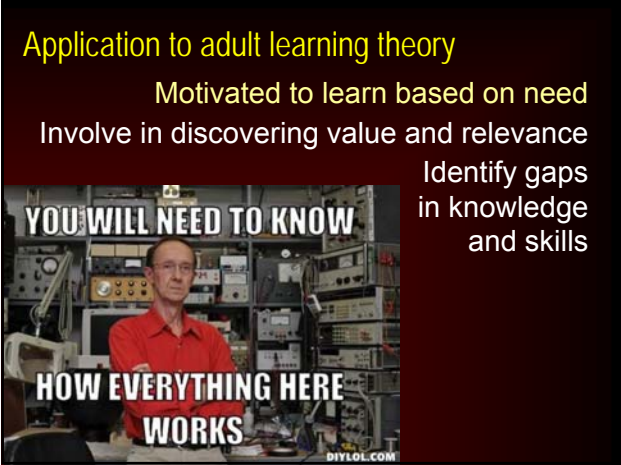
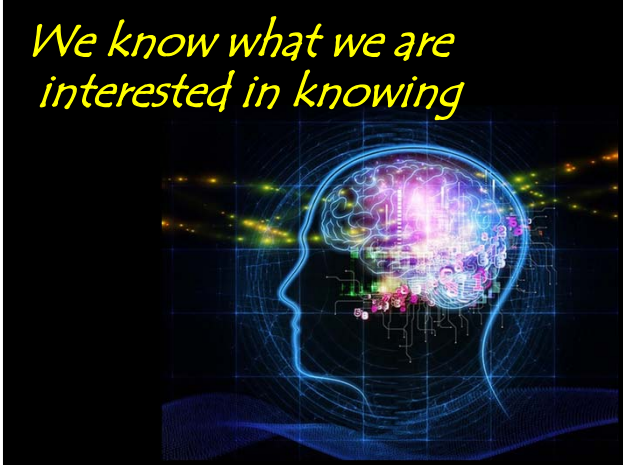
General course objectives cont.

Maintaining inventories per Drug & Supply List.



Preparing equipment and supplies before and after each call.









Paramedic graduate  
**Terminal Competency Form**  
Name of Paramedic Program: Northwest Community Healthcare  
Program Number: 600790

[illegible]

## Outcome-based education

### Bridge to developing:


- Lifelong learners
- Knowledgeable persons with deep understanding
- Complex thinkers
- Creative persons
- Active investigators
- Effective communicators
- Reflective and self-directed learners

# Methods for planning a learning experience

You understand it  
only if you can teach it,  
use it, prove it, explain it,  
defend it, or read  
between the lines.

Wiggins & McTighe, 1998

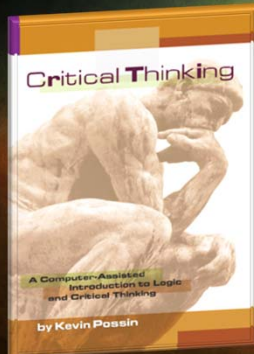
We live in a world of accelerated change,  
intensifying complexity, and  
increasing danger



If students are not learning to **think critically**, how are they going to know how to change their thinking in keeping with the changes of the world?



### Critical thinker traits



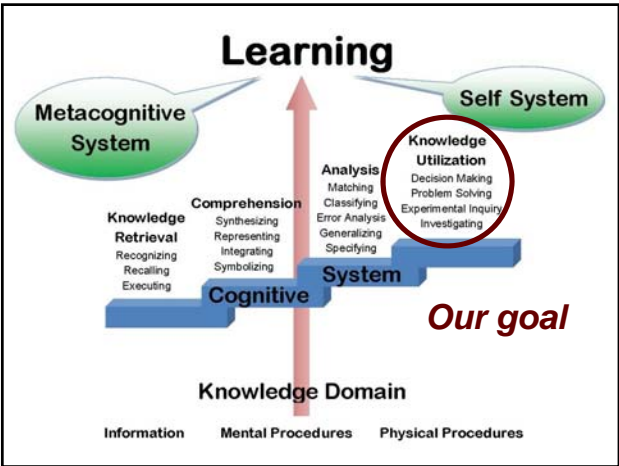
Strive for intellectual ends such as **clarity, precision, accuracy, relevance, depth, breadth, and logicalness**

### 6 facets of understanding

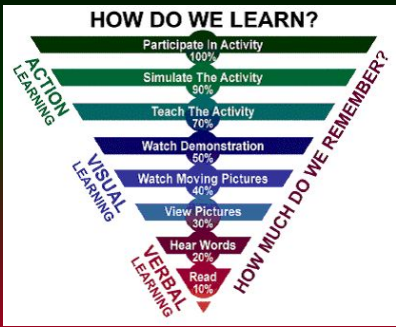
When we truly understand, we...

- Can explain (generalize, connect, provide examples)
- Can interpret (tell accessible stories, provide dimension)
- Can apply (use what we know in real contexts)
- Have perspective (see points of view through critical eyes)
- Can empathize (walk in another's shoes, value what they do)
- Have self-knowledge (metacognitive awareness, know what we don't know, reflect on meaning of learning and experience)

Fijor, M. (2010) Understanding by design and technology. Arlington Hts School District 25, ICE 2010. Accessed on line:  
<http://www.slideshare.net/mfijor/understanding-by-design-and-tech-integration>



Use evidence-based, best practice models of effective education methods to achieve enduring learning



### Challenge in education

Active engagement is necessary to critical thinking, but one can be actively engaged and not think critically!

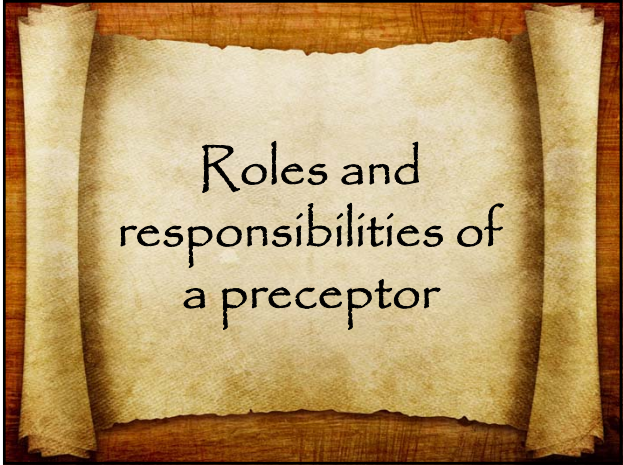
Examples?



### Laws of learning

- Primacy:** First impressions are lasting
- Exercise:** Neural pathways strengthened by repetition
- Disuse:** Use it or lose it!
- Intensity:** Dramatic experiences using all domains of learning and higher level thinking with triggered emotions are more likely remembered





**So, where do you come in?**

"After 25 years of research and \$60 million later, what really moves diverse learners forward is a **masterful teacher** who commits the necessary energy to: create a learning community; provide a learning apprenticeship; and makes plans or content explicit enough so that all (learners) are on the journey!"

*Dr. Donald Deshler, Dir. Center for Research on Learning, U of Kansas*

A cartoon illustration of a teacher and a student. The teacher is a man with a beard, wearing a blue robe, holding a small object. The student is a woman with blonde hair, wearing a green dress, sitting on a small stool and looking up at the teacher.

**What is your job?**

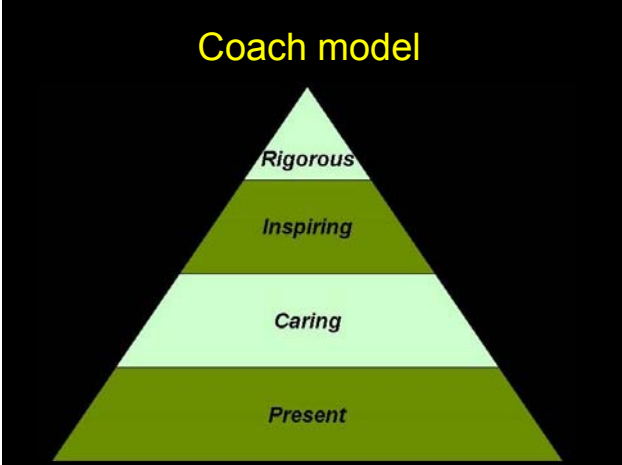
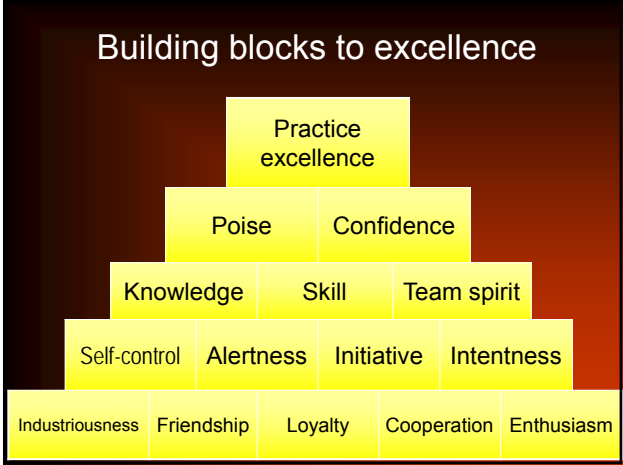
Champion of excellence  
Coach them to competence

Build to practice excellence so student has best possible chance to succeed

Two circular images of coaches. The top image shows a coach in a blue jacket and cap, looking at a player. The bottom image shows two coaches in caps, one of whom is wearing glasses.

**How can you do this?**

- Serve as role model
- Promote clinical and professional competency
- Provide opportunities to develop and refine skills
- Connect student with other providers
- Provide reality of work/life in real-world setting





“A few minutes of attention is worth more than a day’s worth of distractions”

Dr. Chris Nollette



Meetings and coaching at scheduled intervals help teach beyond what is in the books

Since precepting is based on knowledge, skills, and relationships, what characteristics do a preceptor need to be successful?

Preceptor traits



- Preceptors must have the skills to form an effective learning environment and facilitate a constructive clinical learning experience for students
- Preceptors need more than experience to be effective (though having a wealth of it is a prerequisite)
- They also need to possess certain traits and talents

Characteristics of an effective preceptor

- ❑ Desire to be a supporter/ teacher
- ❑ Competency in specialty; models desired behaviors
- ❑ Effective interpersonal and communication skills
- ❑ Teaching skills; motivated to teach
- ❑ Sensitive to learning needs of students
- ❑ Leadership skills
- ❑ Effective decision making and problem-solving skills; can articulate reasons for actions while performing them
- ❑ Positive attitude; shows genuine interest in others
- ❑ Interest in professional growth (self & others)
- ❑ Ability to provide effective feedback (students & faculty)
- ❑ Is accessible to student for completion of projects/obj

Loyola University Chicago, © 2016 Cornerstone OnDemand

What are your strengths?

**PRECEPTOR SELF ASSESSMENT FORM**

**Instructions:**  
Use the following table to rate yourself in a manner that best represents your own attributes. Do not protect an image of who you want to be. Give each attribute a rating, from 1 to 5, based on the following rating scale:

**Rating scale:**  
1=Never, definitely not me  
2=Rarely  
3=Sometimes  
4=Often  
5=Always, this is who I am.

Personal attributes	Attitude attributes
1. Warm	1. Enthusiastic
2. Humorous	2. Respectful
3. Mature	3. Supportive
4. Self-confident	4. Concerned
5. Charismatic	5. Patient
6. Empathetic	6. Accepting
7. Trustworthy	7. Nurturing
8. Flexible	8. Effective in coping
9. Accountable	9. Professional
10. Experienced	10. Delegator

Because of your presence...

Students understand System expectations

Patients are safeguarded


You can NEVER condone sub-standard performance



What's wrong here?

Unleashing the learning potential

**Learning** = Interaction of principles/theory  
+  
Experience/practice




*"It is when sparks jump between two poles - the general and the actual - that learning occurs. So you need both." - John Adair*

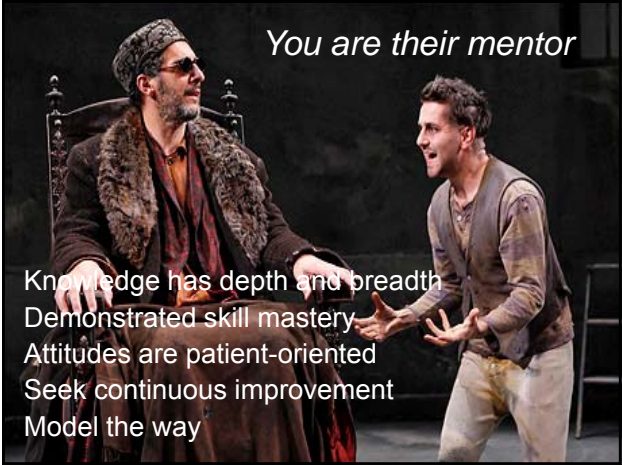
Staging of skill acquisition



How do they get there?



You are their mentor

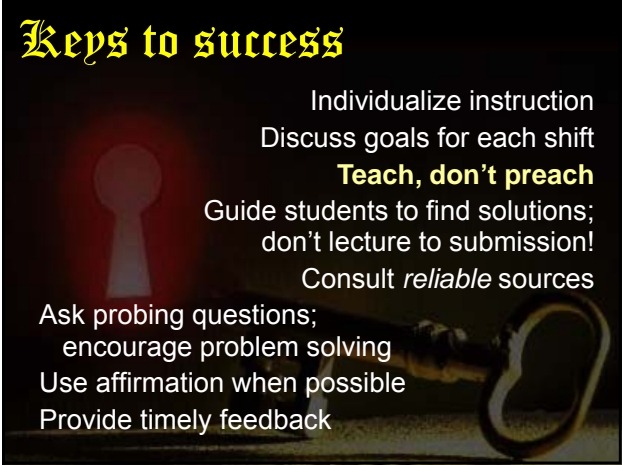


Knowledge has depth and breadth  
Demonstrated skill mastery  
Attitudes are patient-oriented  
Seek continuous improvement  
Model the way



Supervise  
or  
Educate?

Keys to success



Individualize instruction  
Discuss goals for each shift  
**Teach, don't preach**  
Guide students to find solutions;  
don't lecture to submission!  
Consult *reliable* sources  
Ask probing questions;  
encourage problem solving  
Use affirmation when possible  
Provide timely feedback



**Intellectual work**  
**State. Elaborate. Exemplify.**

Ask student to summarize the main point:

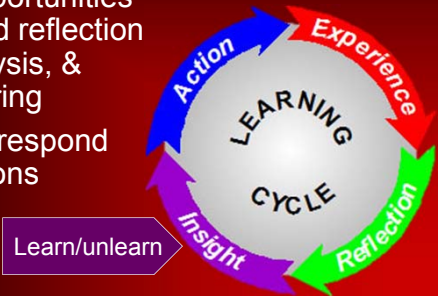
- State it,
- Elaborate it
- Exemplify it in their own words (real English) with their own examples



Discuss patient calls, case studies, or simulations that require problem-solving activities

Create opportunities for guided reflection and analysis, & idea-sharing

Invite and respond to questions



**Individualized instruction** cont.

Clarify objectives of each phase before it starts  
Go over paperwork together  
Discuss goals at the beginning of each shift  
Apply theory to practice by having them perform assessments, interpret data, determine priorities; perform skills *with your supervision* unless pt's condition requires immediate interventions

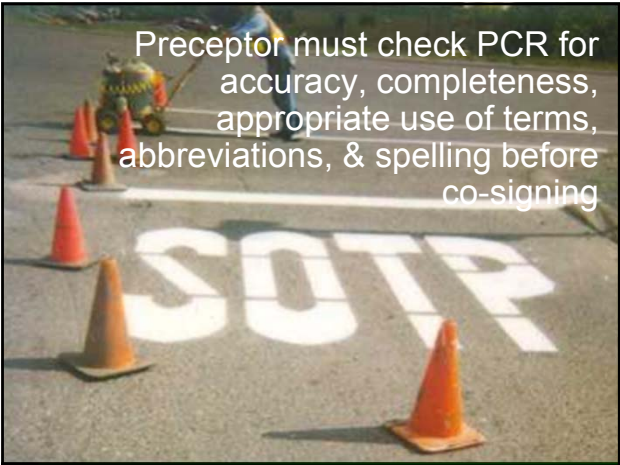
**We learn by doing,  
not watching!**

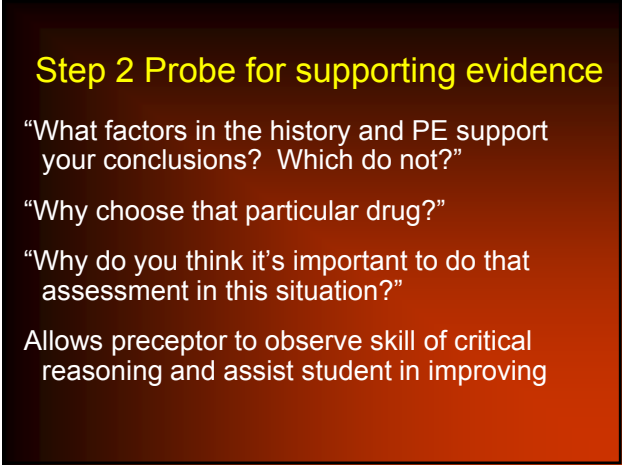
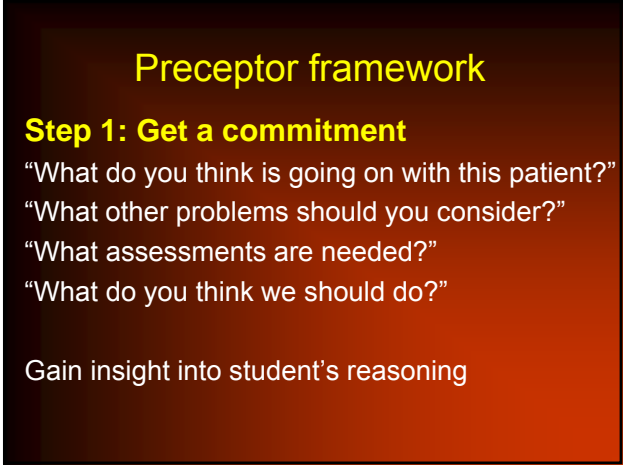
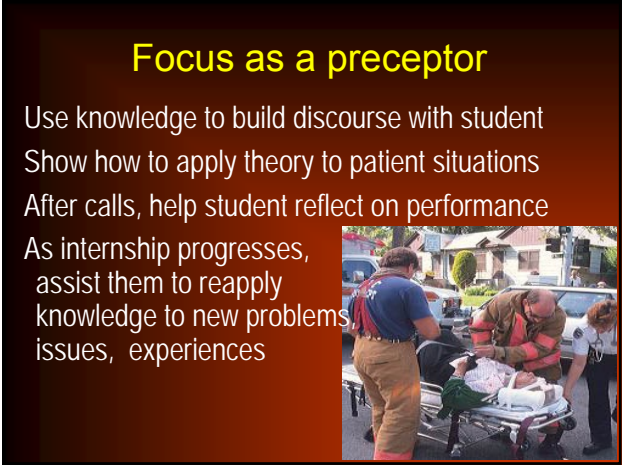
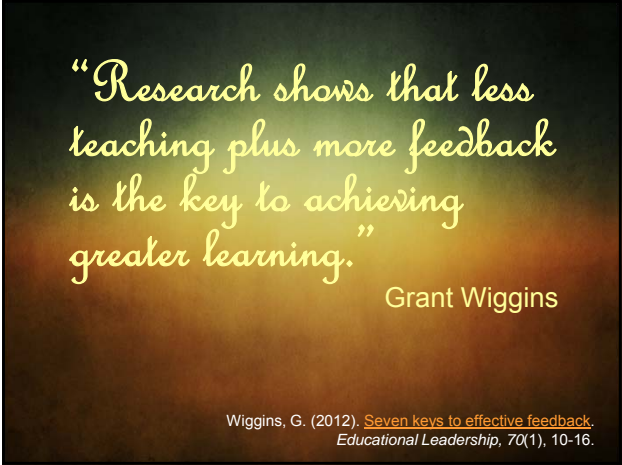
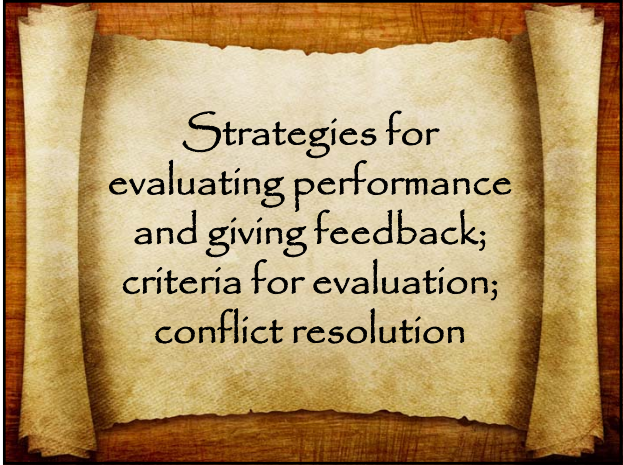
They call must call OLMC; complete PCR's

*"A 60 year old patient c/o of severe abdominal pain. The pain was located in the center of the patient's abdomen causing him extreme discomfort."*

*"A 60 y/o pt c/o severe midline abdominal pain proximal to the navel radiating to the back rated 9 on a 0-10 scale. The pt described pain as sharp & stabbing starting abruptly 15 min ago while resting. Abdomen has generalized guarding but no rigidity to light palpation in both upper quadrants."*

Preceptor must check PCR for accuracy, completeness, appropriate use of terms, abbreviations, & spelling before co-signing









Be non-judgmental

Listen

Reflect

Avoid temptation to say, "Here is how I do it."

Lessen the frustration

Pausing

Paraphrasing

Inquiring

Probing

Extending



Step 3: Reinforce what was done well

Student may be unaware if they've done something well

Acknowledge their accomplishments

Be specific

Enhances self-esteem and reinforces behaviors you would like repeated



Provide praise

Don't assume excellence is expected so praise is unnecessary

Changing and maintaining new behavior requires praise

Praise, like criticism, should be well timed, well targeted and well said



Be specific about the behavior being praised

Poor:

"You're good at that."

Better:

"I like how you used layperson's terms to explain the procedure to the patient. They fully understood what you were going to do."

Reinforce what was done well

“Your diagnosis of probable pneumonia was well supported by your history and physical exam. You integrated them well in reaching the correct field impression.”

“Your radio call-in was well organized. You clearly stated the chief complaint, Hx and PE findings as well as our interventions and ETA. Good job!”

Reinforce what was done well

“You included important information about the scene size up in the comments section of the PCR that the hospital needs to know to get a complete picture of this call. Just what we’re looking for!”

“Your suspicion of hypoglycemia was right on in this patient even though he presented with signs & symptoms of a stroke. Good pick up!”

Evaluation and feedback

Well timed, targeted and said corrective feedback can direct growth, motivate student and offer relief from confusion

PRAISE  
MAKES YOU  
FEEL GOOD  
CRITIQUE  
MAKES YOU  
BETTER

4. Give corrective feedback

Good preceptors share thoughts and feelings directly, respect the person and **address behavior** rather than the student

*Judge the person, and you risk the relationship*

*Judge the behavior, and you take the bite out of criticism*



Why crucial?

If necessary criticism is withheld, preceptor-student relationship remains superficial

Lack depth and resiliency needed to tackle sensitive issues



Must be timely

Well-timed criticism should be delivered shortly after error

Longer you wait, less effective it will be

Be fair; don't drop a bomb and run off

Give student chance to respond





Timely feedback helps you too

Failure to confront problems as they arise may lead to aggressive behavior  
Unexpressed frustrations mount until a small error triggers an avalanche of pent-up criticism



Your preparation

Think through what you will say in advance  
Don't talk when angry, tired, hungry or pressed for time  
Right time,  
place,  
facts,  
focus,  
words



Student's preparation

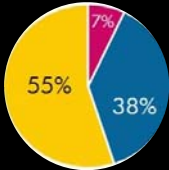
Assess readiness to receive information  
"Is now a good time to talk?"



Elements of personal communication

55% body language  
38% tone of voice  
7% spoken words

Why e-mail messages are often misinterpreted...



Pace learning

Tailor feedback to a particular student performing a particular skill  
Too much at once not helpful

"What's the most important point right now?"



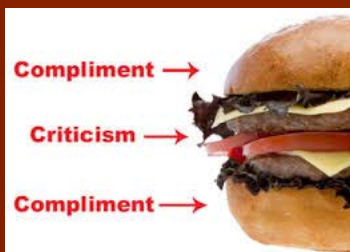
If badly timed, student will be too overwhelmed to hear the message even if criticism is valid

Student will keep a safe distance and all future praise will be received with suspicion



## Don't use sandwich technique

Insincere praise shouldn't be used as a smoke screen to deliver bad news



## Use STAR-AR approach



Situation or Task

Action

Result

Alternative action

Result (preferred)

## STAR-AR approach

Change-oriented feedback involves offering corrective, alternative behaviors to replace the problem behavior, or brainstorming solutions with the student

## Focus on continuous improvement

"What would be a better approach next time?"

"What change in technique might be more successful?"

"What could we do better as a team next time?"

## Giving feedback

Be **specific**

Avoid "always", "never," personal-assault words e.g. "lazy", "irresponsible"

Poor: "You never listen to patients."

Better: "I noticed you interrupted the patient 3 times when taking the history. How might that make them feel? What's a better strategy to get the information you need?"

## Use "I" rather than "you" messages

Own feedback you give rather than saying, "People say X about you."

"When you raised your voice, I noticed the patient stepped back. It appeared that they felt threatened and shut down. What communication strategies would have been more effective in this case?"



Feedback re: errors & omissions

“In the radio report, you mentioned that the patient had crackles but didn’t tell the ECRN they were only in the right upper and middle lobes and the capnography waveform had a sharkfin appearance. This left her with the impression that the patient was in pulmonary edema rather than pneumonia. How could this be reported next time for clearer communication?”

Feedback re: errors & omissions

“This patient may not have chest pain, but they are a long standing diabetic and are complaining of severe weakness and shortness of breath. Why is a 12-lead ECG necessary for this person?”

Feedback re: errors & omissions

“People in pulmonary edema usually need CPAP, but the BP just dropped to 84/56 after the first NTG. What could C-PAP do to this patient?”

Teach a general principle

“Selecting a receiving hospital can be challenging. It depends on patient acuity, patient choice, predetermined destination policies, traffic conditions, and time of day. Let’s explore some examples...”

“If you don’t remember a drug dose or typical 12-lead changes with ischemia where can you find quick reminders?”

Conclusion of teaching encounter

Reclarify roles and expectations to facilitate further learning

“I’ll restock the ambulance while you finish the CARS report. Come and get me when you are done so I can go over it with you before it is checked for validation and uploaded.”

Good feedback model



Intervene early

If student fails to meet objectives, don't allow them to fall hopelessly behind

Contact PEMSC & hospital EMSC/educator; design individualized education program to overcome gaps

Northwest Community Healthcare Paramedic Program  
Individualized Education/Corrective Action Plan (IEP)

Name (First, Last, MI): \_\_\_\_\_ EMT Agency: \_\_\_\_\_

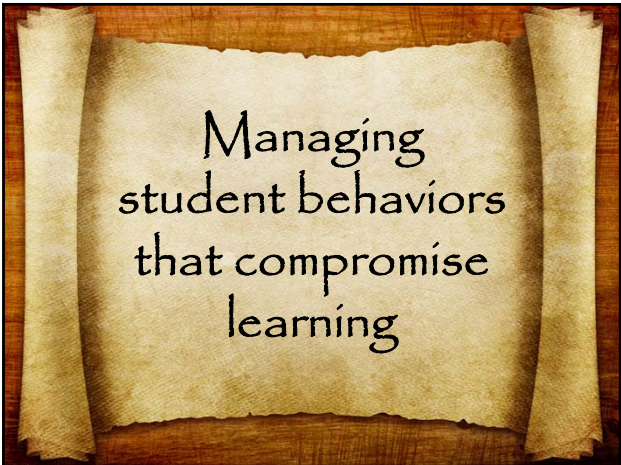
Preceptor(s): \_\_\_\_\_

Domains of Performance Review		
1. Assessment	2. Patient care/management	3. Patient
4. Assessment & patient management	5. History	6. Self-direction
7. Assessment/patient management	8. Knowledge	9. Self-confidence
10. Communication/management of scene	11. Patient advocacy	12. Team leadership
13. Communication/management of scene	14. Planning	15. Technical/professional
16. Communication/management of scene	17. Prioritization & delegation	18. New skill/technology/innovation
19. Communication/management of scene	20. Policy/procedure/protocol	21. Supervision & education
22. Quality	Other: Please specify (e.g., administrative or scope of practice)	

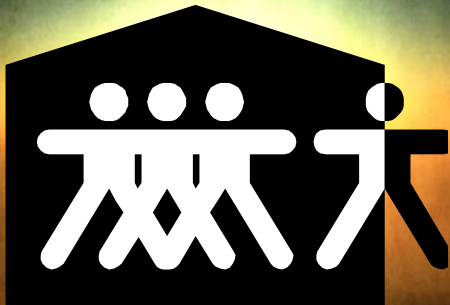
**Specific examples of performance issues/areas:**

This form is not to be used as a punitive tool. It is intended to be used as a tool to help the student and preceptor identify areas of improvement. It is not to be used as a tool to punish the student. It is to be used as a tool to help the student and preceptor identify areas of improvement. It is not to be used as a tool to punish the student. It is to be used as a tool to help the student and preceptor identify areas of improvement.

Problem	Recommendation/Action	Performance improvement/Resolution/Resolution/Resolution



How should you deal with outliers?



Student 1

26 y/o f is riding with your agency  
She tries to fit in but is sometimes better able to dish it out than take it.  
Her skills are marginal but safe , but she dissolves into tears when she is teased and the crew members are not happy with her being there.  
Action needed?

Student 2

27 y/o employee is preparing for medical school. He is very intelligent and challenges everything he believes is incorrect or inconsistent with what he read or was taught in class.  
He sometimes teeters on crossing the line between disrespect and asking a heart question.  
What's the best approach to this student?

Student 3

24 y/o employee has been an EMT-B with a private agency for 4 years  
He is very quiet and usually stands in the background at every call. He must be told to do any ALS assessments or interventions, but performs competently when instructed.  
How should you coach this student?



Student 4

32 y/o employee who's ticket finally came up and he had to come to PM class. Not happy about being here. He demonstrates a great deal of confidence and a take charge attitude, but instincts are not always correct and some skill techniques are marginal.

He becomes very defensive when you attempt to correct his errors

How should you coach this student?

Student 5

25 y/o male is riding with your agency

He has been late 3 times and has called off twice. Talks a good game, but seems to have significant knowledge gaps. Has a part time job at an area hospital. Does not follow through on paperwork as directed. When confronted about his behavior he claims frequent illness.

It's 4 weeks into the internship and he is not progressing in the affective objectives.

What is the best approach with this student?

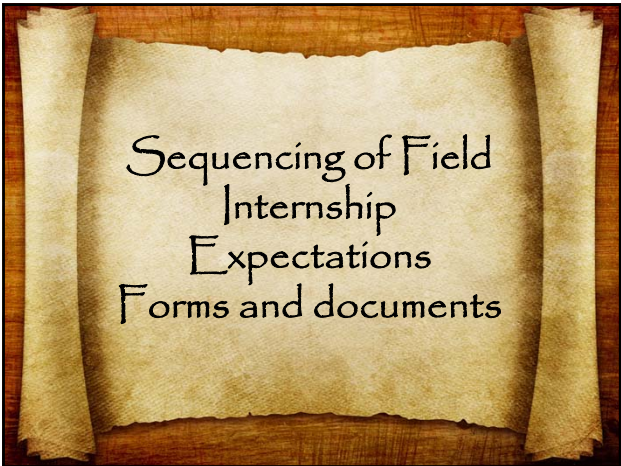
Student 6

28 y/o rider is strongly motivated to become a PM

He is first out to the ambulance, volunteers to assist with cooking, housework, and is very respectful of agency members

He has minimal recall of class concepts and gets ECG rhythms totally confused. When asked what fentanyl is, he stares at you blankly.

What is the best approach with this student?



Sailing ships into the future

EMS 215 Field Internship

Membership - Leadership

Prerequisites for Release to Field Internship

- Successful completion of EMS 213
- EMS 217 & 218 done (except elective); all paperwork submitted to & approved by J. Dyer
- Fisdap entries for labs and EMS 217 & 218 entered by student and approved by J. Dyer
- All simulated runs completed by student, submitted to and approved by J. Albert
- Eligible preceptor(s) identified & approved & paperwork submitted to M. Gentile
- Agency hosting agreements signed by authorized administrator and submitted to C. Mattera

How will you know they are released to start?

From: Mattera, Connie  
To: Sordo, Dana  
Cc:  
Subject: FW: Gripper approved to start field internship

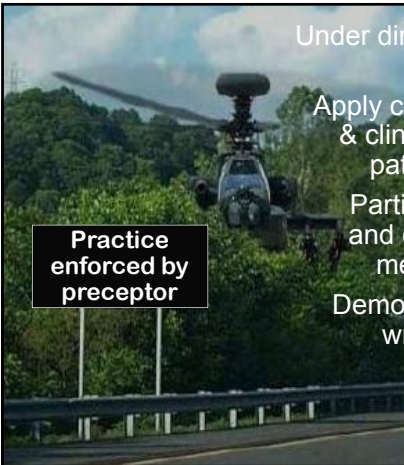
---

From: Mattera, Connie  
Sent: Friday, March 03, 2017 5:04 AM  
To: Gripper, Peter [pgripper@vch.com]; ylamosalt@vch.org; Unti, Noreen  
Subject: Gripper approved to start field internship

Peter is approved to start his field internship effective March 3, 2017. Congratulations!

**Connie J. Mattera, MS, RN, EMT-P, TNS**  
EMS Administrative Director and System Coordinator  
Trauma Nurse Specialist Course Coordinator  
Northwest Community EMS System  
Northwest Community Healthcare  
901 W. Kirchoff  
Arlington Heights, IL 60005

847.618.4405 | tel  
847.618.4489 | fax  
cmattera@nch.org | email  
www.nch.org  
www.mvccems.org



Practice enforced by preceptor


Under direct supervision, a student will:

- Apply classroom theory & clinical skills to real patients in the field
- Participate as a safe and competent team member or leader.
- Demonstrate effective written and verbal communication/documentation.

Sequence – 2 phases

I: Team member – what role?  
II: Team leader – what role?

How long will it take?




It depends...

Phase meetings

**Who?** Student, preceptor; PEMSC welcome; Hospital EMSC/educator

**What?** PCR's (care/ documentation), drug cards, ECGs discussed in detail

**Time estimation:**  
Phase 1: 2-3 hrs  
Phase 2: 3-4 hrs



Prepare in advance for phase meetings

Evaluate as you go!

Complete/sign all paperwork that day; schedule meetings well *in advance*


Submit Phase Eval form and all outstanding paperwork at least 1 week prior to meeting

Quiz student on pathophys, drug profiles and EMS care

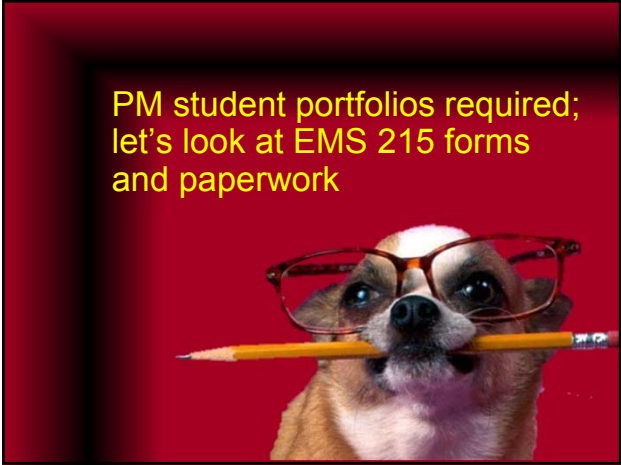
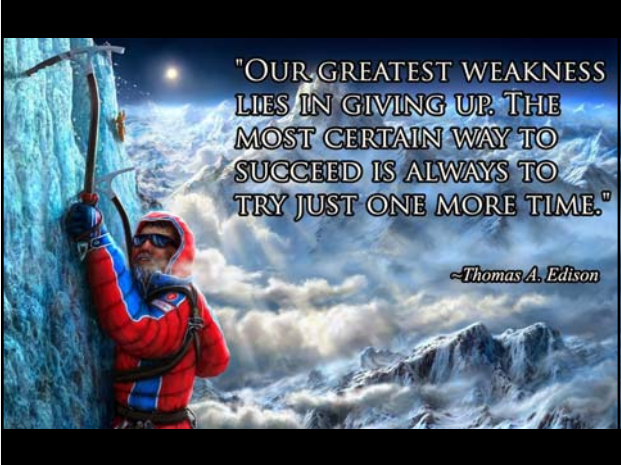
Review calls so you all can explain deviations from SOPs, receiving hospitals, scene times, and ensure PCR is thoroughly documented

Phase 2 conclusion options

- ❑ Internship complete; graduate; allow to take credentialing exam; unrestricted license
- ❑ Graduate; allow to take credentialing exam; retain with preceptor
- ❑ Retain in Phase II (attach IEP)
- ❑ Terminate the internship; sponsorship withdrawn (attach documentation) or recommend to do over







Goal: Done by June 7, 2019

June 2019						
SUN	MON	TUE	WED	THU	FRI	SAT
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Final written

Graduation

NR Practical exam

Go on an...

- A – Allow debate & challenge of ideas
- D – Demonstrate respect for student's opinions
- V – Value student as a resource
- E – Encourage student to share knowledge & ideas
- N – Notice the student's real world problems
- T – Treat student as an adult
- U – Use student's past experience
- R – Relate learning to goals, obj., standards
- E – Emphasize how to apply learning

cmattera@nch.org

[www.nwcemss.org](http://www.nwcemss.org)

Questions?  
Comments?  
Concerns?  
Suggestions?  
Send me a note  
(e-mail)

# CoAEMSP Interpretations of the CAAHEP Standards and Guidelines

## For the Accreditation of Educational Programs in the EMS Profession

Evaluation of the clinical and field internship sites should be done by the program. They should ensure, through tracking (Standard III.C.2) that the clinical and field internship sites provide the minimum requirements for competency (See II.C and IV.A.1).

CoA Standard	Interpretation
<p><b>B. Personnel</b> The sponsor must appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes.</p> <p><b>1. Program Director</b> a. Responsibilities: The program director must be responsible for all aspects of the program, including, but not limited to: 1) the administration, organization, and supervision of the educational program,</p>	<p>1) As part of the administration, organization, and supervision of the program, the Program Director must ensure that there is <b>preceptor orientation/training</b>.</p> <p>The training/orientation must include the following topics:</p> <ul style="list-style-type: none"> <li>• Purposes of the student rotation (minimum competencies, skills, and behaviors)</li> <li>• Evaluation tools used by the program</li> <li>• Criteria of evaluation for grading students</li> <li>• Contact information for the program</li> <li>• Program's definition of Team Lead</li> <li>• Program's required minimum number of Team Leads</li> <li>• Coaching and mentorship techniques</li> </ul> <p>The training media may take many forms: written documents, formal course, power point presentation, video, on-line, or there could be designated trainers onsite that the program relies on. The program should tailor the method of delivery to the type of rotation (e.g. hospital, physician office, field).</p> <p>The program must demonstrate that <b>each field internship preceptor</b> has completed the training.</p> <p>For <b>field internship experiences</b>, the program should focus on the evaluation of the experience, but that evaluation must include an evaluation of <b>each</b> active field internship preceptor.</p> <p>The program must provide evidence of the completion of the training of field internship preceptors by dated rosters of participants, on-line logs, signed acknowledgement by the field internship preceptor.</p>
<p><b>2. Hospital/Clinical Affiliations and Field/Internship Affiliations</b> For all affiliations students shall have access to adequate numbers of patients, proportionally distributed by illness, injury, gender, age, and common problems encountered in the delivery of emergency care appropriate to the level of the Emergency Medical Services Profession(s) for which training is being offered.</p>	<p>2. The clinical resources must ensure exposure to, and assessment and management of the following patients and conditions: adult trauma and medical emergencies; airway management to include endotracheal intubation; obstetrics to include obstetric patients with delivery and neonatal assessment and care; pediatric trauma and medical emergencies including assessment and management; and geriatric trauma and medical emergencies.</p> <p>The program must set and require minimum numbers of patient contacts for each listed category. <b>Those minimum numbers must be approved by the Medical Director and endorsed by the Advisory Committee with documentation of those actions.</b> The tracking documentation must then show those minimums and that <b>each</b> student has met them. There must be periodic evaluation that the established minimums are adequate to achieve competency. <b>No minimum number can be fewer than two (2), including each pediatric age subgroup.</b></p>
<p>2. The program must track the number of times each student successfully performs each of the competencies required for the appropriate exit point according to patient age, pathologies, complaint, gender, and interventions.</p>	<p>2. There must be a tracking system: either paper or computer based. The program must establish the minimum number of encounters for each of the competencies for each of the defined distributions. (see Interpretation III.A.2)</p> <p>The tracking system must incorporate and identify the minimum competencies (program minimum numbers) required for each exposure group, which encompasses patient age (pediatric age subgroups must include: newborn, infant, toddler, preschooler, school-age, and adolescent), pathologies, complaint, gender, and intervention, for each student.</p> <p>Intervention tracking must include airway management with any method or device used by the program.</p> <p>The tracking system must clearly identify those students not meeting the program minimum numbers.</p>



CoA Standard	Interpretation
<p>3. The field internship must provide the student with an opportunity to serve as team leader in a variety of pre-hospital advanced life support emergency medical situations.</p> <p><i>Enough of the field internship should occur following the completion of the didactic and clinical phases of the program to assure that the student has achieved the desired didactic and clinical competencies of the curriculum prior to the commencement of the field internship. Some didactic material may be taught concurrent with the field internship.</i></p>	<p>3. The field internship site must allow students to assess and manage patients in the pre-hospital environment where he/she will progress to the role of Team Leader.</p> <p>Minimum team leads must be established by the program and accomplished by <b>each</b> student. The number of team leads is established and analyzed by the program through the program evaluation system and must reflect the depth and breadth of the paramedic profession.</p> <p>The program must show that the timing and sequencing of the team leads occur as a capstone experience and in relation to the didactic and clinical phases of the program so as to provide an appropriate experience to demonstrate competence.</p> <p>Evaluating the effectiveness of being a team lead is under standard IV.A.1 and IV.A.2.</p>
<p><b>IV. Student and Graduate Evaluation/ Assessment</b></p> <p><b>A. Student Evaluation</b></p> <p><b>1. Frequency and Purpose</b></p> <p>Evaluation of students must be conducted on a recurrent basis and with sufficient frequency to provide both the students and program faculty with valid and timely indications of the students' progress toward and achievement of the competencies and learning domains stated in the curriculum.</p>	<p>1. There are many types of evaluations that are required by the CoAEMSP.</p> <p>Achievement of the competencies required for graduation must be assessed by program criterion-referenced, summative, comprehensive final evaluations. <b>Summative program evaluation is a capstone event that occurs after all components of the program are complete.</b></p> <p>Summative comprehensive evaluation must include cognitive, psychomotor, and affective domains.</p> <p>On-going, documented affective evaluations must be done that assess student behaviors for all learning settings (i.e., didactic, laboratory, clinical, and field) with combined or separate instruments. The affective evaluation items may be incorporated with other evaluations (e.g., skill, competency, field internship). The frequency of the evaluations needs to be done in a timely manner to provide the student and at least the program director and medical director with his/her performance/ progress throughout the program. These periodic affective evaluations are in addition to the required summative, comprehensive affective evaluation at the end of the program.</p> <p>When the program determines that a student is not exhibiting appropriate behaviors, there must be evidence of counseling to attempt to correct the behavior, when appropriate, and continued evaluation of successful remediation or academic action (e.g. probation, failure).</p> <p><b>Terminal Competence</b></p> <p>The program must document that all students have reached terminal competence as an entry level paramedic in all three learning domains.</p>
	<p><b>Field Internship Documentation</b></p> <p>The program must keep a master copy of all field internship evaluation instruments used in the program.</p> <p>Also, the program must maintain a record of student performance on every field internship evaluation. The record could be a summary of scores or the individual evaluation instruments.</p> <p>Documentation should show progression of the students to the role of team leader as required by the program.</p>
<p><b>Safeguards</b></p> <p>The health and safety of patients, students, and faculty associated with the educational activities of the students must be adequately safeguarded. All activities required in the program must be educational and students must not be substituted for staff.</p>	<p><i>Medical control/accountability exists when there is unequivocal evidence that EMS Professionals are not operating as independent practitioners, and when EMS Professionals are under direct medical control or in a system utilizing standing orders where timely medical audit and review provide for quality assurance.</i></p> <p>For educational activities, individuals must be clearly identified as students, in a specified clinical/field experience/internship, under the auspices of the program medical director, and under the supervision the designated preceptor prior to performing patient care.</p> <p>Students must not be substituted for staff.</p>

**WILLIAM RAINEY HARPER COLLEGE**  
**HEALTH CAREERS DIVISION**  
**NORTHWEST COMMUNITY HEALTHCARE PARAMEDIC PROGRAM**  
**COURSE SYLLABUS**

EMS	215	PARAMEDIC: FIELD INTERNSHIP	(0 / 20)	4
Course Prefix	Course Number	Course Title	(Lec-Lab)	Credit Hours

Connie J. Mattera, M.S., R.N., PM

Program Director

Michael Gentile, BA, PM; Lead Instructor

Northwest Community Hospital (NCH)

800 W. Central Rd; EMS Offices in Behavioral Health/901 Kirchoff Center

Arlington Heights, IL 60005

Office hours: M-F 0800-1700

Phone: 847.618.4482 (Secretary) #4490 (Mr. Gentile)

[cmattera@nch.org](mailto:cmattera@nch.org) or [mgentile@nch.org](mailto:mgentile@nch.org)

**Dates: March 1- May 17, 2019** and/or until all objectives and patient care contacts are achieved;  
no later than June 12, 2019 unless an extension is granted

Time & location of classes: EMS agencies within the Northwest Community EMS System

Class days: Dates and times variable depending on preceptor schedules and agency policies

### COURSE DESCRIPTION

This course integrates the theoretical concepts and practical skills acquired during EMS 210, 211, 212, 213, 217, and 218 and requires students to use higher order thinking and critical reasoning to safely care for patients in the out of hospital environment under the direct supervision of an approved paramedic preceptor. The internship is divided into two phases of ascending mastery and accountability with each having a minimum number of patient care contacts and competencies. A full description of the objectives and expectations is contained in the NCH Paramedic Program Student Handbook and on the internship forms. (NOTE: This course has an additional fee of \$1500 to cover the cost of preceptor supervision.)

### Prerequisites for release to Field Internship:

- Successful completion of EMS 213
- All initial Hospital clinical rotations (EMS 217 & 218) done except for the elective; paperwork approved by J. Dyer
- \*All Fisdap entries for labs and EMS 217 and 218 entered by student and approved by J. Dyer
- All class-required simulated runs completed by student, submitted to and approved by J. Albert
- Eligible preceptor(s) identified by agency, approved by hospital educator, & paperwork submitted to M. Gentile
- Agency agreement to host students signed by authorized administrator and submitted to C. Mattera
- Hold harmless statement signed by student and forwarded to agency

### TOPICAL OUTLINE

Students shall complete a minimum of the following:

- I. Orientation to the internship
- II. Phase 1; **Team member** with an emphasis on enhancing assessment and intervention skills.
- III. Phase 2: "Capstone" experience, where students, in an end-of-program sequence field internship, do work that gets assessed against the desired overall course outcomes. They are expected to demonstrate competency as a **team leader**.
- IV. Mandatory actual and/or simulated skills/patient care contacts

### METHODS OF PRESENTATION

- Progression of learning typically sequences from didactic/theory to laboratory practice followed by hospital clinical experience, followed by the field internship.
- While in the field, students are awarded temporary ALS privileges and will perform to that scope of practice as a team member and then leader under the direct supervision of an approved preceptor for a minimum of 300 hours.
- Each phase of the internship has specific objectives, expected outcomes, and forms on which to evaluate the learning experience. A complete description of the Internship is found in the NCH Paramedic Student Handbook.
- Students use independent inquiry to research pathophysiology and drug profiles for patient contacts.



**Learning Goal:** To develop contextual, integrative, and adaptive competencies using higher order critical thinking skills and demonstrate competent entry-level Paramedic performance in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains.

**STUDENT OUTCOMES:** *(The student will...)*

1. during EMS 210, 211, 212, 213, 215, 217 and 218 (combined), complete the following minimum patient care contacts and demonstrate skill competency at the precision level or higher for assessments and interventions included in the National EMS Scope of Practice model, The Illinois Scope of Practice Model, National EMS Education Standards, those approved by the Program MD as specified in the System SOPs, Policy and Procedure Manuals and as approved by the Paramedic Program Advisory Committee:

Assessments	Minimum number
Adult (18-64 yrs)	75
Geriatric (65 or older)	50
Pediatrics total	25
Newborn (0-1 mos)	2
Infant (1-12 mos)	3
Toddler (2-3 yrs)	2
Preschool	2
School age	3
Adolescent	5
Trauma patients total	30
Trauma peds	6
Trauma geriatric	6
Medical patients total	60
Medical peds	12
Medical geriatric	12
Stroke/TIA	2
Acute coronary syndrome/chest pain	10
Cardiac dysrhythmia	2
Respiratory distress/failure	2
Hypoglycemia/DKA/HHNS	2
Sepsis	2
Shock	2
Toxicology emergency/OD	2
Psych/behavior emergency	6
Altered mental status	8
Abdominal pain	4
Skills	
Obtain Hx from A&O pt (total)	10
Comprehensive assessment adult	2
Comprehensive assessment peds	6
Trauma assessment adult	16
Medical assessment (cardiac) adult	54
Direct tracheal intubation adult (4 live)	24
Direct tracheal intubation peds	24
Trauma intubation (inline adult)	6
Nasotracheal intubation adult	2
Supraglottic airway	20
Cricothyrotomy (needle/surgical)	8
CPAP	5
Pleural decompression	6
Vascular access (IV)	47
Vascular access (IO)	8
IV/IO Medication administration	16
IVPB Medication administration	4
IM or subcutaneous medication admin.	6
Inhaled medication (nebulized)	2

Synchronized cardioversion	16
Defibrillation	16
Transcutaneous pacing	15
Normal delivery & newborn care	7
Abnormal delivery & newborn care	7
Neonatal resuscitation	7
Serve effectively as the <b>team leader</b>	20 runs (15 ALS)

<b>SKILLS</b>	<b>Minimum #</b>
<b>BLS skills to be competencied in lab before live patient encounters</b>	
Spine motion restriction (adult supine)	3
Spine motion restriction (adult seated)	3
Joint splinting	3
Long bone splinting	3
Traction splinting	3
Hemorrhage control	3
IN med administration	4
Inhaled med administration	4
Glucose check	2
12 L ECG electrode placement	4
CPR equivalent to AHA BLS for HCP	
1 & 2 rescuer CPR for adults, children, infant	3
BVM ventilations adult and child	2
Use of AED	1
Obstructed airway technique 1 yr & older	2

2. characterize the professional behaviors stated in the program affective objectives.

### **METHODS OF EVALUATION**

1. Formative evaluations are conducted by the Field Preceptors using forms prepared by the Program to rate student achievement of cognitive, psychomotor and affective objectives after each call. These are discussed with the student, Preceptor and EMS Coordinator/educator (EMSC) during Phase meetings.
2. The program uses a computer based tracking system (FISDAP) that incorporates the program-defined minimum numbers of encounters/competencies required for each of the defined exposure groups and patient ages (pediatric subgroups include newborn, infant, toddler, preschooler, school-age, and adolescent), pathologies, complaints, and interventions. The tracking system clearly identifies those students not meeting the program minimum numbers.
3. The program evaluates at least annually that the established minimums are adequate to achieve competency. Terminal competency is validated by the Program Medical Director's signature.
4. **Student evaluations of preceptors** and internship process
5. **Employer evaluations** of student readiness to work completed six months after graduation

**COMPLETION OPTIONS:** To successfully pass EMS 215, students must demonstrate *entry-level* mastery of EMS knowledge, skills, and behaviors as measured by satisfactorily completed all objectives in the Field Internship instruction plan. A summative evaluation is conducted with the student, their primary Field Preceptor, PEMSC and hospital EMSC/educator when all objectives have been achieved. They may select from three options at the end of the first 300 field internship hours:

1. **Objectives fully achieved:** Graduate; recommend for terminal certifying exam and licensure without restriction.
2. **Objectives minimally achieved:** Graduate; recommend for terminal certifying exam; and licensure with restriction in the form of a probationary status where the new licensee shall continue providing ALS care under the direct supervision of an approved preceptor with periodic meetings with the EMSC/educator for an agreed-upon period of time. If this option is selected, the hospital EMSC/educator must specify in detail the rationale and objectives for the probationary status in an education action plan (EAP) and the EMS agency chief/administrator and EMS Medical Director must agree to the plan. A copy shall be forwarded to the Course Coordinator for the student's file.
3. **Objectives not achieved:** The student is given an incomplete at the end of the regularly scheduled Field Internship. If this option is selected, the hospital EMSC/educator must specify the cause in detail and an EAP must be established between the student, the primary preceptor, the PEMSC and the hospital EMSC/Educator. A copy shall be forwarded to the Course Coordinator for the student's file. The student may continue in EMS 215 with an incomplete for a maximum of one month after the class graduation date unless alternative provisions are made.



If licensure cannot be recommended at the end of one month, the hospital EMSC/educator must specify in detail the student's inability to meet the objectives and the EMS agency PEMSC and chief/administrator must be informed of the determination. The EMS MD must be consulted about the final assessment and agree with the findings. A copy of the final report shall be forwarded to the Course Coordinator for the student's file. The student will be given an F for EMS 215 and may attempt to re-enroll the next time EMS 215 is offered.

**GRADING:** Students receive a pass/fail grade for this course based on accomplishment of the objectives.

**TIME REQUIREMENTS:** Varies from student to student as each phase is competency rather than time-based. Students are required to ride a minimum of 300 state-required hours, but may extend to 768 hours as there are 32 possible 24 hour shift days within the full internship time. Eight additional hours are allowed for phase or coaching meetings. Internship time may be extended a maximum of 45 days after the scheduled end of EMS 215 based on limited patient contact opportunities and slow but steady student progress. It will not be extended due to irresponsible student behavior or lack of progress in meeting an IEP. Specific internship attendance requirements and consequences of failing to meet those requirements are specified in the NCH Paramedic Student Handbook.

**ATTENDANCE POLICY:** Students are to be present, duty ready, and have reported to the shift commander/preceptor at least 15 minutes prior to the start of a shift. At a minimum, students are expected to ride an entire day and evening shift extending until the time set by the EMS agency on days that coincide with their preceptor's work schedule. Optimally, this includes a 24 hour shift every three days. Students shall not leave in the middle of a shift except for illness or an emergency, and their early departure must be approved in advance by the Course Coordinator or Clinical Coordinator. No more than one third of the total hours may be completed from 11 pm to 7 am.

### **STUDENT BEHAVIOR**

Information relative to civil, courteous and professional behaviors including, but not limited to, integrity, honesty, empathy, self-motivation, appearance and personal hygiene, self-confidence, communication, time management, teamwork, diplomacy, attitude, respect, patient advocacy, and use of electronic and social media, is specified in the NCH Paramedic Program Student Handbook at [www.nwcemss.org](http://www.nwcemss.org) and Harper College Student Handbook at <https://myharper.harpercollege.edu/pls/portal/url/ITEM/937272F78B81316DE0402E0A0A2A3059>.

Information relative to guided study, corrective coaching, disciplinary procedures, and student resources is also included in the NCH Paramedic Student Handbook.

**INSTRUCTIONAL MATERIALS:** Northwest Community EMS System Standards of Practice: Standard Operating Procedures (SOPs), Policy Manual, Procedure Manual, and Drug and Supply List; NCH Paramedic Program Field Internship paperwork.

### **EQUAL OPPORTUNITY**

The Paramedic Program does not discriminate on the basis of race, color, religion, sex, national origin, ancestry, age, marital status, sexual orientation, disability, or unfavorable discharge from military service as long as the candidate meets statutory requirements of licensure as a paramedic and is able to perform all the essential functions of the paramedic profession during the course with or without reasonable accommodation.

### **STUDENTS WITH DISABILITIES and Academic Accommodations**

If you have a disability (learning, ADHD, physical, psychological or other) and may require any accommodation during this course, please contact the Course Coordinator at the *beginning* of the course to discuss. Students with disabilities must contact Access and Disability Services (ADS) to discuss approval of reasonable accommodations. Any student already connected with ADS should provide the Course Coordinator a copy of your approved Accommodation Plan if you would like to use any accommodations during the course. Access and Disability Services is located in Building D, D119; on the Harper College campus; 847.925.6266 (voice) or 224.836.5048 (videophone for deaf and hard of hearing callers only).

### **STUDENT E-MAIL NOTIFICATIONS**

All notifications related to student registration or other Harper College business activities are sent to students via G-mail account that is assigned to students upon registration. Students access the G-mail account via an icon in the student portal (where you registered for classes). Please check this e-mail frequently. To forward e-mails from this account to a personal e-mail account please follow the instructions for forwarding Harper e-mail available to <http://harper.blackboard.com/>. Students must provide the NWC EMSS office with an e-mail address to be used for all direct correspondence relative to class academic and clinical activities.

# PRECEPTOR SELF ASSESSMENT FORM

## Instructions:

Use the following table to rate yourself in a manner that best represents your own attributes. Do not project an image of who you want to be. Give each attribute a ranking, from 1 to 5, based on the following rating scale:

### Rating scale:

1= Never. *Definitely not me*

2= Rarely

3= Sometimes

4= Often

5= Always. *This is who I am.*

Personal attributes		Attitude attributes	
1. Warm		1. Enthusiastic	
2. Humorous		2. Respectful	
3. Mature		3. Supportive	
4. Self-confident		4. Concerned	
5. Charismatic		5. Patient	
6. Empathetic		6. Accepting	
7. Trustworthy		7. Nurturing	
8. Flexible		8. Effective in coping	
9. Accountable		9. Professional	
10. Experienced		10. Delegator	