

ORIENTATION FOR PRECEPTORS 2017

Roles of a paramedic under the 2009 EMS Education Standards and National Scope of Practice Model

A paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation.

Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found in an ambulance. The paramedic is a link from the scene into the health care system.

A paramedic's scope of practice includes basic and advanced skills focused on the management and possible transportation of a broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

Paramedics must demonstrate each competency within his or her scope of practice for patients of all ages. EMS care is based on an advanced assessment and the formulation of a field impression. A paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with out-of-hospital medical and traumatic conditions. A paramedic provides care designed to optimize health and provide comfort to the patient and family while determining appropriate patient disposition.

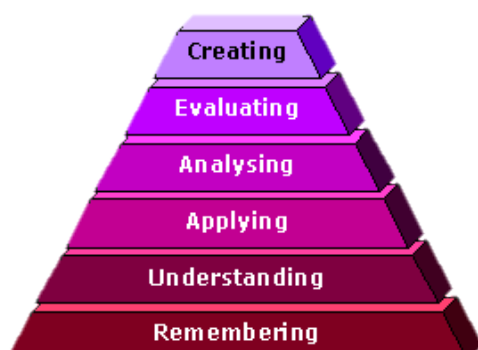
Educational requirements: A paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. A paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of an Emergency Medical Responder (EMR), EMT, and Advanced EMT (AEMT). Because of the amount of complex decision-making, one of the eligibility requirements for paramedic licensure requires successful completion of a nationally accredited Paramedic program at the certificate or associates degree level.

The NCH Paramedic program is conducted as a dual enrollment program with Harper College. Graduates earn 38 college credits in the **Certificate program** and may complete the requirements for an **Associate in Applied Science (AAS) EMS Degree**. It holds a **Letter of Review**, which is NOT Commission on Accreditation of Allied Health Education Programs (CAAHEP) accreditation status, but is a status granted by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) signifying that a program seeking initial accreditation has demonstrated sufficient compliance with the accreditation Standards through the Letter of Review Self Study Report (LSSR) and other documentation. However, it is NOT a guarantee of eventual accreditation. A LOR is recognized by the National Registry of Emergency Medical Technicians (NREMT) for eligibility to take the NREMT's Paramedic credentialing examination(s).

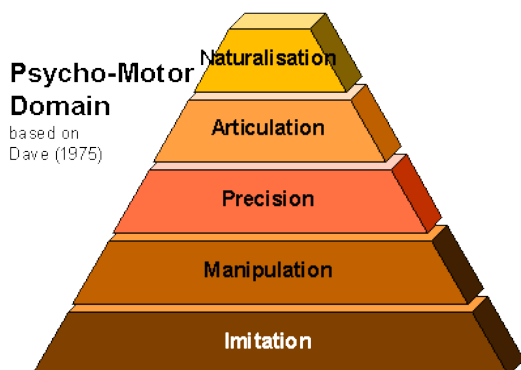
Expected student outcomes following paramedic education

Conceptual competence	Ability to understand theoretical foundations of the profession.
Technical competence	Technical proficiency in performing psychomotor skills.
Contextual competence	Understand how your practice fits within the greater whole of the healthcare continuum. Ability to use conceptual and technical skills in the right context, avoiding the "technical imperative".
Integrative competence	Ability to put all the competencies together to meld theory and practice.
Adaptive competence	Ability to change with evolutions in medicine (big picture) or modify care of a patient based on changing clinical presentations (move from one page of the SOP to another).
Professional behaviors	- Professional identity - Ethical standards - Scholarly concern for improvement - Motivation for continued learning Achieving the affective objectives and demonstrating professional attitudes is just as important as academic and clinical success and is a requirement for graduation. Behaviors to be evaluated: Integrity, empathy, self-motivation, appearance and personal hygiene, self-confidence, communications, time management, teamwork and diplomacy, respect, patient advocacy, and careful delivery of service. Preceptors are asked to document patterns of behavior plus sentinel events.

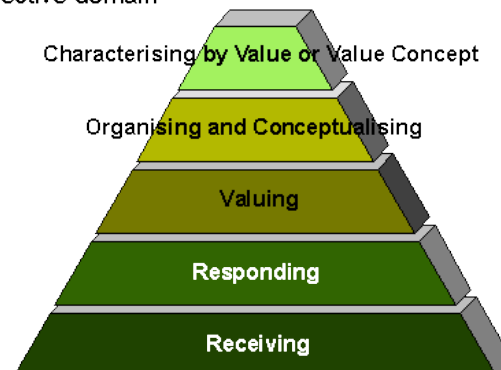
Students must demonstrate achievement of objectives in **all three domains of learning**:



Cognitive domain – Goal is to teach students to **think critically** which entails an interpretation or analysis, usually followed by evaluation or judgment. It requires that learners have mastered some subject matter to think about, so it can't be done in a knowledge vacuum. It involves not only cognition but also character and metacognition/self-regulated learning. Learners must be willing to persist through challenges, evaluate their own thinking fairly, and abandon faulty thinking for new and more valid ways of reasoning (Nilson, 2014).



Affective domain



General course objectives

Upon completion of the program, a PM graduate will consistently demonstrate entry-level competency for each of the following without critical error:

- Assess scene safety and demonstrate effective situational awareness.
- Appropriately gain patient access using a variety of tools and techniques.
- Perform patient assessments using appropriate technique, sequence and timing; recognize alterations from health, set appropriate patient care priorities and coordinate their efforts with those of other agencies and practitioners.
- Establish rapport with patients and significant others to decrease anxiety and meet emotional as well as physical needs.
- Provide care on a continuum from basic through advanced life support within the guidelines prescribed by the EMS MD.
- Exercise higher order thinking to reason critically and problem solve effectively to determine patient needs per standing orders when on-line medical control (OLMC) communication has been delayed, interrupted or aborted.
- Communicate effectively with the designated medical command authority.
- Thoroughly document an electronic patient care report using Image Trend software per System policy.
- Maintain ambulance inventories per the System Drug and Supply list and prepare equipment and supplies before and after each call.
- Characterize professional behaviors through actions, speech, communication and interactions with instructors, preceptors, peers, patients, public safety personnel, and members of the public.

Outcome point 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, and patient-centered care to serve the health care needs of the population.

F15/S16 Student feedback on CoA Paramedic Program Survey	0-5
Summary Paramedic knowledge base (cognitive domain)	4.8
Summary psychomotor domain	4.8
Summary affective domain	4.8

INSTRUCTIONAL DESIGN of our PROGRAM

Paramedic CERTIFICATE Program		Credit hrs
EMS 210	Preparatory (fall)	10
EMS 211	Med. Emerg I (fall)	5
EMS 212	Med. Emerg II (spring)	7
EMS 213	Trauma, special populations (spring)	6
EMS 214	Hospital Internship (fall)	3
EMS 215	Field Internship (spring)	4
EMS 216	Seminar (summer)	3
Total credit hours		38

Required general education and support courses for the Associate in Applied Science (AAS) Emergency Medical Services Degree:

A grade of C or better in all BIO, EMS, (EMS 214 and EMS 215 with a grade of P), and NUR courses is required for all students.

BIO 160	Human Anatomy	4
BIO 161	Human Physiology	4
Electives ¹		4
ENG 101	Composition	3
NUR 210	Physical Assessment	2
SOC 101 ⁺	Introduction to Sociology	3
SPE 101	Fund. of Speech Communication	3
Total credit hours for AAS degree		70

¹Electives: BIO 130, CHM 100, HSC 104, or HSC 213

⁺ This course meets the World Cultures and Diversity graduation requirement.

Paramedic Program Schedule

- Weeks 1-4: **Classroom sessions** M-F from 9:00 am to 5:00 pm.
- Weeks 5-21: **Class/clinical:** Students do hospital clinical rotations 1-2 days a week while attending class the remaining days.
- Week 21: **Complete hospital clinical rotations** unless an exemption applies
- Weeks 22-32: **3-3-17 Field internship full time if all requirements met**
- Weeks 33-36: **Paramedic seminar**
- Week 37: **Graduation! June 14, 2017**



DESCRIPTIONS OF CORE CLASSES

EMS 210 - Paramedic Preparatory

Prerequisite: EMT-B licensure

Introduces students to the roles and responsibilities of paramedics. It presents an overview of EMS system design, constraints, and operating processes; the history and current state of prehospital care and medical oversight; medical-legal and ethical issues; therapeutic communication; life-span development; and general principles of documentation.

Content also includes general principles of pathophysiology: cellular structure and physiology; causes and fundamental mechanisms of disease including degenerative changes; fluids and electrolytes; acid/base imbalances; the body's defenses against disease; and the general pathophysiology of shock and hypoperfusion.

Students study general principles of pharmacology: names and sources of drugs; drug legislation and regulation; schedules of controlled drugs; general properties and forms of drugs; components of a drug profile; drug classifications, routes of administration, interactions, storage, and special considerations; and general drugs used in prehospital care. Vascular access techniques are presented and practiced.

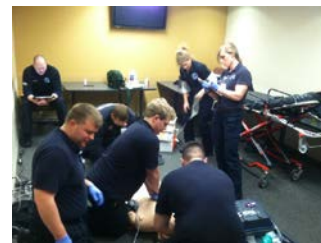
Students must demonstrate competence in calculating drug dosages using the metric system and practice giving drugs through the various routes allowed in prehospital practice.

This module also includes a comprehensive introduction to respiratory anatomy and physiology; advanced airway access methods including intubation, extraglottic airways and cricothyrotomy; pulmonary assessment tools such as breath sound assessment, pulse oximetry and capnography; and the use of oxygen delivery devices. It ends with a presentation on the technique for performing a comprehensive physical examination.



EMS 211 - Paramedic- Medical Emergencies I*Prerequisite: EMS 210 with a grade of "C" or better*

Involves in-depth study of acute and chronic disorders of the pulmonary and cardiovascular systems. Cardiac A&P is presented with an emphasis on the heart's structure, function, and electrical conduction system and the pathophysiology and emergency management of acute coronary syndromes. A significant portion of this module is spent mastering the art of ECG interpretation and learning the cardiac SOPs with multiple labs on cardiac patient and cardiac arrest management. 12-lead ECG interpretation is introduced immediately following this module.

**EMS 212 - Paramedic Medical Emergencies II***Prerequisite: EMS 211 with a grade of "C" or better*

This module covers A&P of the female reproductive system, gynecological emergencies, sexual assault, the physiologic changes of pregnancy, emergency childbirth, complications of pregnancy and delivery, and care/resuscitation of the newborn. Pediatric content includes priorities in providing care to children with medical and trauma emergencies with an emphasis on the pediatric SOPs.

Behavioral and psychiatric emergencies are discussed with an emphasis on patient and responder safety, types of behavioral and psychiatric conditions, general assessment and management, dealing with a suicidal or violent patients and conditions under which restraints may be applied.

The remaining classes cover acute and chronic disorders of the elderly, endocrine, GI, GU, neurologic, immune and hematopoietic systems. Also presented are toxicology and substance abuse, and environmental emergencies. Students have a written and oral project due relative to infectious and communicable diseases.

**EMS 213 - Paramedic Trauma/Special Populations/ EMS Operations***Prerequisite: EMS 212 with a grade of "C" or better*

This section introduces the concept of kinematics and the forces that produce injury along with hypovolemic shock. Trauma to each body system is covered including injuries to the head, face, eyes, neck, spine, chest, abdomen, musculoskeletal, and soft tissues. Burns are differentiated into thermal, chemical, electrical, lightning, inhalation, and radiation trauma. Labs include BLS skills used in splinting, dressing, bandaging, selective spine motion restriction, hemorrhage control, irrigation, and helmet removal. Pleural decompression is introduced as an ALS skill.

This module also includes special patient populations such as those who are culturally diverse, victims of interpersonal violence, and those with special challenges such as patients with vision, hearing or speech deficits, autism spectrum disorders, arthritis, cancer, cerebral palsy, chronic neurological or muscular debilitating conditions, previous brain injury, or a terminal illness. ALS responses to home care patients is presented with an intro to common devices and appliances used or worn by these individuals. Students are introduced to the concept of grief management.

It concludes with field experts presenting concepts multiple patient management incidents, situations involving weapons of mass destruction and terrorism; rescue operations; and responses to hazardous materials incidents.

EMS 214 – Paramedic Hospital Internship**Purpose:**

Allow students to apply concepts presented during class to actual patient situations in a controlled environment under the direct supervision of a hospital-assigned preceptor.

Instruction plans:

Each unit has a clinical instruction plan that lists the student and preceptor objectives, the expected performance outcomes, and a form on which to validate the learning experience. All patient contacts are entered into Fisdap.

Scheduling:

Clinical rotations begin the 5th week of class. Unit assignments depend on hospital availability. Some experiences may be prescheduled by the Clinical Coordinator and others are self-scheduled by the students in FISDAP software. Students must be willing to travel to all System hospitals and complete weekend and evening rotations.



Unit requirements	ED	112 hours	14 shifts
	(Stroke unit optional	8 hours	1 shift)
	ICU	8 hours	1 shift
	Labor & delivery	24 hours	3 shifts
	Operating room	16 hours	2 shifts
	Pediatric ED	24 hours	3 shifts
	Psych	8 hours	1 shift
	<u>Elective</u>	<u>8 hours</u>	<u>1 shift</u>
	Total:	200 hours	25 shifts

EMS 215 – Paramedic Field Internship (Minimum 384 clock hrs plus phase mtgs)

Prerequisite: EMS 214 hospital clinical shifts completed, paperwork submitted; FISDAP entries done, preceptor approved

Goal: Students integrate theoretical concepts learned in class and perform psychomotor skills for which they have demonstrated competency under the direct supervision of an approved preceptor in the field environment. They are expected to develop contextual, integrative, and adaptive competencies using higher order critical thinking skills.

Rules of engagement: Ambulances on which students are functioning must be approved by IDPH to operate at the ALS level. Students are given temporary ALS privileges, but are not a substitute for a licensed ALS team member on ALS calls per System staffing policies. No Paramedic student is authorized to perform any ALS intervention without a System-approved preceptor directly observing and coaching their actions to ensure patient safety.

Field internship objectives

During the field internship a-Paramedic student will

1. effectively participate as a team member and leader under the direct supervision of an approved Preceptor.
2. obtain and organize patient findings and communicate effectively with OLMC.
3. accurately document the call on an electronic patient care report (ePCR) using System approved software, appropriate medical terminology, abbreviations, units of measure, and grammar in accordance with principles of medical documentation. The student's name must be noted as the team member who completed the report.
4. enter all patient care contacts, assessments and interventions performed into FISDAP within one week of completing the call. **The number and nature of patient contacts and interventions logged into FISDAP for that call must match the ALS Critique form and ePCR exactly.**
5. participate in the cleaning, maintenance, and restocking of EMS drugs and equipment commonly found on an ambulance.
6. demonstrate achievement of affective objectives.
7. develop effective coping strategies to mitigate the stressors inherent in EMS practice.

When should the internship begin? First week in March.

However, no student may begin until they are released by the Program Director and Clinical Coordinator in writing. Any delays will impact a student's ability to graduate on time and must be approved in advance by the Program Director.

Sequencing of the internship

INTERNSHIP PHASES: Two phases of ascending mastery and accountability. Each phase has objectives listed on the Field Internship forms that must be achieved before advancing to the next phase or completing the internship.

Phase 1: Orientation to the Provider Agency and its equipment/operation
Team member with an emphasis on skill performance

Phase 2: **Team leader:** "Capstone" experience, where students, in an end-of-program field internship, do work that gets assessed against the desired overall course outcomes. They are expected to demonstrate competency as a **team leader**, assessing scene and team safety, assigning team members to perform duties, reaching appropriate paramedic impressions and determining patient care priorities and destination. See table below for expectations. The student's preceptor is ultimately responsible for ensuring patient safety and that EMS care is timely and appropriate.

How long will it take? It depends! The time varies as each phase is competency rather than time-based and is contingent on the student's knowledge, competency, motivation, and/or number and nature of patient encounters. Phase 1 should be completed in four weeks and Phase 2 should not conclude until the end of May.

Students are required to ride a minimum of 384 hours but usually extend well beyond that as there are ~32 possible 12-24 hour shift days within an internship. Eight additional hours are allowed for evaluation 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.

Team Membership (Followership)	Team Leadership
Demonstrates followership; is receptive to leadership	Takes charge
Leaves ego/rank at the door	Demonstrates confidence, compassion, maturity, and command presence
Avoids freelance activity	Creates an appropriate action plan
Utilizes appreciative inquiry	Receives, processes, verifies, and prioritizes information
Listens actively using closed-loop communication and report progress on tasks	Communicates accurately and concisely while listening and encouraging feedback
Performs tasks accurately and in a timely manner	Reconciles incongruent information
Advocates for safety and is safety conscious at all times	Maintains accountability for team's actions/outcomes
Performs functions using situational awareness and maintains it	Assesses situation and resources and modifies accordingly

NREMT, Feb 2014

Scheduling of internship shifts: No more than $\frac{1}{3}$ of the total hours may be completed from 11 pm to 7 am. At a minimum, students are expected to ride an entire shift extending until the time set by the EMS agency to coincide with their preceptors' work schedule. They may not leave in the middle of a shift unless an emergency exists. Leaving early must be approved in advance by Mike Gentile.

Internship paperwork

Internship paperwork Checklist
Orientation; ambulance inventory form
Run Critique form
Phase I Progress Report

Phase II Progress Report
Hours logs for each phase
Internship Summative evaluation
Student-Agency MOU

PHASE MEETINGS

Meetings are held at the end of each phase with the student, their preceptor(s) and the assigned hospital EMSC/Educator to validate achievement of the objectives for that phase. Attendance by the Provider EMSC is welcome, but not mandatory. However, the PEMSC must sign the Phase II Progress Report and Summative Evaluation.

Students must coordinate and confirm possible meeting dates and times with their Hospital EMSC/educator and preceptor at least two weeks prior to the desired meeting date.

Students shall submit blinded patient care reports (PCRs) for each call on which they participated during that phase along with the completed Run Critique forms, ECG and capnography tracings (if applicable), and drug cards for selective prescription drugs taken by each patient to the hospital EMSC/educator at least one week in advance of the meeting. The EMSC/educator will review the submissions and determine which will be discussed at the phase meeting.

During the meeting, students must be prepared to discuss each patient's history including prescribed meds, physical exam findings, possible causes or contributing factors to the patient's condition; pathophysiology of the condition, how they reached their paramedic impression; interventions/medications administered by EMS, and responses to interventions.

Once a student demonstrates achievement of that phase's objectives, they will be advanced to the next phase or be recommended for graduation. If they do not demonstrate mastery of the objectives, they will be retained in that phase with an individual education plan (IEP) until objectives are met or course deadlines terminate the internship.

Completion: In order to graduate and to take a credentialing exam, students must demonstrate *entry-level* achievement of cognitive, psychomotor, and affective objectives in the internship instruction plan.

Outcomes after the first 384 hours:

- ☐ Internship complete; graduate; allow to take credentialing exam; unrestricted license
- ☐ Graduate; allow to take a credentialing exam; retain with preceptor until: _____
- ☐ Retain in Phase II (attach corrective action plan)*
- ☐ Terminate the internship; sponsorship withdrawn (attach documentation)

* If this option is selected, the hospital EMSC must specify the cause and observation of student performance in detail. If the agency agrees to extend the internship, a corrective action plan must be established between the student, the primary preceptor, the Provider EMSC and the hospital EMSC/Educator. A copy shall be forwarded to the Course Coordinator. The student may continue EMS 215 with an incomplete for a maximum of 45 days after the scheduled end of EMS 215 unless extenuating circumstances apply and have been approved by the Course Coordinator. If licensure cannot be recommended at the end of that time, the student will be given an F for this semester and may re-enroll the next time EMS 215 is offered.

If an agency does not agree to extend the internship for a guest rider, that box should be selected and the student's lack of progress reported to the Program Director.

GOAL: Complete all requirements on or before Graduation: June 14, 2017

Minimum PATIENT CARE CONTACTS/skill competencies that must be entered into FISDAP to confirm skill revolutions during lab practice, EMS 214 and 215 as a prerequisite to graduation:

<u>Assessments</u>	<u>Minimum number</u>
Adult (18-64 yrs)	50
Geriatric (65 or older).....	30
Newborn (0-1 mos).....	2
Infant (1-12 mos).....	2
Toddler (2-3 yrs).....	2
Preschool.....	2
School age.....	2
Adolescent.....	2
(Total peds contacts must $\geq$ 30 minimum)	
Trauma patients.....	40
Chest pain/Cardiac-related complaints	30
Airway/Respiratory-related complaints (adult)	20
Airway/Respiratory-related complaints (peds)	8
Abdominal/GI related complaints	20
Altered mental status/Neuro-related	20
Behavioral problems (including intoxicated/OD/Psych)	20
OB (observe at least 1 vaginal delivery).....	10
<u>Skills</u>	
Medication administration.....	15
Ventilate a nonintubated patient/O2 delivery.....	20
Airway management (with 20 consecutive successful)	*50
Venous access (successful).....	25
<u>Leadership</u>	
**Serve as the Team leader	25 (15 ALS)

EMS 216 - Paramedic Seminar

Corequisite: EMT 215 Paramedic Field Internship



This is a summer course in the Harper calendar and requires separate registration. Seminar hours provide an opportunity for intellectual engagement and allow students to integrate and apply didactic and psychomotor concepts at the highest levels of learning. Students present, evaluate, and create patient cases to illustrate key learning objectives. The seminar approach is designed to prepare students for the final exams as well as the credentialing exams.

National Registry Practical Exam: June 19, 2017

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 make plans or content explicit enough so that all (learners) are on the journey!"

Dr. Donald Deshler, Director Center for Research on Learning, University of Kansas.

Critical Role of Preceptors

- ☐ Serve as a role model/mentor; servant leader
- ☐ Promote clinical and professional competency; ease the transition between school and actual practice by acting as a liaison between the academic and professional aspects of paramedicine.
- ☐ Educator/teacher; provide opportunities to develop and refine skills
- ☐ Coach; encourager
- ☐ Socializer/protector: Connect student with other providers and disciplines
- ☐ Provide reality of work/life in real-world setting (Cornerstone)
- ☐ Evaluator/advocate

Characteristics of an effective preceptor (core capabilities)

Knowledge	Skills/abilities	Attitudes: Models desired behavior
☐ Policies and procedures ☐ Practice standards: Knowledgeable in the content to be reinforced ☐ Unit/agency routines ☐ Documentation ☐ Available resources ☐ Adult learning principles ☐ Methods of teaching/learning ☐ Teamwork ☐ Time management	☐ EMS response and patient care ☐ Communication ☐ Use of equipment ☐ Use of resources ☐ Interpersonal relationships ☐ Work organization ☐ Problem-solving ☐ Decision-making ☐ Priority setting ☐ Delegation and leadership ☐ Ability to provide feedback effectively to students and faculty	☐ Mature ☐ Respectful ☐ Realistic ☐ Patient ☐ Flexible ☐ Dependable ☐ Supporting, encouraging ☐ Positive ☐ Willingness to be available to students for coaching and completion of meetings and paperwork ☐ Has a sense of humor ☐ Constructive ☐ Interest in own professional growth

You were selected to be a preceptor because you have many of these characteristics. Which ones do you possess with good to above average competence?

Which ones need further development?

What steps need to be taken to develop those attributes?

PRECEPTOR APPROVAL

Serving as a paramedic student preceptor is one of the most important and professionally honored roles in our EMS System. They are critically influential in mentoring our students into competent paramedics and we are deeply grateful for their assistance.

Preceptors must meet the eligibility requirements specified in System Policy P1: PRECEPTOR: EMT-P/Prehospital RN/ECRN (posted to the System website – www.nwcemss.org) and attend a **Preceptor Class** before their first preceptor assignment and at least every two years thereafter.

Preceptor Applications and Agreements must be submitted annually, signed by the agency's Chief or EMS CEO, their respective Hospital EMS Coordinator/educator, and the preceptor candidate. Application and Agreements for this year were sent out with System Memo 361.

The Hospital EMSC/educator assigned to the preceptor's agency will review the application along with the candidate's EMS file to determine eligibility based on System policy. If approved, they will forward the signed applications and agreements to the Paramedic Program Lead Instructor.

Signed Preceptor applications and agreements for 2017 are due to Connie Mattera by fax, e-mail, or hard copy by close of business on February 24, 2017. Once approved, a listing of current preceptors will be sent to the Chiefs, Provider EMSCs and the respective hospital EMSCs/educators.

If not submitted by that date, the student and the EMS Provider agency will receive notice of the student's impending suspension for non-compliance with EMS 215 requirements. A primary preceptor cannot be assigned to more than one student at a time.



What is your job?
Provide the student with the best possible chance to succeed!
You are their learning coach.

A coach is a person who gives instruction and imparts knowledge (Coach4Growth.com, 2007). The model (www.thelearningcoach.org) shows the steps that should be taken in a specific order to be most successful.

Present: Spend one-on-one time with the student. However, you need to be more than just physically present. You must be mentally and emotionally engaged. When precepting, you need to pay attention to the student and be 100% available to them when communicating. If not "present" the student will quickly get the message that they are not important. Mentor them at the station or where posted. Stay right with them during a call. Help them learn from every day events. Treat each patient encounter as an opportunity to help them learn and gain some new insight, choice, and flexibility. Provide after-action reviews immediately after a call. Fill out their ALS critique forms right then for the best accuracy of performance assessment.

Caring: *To be concerned or interested.* Coaches provide watchful supervision and needed assistance. They show interest in the student's professional development. Ask the student where they may need help...learning the SOPs, reading ECGs, performing organized, appropriate assessments? Moving from one SOP to another? Setting priorities? Set up mini-drills to target their areas of learning need. Help them see that they and their success are more than an assigned obligation to you. This person could be your partner in less than five months!

Inspiring: Coaches inspire by filling others with an animating, quickening, or exalting influence, feeling, or thought. The System views preceptors as coaches that inspire, encourage, and open doors to learning. Encourage student growth by helping them learn to think critically. Inspire them to see the value and honor in providing EMS services. Open doors to a rewarding career as an EMS professional.

Rigorous: Means to be severely exact or accurate, precise, allowing no deviation from standard. Coaching is not all warm and fuzzy stuff. The pinnacle of coaching is holding the student and yourself accountable to System standards. If an activity, skill or patient interaction should be handled in a certain way, it should be handled that way **ALL THE TIME**. Coaches instill a desire to do work right the first time, every time. The coach should model the standard by which students are measured.

Because of your presence, the System is assured that the student knows and understands expectations and that patients are safeguarded. Whether you are coaching or mentoring depends on the circumstances, as **you can never condone sub-standard performance.**

Unleash the student's learning potential

Learning is an active process between instructor and student that results in **changed behavior** based on the gaining of understanding, comprehension, or mastery of information.

Coach



People learn by the interaction of theory + experience

Help students to connect the dots between the classroom and the street. The best quality-oriented learning with the greatest retention happens on the job with one-on-one coaching. The sooner they can apply the material presented in class, the more it will be retained.

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

Laws of learning

- **Primacy:** First impressions are lasting
- **Exercise:** The more an activity is repeated, the sooner it becomes a habit (either good or bad)
- **Disuse:** Skills not practiced and knowledge not used is soon forgotten
- **Intensity:** Vivid, dramatic experiences are more likely remembered

So, how can you best facilitate learning?

Adults learn through the process of discovery – See additional info in appendix

- See themselves as self-directing
- Are problem-oriented and need to relate new material and information to previous experiences
- Like to participate; need a learning climate that is collaborative
- Must participate in planning and in their own evaluation
- Need to see a direct benefit from the activity
- Become impatient with long-winded explanations
- Prefer being treated as mature peers

How to use Adult Learning Theory when precepting	
Motivated to learn when they experience a need	☐ Ask what their needs and expectations are. ☐ Involve them in discovering the value and relevance for themselves ☐ Help them identify gaps in knowledge and skills (include assessments)
Come to work with a task-oriented problem-solving approach to learning	☐ Include problem-solving activities such as case studies or simulations ☐ Build in time for application and practice ☐ Structure mini-drills around tasks concerning problems & real situations
Bring life-experiences to the learning environment	☐ Use the student's experiences as a catalyst for learning ☐ Create a variety of opportunities for discussion & idea-sharing
Motivated to learn by internal and external factors	☐ Ask what motivates them ☐ Recognize need for achievement and self-esteem
Need to see themselves as self-directed learners	☐ Include experiential activities ☐ Invite and respond to questions
Need to know why they are being asked or required to learn something	☐ Ask them to state the consequences of not knowing ☐ Ask them to clarify what they will be able to do or do better w/ knowing

When setting your expectations, remember that they are just starting on the journey!

Stages of Clinical Practice Development (based on Benner model)	
Stage 1: Novice ▪ Limited background understanding of the situation due to lack of experience ▪ Unable to use discretionary judgment ▪ Somewhat detached from the clinical situation (outside looking in) ▪ Limited involvement with the patient ▪ Task oriented; frustrated if can't complete a task ▪ Heavy dependency on policies & procedures ▪ Limited ability and inflexible (limited compromise) ▪ Transitioning from role of student to paramedic assuming responsibilities of the practice ▪ Requires close supervision, assistance with non-routine situations and on-going education. Under guidance of a preceptor will practice skills and seek assistance for clinical decision-making.	Stage 2: Advanced beginner ▪ Can describe situations in textbook terms but beginning to perceive recurrent meaningful patterns in patient situations ▪ Relies on protocols but is beginning to make decisions based on theoretical knowledge ▪ Can formulate guidelines for action ▪ Focus on what they need to do rather than how the patient is responding ▪ Unable to determine context and what is relevant; cannot prioritize well; treats all aspects as equally important ▪ Delegates up ▪ Period of rapid learning ▪ Requires mentoring support; assistance in setting priorities and determining essential interventions in complex situations.

Stage 3: Competent ▪ Skilled and confident practitioners ▪ Applies experience and judgment in assessing the importance of various patient situations ▪ Demonstrates mastery of most technical skills ▪ Able to plan and organize ▪ Less dependent on SOPs ▪ Describes situations in fine detail ▪ Begins to see actions in terms of long-term goals of patient care ▪ Limits the unexpected by managing the environment; manages conflicts well ▪ Increased level of efficiency ▪ Beginning to develop speed and flexibility ▪ Can prioritize	Stage 4: Proficient ▪ In depth knowledge; can automatically do tasks ▪ Perceives situations as a whole rather than aspects of the situation ▪ Perceptions are based on experience ▪ Able to change relevance ▪ Reaches beyond the boundaries ▪ Risk-taking behavior ▪ Struggles with ethical & moral issues ▪ Can recognize and anticipate the typical progression of events in a given situation and can modify approach to patient's needs ▪ Responds with speed, confidence and flexibility ▪ Can evaluate patient care outcomes from a perspective of seeking improvement
Stage 5: Expert ▪ Comprehensive knowledge grounded in extensive experience; operates from a deep understanding of the total situation ▪ Deep sense of involvement and participation ▪ Good sense of attunement (what's going on): anticipates problems, picks up on subtle changes ▪ Zeros in on the problem, does not waste time looking for alternative solutions ▪ Moves from analytical thinking to intuition ▪ Readily learns new clinical knowledge (open to seeing things in a new way) ▪ Skillfully manages rapidly changing situations; is able to deal with multiple priorities ▪ Effective communication and collaboration skills ▪ Self-directed; little dependency on resources	

Methods to individualize instruction for a successful internship

- **They are coming to you as a novice.** It is expected that their knowledge will be superficial, that they will be dependent on referring to the SOPs and written policies, that their skills will be competent but tentative, their attitudes self-oriented, their habits of mind unknown, and that they may not yet know what they don't know about the street (blissful ignorance or unconscious incompetence).
- We are entrusting them to you, the **expert**. It is expected that your knowledge has depth and breadth, that you have demonstrated skill mastery, your attitudes are patient-oriented, your habits of mind seek ever to improve, and you have full understanding of what it takes to be an exemplary paramedic.
- **Clarify the objectives** of each phase **before** it starts. Go over evaluation sheets together. Discuss predetermined goals with them at the beginning of each shift.
- Help them apply theory to practice by allowing them to perform the assessments, interpret the data, perform the skills and complete the PCR *with your coaching*, not doing it yourself unless the patient's condition requires immediate interventions. **They will learn more by doing than watching.**
- **Teach, don't preach;** facilitate discussion. Guide students to find responsible answers or solutions. Make yourself available to answer questions. If you don't know the answer (and *none* of us knows all the answers), consult a *reliable* source and get back to the student.
- **Use affirmation whenever possible.** Sometimes people are unaware or unsure that they've done something special or skillful. This is often true when a person lacks a basis for comparison, such as when they are new to a job or learning a skill. Your praise acknowledges their accomplishments and points out exactly what they did that was effective. This enhances self-esteem and reinforces behaviors you would like them to repeat and build on in the future.
- All **students succeed at a different pace**. If a student is failing to meet the objectives in a timely fashion, **intervene early**. Don't allow them to fall hopelessly behind. Contact your PEMSC and the assigned hospital EMSC and design strategies to help the student overcome their deficiencies. You don't own the responsibility for learning...you are their coach.
- Help them prepare for phase meetings by **having all the paperwork completed in a timely manner** and submitted to the EMSC at least one week *in advance* of the meeting. Quiz the student about pathophysiology, the actions, indications, contra-indications, and side effects of prescription drugs and any EMS interventions. Review each call to make sure that you all can explain any deviations from SOPs, receiving hospital guidelines, or scene time expectations, and that the patient care report is thoroughly documented.

One Minute Preceptor Method to use during teachable moments	
Steps in the process	Examples
Get a commitment	"What do you think is going on with this patient?" "How do you think we should treat this patient?" "Based on the history you obtained, what parts of the assessment should we focus on?" "Based on the possible things that could be going on, what further assessments should we do, i.e., 12-lead ECG, glucose level, etc.?"
Probe for supporting evidence	"What factors in the history or physical exam support your paramedic impression?" "Why would you choose that particular intervention?"
Reinforce what was done well.	"Your radio call-in was well organized. You had the chief complaint, history and physical exam findings clearly stated as well as our interventions and ETA. Good job!" "You included important information about the scene in the comments section of the CARS report 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!"
Give guidance about 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. This left her with the impression that the patient was in pulmonary edema rather than pneumonia." "This patient may not have chest pain, but they are complaining of severe weakness and are short of breath with a history of HTN. Your rhythm strip shows NRS. Why is a 12-lead ECG necessary for this person?" "I understand that the patient is in pulmonary edema and that NTG is usually indicated, but the ECG shows V-Tach. What is the higher priority right now?" "People in pulmonary edema usually need C-PAP, but this patient's 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 based on travel time can be challenging. We have already done transport time tests from all over town and have found these guidelines to work well." "If you don't remember a drug dose or typical 12-lead changes with ischemia, use the SOP appendix as a quick reminder."
Conclusion	"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 validated and uploaded."

GUIDELINES FOR GIVING CORRECTIVE FEEDBACK

- Assess the student's readiness to receive the information before giving corrective feedback.
- Evaluate performance against known System standards of practice, not your individual preferences.
- Eliminate barriers that hinder communication. Be discrete; Praise in public; always provide corrective feedback in private.
- Provide concrete observations about behaviors rather than giving judgmental opinions. Concentrate on the aspects of EMS care

Safety	Judgment	Fact finding	Leadership
Communications	Practical skills	Decisiveness	Empathy
- Be specific, e.g., "your assessment of the patient's eyes did not include a pupil check. This is necessary because.....you might miss early clues of....and the patient may experience..."
- Use "I" rather than "you" messages when approaching a problem.
- Pace the learning. Provide feedback in manageable bites. Don't try to correct everything at once!
- Pay attention to non-verbal communication; both yours and the student's.
- Focus on continuous improvement, e.g., "based on that experience, how would you approach a similar situation in the future?"

COACHING /Counseling TIPS

If feedback must be given to change behavior or improve performance, use the **STAR-AR** approach. Provide specifics about the **Situation/task**, the person's **action**, and the **result**. Then also suggest:

- an **alternative Action** - What they might have said or done instead or might try in the future.
- an expected **Result** - Why the alternative action might be more effective.

Specific suggestions are easier to receive because they focus on the person's **actions**, not them personally. Vague, unsubstantiated feedback or feedback that focuses on the person, instead of his or her actions, can damage self-esteem and make them defensive.

Example:

Name: Student XYZ		Date: April 18, 2015	
Situation or task: A person walked into the station today and asked to have his blood sugar checked			
ACTUAL		ALTERNATIVE	
Action: <i>Before he could finish, you interrupted him and told him that there was nothing you could do because he wasn't a patient.</i>		Action: <i>Our preferred approach is to explain that we can only provide invasive procedures on patients who have consented to them and that we would be happy to care for him if he consented to an exam even if he later signs a release of transport.</i>	
Result: He left looking really upset.		Result: That way, he would have understood that we were not just blowing him off and refusing to help him.	
Recorded by:			
cc: EMS Coordinator			

We are counting on you to help *complete* this student's entry level education. Learning to apply their knowledge appropriately in the prehospital environment and to put on the mantle of professionalism are critical steps in becoming a paramedic of excellence.

Our grateful thanks for taking on this important responsibility!

Questions? Concerns? Contact Connie Mattera at cmattera@nch.org

The System uses Competency-Based Instruction		
	Competency-based approach	Examples
Pre-instructional period	Learners acquire experience and knowledge in their lives Instructors develop an experience that will tap learner's values & ideas	Instruction is individualized All learners have the opportunity to succeed.
Instructional period	Learners experience new situations; match new experience with previous learning Learners distill new values and new knowledge. Learners try out new behaviors & acquire new experiences & knowledge in both simulated and "real world" environments.	Learners take competency-based tests ("criterion checks") a number of times. Learners who have problems can obtain individual help from instructors. Learners have frequent checks for understanding and receive feedback on how much they have learned. Learning is measured according to how well the learner performs in relation to competencies (objectives) not in relation to other learners (no grading on a curve).
Post-instructional period	Learners continue to process experiences & knowledge based on original knowledge & experience. Learners apply new behaviors in the "real world" environment.	Various assessments (written & observational) may be used to monitor progress. Learning outcomes can be replicated by other instructors in other locations at a later time.

FYI: Digging Deeper

Universal Intellectual Standards

by Linda Elder and Richard Paul

Universal intellectual standards are standards which must be applied to thinking whenever one is interested in checking the quality of reasoning about a problem, issue, or situation. To think critically entails having command of these standards. To help students learn them, preceptors should pose questions which probe student thinking; questions which hold students accountable for their thinking; questions which, through consistent use by all faculty and facilitators, become internalized by students as questions they need to ask themselves.

The ultimate goal, then, is for these questions to become infused in the thinking of students, forming part of their inner voice, which then guides them to better and better reasoning. While there are many universal standards, the following are some of the most essential:

CLARITY: *Could you elaborate further on that point? Could you express that point in another way? Could you give me an illustration? Could you give me an example?* Clarity is the gateway standard. If a statement is unclear, we cannot determine whether it is accurate or relevant. In fact, we cannot tell anything about it because we don't yet know what it is saying. For example, the question, "What can be done about the education system in America?" is unclear. In order to address the question adequately, we would need to have a clearer understanding of what the person asking the question is considering the "problem" to be. A clearer question might be "What can educators do to ensure that students learn the skills and abilities which help them function successfully on the job and in their daily decision-making?"

ACCURACY: *Is that really true? How could we check that? How could we find out if that is true?* A statement can be clear but not accurate, as in "Most dogs are over 300 pounds in weight."

PRECISION: *Could you give more details? Could you be more specific?* A statement can be both clear and accurate, but not precise, as in "Jack is overweight." (We don't know how overweight Jack is, one pound or 500 pounds.)

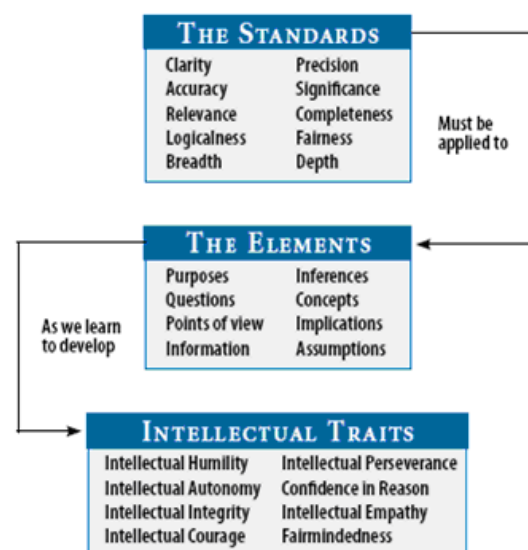
RELEVANCE: *How is that connected to the question? How does that bear on the issue?* A statement can be clear, accurate, and precise, but not relevant to the question at issue. For example, students often think that the amount of effort they put into a course should be used in raising their grade in a course. Often, however, the "effort" does not measure the quality of student learning; and when this is so, effort is irrelevant to their appropriate grade.

DEPTH: *How does your answer address the complexities in the question? How are you taking into account the problems in the question? Is that dealing with the most significant factors?* A statement can be clear, accurate, precise, and relevant, but superficial (that is, lack depth). For example, the statement, "Just say No!" which is often used to discourage children and teens from using drugs, is clear, accurate, precise, and relevant. Nevertheless, it lacks depth because it treats an extremely complex issue, the pervasive problem of drug use among young people, superficially. It fails to deal with the complexities of the issue.

BREADTH: *Do we need to consider another point of view? Is there another way to look at this question? What would this look like from a conservative standpoint? What would this look like from the point of view of . . . ?* A line of reasoning may be clear, accurate, precise, relevant, and deep, but lack breadth (as in an argument from either the conservative or liberal standpoint which gets deeply into an issue, but only recognizes the insights of one side of the question.)

LOGIC: *Does this really make sense? Does that follow from what you said? How does that follow? But before you implied this, and now you are saying that; how can both be true?* When we think, we bring a variety of thoughts together into some order. When the combination of thoughts are mutually supporting and make sense in combination, the thinking is "logical." When the combination is not mutually supporting, is contradictory in some sense or does not "make sense," the combination is not logical.

Critical thinkers routinely apply the intellectual standards to the elements of reasoning in order to develop intellectual traits.



FAIRNESS: *Do I have a vested interest in this issue? Am I sympathetically representing the viewpoints of others?* Human think is often biased in the direction of the thinker - in what are the perceived interests of the thinker. Humans do not naturally consider the rights and needs of others on the same plane with their own rights and needs. We therefore must actively work to make sure we are applying the intellectual standard of fairness to our thinking. Since we naturally see ourselves as fair even when we are unfair, this can be very difficult. A commitment to fairmindedness is a starting place (Paul, R. and Elder, L. (October 2010). Foundation For Critical Thinking, online at website: www.criticalthinking.org).

For a deeper understanding of intellectual standards and their relationship with critical thinking, see the *Thinker's Guide to Intellectual Standards*.

Critical thinking requires that they must develop and demonstrate the following intellectual traits

- **Intellectual Humility:** Having a consciousness of the limits of one's knowledge, including a sensitivity to circumstances in which one's native egocentrism is likely to function self-deceptively; sensitivity to bias, prejudice and limitations of one's viewpoint. Intellectual humility depends on recognizing that one should not claim more than one actually knows. It does not imply spinelessness or submissiveness. It implies the lack of intellectual pretentiousness, boastfulness, or conceit, combined with insight into the logical foundations, or lack of such foundations, of one's beliefs.
- **Intellectual Courage:** Having a consciousness of the need to face and fairly address ideas, beliefs or viewpoints toward which we have strong negative emotions and to which we have not given a serious hearing. This courage is connected with the recognition that ideas considered dangerous or absurd are sometimes rationally justified (in whole or in part) and that conclusions and beliefs inculcated in us are sometimes false or misleading. To determine for ourselves which is which, we must not passively and uncritically "accept" what we have "learned." Intellectual courage comes into play here, because inevitably we will come to see some truth in some ideas considered dangerous and absurd, and distortion or falsity in some ideas strongly held in our social group. We need courage to be true to our own thinking in such circumstances. The penalties for non-conformity can be severe.
- **Intellectual Empathy:** Having a consciousness of the need to imaginatively put oneself in the place of others in order to genuinely understand them, which requires the consciousness of our egocentric tendency to identify truth with our immediate perceptions of long-standing thought or belief. This trait correlates with the ability to reconstruct accurately the viewpoints and reasoning of others and to reason from premises, assumptions, and ideas other than our own. This trait also correlates with the willingness to remember occasions when we were wrong in the past despite an intense conviction that we were right, and with the ability to imagine our being similarly deceived in a case-at-hand.
- **Intellectual Autonomy:** Having rational control of one's beliefs, values, and inferences, The ideal of critical thinking is to learn to think for oneself, to gain command over one's thought processes. It entails a commitment to analyzing and evaluating beliefs on the basis of reason and evidence, to question when it is rational to question, to believe when it is rational to believe, and to conform when it is rational to conform.
- **Intellectual Integrity:** Recognition of the need to be true to one's own thinking; to be consistent in the intellectual standards one applies; to hold one's self to the same rigorous standards of evidence and proof to which one holds one's antagonists; to practice what one advocates for others; and to honestly admit discrepancies and inconsistencies in one's own thought and action.
- **Intellectual Perseverance:** Having a consciousness of the need to use intellectual insights and truths in spite of difficulties, obstacles, and frustrations; firm adherence to rational principles despite the irrational opposition of others; a sense of the need to struggle with confusion and unsettled questions over an extended period of time to achieve deeper understanding or insight.
- **Confidence in Reason:** Confidence that, in the long run, one's own higher interests and those of humankind at large will be best served by giving the freest play to reason, by encouraging people to come to their own conclusions by developing their own rational faculties; faith that, with proper encouragement and cultivation, people can learn to think for themselves, to form rational viewpoints, draw reasonable conclusions, think coherently and logically, persuade each other by reason and become reasonable persons, despite the deep-seated obstacles in the native character of the human mind and in society as we know it.
- **Fairmindedness:** Having a consciousness of the need to treat all viewpoints alike, without reference to one's own feelings or vested interests, or the feelings or vested interests of one's friends, community or nation; implies adherence to intellectual standards without reference to one's own advantage or the advantage of one's group. Valuable Intellectual Virtues (September 2014). Foundation For Critical Thinking, Accessed online at: www.criticalthinking.org)

Learning Style	Implications and Strategies for Preceptors
Visual: <i>Learning by seeing, observing, and picturing things and events. There is more equipment in humans for processing visual information than for any other sense. Most people are visual learners. Research demonstrates that mental imagery increases learning ~12% on immediate recall and ~26% on long-term retention regardless of age, ethnicity, gender, or preferred learning style (Meier 2000). Students think and communicate in pictures and multiple dimensions.</i>	• Students learn best when they can see real-world examples, diagrams, idea maps, icons, pictures, and images of all kinds while they are learning. • They use peripheral learning objects (e.g., bulletin boards, wall maps and diagrams, and unit dashboards). • They ask learners to observe a clinical situation, and then to think and talk about it, drawing out the processes, principles, or meanings it illustrated. • Appeal to these students by - adding visual words to describe what things look like - drawing pictures to illustrate your points - writing things down for them - providing charts and diagrams
Auditory: <i>Learning by talking, hearing, and reading, especially out loud. All learners, particularly strong auditory ones, learn by sounds, dialog, reading out loud, telling someone out loud what they just experienced, heard, or learned, talking to themselves, remembering jingles and rhymes, listening to audio cassettes, and repeating sounds in their heads.</i>	• Have students read out loud and paraphrase content. • Have them tell stories with embedded information (e.g., case studies, reflective discussion). Let students describe what they learned and how they might apply it. • Have them practice a skill and describe in detail what is being done. Ask students to talk nonstop while problem-solving. • Appeal to these students by - making eye contact - slowing down your speech - keeping control of your body language - resisting the urge to draw or write - pausing - resisting the urge to interrupt
Kinesthetic (or somatic): <i>Learning by actively moving and doing, engaging the body (somatic) in the learning process. These learners often cannot sit still, must move their bodies to keep their minds alive and active, and prefer hands-on learning activities. Sometimes these students may be considered disruptive or hyperactive, inattentive and disrespectful of the preceptor's attempts to explain details or review lengthy policies and procedures. It is important for the preceptor to understand that for students who prefer to access information kinesthetically, inhibiting them from using their bodies in learning also interferes with their ability to fully engage their minds.</i>	• Don't just sit there, <i>do something!</i> • Get the body involved in activities. • Have students practice techniques, perform procedures, do an active learning exercise, or complete a project that requires physical activity. • If part of the orientation is classroom-based, allow these students frequent breaks and permission to get up and walk about in the back of the room. • Limit distractions to students who might be present and have different learning styles by managing the types of activities and learning environments chosen for the competency verifications. • Appeal to these students by - allowing them to multitask - asking them to talk - interrupting them to move faster - giving them something to take with them - asking about and talking about emotions

Learning Style	Implications and Strategies for Preceptors
Intellectual: <i>Learning by critical thinking, problem-solving, and reflecting—what learners do in their minds internally as they exercise their intelligence to reflect on experience and to create connections, meanings, plans, and values out of it; the reflecting, creating, problem-solving part of a person. This process connects the body's mental, physical, emotional, and intuitive experiences to build fresh meaning. To some degree, all preceptors and students engage this learning style. It is the sense-maker of the mind, how people "think," integrate experience, create new neural networks, and learn. This is how students turn experience into knowledge, knowledge into understanding, and understanding into wisdom.</i>	• Students may need to receive the information and have time to reflect on it, to mentally pull it apart and restructure it before they can accept this learning for application. • Use competency verification methods that involve the following: - Solving problems - Formulating questions - Analyzing experiences - Applying new ideas to work - Doing strategic planning - Creating personal meaning - Generating creative ideas - Thinking through implications of ideas - Accessing and distilling information - Creating mental models

Elements of Thought:

Each element plays a crucial role in thought.

- What is our purpose?
- What questions are we raising?
- What information are we using?
- What assumptions are we making?
- What data are we gathering?
- What data do we not have?
- Given the data that we have, what is it telling us?
- And, when we come to conclusions about the data, what do those conclusions imply? Within what point of view are we thinking? Do we need to consider another point of view? Where can we get access to such points of view? (Paul, 2007)



CHARACTERISTIC OF ADULT LEARNERS

1. Adult learning is a self-activity—preceptees will learn more, will learn faster, and will retain what they've learned longer when they are actively engaged in learning experiences and have contributed their own objectives.
2. Adult learning is intentional—purposeful and aimed at meeting the student's learning needs. It is most effective when directed at useful and necessary objectives that have been negotiated between the orientee and the preceptor for the orientation and competency verification periods.
3. Adult learning is an interactive process—hands-on, experiential clinical experiences (task- oriented, problem-solving) maximize the amount of learning achieved and retained for students who access and process information in multiple ways and preferences (Gardner 1996; Russell 1999).
4. Adult learning is a unifying process—students respond to teaching—learning situations as whole entities influenced by all of their dimensions of being, their social and physical environments, and their lived experiences. Preceptors incorporate individual differences and learning styles, as well as variable interests, opinions, and paces of instruction when planning orientations and competency verifications with students.
5. Adult learning is influenced by the motivation of learners—a strong and sustained desire to learn allows students to more readily acquire and retain information and skills. Preceptors can enhance motivation by allowing students to participate in identifying and meeting their own learning needs whenever possible.
6. Adult learning is influenced by the readiness of the learner—students have a high degree of readiness to learn whatever is required of them that is typically associated with a new job or role expectation. Preceptors increase this readiness by emphasizing how useful, meaningful, and worthwhile the learning is to the situation, clinical experience, and patient care outcomes.
7. Adult learning is influenced by the learning environment, which is both psychological and physical—preceptors need to provide a comfortable, relaxed, nonjudgmental atmosphere for students: sufficient work space, adequate lighting and visibility, and minimal noise and distractions. Clinical learning experiences are highly stressful to students (e.g., learning emergency procedures and treatments, dealing with death and dying).
8. **Adult learning is most effective when it is organized and clearly communicated**—preceptors facilitate learning best for students in several ways:
 - Select appropriate organizing principles that are conducive to learning (easy to hard, known to unknown, first step to last step) for orientation, verification of competencies, and teaching new skills and abilities, particularly on specialty units (e.g., critical care, pediatrics, operating room)
 - Use teaching aids (media, worksheets, flipcharts, models, overheads, bulletin boards, books) that complement how students access and process information
 - Communicate orientation schedules, objectives, clinical guidelines and procedures, and evaluations clearly and accurately.
9. **Adult learning is facilitated by positive and immediate feedback**—preceptors facilitate learning by giving timely feedback and criticism in a constructive and sensitive manner. It is important here for preceptors to be generous in giving recognition, approval, encouragement, and praise when it is appropriate. Celebrate moments of excellence with students frequently.
10. **Adult learning is built on past knowledge and lived experiences**—students vary in the speed and effectiveness with which they combine new learning with previous knowledge, skills, or abilities.
11. **Adult learning is reproducible**—preceptors can best reproduce retention and transfer of learning in students by emphasizing principles and general concepts in clinical experiences, offering frequent practice and performance opportunities, and giving feedback throughout the preceptorship. When preceptors compare similarities and differences of new applications of previous learning or performance, they reinforce new knowledge and skills for students who can then reproduce and apply what they have learned.
12. **Adult learning continues lifelong**—after the orientation and competency verification periods end, learning continues as students become preceptors and continue their own journey to excellence.

(NCH RN Preceptor Workbook, 2016)

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	