

Professional role of a paramedic

A paramedic is an allied health professional whose primary focus is to provide essential care and services as part of an EMS System. A paramedic functions under medical oversight and is a key link between the out-of-hospital environment and the health care system.

Paramedics possess complex knowledge and skills necessary to provide competent care and appropriate disposition to those seeking their assistance.

Paramedics provide care using drugs, pharmacologics, equipment and supplies as authorized by the EMS Medical Director (EMS MD). The Paramedic's scope of practice ranges from basic to advanced life support and may occur at the point of patient contact, enroute to or between health care facilities, or in other settings.

Paramedics must demonstrate each competency within their scope of practice in a wide variety of environmental conditions and for patients of all ages. Care is based on an appropriate patient assessment, forming an accurate impression, and providing interventions designed to optimize health, mitigate or reverse the signs and symptoms of illness and injury and provide comfort to patients and family members.

Paramedics must care for people with empathy and compassion, have an awareness of their abilities and limitations, and demonstrate transdisciplinary professionalism, strong inter-personal and communication skills, and a capacity for calm and reasoned judgment while under stress. They must blend multiple intelligences with common sense and be service oriented.

ACADEMIC CURRICULUM

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** on a voluntary basis.

Prerequisite:

EMS 111, 112, 113 or EMT Education 9

Paramedic CERTIFICATE Program		Credit hrs
EMS 210	Preparatory (fall)	10
EMS 211	Med. Emerg I (fall)	5
EMS 217	Hospital Internship (fall)	2
EMS 212	Med. Emerg II (spring)	7
EMS 213	Trauma, special populations (spring)	6
EMS 218	Hospital Internship (spring)	1
EMS 215	Field Internship (spring)	4
EMS 216	Seminar (summer)	3
Total credit hours		38

Required 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.

Program Accreditation

The Higher Learning Commission of the North Central Association of Colleges and Secondary Schools (NCA) Commission on Accreditation of Allied Health Education Programs www.caahep.org upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions www.coaemsp.org.

Illinois Department of Public Health Division of EMS and Highway Safety

Expected student outcomes following paramedic education

Outcome-based education is a bridge to developing:

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

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

Cognitive	Psychomotor	Affective
Creating	(What they can do)	(Values & attitudes)
Evaluating	Naturalization	Characterization
Analyzing	Articulation	Organization
Applying	Precision	Valuing
Understanding	Manipulation	Responding
Remembering	Imitation	Receiving

Critical thinker traits: A student must strive for clarity, precision, accuracy, relevance, depth, breadth and logicalness.

General course objectives

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

- Assess scene safety and demonstrate effective situational awareness.
- Appropriately gain patient access using a variety of tools and techniques.
- Perform assessments using appropriate technique, sequence and timing; recognize alterations from health, set appropriate care priorities and coordinate efforts with other agencies and practitioners.
- Communicate effectively orally and in writing with a sense of purpose and audience.
- Establish rapport with patients and significant others to meet emotional as well as physical needs.
- Provide care on a continuum from BLS to ALS within the guidelines prescribed by the EMS MD.
- Use quantitative and scientific reasoning to solve problems effectively.
- Think critically and apply these skills appropriately and in various situations.
- Be technologically literate and thoroughly and accurately document an ePCR using ImageTrend software.
- 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.

Expected professional behaviors (See code of student conduct):

- Professional identity (appearance/personal hygiene)
- Acting ethically based on codes for the profession
- Scholarly concern for improvement
- Integrity, empathy, self-motivation, self-confidence, time management, teamwork and diplomacy, respect, patient advocacy, and careful delivery of EMS services.
- Be committed to life-long healthy living and well-being.

EMS 215 – Paramedic Field Internship

(Minimum 300 clock hrs plus phase mtgs)

Prerequisites for release to Field Internship:

- Successful completion of EMS 213
- EMS 217 & 218 done except for the elective and all paperwork submitted to & 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 HEMSC/educator, paperwork submitted to M. Gentile.
- Agency agreements to host students signed by an authorized administrator; submitted to C. Mattera.
- Hold harmless statement signed by student and forwarded to agency by M. Gentile.

*Students must have completed the lab and hospital patient care contacts and skill revolutions that are required per Appendix G before being released to the field. There are additional contacts and skills that must be completed during the field internship. The numbers to be done prior to and during EMS 215 and 216 have been approval by the Paramedic Program Advisory Committee and the EMS MD.

No student may begin the field internship until they are released by the Program Director in writing. Any delays will impact a student's ability to graduate on time and must be approved in advance by the Program Director.

Target start date: First week in March

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

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 or modify care of a patient based on changing clinical presentations (move from one page of the SOP to another).

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.

Scheduling: Fatigue can threaten safe EMS operation. "Most of the work EMS clinicians do is patient care, and fatigue can have negative consequences for decision-making abilities and overall performance. The outcomes of fatigue can be devastating for EMS personnel and their patients (Patterson, 2018).

"No student may ride for more than a 24 hour continuous shift without a minimum of a 12 hour rest period between shifts. No more than 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 within those boundaries with hours defined by the EMS Agency. Shifts should coincide with their preceptors' work schedule. They may not leave during a shift unless a health or family emergency exists. Leaving early must be approved in advance by Mike Gentile.

Patterson, P.D., Higgins, J.S., VanDongen, P.A. et al. (2018) Evidence-based guidelines for fatigue risk management in emergency medical services, Prehospital Emergency Care, 22:sup1, 89-101, DOI: 10.1080/10903127.2017.1376137.

**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.

Sequencing of the internship

INTERNSHIP PHASES: The field internship is divided into 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 enhancing assessment and intervention skills

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.

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

Minimum PATIENT CARE CONTACTS and skill competencies: The NCH program complies with recommendations of the CoA and national guidelines. The number of patient contacts (by age and diagnosis) and skill revolutions were released in September 2019 following Advisory Committee consideration, input, and approval. The specifics of these requirements and the process of satisfying them are listed in **Appendix G**.

Internship paperwork – see handout packet

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

How long will it take? It depends! The times vary 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. Students must ride a minimum of 300 state-required hours but usually extend well over that as there are over 25 possible shift days within a full internship time. Eight additional hours are allowed for phase or coaching meetings.

Phase 1 should be completed in 4 weeks or less.

Phase 2 **EMS 215 ride time and leadership run experiences may not stop sooner than the 3rd Friday of May.**

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.

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.

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

PRIOR TO MEETING – DOCUMENTS TO SUBMIT TO EMSC/EDUCATOR: Students must organize their patient care reports by nature of call and submit blinded PCRs for each call on which they participated during that phase along with the Critique forms with skill competencies evaluated by the preceptor, ECGs 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 all of 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. See the first page of the critique form for "fair game" questions.

Outcomes and recommendations: 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.

Outcomes after the first 300 hours (Phase 2 Progress Report):

- Capstone Field internship (Phase 2) complete
- Retain in Phase 2 (attach corrective action plan)
- Terminate the internship; sponsorship withdrawn (attach documentation)

Extension requests: If this option is selected, the hospital EMSC must specify the cause and observed student performance in detail. If the agency agrees to extend the internship, an IEP 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 Lead Instructor. 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, the " Terminate the internship; sponsorship withdrawn" box should be selected and the student's lack of progress reported to the Program Director.

Summative Evaluation recommendation options:

- [] We hereby attest that the candidate successfully completed all of the Terminal Competencies required for graduation from the Paramedic Education program as a minimally competent, entry-level, Paramedic and as such is eligible for National Certification written and practical examination testing in accordance with our published policies and procedures and Illinois State Licensure as a paramedic upon successful exam completion.
- [] Terminate the internship; sponsorship withdrawn (attach documentation)

GOAL: Complete all requirements on or before Graduation: June 10, 2020

National Registry Practical Exam: June 19, 2020

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

Preceptor Inventory: 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 Field Preceptor is one of the most important and professionally honored roles in our System. You are **critically influential** in molding our students into competent paramedics and we are **deeply grateful for your assistance!**

Preceptors must meet the requirements specified in policy P-7 Peer Educator I-IV/Illinois Lead Instructor (9/12/19) and P1: Preceptors: Paramedic/PHRN/ECRN (3/14/19) (see System website – www.nwcemss.org). All Field Preceptors must attend a **Preceptor Class** before their first preceptor assignment and at least every two years thereafter. All new Field Preceptors must also hold a Peer II Educator certificate from the System.

Field 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.

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

Signed Preceptor applications and agreements for 2020 were due to Mike Gentile by close of business on February 14, 2020. They will be added to the Preceptor/Peer Educator Excel file and be sent to the Chiefs, Provider EMSCs and the respective hospital EMSCs/educators.

If no preceptor is approved for a particular student, the student and the EMS 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 Coach 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.

People learn by the interaction of theory + experience

Help students to connect the dots between the classroom and the street. The best 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 longer it will be retained.

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



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

How to use Adult Learning Theory when precepting	
Motivated to learn when they experience a need	<input type="checkbox"/> Ask what their needs and expectations are. <input type="checkbox"/> Involve them in discovering the value and relevance for themselves <input type="checkbox"/> Help them identify gaps in knowledge and skills (include assessments)
Come to work with a task-oriented problem-solving approach to learning	<input type="checkbox"/> Include problem-solving activities such as case studies or simulations <input type="checkbox"/> Build in time for application and practice <input type="checkbox"/> Structure mini-drills around tasks concerning problems & real situations
Bring life-experiences to the learning environment	<input type="checkbox"/> Use the student's experiences as a catalyst for learning <input type="checkbox"/> Create a variety of opportunities for discussion & idea-sharing
Motivated to learn by internal and external factors	<input type="checkbox"/> Ask what motivates them <input type="checkbox"/> Recognize need for achievement and self-esteem
Need to see themselves as self-directed learners	<input type="checkbox"/> Include experiential activities <input type="checkbox"/> Invite and respond to questions
Need to know why they are being asked or required to learn something	<input type="checkbox"/> Ask them to state the consequences of not knowing <input type="checkbox"/> 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)	
<p style="text-align: center;">Stage 1: Novice</p> <ul style="list-style-type: none"> ▪ Limited understanding due to lack of experience ▪ Unable to use discretionary judgment ▪ Somewhat detached from 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. 	<p style="text-align: center;">Stage 2: Advanced beginner</p> <ul style="list-style-type: none"> ▪ Can talk in textbook terms but beginning to perceive meaningful patterns in patient situations ▪ Relies on protocols but is beginning to make decisions based on knowledge ▪ Can formulate guidelines for action ▪ Focus on tasks rather than how 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 support; assistance in setting priorities and determining essential interventions in complex situations.
<p style="text-align: center;">Stage 3: Competent</p> <ul style="list-style-type: none"> ▪ Skilled and confident practitioners ▪ Applies experience and judgment in assessing the importance of various patient situations ▪ Demonstrates proficiency for most technical skills ▪ Able to plan and organize ▪ Less dependent on SOPs ▪ Describes situations accurately and completely ▪ Begins to see actions in terms of long-term goals of patient care ▪ Manages the environment and conflicts well ▪ Increased level of efficiency ▪ Beginning to develop speed and flexibility ▪ Can prioritize 	<p style="text-align: center;">Stage 4: Proficient</p> <ul style="list-style-type: none"> ▪ In depth knowledge; can problem solve ▪ Perceives situations as a whole rather than aspects of the situation ▪ Perceptions are based on experience ▪ Able to change relevance ▪ Advocates for strong ethical & moral practice ▪ 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
<p style="text-align: center;">Stage 5: Expert</p> <ul style="list-style-type: none"> ▪ 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, challenge student to find it.
- **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.** Contact your PEMSC and the assigned hospital EMSC and design strategies to help the student overcome their deficiencies.
- Help them prepare for phase meetings by **ensuring all paperwork is 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?" "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!" "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. Why is a 12-lead ECG necessary for this person?" "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	"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.
- Be discrete; Praise in public; provide corrective feedback in private.
- Provide concrete observations about behaviors rather than giving judgmental opinions. Concentrate on:

Safety	Judgment	Fact finding	Leadership
Communications	Practical skills	Decisiveness	Empathy
- Be specific, e.g., "your assessment of the patient's eyes did not include visual acuity or loss of visual fields. This is necessary because.....you might miss early clues of....and the patient may experience..."
- 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 +△ approach.

Plus = Positive

In this step we identify where the objectives, standards, or expectations have been met or exceeded. These are the things that fall into the range from "at least good enough" to "unexpected excellence." Focus on what went so well that you would want exactly that to happen every time the situation occurs. Emphasize those things you'd want everyone to learn to do, especially new ideas and innovations. When appropriate, identify the specific learning objective or performance standard met or exceeded. Then ask how these successes can be built on for even better results. Specify how the improved performance will result in improved outcome

Delta: Change

This is the step where we identify the parts of performance that need to be changed. Identify the specific learning objective or performance standard that was not met and connect that with the consequences: Be as specific as you can, but keep in mind that your aim is to help build improvements that can be applied to different situations.

Where appropriate, demonstrate or model the desired behavior, but know when to "teach with your hands behind your back." Students need time to try it themselves more than they need to see you do it your way. You don't want them to simply copy you. You want them to build on what you've shown them. Sometimes through this step you will improve more than just student behavior. You may identify opportunities to improve processes or parts of your system of care. For example, perhaps an individual performed in a certain way because they didn't know or understand the expectations (education problem) or didn't have what they needed (resource problem) or didn't appreciate the need to perform differently (communication problem). Remember that you don't always have to have the answer. Treat a delta question as a puzzle for the student(s) to figure out with your help (Duckworth, 2019).

Plus/Delta Dos and Don'ts

Don'ts

- Don't use the confusing and contradictory compliment sandwich;
- Don't allow people to assign blame;
- Don't get stuck on excuses;
- Don't let the discussion go off course;
- Don't just tell how you would have done it;
- Don't take over when you demonstrate.

Dos

- Do be polite and respectful;
- Do allow time for students to think before doing or answering;
- Do use objective recording and data to review;
- Do identify specific relevant performance standards and learning objectives;
- Do provide "try it out" time;
- Do focus on ways that systems can be developed to make it easier for people to succeed;
- Do identify key take-home points;
- Do be specific about next actions;
- Do emphasize connections between actions and desired outcomes.

Our grateful thanks to you for accepting this important responsibility!

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

2018-2019 CoA Appendix G and Program Patient Contact and Skills with Stats
2019-2020 Patient Contact and Skills Recommendations

TABLE 1

Required Competencies, Skills, Ages, Differential Diagnoses, and Complaints on Patients in Clinical, Field Experience, or Capstone	CoA <i>Rec</i> Minimum	2018-19 Program Required Minimum	2018-2019 Avg / Mean			Range	2019-2020 Suggested Minimum	Notes
				Median	Mode			
Trauma	30 Total	30 Total	28.6	29	Mult	18-43	30	
Trauma – Pediatric	6						6	Not reported 2018-19; begin Fall 2019
Trauma - Geriatric	6						6	Not reported 2018-19; begin Fall 2019
Pediatrics	18 Total	25	30.6	29	27	20-55	25	
Newborn	2	2	4.5	4.5	Mult	1-8	2	Likely observed assessment only
Infant	2	3	2.9	3	2	0-7	2	
Toddler	2	2	5.4	5	4	1-11	3	
Preschool	2	2	2.4	2	2	1-5	2	
School-age	2	3	5.7	5	5	2-11	3	
Adolescent	2	5	9.8	9	9	4-24	5	
Medical	60 Total	60	61.5	60	Mult	44-80	60	
Medical – Pediatric	12						12	Not reported 2018-19; begin Fall 2019
Medical – Geriatric	12						12	Not reported 2018-19; begin Fall 2019
Stroke / TIA	2	2	3.9	4	4	0-9	2	
Acute Coronary Syndrome	2						2	Not reported 2018-19; begin Fall 2019
Cardiac Dysrhythmia	2						2	Not reported 2018-19; begin Fall 2019
Resp Distress/Failure	2	20	17.3	18	Mult	8-26	15	
Hypoglycemia/DKA/HHNS	2						2	Not reported 2018-19; begin Fall 2019
Sepsis	2						2	Not reported 2018-19; begin Fall 2019
Shock	2						2	Not reported 2018-19; begin Fall 2019
Toxicological Event/OD	2						2	Not reported 2018-19; begin Fall 2019
Psychiatric	6	6	14.1	14	Mult	7-21	6	
Altered Mental Status	2	8	19.7	19	18	7-31	8	
Abdominal Pain (CC or Impr)	2	4	11.3	10	Mult	4-24	4	Chief Complaint or Impr
Chest Pain	2	8	13.5	12.5	8	6-29	8	This CC may also satisfy Impr of ACS
Skills								
IV Bolus Med Admin	20						20	Not reported specifically (total only); begin fall
IM or SQ Injection	2						2	Not reported specifically (total only); begin fall
Inhaled Med (MDI, Neb)	2						6	Not reported specifically (total only); begin fall
Team Leads in Capstone	20 Total	20	49.3	46	Mult	26-80	20	
(Team Leads – ALS)	(N/A)	(15)	(27.7)	(26.5)	(Mult)	(15-48)	(15)	No CoA rqmt for ALS Team Leads. See p 4.

Sequence of Learning Progression	Individual Skill Evaluation ➔		Individual Skill Scenario ➔		Live Application Individual Skills ➔		Putting It All Together-Evaluation of Skills in a Comprehensive Lab Scenario or Live Patient Encounter ➔	
Required Competencies and Skills Prior to Capstone Internship	Individual Student Competency Evaluation in Lab (Min # Times)		Individual Student Competency Evaluation in a Lab Scenario (Min #)		Isolated Skill Performed and Evaluated on Live Patient ONLY (Total Min #)		Skill Competency Performed and Evaluated in Lab Scenario or Live Patient in Clinical or Field (Total Min #)	
	CoA <i>Recommended</i>	Program Required Minimum	CoA <i>Recommended</i>	Program Required Minimum	CoA <i>Recommended</i>	Program Required Minimum	CoA <i>Recommended</i>	Program Required Minimum
Obtain a Patient History from Alert and Oriented Patient	2	2					8	8
Comp Normal Physical Assessment-Adult	2	2						
Comp Normal Phys Assessment-Pediatric	2	2	2	2	2	2		
Direct Orotrach Intubation - Adult	10	10	2	2		4	12	12
Direct Orotrach Intubation - Pediatric	10	10	2	2			12	12
Nasotrach Intub-Adult	2	2						
Supraglottic- <u>Adult & Peds</u>	2	2	6	6			12	12
Needle Cricothyrotomy	2	2	4	4			2	2
CPAP or PEEP	1	1	2	2			2	2
Trauma Phys Asmt-Adult	2	2	2	2	6	6	6	6
Trauma ETI-Adult (Inline)	2	2	2	2			2	2
Pleural Decompression	2	2	2	2			2	2
Medical Asmt incl Cardiac	2	2	2	2	40	40	10	10
IV Therapy	2	3	10	10	20	20	15	15
Intravenous Bolus	2	2	2	2	2	2	10	10
IV Piggyback Infusion	2	2	2	2				
Intraosseous Infusion	2	2	4	4			2	2
IM or Subq Med Admin	2	2	2	2			2	2
Sync Cardioversion	2	2	4	4			10	10
12L ECG Placement		2		2	4	4		
Defibrillation	2	2	4	4			10	10
TCP	2	2	4	4			10	10
Normal Deliv w/ NB Care	1	1	2	2		1	4	4
Abn Deliv w/ NB Care	1	1	2	2			4	4
Neonatal Resuscitation	1	1	2	2			4	4
Totals	60	63	64	66	74	79	139	139

Total Minimum Number of Scenarios Where the Student is Team Leader <u>OR</u> Team Member Throughout the Program but <u>Prior to Capstone</u>					
Laboratory Scenario Pathology or Patient Complaint	CoA <i>Recommended</i> Minimum # as Team Leader	Program Required Minimum # as Team Leader			*Not reported specifically- Begin Fall 2019
		Pediatric	Adult	Geriatric	
Resp distress / failure	1 Pediatric	1			CoAEMSP <i>Recommended</i> Minimum # as Team Member Total of 10 Team Member Evaluations in ANY Scenario
Chest pain			1		
Cardiac Dysrhythmia/Cardiac Arrest	1 Adult		1		
Stroke	1 Geriatric			1	
Overdose					
Abd pain					
Allergic Reaction/Anaphylaxis					
Hypoglycemia/DKA/HHNS					
Psychiatric					
Seizure					
Obstetric or Gynecologic	1 Adult		1		
Delivery w/ Neonatal Resuscitation	1 Neonate	1			
Trauma (blunt/penetr/burn/hemorrhage)	1 Pediatric, 1 Adult	1	1		
Shock					
Sepsis	1 Geriatric			1	
Elective	2	+ 2 any age group			
Minimum Number Team Lead Eval	10	11			Total of 10 Team Member Evaluations in Any Scenario

**These were not reported specifically 2018-2019.
 Will begin tracking and reporting in Fall 2019.**

CoA Appx G Page 4

Basic Competencies to be Evaluated in Lab Prior to Any Live Patient Encounters in Clinical, Field or Capstone Internships	Peer or Instructor Evaluation		Instructor Eval in Scenario Prior to Capstone Field Internship	
	CoA <i>Recommended</i>	Program Required Minimum	CoA <i>Recommended</i>	Program Required Minimum
Basic Competencies Lab overseen by instructor as students check off each other (peer eval). There must be at least 1 peer eval for each of the following:				
Spinal Immobilization Adult (Supine)	1	1	2	2
Spinal Immobilization Adult (Seated)	1	1	2	2
Joint Splinting	1	1	2	2
Long Bone Splinting	1	1	2	2
Traction Splinting	1	1	2	2
Hemorrhage Control	1	1	2	2
Intranasal Med Administration	2	2	2	2
Inhaled Med Administration	2	2	2	2
Glucometer	2	2		
12-Lead ECG placement	2	2	2	2
CPR competencies Lab equivalent to AHA BLS for Healthcare Providers overseen by instructor as students check off each other:				
1 & 2 Rescuer CPR for Adults, Children, and infants	1	1	2	2
Bag-mask Technique and Rescue Breathing Adults & Peds	1	1	1	1
Automated External Defibrillator	1	1		
Relief of Chocking in Infants or Victims 1 Yr or Older	1	1	1	1

**These were not reported specifically 2018-2019.
Will begin tracking and reporting in Fall 2019.**

2018-19 Graduation Requirements: All settings (Lab, Clinical, and Field)

Requirement	CoA	2018-19	Mean	Median	Mode	Range	2019-20	Notes
HOURS-field	N/A	300	541	546	624 (3)	305-779	300	IDPH required minimum
% ETI Success	90% of last 10	90%	-	-	-	-	90% / 10	CoA Interp of CAAHEP 2015 Standards & Guidelines
% Airway Mgmt Success	100% of last 20	100%	-	-	-	-	100% / 20	
<u>ALS</u> TEAM LEADS		15	27.7	26.5	mult	15-48	15	

JVD 8/30/2019

COMMENTS and DISCUSSION: Table 1

- **Neonate age range minimum:** For most, this will be a mostly-observed assessment as the OB nurse is responsible for assessing the newborn in a methodical and rapid manner. This requirement often is not conducive to the pace at which a novice level student would likely need to complete the assessment. Student documentation of the required assessments will be accepted for credit even though the student did not personally complete it.
- **Infant age range minimum:** dropped minimum from 3 to 2. This age range was not plentiful in the Peds ED.
- **Toddler age range minimum:** increased from 2 to 3. Toddler – aged patients are plentiful in the Peds ED!
- **Abd pain minimum:** Fisdap options allow for both a CC of abd pain, and an Impression of “Abd pain / problems”. It is not clear whether Fisdap will report this in Appx G based on entry of the CC or the Impression. Students will be instructed on Fisdap entry to ensure both options are documented to ensure credit.
- **Chest pain:** Chest pain is entered into Fisdap as a CC. The final impression may be a variety of related conditions, including ACS (pt has acute changes requiring interventions for same). Other patients with chest pain may have no findings, and thus no treatment for a cardiac condition. The common theme here is that the patient with this CC is ASSESSED appropriately, which is how students will or will not be awarded credit for this requirement.
- **Skills: Inhaled Meds:** CoA req is 2. This was a very frequent method of med administration in both clinical and field setting last year – suggest increasing minimum to 6.
- **Team Leads:** CoA recommends a minimum number (ALS and BLS combined) of Team Leads – 20. Most students met and surpassed that minimum easily, with the exception of those students and departments with lower call volumes (average total was 49!). To be fair to students at those low volume depts. (student w/ 26 TL’s total), we did not recommend increasing the minimum past 20.

COMMENTS and DISCUSSION: Table 2

- **Column 2 vs Column 4:** Note that the difference in Column 2 scenario skills and Column 4 scenarios lies in the fact that Column 2 refers to an isolated skill performed as appropriate in response to the presented scenario. Column 4 refers to a scenario that requires performance of multiple skills in a more complex situation (clinical or field) or scenario (lab).
- **Direct Orotrach intubation-Adult:** Past program requirement has been 4 successful live adult intubations (done in OR, while on rare occasion encountered in clinical and field). CoA does not stipulate live ETIs. Requirement will be retained by modifying Table 2 to require 4 live adult intubations.
- **Supraglottic airway:** CoA standard specifies adult only; *For our Program*, Table 2 “Supraglottic” will reflect a total of both adult and pediatric lgel insertions, combined.
- **Normal Delivery w/ newborn care:** Past program requirement has been for all students to witness one live vaginal birth. (CoA does not specify a live patient experience.) This requirement will be retained by modifying CoA Table 2 to require one live birth, inclusive of an OB assessment of the delivering patient and observation of routine newborn care.

COMMENTS and DISCUSSION: NCH Paramedic Program – Specific Requirements (Last page)

Percent Success on ETI and overall Airway Mgmt requirement: This guideline is not included in the Appx G tables. However, the recommendation appears in multiple CoA documents addressing airway management and competence. This requirement will continue to be measured, and will be reported in the Fisdap Graduation Requirements report, along with the IDPH **Field hours** requirement and the Program-specific **ALS Team Leads** requirement, which are not reported anywhere in the Appendix G report.

PRECEPTOR SELF ASSESSMENT FORM

Name: _____

Agency _____

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.*

These findings are for data collection purposes only.
All responses will be held strictly confidential.

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	

Total Self-reflective Score: _____