Clinical Internship Preceptor Orientation Manual

Princeton Rescue Squad

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TABLE OF CONTENTS

CLINICAL AND FIELD SITE GUIDELINES

Clinical and Field Training Site Objectives

1. The main objective of clinical and field rotations is to allow the student to perform or observe as many medical skills as allowed during clinical rotation throughout the course of the program.
2. The EMS Education Clinical and Field Training is designed for the student's competency in specific patient disease states or conditions and is not primarily based on the number of clinical hours the student spends in each department.
3. Clinical and Field site locations essential awareness is that the EMS Education student is operating under the medical license and guidance of this Program's Medical Directors and no other physician is responsible for the student's activity during clinical and field rotations. It is this Program's sincere desire that various clinical and field sites will be made available for our students and that the clinical and field site will give our students the opportunity to gain competency in evaluating various medical conditions through the process of assessment, procedures, and communications with patients, family, and medical staff.

Preceptor Role During Clinical and Field Rotations

1. Preceptors need to evaluate, assist, and monitor student's activity while they are performing clinical and field rotations within the department.
2. Preceptors need to evaluate what type of skills have been previously performed and sign off as completed by instructors of the program with every visit to the clinical or field site. NOTE: The skills proficiency that each student can perform will increase as the instructional education progresses.
3. Preceptors need to evaluate the student's patient assessment parameters.
4. The preceptor should monitor and assist the student's performance of these assessment skills.
5. The preceptor should complete clinical and field evaluation forms on the student's performance during rotation through that clinical or field site. The student is responsible for providing this form to the appropriate representative. Return form to the student for delivery to the Program's Instructor. The form must be **SEALED** in an envelope and the seal signed by the preceptor and then the student returns it to the clinical coordinator.
6. The Preceptor will use the "Field Internship or Clinical Internship Evaluation Form" for the student's evaluation. It should be noted that the preceptor has the right, at any time during clinical or field rotation, to immediately remove a student who has demonstrated:
    a. Any rude/demanding manner to patients or staff.
    b. Showed careless or reckless disregard for safety.
    c. Showed a disinterest in clinical activities.

    This problem must be noted on the evaluation sheet. The sheet should be sealed in an envelope and leave a message at 304-716-0129 ext. 602 for the Education Director to pick up this evaluation.

7. The preceptor, who can review pathophysiology of the disease process, would be an asset to the EMS student's education.
8. The preceptor should try to assist the student in the common understanding of patient's medical condition.

NOTE: Some of the medical emergency conditions will not be reviewed until future semesters and any additional help with informing the students of medical conditions will improve the student's understanding.

Student Role During Clinical Rotations

1. Appropriate dress for the clinical rotation will include:
    a. Dark blue or black work-type pants.
    b. Official Princeton Rescue Squad's Educational Institute polo indicating the EMS program of study with the appropriate PRS Educational Institute logo.
    c. Black shoes. Boots are preferred in the field and black soft-shoes are preferred in the hospital setting.
    d. Students must wear ID badges for all clinical rotations and the ID badge needs to be surrendered to the Instructor at the end of the program.
    e. The student cannot wear any non-Princeton Rescue Squad's Educational Institute symbols or lapel pins on uniform shirt or cap.
    f. The student should not wear a cap during clinical rotations inside the hospital and the only allowable cap/hat during field rotations is a Princeton Rescue Squad cap or plain dark blue/black cap.
    g. Long hair should be pulled up and away from the face.
    h. No visible piercings unless it is a female student wearing post earrings only.
2. Transportation to and from all clinical and field assignments is the responsibility of the student.
3. The student should be at each clinical or field site at least 15 minutes before scheduled time.
4. If the student is unable to make clinical or field rotations for any reason, notify the Clinical Coordinator or Instructor as soon as possible.
5. If the student is unable to make clinical or field rotations due to car trouble, it is the student's responsibility to notify the Instructor or Clinical Coordinator at least one hour before scheduled start time.
6. The student is supposed to complete all clinical and field rotations as scheduled. If the student needs to reschedule a rotation, it is the student's responsibility to notify the Clinical Coordinator.
7. It is the student's responsibility to complete clinical and field internship forms and to hand deliver these forms to the Clinical Coordinator/Instructor. The recommendation is to turn in completed forms at least once per week.
8. Without rescheduling, missing two clinical or field rotations during the semester will place the student on probation. To remove probation, the student needs to successfully complete eight clinical or field rotations without an absence. One more absence will cause the student to exit the program.

9. While performing clinical rotations, students are to follow the EMS Code of Ethics (Integrity, Compassion, Accountability, Respect, Empathy):
    a. Whether the student is interacting with staff, families, or patients, any deviation in behavior noted by the preceptor is grounds for dismissal and termination of that day's clinical rotation.
10. While performing clinical rotations, students are to:
    a. Perform ONLY the skills they are signed off to perform on live patients.
    b. Make good use of time.
    c. Assist staff with their needs.
    d. Ask questions as they arise in response to patient care plans, skills review, and other appropriate questions specific to their paramedic education.

CLINICAL TRAINING GUIDELINES

The following pages give you guidance on the actions that EMS students are allowed to perform in each individual clinical setting/unit to which he/she is assigned. REMINDER: Only skills that have been signed off by the Instructor can be performed in the clinical setting. At any time a preceptor or department manager can request the student's documentation to identify/verify appropriate skills.

EMT STUDENT CLINICAL TRAINING GUIDELINES

FIELD INTERNSHIP

Possible learning opportunities for the EMT student during field rotations include:

1. Perform a basic history and physical examination to identify acute complaints and monitor changes.
    a. Identify the actual and potential complaints of emergency patients
2. Communicate in a culturally sensitive manner
3. Safely and effectively perform all psychomotor skills listed on page 16 of this manual.
4. Demonstrate professional behavior including, but not limited to: integrity, empathy, self-motivation, appearance/personal hygiene, self-confidence, communications, time management, teamwork/diplomacy, respect, patient advocacy, and careful delivery of service.
5. Initiates basic interventions based on assessment findings intended to mitigate the emergency and provide limited symptom relief while providing access to definitive care.
6. Report and document assessment data and interventions.
7. Perform a patient assessment and provide prehospital emergency care and transportation for patients with a variety of illness and injury complaints.
8. Serve as a EMS team member on an emergency call with more experienced personnel in the lead role. EMT's may serve as a team leader following additional training and/or experience.
9. Ensure the safety of the rescuer and others during an emergency.

EMERGENCY DEPARTMENT/TRIAGE

Perform comprehensive patient assessments of all age groups and chief complaints, including developing relevant medical history and conducting a physical examination. The assessment should include, at a minimum, taking vital signs and auscultation of chest sounds.

Assist, Observe, and Review the treatment of all chief complaints and emergencies.

Formulate a treatment plan for patients with all varieties of chief complaints as though the patient currently being assessed was brought into the ED for the first time. Students should work directly with precepting staff members on verification of the appropriateness for their hypothesized treatment plans,

Assist in the triaging of patients.

Assist in trauma cases requiring hemorrhage control, suturing and splinting.

Perform peripheral IV insertions using angiocaths and butterfly needles only.

Prepare and **Administer** intramuscular, SQ, and IV medications under supervision of an RN, MD, or course instructor/designee. Observe and record effects of medications.

Record and attempt to accurately **Interpret** EKG's.

Draw blood samples as appropriate.

Perform ventilations on unintubated patients of all age groups.

Assist in cases of cardiac arrest, including performance of CPR, airway management, intubation, defibrillation, drug administration, and suctioning.

Assist in prepping minor wounds.

Assist in setting up sterile fields for suturing, etc.

Assist, if appropriate, in the application of casts and splints.

Assist staff with other duties as needed within Scope of Practice.

Become familiar with the lab reports used.

FIELD INTERNSHIP CAPSTONE

This is a capstone clinical experience intended to develop leadership ability and refine advanced life support assessment and treatment skills in the filed setting. Pre-requisite: NRPM 201, NRPM 202

MINIMUM # OF SUCCESSFUL TEAM LEADS REQUIRED: 20

DEFINITION OF A **"SUCCESSFUL TEAM LEAD":**

The student has successfully led the team if he or she has conducted a comprehensive assessment (*not necessarily performed the entire interview or physical exam, but rather been in charge of the assessment*), as well as formulated and implemented a treatment plan for the patient. This means that most (*if not all*) of the decisions have been made by the student, especially formulating a field impression directing the treatment, determining patient acuity, disposition and packaging/moving the patient (*if applicable*). Minimal to no prompting was needed by the preceptor. No action was initiated/performed that endangered the physical or psychological safety of the patient, bystanders, other responders or crew. (*Preceptor should not agree to a "successful" rating unless it is truly deserved. As a general rule, more unsuccessful attempts indicate a willingness to try and are better than no attempt at all.*) To be counted as a Team Lead the paramedic student must conduct a comprehensive assessment, establish a field impression, determine patient acuity, formulate a treatment plan, direct the treatment, and direct and participate in the transport of the patient to a medical facility, transfer of care to a higher level of medical authority, or termination of care in the field. For the NRPM 204 Capstone: Paramedic Field Practicum to meet the breadth of the paramedic profession, team leads must include transport to a medical facility and may occasionally include calls involving transfer of care to an equal level or higher level of medical authority, termination of care in the field, or patient refusal of care.

SPECIAL NOTATIONS:

"Patient refusals and/or termination of care in the field": The paramedic student **MUST** complete and document an **assessment of ALL body systems** to count the patient encounter as a "Successful Team Lead".

18 of the 20 calls MUST be ALS transports to an emergency room or an ALS Interfacility transfer to higher level of care.

No more than 2 of the 20 calls can come from: "**BLS transports, termination in the field, OR patient refusals**."

Capstone field internship team leads cannot be accomplished with simulation.

ICU/CCU

Perform comprehensive patient assessments of all age groups and chief complaints, including developing a pertinent medical history and performing a physical examination. At a minimum, the patient assessment should include a review of the patients chart, the taking of vital signs and auscultation of chest sounds.

Formulate a treatment plan for patients with all varieties of chief complaints as though that patient currently being assessed would be transferred out from the facility. Students should work directly with precepting staff members on verification of the appropriateness for their hypothesized treatment plans.

Review all cases including patients' charts, diagnosis, and treatment.

Perform peripheral IV insertion, as appropriate.

Prepare and **Administer** intramuscular, SQ and IV medications.

Monitor IV infusions.

Monitor and attempt to correctly **Interpret** EKG's, attach/change monitor electrodes.

Assist in cases of cardiac arrest. Perform CPR, management of the airway, placement of ET tubes, ventilation of the unintubated patient, defibrillation and the administration of medications, all as is appropriate.

Assist in the care of patients with ET or Tracheostomy tubes and patients on ventilators.

Assist in the total care of patients with staff direction.

Assist and **Monitor** surgical cricothyrotomies

Assist and **Monitor** surgical chest tubes

PEDIATRICS

Perform comprehensive assessments on pediatric patients with a variety of chief complaints including, at a minimum, a review of the patient's chart, taking vital signs, and auscultation of lung sounds.

Formulate a treatment plan for patients with all varieties of chief complaints as though the patient currently being assessed was to be transferred out to another facility via ambulance transport. Students should work directly with precepting staff members on verification of the appropriateness for their hypothesized treatment plans.

Preparation and Administration of intramuscular and IV medications as is appropriate.

Monitor IV infusions.

Starting IV therapy as is appropriate.

Perform ventilations on unintubated patients of all age groups.

Assist in the care of patients as is appropriate.

Observe techniques used to manage difficult patients.

Observe techniques for family interactions.

RESPIRATORY DEPARTMENT

Perform comprehensive patient assessments on patients of all age groups and all varieties of chief complaints; including developing relevant medical history and conducting a physical examination. The assessment should include, at a minimum, noting vital signs and auscultation of chest sounds.

Assist, Observe, and Review the treatment of respiratory care cases, medical and trauma emergencies.

Perform peripheral IV insertions.

Assist in preparation and administration of IV medications and nebulized medications under supervision of respiratory department staff. Observe and record effects of medications.

Record and attempt to accurately **Interpret** EKG's.

Assist in 12 lead monitoring and interpretation.

Draw blood samples as appropriate.

Assist in cases of cardiac arrest, including performance of CPR, airway management, ventilation of the unintubated patient, perform intubation, defibrillation, drug administration, and suctioning as is appropriate.

Assist staff with other duties as needed within Scope of Practice.

Assist in the care of patients with ET or Tracheostomy tubes and patients on ventilators.

Become familiar with the lab reports used.

LABOR AND DELIVERY

Perform comprehensive assessments on obstetric patients.

Perform comprehensive assessments on neonate patients.

Formulate a treatment plan for obstetric patients and neonates as though the patient currently being assessed was initially being brought into the unit, or was to be transferred out to another facility via ambulance transport. Students should work directly with precepting staff members on verification of the appropriateness for their hypothesized treatment plans.

Identify and label the three stages of labor, common complications, and types of abnormal deliveries.

Assist, if possible, in normal cephalic deliveries.

Observe and **Assist**, if possible, in abnormal deliveries.

Observe or **Assist** in control of postpartum hemorrhage by uterine massage and infusion of oxytocin.

Observe and **Assist** in the management of the newborn, including severing the cord, suctioning, etc. as is appropriate.

Observe and **Assist**, if possible, in the resuscitation of the newborn.

Perform, as is appropriate, ventilation of the unintubated patients of all age groups.

OPERATING ROOM/RECOVERY

Perform comprehensive patient assessments of all age groups and chief complaints.

Perform endotracheal intubation under the supervision of anesthesiologist/anesthetist.

Perform peripheral IV insertion.

Perform aseptic endotracheal and orotracheal suctioning as directed.

Prepare and **Administer** IV medications and observe and record effects of pharmacologic agents.

Maintain airway in an unconscious patient using manipulations and positioning of the head, oropharyngeal airways, etc.

Monitor the cardioscope and attempt to accurately interpret an EKG, noting any irregularities.

Operate oxygen equipment and assist as directed in the operation of mechanical respirators.

Observe the treatment of various soft-tissue and musculoskeletal injuries; as well as the observation of a variety of surgical procedures, as is appropriate.

PSYCHIATRIC DEPARTMENT

As is allowed, **Observe** the management and assist in the interview of patients with the following disturbances:

- suicidal feelings
- hostility and violent behavior
- acute grief and depression
- paranoia
- hysterical conversion
- substance abuse

As is allowed, **Observe** the restraint of combative patients and review the protocols, and documentation, for doing so.

As is allowed, **Participate** in group sessions and counseling.

Formulate a treatment plan for psychiatric patients as though the patient currently begin assessed was to be brought into the facility for initial consult, or was to be transferred out to another facility via ambulance transport. Students should work directly with precepting staff members on verification of the appropriateness for their hypothesized treatment plans.

FIELD INTERNSHIP

1. Observe and obtain patients history and complete physical exam.
2. Review chart thoroughly including labs, radiology reports and physicians progress notes.
3. Review any radiology films available
4. Observe and participate with the maintenance of basic and advanced airway management.
    a. Suctioning
        i. Orally
        ii. Nasally
        iii. Endotracheally
        iv. Tracheally
    b. Oxygen administration by various devices
    c. Incentive Spriometer
    d. Chest PT
    e. Administration of Breathing Treatments
5. Observe and assist with peripheral or central IV placement and maintenance, including Swan Ganz Catheters, and focusing on:
    a. Sterile techniques
    b. Cardiac output
    c. Pulmonary artery wedge pressure
    d. All swan pressure readings and wave forms
6. Observe and assist with administration of medications as well as calculating drug doses on their own and showing work on the skill sheet. Participants must calculate all IV infusions that the patient would be receiving.
7. Observation and assist with Pulse Ox, ETCO2, pressure reading on ventilators, Accucheck, etc.
8. Read 12 Lead EKG's of patient and compares finding with preceptor and document finding on clinical skills sheets.
9. Observe IABP mechanics, inflation/deflation waveforms, timing ratio, and troubleshooting.
10. Observe ICP pressure monitoring devices, waveforms, maintenance and releasing of pressure.

PERSONAL DOCUMENTATION RECORDS*

It is vital that the preceptor keep the EMS student's informed throughout the rating period, field training, on what is expected and how well they are performing. This is usually done through the use of verbal feedback.

It is at the discretion of each individual preceptor to decide whether or not to keep a written record of the student's progress throughout the course of his or her rotations. It is recognized, however, that some of the judgments' made may be erroneous. This may result because the preceptor made a snap judgment based upon only one performance, or a personality conflict with the student occurs (sometimes unwittingly) or the assumption is made that this student, like all other students, knows very little about EMS or that the preceptor receives false information from another well-meaning but misguided student. Because of these erroneous judgments, some formal procedure or method is necessary to minimize the possibilities of bias and discrimination as well as uninformed judgments.

Documentation is an objective way to look at performance. It should not be viewed as a negative process or as "keeping a book" on the EMS student. Rather, it should be considered as a positive technique to support and sustain performance appraisals leading to performance personnel retention, remediation, or dismissal decisions.

It is necessary that the preceptor know what should be documented. Only those behaviors which are observable, measurable, and job related should be noted. For documentation to be legally defensible, an evaluator must show specific actions. Hearsay or an opinion about an attitude cannot be defended in either a court of law or the court of public opinion. The rules are simple; "if you didn't write it down, it didn't happen." Remember that documentation should be positive as well as negative. Documentation serves many functions:

- Provides recognition of a job well done;
- Prevents denial later by the EMS student;
- Aids the preceptor for a memory of events;
- Minimizes misunderstandings through remedial training;
- Stimulates the student's "thoughtfulness";
- Over the course of time the cumulative results show patterns of results;
- Speaks in your absence if you are promoted, transferred, or otherwise unable to complete the training; and,
- Supports observations of the EMS student for future supervisors who may have similar thoughts about a student's behaviors.

The ABCs of Documentation

Accurate, Behavioral, Consistent

Documentation must be accurate. The preceptor should record only objective facts concerning actual performance. These should be direct observations, and it is better if they are

recorded as they occur. Negative quotes by showing unacceptable attitude or insubordination are valuable documentation.

Behavioral documentation should record only relevant behavior. The behavior should be described with specificity and should avoid meaningless non-behavioral descriptions like poor attitude, reasonable, adequate, attempted, and approximate. These words are difficult to define in a legal proceeding, either at the squad level or in a court of law. The behavior should be placed in the context of the assignment given to the paramedic student. For example, it is one thing to say “the EMS student could not take a blood pressure at this advanced date in his training” as opposed to “the EMS student could not take a blood pressure on the multiple stab wound victim who had been shot.”

The documentation should explain the consequences of the student’s behavior, whether positive or negative, upon the patient’s condition. Behavioral documentation does not describe the EMS student’s personality or general attitude unless they directly impact on job performance in a meaningful and measurable manner. You must be specific and show how the behavior relates to the job.

Consistency also plays a role in documentation. It is important that your documentation shows both positive and negative behavior. This demonstrates impartiality and evenhandedness. This is particularly difficult for those preceptors who were taught in a para-military model common in schools during the 50’s and 60’s. You must adopt consistent formats and levels of detail. You should periodically review the collective documentation of a student for consistency.

The time you decide to devote to documentation will depend upon your style as a preceptor, the quality of the EMS student, the nature and complexity of the assignment, and your familiarity with the student. There is a rule of thumb for how much documentation is enough. Someone else at your level with the appropriate experience should be able to read your documentation and come to the same conclusion or at least be able to say. “I can see how you reached that conclusion”.

Remember, you are only one judge of the student’s performance. The Education Director, EMS Program Instructor, and Medical Director might review your documentation at a later date. Remember the ABC’s: ACCURACY, BEHAVIORAL, CONSISTENCY and you will never have a problem supporting your recommendations.

**From Bassett Healthcare Paramedic Program-clinical instructor manual*

INTERNSHIP EVALUATION FORMS*

In the course of education every instructor meets the student whose performance is not acceptable or up to standards. With the student's best interest in mind, the instructor is obligated to commence a process of correction and remediation. The first step in that process is the Internship Evaluation Form.

An Internship Evaluation Form is not only documentation of the events within a given clinical rotation but is a means to document problem behaviors as well as a written plan (or suggestion) of remediation to correct those behaviors. Typically, an internship evaluation form is written and signed by the preceptor at the end of the clinical rotation, after the preceptor has sat down with the student and reviews the situation and discusses the problem as well as the preceptor's expectations.

The Internship Evaluation Form should contain the following elements (if a problem performance exists). First, the preceptor should begin with a description of the performance problem. This description should be tied to a written standard or other supporting documentation. If the misconduct involves a breach of ethics, for example, then the code of ethics should be cross-referenced.

It is important to include any previous statements that have been made to the student regarding the student's lack of progress with expected performance or misconduct and, specifically, if any verbal warnings were issued. These statements and warnings must be referenced in the evaluation form as a failure to do so may not permit the preceptor to raise these points later.

The next statement is important. The student needs to know how his or her failure to perform or misconduct has affected the organization in a negative manner and that these impacts, intended or unintended, are not acceptable. This statement should clearly place the conduct or performance as unacceptable.

With that said, the preceptor would then proceed to outline what changes in the student's behavior or performance are expected and how the student can facilitate those changes. These changes should be time-limited. Requirements without deadlines are a plan for disaster from a disciplinary perspective.

While every effort should be made to delicately word the consequences of the student's failure to comply, in order to spare the student's feelings, the consequences of such a failure should be clear and unequivocal. To a student ambiguity translates to an opportunity to test the preceptor's metal and the organization's resolve to maintain quality.

The preceptor should conclude the evaluation form with a statement that re-enforces the organizations commitment to its students and specifically what aspects about that student's performance are positive. These points are made in order to provide a platform from which to launch the plan of remediation.

Sometimes, a simple statement, such as thanking the student for addressing these matters, is all that is necessary. Of course, that statement should always be followed up with an invitation to the student to contact the preceptor if any further clarification is needed. This last statement helps remove ambiguity and places the onus on the student to ask questions before acting.

Common Evaluation Appraisal Errors

Person-oriented approach suffers from numerous shortcomings and inevitably results in rating errors. Despite these facts, person oriented appraisals are still the most widely applied approach. Some of the most common errors of this appraisal approach are as follows:

The Error of Leniency occurs when the evaluator marks most of the reports in the highest categories resulting in an over-rating of the EMS student.

The Error of Personal Bias occurs when the evaluator allows personal feelings about the EMS student to affect the student's ratings. Likes and dislikes tend to limit appraisal objectivity.

The Error of Central Tendency occurs when the evaluator places all students somewhere near the center of the rating scale or when they routinely "bunch" the rating scores near the center. This occurs because the rater may not be aware of how the rating is to be used or subordinates are not well known or because justification is required in extreme ratings.

The Error of Related Traits occurs when the rater gives the same rating to traits that are considered to be related in some manner. The value of each rating is lost and the overall rating is less valid.

The Halo Effect occurs when the rate lets one or two traits, particularly those that the rater admires, dominate the appraisal of the student. The rater evaluates all remaining traits based on the dominant trait or traits. Halo effect may also occur when the rater is influenced in a particular category by one outstanding event which occurred in that category. For example: technical proficiency in CPR at the scene of a cardiac arrest. The rater's desire to avoid "playing God" in evaluating people negatively can result in an overwhelming over-evaluating of the EMS student.

These errors are passed on to "downstream" consumers of these student's i.e. Crew Chief's and the like. The process of change and remediation at those times is much more difficult and often results in dismissal or resignation of the student rather than re-education.

Use of personal traits does not provide needed guidance for performance improvement. There is often a defensive reaction by EMS students to "personal" evaluations which can lead to a breakdown in communications with the evaluator. There is questionable relationship between traits used for evaluation and those required for successful performance.

Results Oriented Approach

This approach tends to be objective, center on the job performance rather than individual traits, and generally result in more effective motivation. Moreover, the preceptor does not have

to be a personality expert and he or she can identify effectiveness of performance more readily. Students want their performance and not their character discussed during performance review.

It is the job of the Advisory Board to obtain information about and make judgments of an Applicant's character. When the student is presented to the preceptor all such decisions should have been put to rest. If an issue does arise, then it should be handled by the Education Director/EMS Program Instructor, and as is deemed necessary, the medical director and various members of the Advisory Board. It is in this manner that the preceptor can keep "clear" of any potential conflicts and maintain the air of the professional educator.

Due Process

Every student has a right to a fair hearing and a right to face his or her accuser and a right to defend their actions or decisions. An EMS student must be treated fairly. This includes the privilege of reviewing any evaluations that are written about him or her. Every internship evaluation form has two (2) sign offs; one for the preceptor and one for the EMS student.

If you as the preceptor are not comfortable with saying what you think to your student, then you should not write it down. There are times when the discussions may be brief. These final evaluations are summative not formative. That means to say they are not to teach the EMS student about his or her shortcomings and how they might improve. That particular issue should have been addressed in previous evaluations and laid to rest before the final summative evaluation. That is not to say that maximum leniency would not be applied to the student's case during the formative phase. A plan of remediation that is agreed upon by both the preceptor and the student should have already been put in place.

If it gets to a point that these plans do not appear to be having the desired effect, then the Education Director should be consulted. But, there is a point when further efforts are beyond the limits of endurance and practicality. And, unfortunately, these students must be released from the Program. However, this decision remains with the Education Director and the Medical Director, as well as (if necessary) members of the Advisory Board. But this process is greatly enhanced by your paperwork. And remember you are not involved with dismissing a student as much as maintaining the quality of patient care.

**From Bassett Healthcare Paramedic Program-clinical instructor manual*

Please see the following Clinical Internship Evaluation Worksheet and Field Internship Evaluation Worksheet to be completed and turned into Princeton Rescue Squad's Educational Institute. If you have any questions, please contact 304-425-3914 ext.224.

DOCUMENTING CLINICAL/FIELD INTERNSHIP WORKSHEETS

If you are precepting an EMT student, and are documenting the day's encounter on the internship worksheet, you will need to confirm the trip sheets for each encounter and:

Princeton Rescue Squad
EMT Course Clinical Evaluation

Student Name: _____ **Date:** _____
Preceptor Name: _____
Clincal Shift Time: _____ **Arrival Time:** _____
All Crew Members: _____

Please fill the entire form out at the end of the student's scheduled shift. Read each section carefully and grade them appropriately. Total all points at the end of evaluation. Please grade the student honestly. After evaluation is complete, place this form in a sealed envelope and sign your signature on the seal. Place the envleope in the box outside of the Education Coordinators Office. Student will have been shown and participated in basic skills prior to clinicals. You may review with student if you wish. (*Airway, Ventilation, 12-lead, CPR, Spinal and Extremity Mobilization, Medication Administration, Patient Assessment, Patient Movement, Bleeding Control, Basic Vitals)* Do Not Pentalize the student for advanced or non-covered skills

Preparedness		
Skill/Task	**Obtainable Points**	**Received Points**
Student arrived on time to clinical site.	**5**	
Student is wearing required clothing for clinical shift. (Clinical shirt, Dark EMS pants, black boots, badge)	5	
Student presents with clean appearance, neatly groomed, and no unnecessary fragrences or piercings.	5	
Total	**15**	
Please provide feedback for student improvement:		

Performance		
Skill/Task	**Obtainable Points**	**Received Points**
Student performs a comprehensive interview, including a detailed history, and demonstrates active listening.	5	
Student completes a primary assessment, to include general impression, level of consciousness, airway, breathing, and circulation examination.	5	
Student completes an appropriate secondary assessment: head-to-toe and/or focused physical examination.	5	
Student formulates a field impression based on their exam and implements a treatment plan appropriate to their current class studies.	5	
Student performed all interventions and treatments were completed in a satisfactory and timely manner appropriate to their current class studies.	5	
Total	**25**	
Please provide feedback for student improvement:		
Evaluation Continued on Back		

The student will fill this out. You will need to confirm the date, & times reported.

Please follow these directions when completing the rest of the form.

***Reminder**: EMT students have completed all skills PRIOR to release for internship*

Any insights you can provide are helpful for student and faculty

EMT Field Internship – PAGE 2

Affective		
Skill/Task	**Obtainable Points**	**Received Points**
Student was confident.	5	
Student appeared motivated.	5	
Student responded well to criticism and took responsibility for self improvement.	5	
Student exhibited strong values needed as a healthcare	10	
Student worked as part of the EMS team.	15	
Total	**40**	
Please provide feedback for student improvement:		

Shift Duties		
Skill/Task	**Obtainable Points**	**Received Points**
Student assisted with start of shift duties (Truck Check)	5	
Student assisted with post run duties (restock, decon)	5	
Student assisted with end of shift responsabilities	5	
Student stayed for entire duration of clinical shift	5	
Total	**20**	
Please provide feedback for student improvement:		

Evaluation Summary		
Skill/Task	**Obtainable Points**	**Received Points**
Total of all points received in evaluation:	**100**	
Leadership, Development, and Progression		
Student shows potiental and development beyond mean of course. Student makes effort to participate without direction in a safe and proper manner. Student shows an understanding of the job and duties associated towards the level of an EMT.		
YES	**NO**	
Please provide constructive feedback to assist student in development		

Number of Calls		**Number of Patient Contacts**		**Departure Time**	
Preceptor Signature:					
Student Signature:					
Clincal Coorinator Signature:					
Educational Administrative Use Only:					
Date Received:		*Student Improvement Seen?*		**YES**	**NO**
Does Student Require A Performance Review based on Preceptor's Evaluation?				**YES**	**NO**
Date Student Performace review was completed (If applicable)					
Comments:					

*We absolutely **do not** expect a new EMT student starting internship to be a team leader; however, we do want to see development over time.*

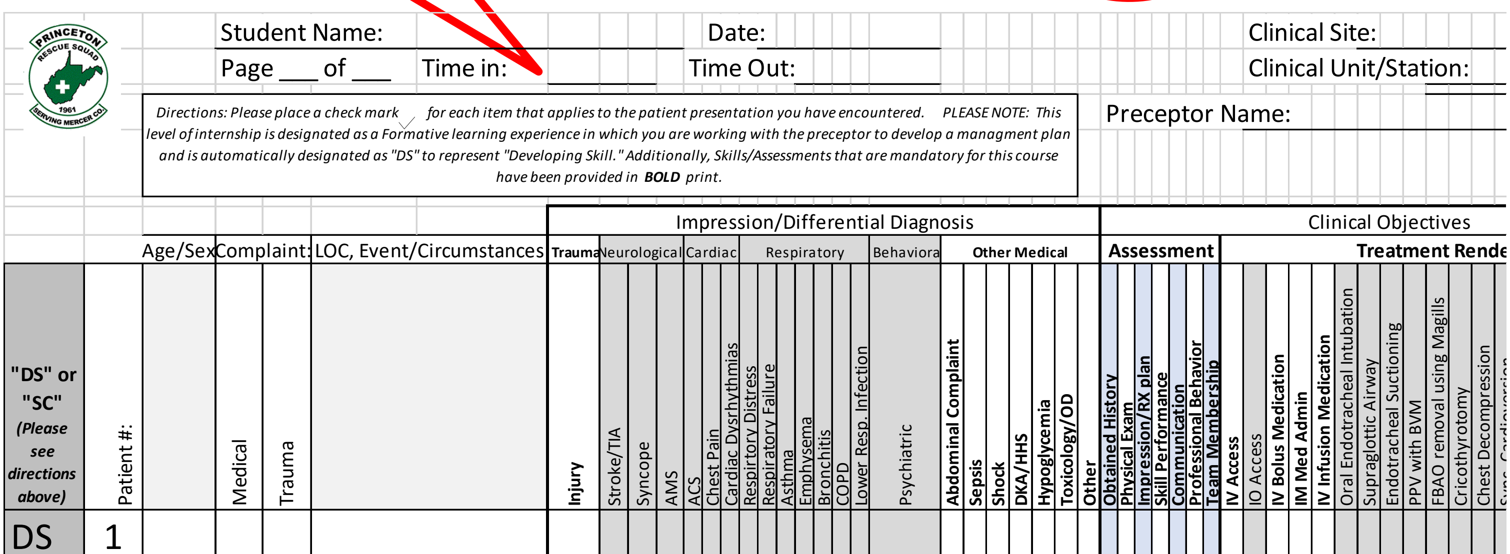
If you have precepted this student in the past, please provide as much detail here as you can to indicate progression in development

Please sign, after verifying the number of calls, number of contacts, and student departure time.

If you are responsible for Precepting Paramedic students in the Hospital or during Pre-Hospital Field Internship setting,

Please verify that the date, time in/out, clinical site/unit are accurate

REMINDER: *The student is responsible for filling out the majority of this form. Only fill in the sections identified in the picture below*



Student Name: Date: Clinical Site:

Page ___ of ___ Time in: Time Out: Clinical Unit/Station:

Directions: Please place a check mark ✓ for each item that applies to the patient presentation you have encountered. PLEASE NOTE: This level of internship is designated as a Formative learning experience in which you are working with the preceptor to develop a managment plan and is automatically designated as "DS" to represent "Developing Skill." Additionally, Skills/Assessments that are mandatory for this course have been provided in ***BOLD*** *print.*

Preceptor Name:

Impression/Differential Diagnosis — Clinical Objectives

Age/Sex | Complaint: | LOC, Event/Circumstances | Trauma | Neurological | Cardiac | Respiratory | Behavioral | Other Medical | Assessment | Treatment Rende[red]

"DS" or "SC" ***(Please see directions above)*** | Patient #: | Medical | Trauma | Injury | Stroke/TIA | Syncope | AMS | ACS | Chest Pain | Cardiac Dysrhythmias | Respirtory Distress | Respiratory Failure | Asthma | Emphysema | Bronchitis | COPD | Lower Resp. Infection | Psychiatric | **Abdominal Complaint** | **Sepsis** | **Shock** | **DKA/HHS** | **Hypoglycemia** | **Toxicology/OD** | **Other** | **Obtained History** | **Physical Exam** | **Impression/RX plan** | **Skill Performance** | **Communication** | **Professional Behavior** | **Team Membership** | **IV Access** | IO Access | **IV Bolus Medication** | **IM Med Admin** | **IV Infusion Medication** | Oral Endotracheal Intubation | Supraglottic Airway | Endotracheal Suctioning | PPV with BVM | FBAO removal using Magills | Cricothyrotomy | Chest Decompression | Sync. Cardioversion

DS | 1

To reduce the documentation load required on the part of the preceptor, the form has been redesigned to focus on key points only. When a student is engaged in Formative learning, he/she is working with the preceptor to develop and/or implement a management plan and this patient encounter is designated with a "DS" to represent a "Developing Skill." As the student continues to attend to patients, learns more, and becomes more confident throughout the program, it may be appropriate to begin marking the encounters as "SC". "SC" represents "Skill Competent" and indicates that the student required minimal to no assistance. Please take the time to confirm your rating for each encounter and discuss how the student can improve based on their actions.

PARAMEDIC CLINICAL INTERNSHIP FORM – PAGE 2

The back of the form has also been streamlined for the preceptor to be able to rate the student globally in a more concise manner while still reporting the necessary components in competency development.

Preceptor Comments on any unsatisfactory ratings or discrepancies: _____

Professional Behavior Objectives: Student demonstrates they are: **Self-motivated**: Takes initiative to complete assignments and improve/correct problems, strives for excellence, incorporates feedback and adjusts behavior/performance. **Efficient:** Keeps assessment and treatment times to a minimum, releases other personnel when not needed and organzied team to work faster/better. **Flexible**: Makes adjustments to communication style, directs team members and changes impressions based on findings. **Careful:** Pays attention to detail of skills, documentation, patient comfort, set-up and clean-up and completes tasks thoroughly. **Confident:** Makes decisions, trusts and exercises good personal judgement and is aware of limitations and strengths. **Open to feedback:** Listens to preceptor and accepts constructive feedback without being defensive (interrupting, giving excuses)

Pt. Interview/Hx Gathering: Student completes an appropriate interview and gathers appropriate history; listens actively, makes eye contact, clarifies complaints, respectfully addresses patient (s); demonstrated compassion and/or firm bedside manner depending on the needs of the situation.

Physical Exam: Student completes an appropriate focused physical exam specific to the chief complaint and/or comprehensive head-to-toe physical examination.

Impression & Rx Plan: Student formulates an impression and verbalizes an appropriate treatment plan.

Skill Performance: Student performs technical skills accurately and safely.

Communication: Student communicates effectively with team, provides an adequate verbal report to other health care providers and completes a thorough written patient narrative.

Team Membership Objective: Clinical experience evaluation of field performance assesses a student as a Team Member and is isolated to evaluation of individual skill delivery or a portion of patient care that is delivered. The student is not assuming the Team Leader role but integrating with other Team Members. When evaluating the student performance as a team member, only the portion of care completed by the student is evaluated. The Team Member role contains an affective component and evaluates the students' cognitive understanding of complete patient care that paramedic's are expected to deliver.

**NOTE: Ideally, students will progress their role from observation to participation in simple skills, to more complex assessments and formulating treatment plans. Students will progress at different rates and case difficulty will vary. Students should be active and ATEMPT to perform skills and assess/treat patients early even if this results in frequent prompting and unsuccessful ratings. Unsuccessful ratings are normal and expected in the early stages of the clinical learning process when student needs prompting. Improvement plans MUST follow an unsuccessful or inconsistent ratings.*

Rating: NA = Not applicable - not needed or expected; this is a neutral rating (Example: student expected to only observe, or the patient did not need intervention). **0 = Unsuccessful** - required excessive or critical prompting; includes "Not Attempted" when student was expected to try; this is an unsatisfactory rating. **1 = Marginal** - incosistent, not yet competenent; thi sincludes partial attempts. **2=Successful/competent** - no prompting.

Score on today's Clinical Objective Performance	Pt. Interview & History Taking	Physical Exam	Impression/Treatment Plan	Skill Performance	Communication	Professional Behavior	Team Membership

Yes	No	
		Student asked relevant questions and participated in learning answers, used downtime to its highest potential
		Student knows equipment location and use
		Student helps clean up and restock, unprompted
		Student left site early (Did NOT complete shift)

Student reported:		on Time
		well groomed
		In uniform and prepared to begin the shift
Professional Behavior Objectives:		Accepts feedback openly
		Self-motivated
		Efficient
		Flexible
		Careful
		Confident

Preceptor - PLEASE INITIAL HERE: _____

BY initialing here, I acknowledge that I have reviewed the PRS Preceptor Orientation Packet regarding: 1. Student/Preceptor Roles and Responsibilities. 2. The training guidelines per unit/ward. 3. Student FERPA rights regarding privacy of their education. *If you have not seen this material, please ask the student to provide you with the material for your review and approval, or see the Unit Manager/Education Coordinator of your facility to review the material provided.*

I agree to the above ratings:
Preceptor Signature: _____

Preceptor requests a follow-up with appropriate program personne Phone call _____ Email _____

If needed, please feel free to contact the Education Director: Paula Johnson at: 304-716-0129 ext. 602. If not in, please leave a voicemail.

Please see the next few pages for a more detailed breakdown of each section.

Comment on any unsatisfactory ratings or discrepancies:

Please provide any additional detail on student performance noted from page one

Rating: **NA** = Not applicable - not needed or expected; this is a neutral rating (Example: student expected to only observe, or the patient did not need intervention). **0 = Unsuccessful** - required excessive or critical prompting; includes "Not Attempted" when student was expected to try; this is an unsatisfactory rating. **1 = Marginal** - incosistent, not yet competenent; thi sincludes partial attempts. **2=Successful/competent** - no prompting.	Pt. Interview & History Taking	Physical Exam	Impression/Treatment Plan	Skill Performance	Communication	Professional Behavior	Team Membership
Score on today's Clinical Objective Performance							

This section is a "carry over" from the original form. However, instead of rating each and every patient encounter conducted during the student's rotation, you are now asked to provide a single rating for each category based on their overall performance for this day's rotation. *Ratings are as follows:*

NA = Not Applicable (not needed or expected),
0 = Unsuccessful (required excessive or critical prompting, includes "not attempted" when student was expected to try.
1 = Marginal – inconsistent, not yet competent
2 = Successful/competent

Yes	No	
		Student asked relevant questions and participated in learning answers, used downtime to its highest potential
		Student knows equipment location and use
		Student helps clean up and restock, unprompted
		Student left site early (Did NOT complete shift)

Student reported:	on Time
	well groomed
	In uniform and prepared to begin the shift
Professional Behavior Objectives:	Accepts feedback openly
	Self-motivated
	Efficient
	Flexible
	Careful
	Confident

If you are familiar with the older form, you will recognize theses questions. Please check each box accordingly. If you require a definition to rate the student appropriately, please see the dark grey box provided on this page.

I agree to the above ratings:
Preceptor Signature:

email.

Next, Please sign attesting to your ratings above

Preceptor - PLEASE INITIAL HERE:	**BY initialing here, I acknowledge that I have reviewed the PRS Preceptor Orientation Packet regarding: 1. Student/Preceptor Roles and Responsibilities. 2. The training guidelines per unit/ward. 3. Student FERPA rights regarding privacy of their education.** *If you have not seen this material, please ask the student to provide you with the material for your review and approval, or see the Unit Manager/Education Coordinator of your facility to review the material provided.*

One final step: Please initial in this box to confirm that you have reviewed the orientation packet. This document can be found on your unit and/or designated affiliation contact. HOWEVER, the student will also have this information readily available to you in their clinical packet. If he/she cannot produce this document PLEASE let me know on this form so that I can make sure you receive a copy.

Preceptor requests a follow-up with appropriate program personne	Phone call _____	Email _____	
If needed, please feel free to contact the Education Director: Paula Johnson at: 304-716-0129 ext. 602. If not in, please leave a voicemail.			

Finally, I did want to include a very clear section that provides you, as the preceptor, with a way to reach me directly should any concerns or questions arise that require my more immediate attention. Filling this section out is only required if you need to speak with me.

If you are responsible for Precepting Paramedic students during CAPSTONE (Pre-Hospital) Field setting,

Please note that this session is considered the Capstone event of the program and all students have been validated on skills, patient assessments, and the formulation of treatment plans for disease pathology. In addition, the student has met the criteria to receive a certification card in areas such as: ACLS, PHTLS, GEMS, PALS/PEPP.

It is your responsibility as the preceptor to provide the individual with Team Leadership opportunities and evaluate them in such manner. Your role is crucial to the determination of entry level competence.

The goal is to provide the student with as much exposure to a diverse set of patient problems as possible. Students should have a mix of BLS and ALS patient encounters. In most cases, a student that has reached this component of the program will most likely be identified as "SC" (Skill competent) which indicates the student has entered the summative learning phase where he/she develops a management plan with minimal to no assistance; however, it is possible that a student encounter something that requires more preceptor engagement. If this should occur and you, as the preceptor, feels the rating should be listed as "DS" (Developing skill) then by all means, record it as such. **The student, by the end of this course, must have documented proof of 20 "SUCCESSFUL TEAM LEADS" which are identified and documented as "SC" for each patient. Please carefully review the definition and special notations provided below:**

DEFINITION OF A **"SUCCESSFUL TEAM LEAD":**

The student has successfully led the team if he or she has conducted a comprehensive assessment (*not necessarily performed the entire interview or physical exam, but rather been in charge of the assessment*), as well as formulated and implemented a treatment plan for the patient. This means that most (*if not all*) of the decisions have been made by the student, especially formulating a field impression directing the treatment, determining patient acuity, disposition and packaging/moving the patient (*if applicable*). Minimal to no prompting was needed by the preceptor. No action was initiated/performed that endangered the physical or psychological safety of the patient, bystanders, other responders or crew. (*Preceptor should not agree to a "successful" rating unless it is truly deserved. As a general rule, more unsuccessful attempts indicate a willingness to try and are better than no attempt at all.*) To be counted as a Team Lead the paramedic student must conduct a comprehensive assessment, establish a field impression, determine patient acuity, formulate a treatment plan, direct the treatment, and direct and participate in the transport of the patient to a medical facility, transfer of care to a higher level of medical authority, or termination of care in the field. For the NRPM 204 Capstone: Paramedic Field Practicum to meet the breadth of the paramedic profession, team leads must include transport to a medical facility and may occasionally include calls involving transfer of care to an equal level or higher level of medical authority, termination of care in the field, or patient refusal of care.

SPECIAL NOTATIONS:

"Patient refusals and/or termination of care in the field": The paramedic student **MUST** complete and document an **assessment of ALL body systems** to count the patient encounter as a "Successful Team Lead".

18 of the 20 calls MUST be ALS transports to an emergency room or an ALS Interfacility transfer to higher level of care.

No more than 2 of the 20 calls can come from: "**BLS transports, termination in the field, OR patient refusals**."

Capstone field internship team leads cannot be accomplished with simulation.

Final Document for Precepting CCT students in the Pre-Hospital (Field) setting,

One final document is included that is specific ONLY to CCT students in field internship. This document should accompany the Field Internship Worksheet and accounts the specific skills completed during each internship rotation.

Please initial next to each skill "observed" or "performed" & Date completed

The student should prepopulate this with your names

Skills Checklist for CCT Agency Ride-a-Long

CCT Agency:	**Preceptors**		
Skills	**Observed**	**Performed**	**Date**
Patient Assessment			
Obtained History			
Basic Airway (Oral/Nasal airway, BVM)			
Advanced Airway (Intubation)			
Chest decompression			
Lead placement/EKG Monitoring, 12 lead ECG			
ETCO2 monitoring			
IV Therapy			
IM/SQ Injection			
IV Medication Administration			
Immobilization/Splinting			
Other Skill			
RSI			
Foley Catheter Insertion			
Basic random skills (Please list) * * *			

Preceptor's Signature: _____

Program Coordinator's Signature _____

Please sign at the end of the shift

MANDATORY CLINICAL/FIELD ROTATIONS: (BASED ON PROGRAM AND LOCATION):

EMT – BASIC

Field Internship = minimum 10 hours AND 10 patient contacts

PARAMEDIC

NRPM 114: Clinical Practicum I

Location/Unit:	**Minimum** Hours Required:
Cardiopulmonary	4
ER	36
Field Internship	48
TOTAL HOURS:	**88**

NRPM 201: Clinical Practicum II

Location/Unit:	**Minimum** Hours Required:
ER	120
Pediatrics	25
L&D	12
Behavioral Science	8
CCU/ICU	12
Operating Room	12
TOTAL HOURS:	**188**

NRPM 204: Capstone: Paramedic Field Practicum

Location: EMS Unit: Required Hours: ~150

Team Leads Required = 20

Definition of a "Successful Team Lead" in the Paramedic Program: - Please see page: 8 or 28-29 of this booklet

CRITICAL CARE TRANSPORT

Field Internship 56 hours on a designated CCT truck

Ensuring Cultural Humility in Precepting

WHAT IS CULTURE?

Culture is a mental construct that is acquired consciously and unconsciously from our environment. This begins at a young age from our involvement with parents, family, friends, school, and religious teachings. Moreover, this is learned through language and modeling of others. By age 5 many of our foundational aspects are internalized and by the time we reach our teenage years these aspects are elaborated upon through socialization. As we age, we seek acceptance to provide a sense of security toward our personal identity and this identity changes over time. For example, a woman in her lifetime will go through various changes within her personal identity to include: wife, mother, grandmother, worker, perhaps divorcee, and the list goes on. Each of these identities carries its own set of cultural norms and expectations which can lead to unpredictable or uneven changes even amongst individuals within the same culture.

Culture is defined as: *"…it comprises beliefs about reality, how people should interact with each other, what they "know" about the world, and how they should respond to the social and material environments in which they find themselves." "It is reflected in their religions, morals, customs, technologies, and survival strategies.*" The aspect of culture affects how we work, parent, love, who we marry, our understanding of health, illness, disability, and even death.

The concept of culture also contains "Subcultures" which can be viewed as distinctive characteristics that sets one group apart from others. The idea of subcultures specifically looks at areas including gender, age, orientation, and race; but can also include occupation, geographic location as well as many others. For example, Generation X is a unique subculture of individuals born between 1965 and 1981 who are sometimes referred to as the "feral generation" that feature a generation known for raising themselves as latch key kids but are young enough to integrate easily into the newer technology of today's society with very strong viewpoints on many subjects. Another example comes from those that identify themselves as "Southerners." If you engage in a discussion with a southerner, you will quickly see differences in their norms, customs, and world views that accrue to their place of birth or upbringing.

Another component of culture involves those that migrate from their area of origin to a new country and involves intra-ethnic variation and this is referred to as "Acculturation." For example, if a Mayan immigrant from Mexico enters the United States, he/she will retain their core cultural values from their native upbringing. However, this will be modified or added to over time depending on the amount and quality of contacts within the United States. This level of assimilation can lead to a loss or gain of cultural traits which can be more clearly seen in the sons and daughters of that immigrant. The children will retain those parental values and ideations but acquire cultural norms prevalent in the mainstream society in which they grow.

What is Ethnocentrism?

Ethnocentrism is the idea that "my culture is the most important culture in the world, and my culture's beliefs are the most valid." Unknowingly, we pass on mental scripts or belief structures to our children giving them a very specific view of the world through the lens of ethnocentrism. In the past that script has been very blatant. For example, between 1960 and 1970 the native American Indians were unknowingly being sterilized against their will and included cases in some as young as 11 years old. And they weren't the only ones, this also included African Americans and the poor. It is estimated that the number of sterilizations could be as high as 70,000 in women under the age of 21. The motivation behind this movement was based on those living in reservations surviving on government programs such as welfare, thus it was decided that sterilization would improve their financial situation and their family's quality of life. In 1927 the Supreme Court upheld an involuntary sterilization of a female child in the case "Buck vs. Bell". The court reviewed three generations of Buck women and deemed that there was such an inherited intellectual deficiency that it clearly caused a danger to public welfare. To quote the attorney from the case: "It is better for all the world if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind." The daughter was forced to undergo the procedure despite her only crime as being a shy girl who was raped by the nephew of her adoptive mother.

Cultural Competence vs. Cultural Humility

While we have come very far from those days of segregation and discrimination, we need to consciously identify and address any scripts cultivated from our past that can subconsciously influence our attitudes/bias and behaviors today. Many would press that to accomplish this goal we should become culturally competent. However, competence is defined as being able to assess and identify commonalities amongst ALL cultures to drive our interactions with individuals from different heritages. This can be accomplished by practicing cultural humility in our everyday encounters. Instead, it is far more feasible to approach culture from the lens of cultural humility where you are observant of similarities and differences among and between groups. Cultural humility "…recognizes individual limitations in knowledge and skills and aligns with the growth mindset of lifelong learning" (Tinkler & Tinkler, 2016).

The goal of cultural humility is to foster inclusivity, empowerment, respect, collaboration, and lifelong learning. This practice can counter impediments to education such as stereotyping, marginalizing, stigmatizing, and bullying. To practice cultural humility as a preceptor, you must relinquish your expertise. Don't assume that an individual is either underprepared or over prepared for their internship. When you do, you can potentially ignore the needs that would challenge a student and help them excel. For example, an employer assumes that another administrator's son will automatically know step-by-step what needs to be done at shift change on his first day of work, just because he is the administrator's son. When we approach precepting from the lens of supporting and challenging their perceptions and exercise of power, then we promote acceptance.

The key point is to acknowledge historical scripts that precede us which can carry the potential to undermine our best, most competent efforts. It is imperative that we identify our own scripts that put our needs above those we serve to prevent unintentional stereotyping, marginalizing, and stigmatizing. As preceptors, we should approach every discussion authentically and with a mindset of open inquiry as a partnership with that student to cultivate healthy debate.

Effective Communication in a Multicultural Environment

The purpose of the university and clinical internship is to provoke each other to question his/her current beliefs and change the ones he/she cannot defend. As preceptors we want to challenge our students to be resilient. Nassim Nicholas Taleb, a professor of risk engineering at NYU argues that most of us think about risk in the wrong way. We are not china that has to be handled with care. Instead, we are "antifragile" and require regular physical and mental challenges and stressors or we will deteriorate. For example, a fractured arm after 3 months of being in a cast will atrophy simply because it was not challenged. Secondly, we need to remember that while feelings are compelling, they are not always reliable. Feelings can distort reality, deprive us of insight, and needlessly damage our relationships. These cognitive distortions manifest themselves as emotional reasoning, catastrophizing, overgeneralizing, and dichotomous thinking to name a few. Using Behavioral Therapy techniques can help sidestep emotional reasoning and help us ground assertions with textual evidence. Lastly, reality is extremely complicated and comes in many shades of grey. Nothing is ever "black and white" and believing that someone is either good or evil results in people becoming unfairly demonized.

OPEN INQUIRY

Student centered learning should include open inquiry where a student has the freedom to ask questions without fear of reprisal and given the stage to debate topics in a healthy way. To do so means that we must first accept the fact that we are flawed thinkers. We will vigorously search for evidence to confirm what we already believe, and this leads to confirmation bias. When this happens, we congregate around methods or ideals that conform to our narrative and ignore questions that don't offer support. The act of confirmation bias thwarts critical thinking which is absolutely necessary to practice in the ever-evolving field of medicine. We should practice and promote intellectual humility and graciously admit when we are mistaken and thank those who gave us a new perspective.

NAVIGATING CONFLICT

When we expect students to engage in discussion, we must be prepared to navigate or deploy methods to prevent or circumvent conflict. All it takes is one student to make a comment or call on a slight offense (microaggression) to trigger what is referred to as the "Call Out Culture." This is defined as a brief and commonplace verbal, behavioral, or environmental indignity (whether intentional or unintentional) that communicates hostility and derogatory insults. While it is undeniable that some members of various identity groups encounter repeated indignities because of their culture, even if the offender harbors no ill will, their clueless responses can become burdensome and hard to tolerate. HOWEVER, we should practice what is referred to as a "Principle of Charity" in which we approach the comment by giving benefit of the doubt that the faux pau does not make the person evil or an aggressor. A way to approach this would be to use a phrase such as: "I'm guessing you didn't mean any

harm when you said _____, but you should know that some people might interpret that to mean _____."

As preceptors we should preach open communication between parties rather than external intervention. We want students to work through their differences together as opposed to using an external entity to navigate conflict. To better prepare learners, we should deploy cognitive behavioral therapy techniques where we press for logical evidence to ground assertions and reject emotional reasoning. Additionally, remaining mindful in the moment, as a calm and present participant without passing judgement can help shape positive outcomes during times of conflict. Afterall, having people around us that are willing to disagree with us is a gift!

At the end of the day, practicing cultural humility and recognizing our shortcomings as flawed thinkers will help us break through cognitive dissonance and free ourselves from confirmation bias which can trigger the unconscious script of ethnocentrism. Explicitly reject the idea of "Good and Evil" by talking about the ways in which you can unwittingly offend or exclude others and encourage politeness, empathy, and the Principle of Charity. Ultimately, we are all healthcare professionals, and we were brought to this field to make a positive difference in the lives of those in need. To do so means we must remain connected to the basic human need to be socially accepted amongst all individuals despite our cultural differences and treat all people with fairness.

Family Educational Rights and Privacy Act

PRECEPTOR FACULTY TRAINING VERIFICATION

As determined by your Scope of Practice as Preceptors of EMS Education, it is imperative that all Faculty members have a working knowledge of FERPA guidelines before releasing educational records.

I understand that students have specific, protected rights regarding the release of educational records and FERPA requires that Princeton Rescue Squad's Educational Institute must adhere strictly to these guidelines. As a Preceptor, I understand that I am an extension of the Instruction received in the classroom, and must maintain FERPA regulations just as if I am a regular faculty member.

I understand that students have the following rights regarding educational records:

- The right to access educational records kept by the school
- The right to demand educational records be disclosed only with student consent
- The right to amend educational records
- The right to file complaints against the school for disclosing educational records in violation of FERPA

I understand that educational records are defined under FERPA as: *"Records that directly relate to a student and that are maintained by an educational agency or institution or by a party acting for the agency or institution."* And may include the following:

- Written documents (including student advising folders)
- Verbal discussions in front of those individuals that do not have "right to know"
- Computer media
- Microfilm and microfiche
- Video or audio tapes or CD's
- Film
- Photographs

I understand that any record that contains personally identifiable information that is directly related to the student is an educational record under FERPA. This information can also include records kept by the school in the form of student files, Field/Hospital Internship Evaluation Forms, student system databases (Platinum Planner) kept in storage devices such as servers, or recordings or broadcasts which may include student projects.

PRINCETON RESCUE SQUAD'S EMS Education Programs:

Preceptor Faculty Program

FERPA

I understand that the following items are not considered educational records under FERPA:

- Private notes of individual staff or faculty (NOT kept in student advising folders)
  - However: Private notes are for the preceptor's records and should not be divulged to any individual who does not have "right to know"
- Campus police records
- Medical records
  - Statistical data compilations that contain no mention of personally identifiable information about any specific student

Faculty notes, data compilation, and administrative records kept exclusively by the maker of the records that are not accessible or revealed to anyone else are not considered educational records and, therefore, fall outside of FERPA disclosure guidelines. However, these records may be protected under other state or federal laws such as the doctor/patient privilege.

I understand that a student must submit written consent prior to the legitimate disclosure of educational records, and the written consent must include the following elements:

- Specify the records to be disclosed
- State the purpose of the disclosure
- Identify the party or class of parties to whom the disclosure is to be made
- The date
- The signature of the student whose record is to be disclosed
- The signature of the custodian of the educational record

I understand that prior written consent is not required when disclosure is made directly to the student or to other school officials within the same institution where there is a legitimate educational interest.

I agree that I will comply with all confidentiality policies and procedures set in place by Princeton Rescue Squad's Preceptor Faculty Program during my entire association with Princeton Rescue Squad's EMS Programs. If I, at any time, knowingly or inadvertently breach the FERPA policy, I agree to notify the EMS Program Coordinator or Education Director immediately.

In addition, I understand that a breach of student confidentiality may result in suspension of my right to precept EMS students. I also understand that my duties as a preceptor are voluntary and can be withdrawn by myself or the EMS Program Director at any time.

I have read and understand the FERPA policy that has been provided to me by the New River Community and Technical College EMS Program. I agree to abide by the FERPA policy or be subject to disciplinary action.

My signature verifies I have received FERPA training and understand the FERPA policy.

Preceptor - Print Name: Date: Preceptor Signature:

PRINCETON RESCUE SQUAD
EMS Education Programs
Preceptor Articulation Agreement

Preceptor Information

Preceptor Name:_____ Home Phone: _____
E-mail: _____ Work Phone: _____
Address: _____
_____
_____

Employer Information

Employer Name:_____ Current Position:_____

Years of Employment:_____ Address: _____
_____
_____

Previous
Positions/Departments:_____
_____
_____
_____
_____

Level(s) of Certification/Licensure

EMT-B Certification #:_____ Exp. Date: _____
Years of Certification: _____
EMT-P Certification #:_____ Exp. Date: _____
Years of Certification: _____
Nurse Years: _____
Physician Years: _____

Level(s) of Certification/Licensure (Cont.)

Other certifications or license
held:_____

Have you worked with paramedic students in the clinical setting before? _____

If so, where? _____ Years? _____

****PLEASE ATTACH A COPY OF ALL CURRENT CERTIFICATES (EMS personnel only)**

Preceptor Articulation Agreement

- **I agree to serve as preceptor for students in the EMS Education Programs at Princeton Rescue Squad's Educational Institute. I will submit documentation of credentials to the Squad if requested for accreditation purposes.**
- **I understand that the students will receive one – on- one instruction from me. It is the Squad's responsibility to acquire an affiliation contract with the facility in which I will be precepting students.**
- **I will not receive monetary compensation.**
- **I understand the student will evaluate me at the end of each clinical rotation.**
- **I understand I may not be able to address all of the student's needs. If this situation occurs, I will refer the student to the Instructor/Clinical Coordinator immediately.**
- **I am expected to provide and supervise clinical hands – on experience in the manner expected from a medical professional.**
- **I will evaluate the student at the end of each rotation.**
- **The student is allowed to perform skills on live patients only after demonstrating skill competency in the lab. The student MUST present his/her Approved Skills Check-off sheet at the beginning of each internship rotation.**
- **By the Final quarter the student is expected to perform as a competent entry level EMS Provider with direct preceptor supervision in all patient encounters.**
- **The student will bring their copy of the Syllabus/Handbook during each clinical rotation, which contains the clinical guidelines and objectives set forth by Princeton Rescue Squad's Educational Institute.**
- **I understand that I can reference the student's Syllabus/Handbook at any time during the clinical rotation if I have questions or concerns regarding the skills, objectives, or guidelines to be met by any student.**
- **I understand that if immediate attention must be made to the Education Director, I can contact them by calling the name and number listed on the bottom of the evaluation form.**
- **I understand that I can review any program's current status and pertinent documents by logging on to www.princetonrescue-edu.com and clicking on the "Precepting Faculty" tab.**
- **I understand that I may receive emails from the Education Director that provides updated information regarding the internship programs at Princeton Rescue Squad.**
- **Princeton Rescue Squad agrees not to use your personal data for any activities outside of those necessary for the internship programs.**
- **I understand as the Preceptor I can terminate this contract at any time.**

Preceptor Signature: _____ **Date:** _____

Director's Signature: _____ **Date:** _____

Clinical Coordinator Signature: _____ **Date:** _____

NOTES: