Preceptor Expectations and Responsibilities

Clinical Review and Training Committee (ver. 7-9-2018)

Preceptor Qualification Requirements

Purpose: To establish a guideline that outlines the qualifications required to precept BLS and ALS providers.

BLS Preceptor:
In order to function as a BLS field preceptor, the provider must meet the following requirements:

- Maintain a valid state EMT certification
- Run a minimum of six (6) months as a released Attendant-in-Charge
- Demonstrate willingness and ability to serve as a mentor to less experienced members
- Receive the recommendation of Crew Captain, chief, or approved senior preceptor (check with Training Officer)
- Receive the approval of the OMD and the Clinical Review and Training Committee

Advanced Preceptor:
In order to function as an Advanced field preceptor, the provider must meet the following requirements:

- Maintain a valid state EMT-Enhanced or Advanced certification or higher
- Run for a minimum of six (6) months as a released Enhanced or Advanced technician
- Be a released BLS preceptor
- Receive the approval of the OMD and the Clinical Review and Training Committee

Intermediate/Paramedic Preceptor:

- Maintain a valid state EMT-Intermediate/Paramedic certification
- Run for a minimum of 1 year as a released Intermediate/Paramedic technician
- Be a released BLS preceptor
- Receive the approval of the OMD and the Clinical Review and Training Committee

To Apply: The candidate should send a statement to their recommending officer answering the following questions:

1. Why do you want to be a preceptor?
2. What makes you believe you'll be a good preceptor?
3. What have you done so far to demonstrate that you have the dedication necessary to take on the role of preceptor?

The recommending officer will then fill out the "Release to Precept" form at carsrescue.org/forms

Expectations

Becoming a preceptor is not a task to be taken lightly. Preceptors are held to a higher standard than other members of the agency. You must act as a role model and mentor in terms of both clinical knowledge and professionalism. Newer members will look to you for guidance on how to behave both in the field and at the building, and you are expected to display competence and maturity at all times.

However, this does not mean that you must be perfect in every way. If anything, preceptorship is the next step in your own training. In addition to helping teach other members, you should continue furthering your own education in emergency medicine both on and off duty. Feel free to ask more experienced preceptors and providers or the training officer for advice. Continue researching new topics, sharing what you learn with your preceptees and crew mates.

Please remember that precepting is more work than simply being an AIC, and not just a way to get someone else to write your call sheets. You will have to pay far more attention during calls, allowing your preceptee to make their own mistakes without compromising safe and effective patient care. It will be frustrating at times, but you are expected to provide encouragement without judgment, regardless of your mood or personal feelings.

EMS work comes more naturally to some preceptees than others. You cannot expect every preceptee to be near-perfect right out of the gate. Some will require more attention and time. Others might require a different teaching method. You are expected to work with your preceptee, other preceptors, your crew captain, and the CRAT committee to ensure that every preceptee is receiving the resources they require to succeed at CARS.

Precepting in the Field

During a call, a preceptor should:

1) Oversee the preceptee to critique their assessment and treatment of the patient
2) Ask leading questions to help guide the preceptee to the next step when the preceptee is struggling, heading in the wrong direction, or getting distracted
3) Ensure the safety of both the patient and the preceptee
4) Be prepared to step in to take over the call if necessary, but
5) Know when to step back and let the preceptee flounder a bit
6) Review the preceptee's documentation for comprehensiveness and accuracy before submission
7) Remember that the preceptor is ultimately the AIC and responsible for all aspects of the call

After a call, a preceptor should:

1) Discuss with the preceptee clinical findings and the significance of those findings
2) Discuss with the preceptee how to improve their clinical skills and operational proficiency (call flow, equipment availability, safety, efficiency, handling multiple patients, etc.)

Precepting at the Station

A preceptor:

1) Plans and executes weekly training sessions, including clinical discussions and practice scenarios in coordination with the crew captain and other preceptors
2) Ensures that all crew members maintain low frequency/high acuity skills such as airway management, backboard rule-in/rule-out, CPR, etc.
3) Assists observers and preceptees in completing their skills checklists and ensuring that they understand the procedure for collecting and applying for release
4) Discusses precepting methods with other preceptors
5) Reports ongoing preceptee issues with the crew captain and/or the CRAT committee
6) Attends at least one preceptor class

Starting a New Preceptee

Once you've been a released AIC for any amount of time, it can be very difficult to step into the shoes of an EMT who is just starting out. Preceptees were exposed to an incredible amount of material in class and it's a huge step to remember and apply this information in the field. Additionally, it can be difficult for some preceptees to go from a passive observer role to taking the team lead. Give new preceptees a chance to prove themselves, but don't assume that their observation period prepared them to be the AIC.

Here is a framework for starting a preceptee from the beginning. Don't feel locked into following this line by line, it's only meant to give you some guidelines to follow. Additionally, this framework can be used to identify how far along a preceptee should have progressed, and help shore up any particular difficulties. Each phase should last about 6-7 weeks.

Starting Out (Weeks ~1-4):

- Introduce Probationary Member Check List to preceptee
- Go over CARS BLS Protocols. Use http://carsrescue.org/downloads/ and the TJEMS Manual/App
- Preceptee will begin initiating patient contact and assessment
    - Preceptee and preceptor will jointly take report from first responders
    - Let preceptee focus on patient. Preceptor can obtain info from family and bystanders
    - Preceptor will manage the scene for the preceptee
    - Preceptor will help with tasks such as vital signs
    - Preceptor will be ready to step in and help with any aspect of the call at preceptee's request

- Preceptor will discuss the basic provider's role on ALS calls and in larger scenes i.e. MVAs, Fire standbys
- Preceptor will assist with prehospital report, allowing preceptee to focus on patient care
    - Make sure to have preceptee practice giving prehospital report after the call
- Preceptee will begin giving hospital report with input from preceptor
- Preceptor will walk the preceptee through filling out the call sheet
    - Consider writing a "cheat sheet" with the preceptee
- Complete Backboard Scenarios 1-2

The Middle Part (Weeks ~5-12):

- Complete Probationary Member Checklist
- Preceptee will begin attempting to run entire call with assistance from preceptor
- More emphasis will be placed on preceptee handling multiple simultaneous aspects of the call through delegation and/or multitasking
- Preceptee will begin anticipating their role on ALS calls and on larger scenes
- Preceptee should begin verbalizing delegation of tasks like obtaining vital signs and obtaining and retrieving equipment
- For complex calls, preceptor will run through prehospital report with preceptee before preceptee makes the report.
- Preceptee will write their own call sheets. Preceptor will assist as needed, and review before submission to ensure accuracy and compliance with regulations
- Complete Backboard Scenarios 3-4

Wrapping it Up (Weeks ~13 -16):

- Preceptee should be running entire call with little or no input from preceptor
- Preceptor may still need to assist in unusual situations
- Preceptee will interact with first responders and bystanders while also handling patient care and assessment
- Discussion should be mostly focused on style tips and expanding clinical knowledge with the preceptee, who should already have a strong grounding in operational issues
- Complete Backboard Scenario 5

Non-Primary Precepting

It is commonplace for preceptees to work with more than just one preceptor. Although this can be beneficial for preceptees to obtain additional guidance and perspectives, hearing too

many contradictory opinions can be frustrating for them. Sometimes a preceptee will advise you that they've been taught a different method. When this situation inevitably arises, try and explain why they were taught that way, then explain the reasoning behind your own process. Avoid criticising other preceptors, and never ever tell a preceptee that "that's just the way it's done." If you're not sure why a procedure is done a certain way, or why specific assessment questions are important, ask for help! In cases where it seems that multiple approaches might be viable, have the preceptee defer to their crew preceptor.

If you notice any particular problems a preceptee is having, let their crew preceptor know. Having a team of preceptors working with a preceptee can be extremely helpful. However, the occasional preceptee will benefit more from one-on-one guidance. Work with the preceptee, their crew preceptor, and the crew captain to determine the best plan of action.

Releasing a Primary Preceptee

No one expects an EMT with 5 months of experience to be perfect, as EMS is a lifelong learning experience. However, you don't want to push a preceptee through when they're not ready, either. It can be very difficult to tell when a preceptee is ready to be released. Some things to consider:

- Are they running calls from start to finish entirely on their own?
- Do you feel comfortable stepping away during calls?
- Do you feel confident that they'd figure out what to do when placed in a new situation?
- Do they write their narratives with little or no feedback from you?
- Are you consistently giving them high marks on their evaluations?

When you feel that a preceptee is ready, make sure that they have their entire probationary member checklist in order. Before submitting their paperwork, you need to go through their evaluations with them making sure that everything is in order, and looking for consistent issues in the evaluator comments.

What to Do When a Preceptee Isn't Progressing

Sometimes preceptees will hit a point where they have difficulty improving. This is often a temporary issue that resolves itself by the next shift. However, if a preceptee seems to be having the same hangups multiple weeks in a row, it's your job to work with them and figure out a way to move past the problem

If a preceptee is having a recurrent issue, it might be time to try a new teaching strategy or tactic. Lock down exactly where the problem is occurring so that you can target it during training sessions and post-call discussions. Try asking another preceptor for advice, or a second opinion.

If the problem persists, it's time to have a sit-down with the preceptee. Keep a positive attitude and provide lots of encouragement, but also make it clear to the preceptee that there is a problem. Ask how the preceptee feels about his or her progress and if there's anything you can do to help the preceptee along. You can decide at this point whether to involve other members, but make sure that your captain and the CRAT committee are aware of the situation.

If, after discussing the issue with your preceptee, they continue to struggle, consult the CRAT Committee on how to proceed. The most important thing is to keep them from languishing, or from thinking that everything is going swimmingly. Provide help to the utmost of your ability, but keep in the back of your mind that EMS can be a difficult job, one that is not suited for everyone. When you reach this point in your thinking, go to the CRAT Committee to discuss the next step. The CRAT committee will work with you and your preceptee to develop a plan of action going forward.

Probationary Objectives and Tasks (The Collector Checklist)

- Objectives do not have to be initialed by a preceptor
- After learning a new skill, have the preceptee demonstrate understanding by teaching the skill to another person
- Ultimately, it is the preceptee's responsibility to complete, with assistance from crew, but make sure they know about it

Evaluation Forms

- Candidate's self-evaluations should be completed before preceptor's evaluations
- Evaluation form is divided into Scene Management, Primary Assessment, Secondary Assessment and Operations with two sections at the bottom for reflection.
- Preceptors are responsible for debriefing each call with the collector, reviewing the call (what went well, what could have improved, differential diagnoses).

Spinal Immobilization

- The five required backboard scenarios are set scenarios where there was a significant mechanism of injury, and the preceptee will choose to fully immobilize, partially immobilize, or rule out any immobilization
- The "Spinal Immobilization Worksheet" is to be completed by the collector. Using the TJEMS Spinal Immobilization guidelines are encouraged. There is no answer key!

Release Binder

- Before submitting, go through all paperwork and evaluations with preceptee to ensure that everything is in order, and to look for consistent issues collector has had on calls.
- Every Call Evaluation should be signed by the recommending preceptor

Required Backboard Scenarios
Backboard Scenario 1

General Idea: Supine backboard meant to be simple. Patient meets backboard criteria due to head trauma plus history of dementia and total confusion at baseline

Equipment: Backboard materials
Actors: Patient. Nursing home staff member. Crew member.

Dispatch Info:
"You are dispatched to Cedars Golden Living Nursing Home for the Ambulance Level fall, 82 year old female, laceration on head, bleeding controlled. You arrive on scene to find the patient lying supine on the floor next to her bed."

From Staff Member:
Staff member heard a thud from patient's room, found patient in this position with a minor cut on her head, guesses that patient must have hit her head on the nightstand.

IF collector asks about baseline mentation, total confusion is baseline.

Patient Presentation:
Neuro: Awake and talking, but confused, answers no questions appropriately.
M/S: Minor laceration to head, bleeding controlled. No other obvious injuries. Patient denies all pain.

Scenario Flow:
If collector is relatively new, end on verbalizing moving patient to ambulance. Can go further if appropriate for collector's level of training.

Backboard Scenario 2

General Idea: 18 month old patient fell off of swing. Supine pediatric immobilization.

Equipment: Pediatric immobilization equipment. Patient is infant CPR mannequin

Dispatch Info:
"You are dispatched to Venable Elementary school for an 18 month old patient fell off of the swings, now crying inconsolably and 'not moving much' per caller"

Patient Presentation:
Patient is crying inconsolably. No obvious signs of trauma. Patient lying supine on ground not moving limbs.

Scenario Flow:
Collector should use pedi-immobilizer. Can provide parent to talk to or not, but if so parent is helpful and easy to talk to. Take scenario to prehospital report.

Backboard Scenario 3

General Idea: MVC Significant Impact. Obvious neuro symptoms. Backboard out of driver's seat of car. Not a lot of information about the actual accident is available due to everyone being busy

Equipment: Car. Backboard materials.
Actors: Patient. Crew members.

Dispatch Info:
"You are dispatched along with another CARS unit and Medic 8 to the intersection of Hydraulic Rd and Route 29 North for the Motor Vehicle Accident with multiple patients. When you arrive on scene you are directed by incident command to take care of the priority green patient."

From Car:
Severe damage to vehicle. Airbags deployed. Patient sitting in driver's seat, still seatbelted. Starring on windshield. Patient unable to recall details of accident.

Patient Presentation:
Neuro: Awake and talking, but slow to respond to questions. Occasionally answers questions correctly, occasionally not. Slow to follow commands.
M/S: Random bruising and scrapes about body. PMS intact in all extremities.

Scenario Flow:
This patient meets full immobilization criteria due to neurologic deficits s/p trauma. Patient must be backboarded out of vehicle (collector should place backboard on top of stretcher prior to extricating patient). Have collector place patient in ambulance, then time them for a 5 minute "transport time". Prehospital report and transfer of care report should be given.

Backboard Scenario #4:

General Idea: Prone backboard on an uneven surface, partially on mat, partially off. Pt meets full backboard criteria due to LOC and other neuro deficits (bilateral paresthesia in upper extremities).

Equipment: Backboard materials
Actors: Patient.

Dispatch Info:
"You are dispatched to the UVA Outdoor Rental Center for the Ambulance level fall, 23 YOM with numbness/tingling in arms. You arrive on scene to find pt lying prone on the floor, with his lower half on a padded surface, and his upper half on a concrete floor.

From Witness: "He was trying to do a backflip off of the wall, but he kicked out too hard and missed the mat. He hit his head on the concrete floor pretty hard, and it took me a second to wake him up after."

Patient Presentation:
Neuro: Awake and talking, readily answers questions, but does not remember fall well. Pt reports head/neck pain, and bilateral numbness/tingling in arms.
M/S: "Goose egg" on back of head, pulse and motor in all 4 extremities, but no sensation in arms, no other obvious injuries.

Scenario Flow:
This patient meets full immobilization criteria due to neurologic deficits s/p trauma. Take scenario to prehospital report.

Backboard Scenario 5

General Idea: MVC Significant Impact. Obvious neuro symptoms. Backboard out of back seat of vehicle.

Equipment: Car. Backboard materials.
Actors: Patient. Crew members.

Dispatch Info:
"You are dispatched for the MVA on Milton Farm Rd, severe impact, possible entrapment. On arrival, you note the car collided head on with a tree. PD is in the middle of arresting the driver for DWI. Patient is still in back seat of vehicle."

From Car:
Per PD, vehicle was going 90mph. Severe damage to vehicle. Airbags deployed. Patient lying on side, back against seat, not seatbelted.

Patient Presentation:
Neuro: Awake and talking, conversing appropriately. Sobbing from extreme pain.
M/S: Complaining of severe pain in neck and back. PMS intact in all extremities.

Scenario Flow:
This patient meets full immobilization criteria due to neck and back pain s/p trauma. Patient must be backboarded out of vehicle (collector should place backboard on top of stretcher prior to extricating patient). Have collector place patient in ambulance, then time them for a 5 minute "transport time". Prehospital report and transfer of care report should be given.

Training Ideas for Preceptees AND Released Providers

- Monthly airway training
    - BLS airway adjuncts
    - Proper BVM use and associated risks of improper use
        - BLS providers will often end up doing this alone on calls
    - CPAP
        - http://carsrescue.org/wp-content/uploads/2012/Downloads/cpapguideline.pdf
    - Supraglottic Airways
        - Kings: http://carsrescue.org/wp-content/uploads/2012/Downloads/kingairwayguide.pdf
        - LMAs: http://carsrescue.org/wp-content/uploads/2015/02/Pediatric-LMA-Guideline.pdf
    - How to assist with intubation
- Equipment review
    - Advanced Airway Kit
    - Pediatric ALS Kit
    - OB Kit
    - Philips Heart Monitor
        - Taking and transmitting 12-Leads
            - http://carsrescue.org/wp-content/uploads/2015/06/12-lead-guideline-V2.pdf
        - Taking vitals -- NBP, O2, CO2, RR, HR, Auto scheduling
        - Data Recovery
    - LUCAS Training
        - Take it out. Practice putting someone on it smoothly and quickly.
        - http://carsrescue.org/wp-content/uploads/2015/02/LUCAS-2-Chest-Compression-Guideline.pdf
        - http://www.lucas-cpr.com/web_training_center/index.php?top=lucas2&sub=
    - Bariatric stretcher and Bariatric lift
        - https://docs.google.com/open?id=0BzQmtlJmXMr0Y1R5dEZSbjQ5cGc
        - http://youtu.be/boFgQfGmyyM
    - Lifting equipment
        - Reeves
        - Scoop Stretcher
        - Stair chair
        - Actually Practice!
    - Splinting
        - Traction Splint
        - Cardboard splints

            - Most providers learned board splints in class and have never seen the cardboard splints
        - MCI Bag
        - Water Rescue Bag
        - Flares
- ALS Assist Skills
    - IV setups (start kits and drug box)
    - 12-lead placement
    - Nebulizer setup
    - CPAP setup
    - Intubation setup
    - Not sitting there like a lump
- Radio Operations
    - How to speak on the radio
    - Purpose of the 800MHz system and trunking
- TJEMS and CARS Protocols
    - http://static1.squarespace.com/static/533c0f0de4b029e9c590a99b/t/56254f49e4b01b3b2a707e41/1445285889490/2015+Regional+Protocols
    - Medical
    - Trauma
    - Medications
        - http://carsrescue.org/downloads/
    - Spinal Immobilization
        - https://docs.google.com/a/virginia.edu/file/d/0B5WwHaW5wpb2Rk5SeFRuRy0tZVpaZmJBYnpWOUhRU3c0Mmgw/edit
    - 12-Lead protocol
        - https://static1.squarespace.com/static/533c0f0de4b029e9c590a99b/t/5ac3c9f2f950b7e45421c327/1522780659460/Procedures.pdf
- Scenarios **(You can request a tac or event channel from ECC for training)**
    - Backboard scenarios
    - Scenarios based on past calls
    - Code scenarios (BLS or ALS)
- Seen something interesting about medicine or healthcare? Share it with your crew!