Paramedic Preceptor

Roles & Responsibilities

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PRECEPTOR ROLES AND RESPONSIBILITIES

Although EMS Interns receive extensive classroom and hospital clinical instruction, they are taught how their profession works on the streets. Guidance during the early stages of their careers by experienced paramedic preceptors is **key** to producing quality EMS professionals.

The role of the paramedic preceptor is to:

1. Orient the Intern to pre-hospital policies, procedures, and equipment specific to your service.

2. Review with each Intern the knowledge, skills, and personal behaviors/attitudes required of an ***entry-level practitioner*** as defined by the Field Internship Objectives and the Ambulance Ride Evaluation Form.

3. Ensure the Intern obtains the experiences necessary to acquire the knowledge, skills, and personal behaviors/attitudes required of an ***entry-level practitioner***.

4. Use the Field Internship objectives to guide the Intern through a structured sequence of experiences which begins with the Intern **functioning primarily as an observer, progresses to participation as a team member, and ends with the Intern acting as a team leader and directing the management of calls**.

5. Based on the Intern's clinical experience and skill, provide supervision which is adequate and appropriate to assuring effective and efficient learning.

6. Provide the Intern with feedback and evaluation regarding his/her clinical performance related to the objectives for an ***entry-level practitioner***.

7. Provide objective written and oral evaluations to the EMS Program, documenting the Intern's progress toward mastery of the Field Internship Objectives and attainment of ***entry-level competency***.

8. Attest to the Intern's attainment of entry-level competency through completion of the Preceptor's *Statement of Entry-Level Competency*.

9. Advise the EMS Program immediately of any significant problems with Intern knowledge, skills, or personal behaviors/attitudes **that require immediate intervention**.

10. Work with the EMS Program faculty in remediation of problems with Intern performance.

11. Work with the EMS Program in the on-going evaluation and improvement of the Program's curricula and instructional methodologies.

12. Communicate openly, effectively, and objectively with the EMS program faculty on a routine basis throughout the field internship.

PRECEPTOR REQUIREMENTS AND QUALIFICATIONS

1. Current certification as an EMT-Paramedic by the Tennessee Department of Health, EMS Division.

2. Current medical control authorization by the Medical Director.

3. Minimum of **FIVE YEARS** of field experience unless waved by the Program Director.

4. Demonstrated training in educational methodology and techniques as evidenced by **three** or more of the following:
   a. Current certification as a Tennessee Department of Health, EMS Division, EMS Instructor/Examiner or EMS Instructor/Coordinator.
   b. Current certification by the American Heart Association as an Advanced Cardiac Life Support or ACLS EP (Provider or Instructor) or Basic Life Support Instructor, Instructor-Trainer, or Regional Faculty. (**ACLS**)
   c. Current certification by the American Heart Association as a Pediatric Advanced Life Support or equivalent (Provider or Instructor). (**PALS**)
   d. Current certification by the National Association of Basic Trauma Life Support or equivalent as a Provider or Instructor. (**BTLS**)
   e. Documentation of instruction in adult education methodology through completion of courses or recognized programs in adult education such as those offered by Columbia State Community College and the Tennessee Department of Health, EMS Division.
   f. Other evidence of knowledge and skill in effective instructional delivery acceptable to the EMS Program Director, the Medical Director, and the Columbia State Community College EMS Program's Preceptor Training and Education Committee.

5. Completion of an orientation to EMS Program field internship program policies and procedures to include:
   a. Preceptor roles, responsibilities, and requirements
   b. Internship philosophy (opportunity intensive and competency based approach)
   c. Internship Objectives and Minimum Requirements
   d. Required documentation
      Field Internship Objectives
      Preceptor's Statement of Entry-Level Competency
   e. Optional Policies and Procedures
   f. Clinical Teaching Techniques, including procedures for dealing with unsatisfactory progress.

PRECEPTOR APPLICATION APPROVAL AND RE-EVALUATION

1. Individuals wishing to serve as preceptors will submit an application to the EMS Academy on a form provided by the Program.

2. Applicants will be evaluated and approved by the CSCC Faculty and Director. Criteria used for evaluation of applicant may include, but are not limited to:
   a. Review of the content and process of the EMT and Paramedic courses attended by the applicant.
   b. Review of the applicant's teaching credentials and experience.
   c. Review of the applicant's field experience including comments from supervisors.
   d. Final determination by the service's Director must be obtained.

3. Following initial approval, preceptors will be on probation status for a period of one year. At the end of the one year probationary period, the probationary preceptor will be evaluated by the EMS Program using the following criteria:
   a. Intern comments and evaluations.
   b. Completeness of required Intern documentation.
   c. Comments received from other preceptors with whom the probation preceptor works.
   d. Demonstration of commitment to maintaining the quality and effectiveness of the preceptorship program.
   e. Maintenance of clinical proficiency as determined by evaluators conducted by the preceptor's supervisors and medical director.

4. Preceptors who complete probationary status will be extended formal appointments as Paramedic Preceptors in the Columbia State Community College EMS Academy Program.

5. Continued status as a preceptor is subject to re-evaluation by the Director on an annual basis, using the same criteria used for evaluation of probationary preceptors.

GENERAL GUIDELINES AND INSTRUCTIONS

Thank you for agreeing to precept Interns during their field internship. Field internship preceptors are vital to the development of competent EMS personnel. Although Interns come to their field internship experience with extensive classroom and in-hospital clinical preparation, it is their experiences on the ambulance during field internship which makes them competent ***entry-level practitioners***. As a preceptor during field internship, you will have a greater impact on the Intern's effectiveness as a future colleague than anyone else the Intern works with during his/her education.

The following general guidelines are provided to assist you in precepting EMS Interns. If you ever have any questions or concerns, please contact the Director, David Cauthen at 931.540.2686.

1. Interns are **assigned** for internship to a specific preceptor. The Intern "belongs" to the preceptor to which they are assigned.

2. The Intern will move with the preceptor to the new station or shifts if reassigned during the field internship component of their training.

3. If the Intern's preceptor is absent during a particular period during the Intern's internship the Intern may be reassigned to an alternate preceptor per EMS Academy approval.

4. **ANY EMT-PARAMEDIC WHO HAS COMPLETED FIELD TRAINING AND WHO HOLDS MEDICAL CONTROL AUTHORIZATION FROM THE MEDICAL DIRECTOR MAY SUPERVISE AN INTERN AND RELEGATE PATIENT CARE TASKS. INTERNS ARE PERMITTED TO PERFORM PATIENT CARE EVEN THOUGH THE PRECEPTOR HAPPENS TO BE DRIVING RATHER THAN PERFORMING PATIENT CARE. THE PARAMEDIC SUPERVISING THE INTERN SHOULD REPORT ON THE INTERN'S PERFORMANCE TO THE PRECEPTOR FOLLOWING THE CALL.**

5. Interns may sign up for clinical rotations between 0700 and 2400 hours any day of the week. At any time an advanced Intern may remain on the units beyond 2400 hours **if** the unit is continuing a dispatched call. Interns **ARE NOT** permitted to sleep **AT THE STATION**. Note: All hours allowed in clinical facilities are subject to the policies and procedures of that facility.

6. If an Intern signed up for a field internship shift fails to appear as scheduled, please report their absence to the Director at 931.540.2686 as **SOON** as possible. Interns who fail to show up for scheduled field internship time are subject to disciplinary action and possible expulsion from the program.

7. Preceptors must be sure the Intern meets the Clinical Dress Code. Interns not meeting the Clinical Dress Code should be sent home immediately and should be reported. (See Clinical Dress Code.)

8. During the Intern's first shift, provide the Intern with an orientation to the unit, including:
   a) Chain of command. This can prevent embarrassing incidents.
   b) Station arrangement, routine, and duties.
   c) Locations of equipment or supplies which the Intern may be asked to get. The Intern should inventory the truck each shift to remain familiar with equipment locations.
   d) Use of equipment such as the EKG Monitor/defibrillator and the radio systems.
   e) Special policies, procedures, or regulations, especially those which will affect the Intern's activities. Examples would include:

1. Procedures for responding to calls, including procedures for use of seat belts in the ambulance and for unrestrained movement in the patient compartment when delivering patient care.
2. Infection control/personal protective equipment procedures
3. No transport/refusal of treatment procedures
4. Patient dead on scene procedures
5. Requesting additional units or supervisors
6. Treatment of minors
7. Treatment of coma victims, including sexual assault victims
8. Requesting assistance from and interacting with the police or fire departments
9. Routine paperwork
10. Radio procedures
11. Transfer of care at hospital procedures
12. Audit cleaning / restocking Raced
13. Interns MUST be encouraged to study the protocols since they will be expected to direct calls near the end of the internship and will need to understand the use of the protocols.
14. Emergency procedures and responsibilities. In particular, if you and your partner have any special "reaction drills" worked out for potentially hazardous situations, let the Intern know what to expect

9. Review the objectives for the rotation with the Intern. If either of you is unsure about what is expected or permitted, please contact the EMS Academy at 931.626.3883.

10. **The Field Internship Objectives provide a general outline to follow in taking the Intern from initial status as a "green" observer, through assisting you as a team member, to finally functioning as a team leader. Although the objectives are grouped into phased blocks, based on progress that an "average" Intern would be expected to make, some Interns may move through the objectives faster while some may take longer. As long as the Intern is making progress, he/she should be reassured that the important factor is mastery of the objectives, not how long it takes.**

11. During your shifts with the Intern, try to:
    a. **REVIEW** the history, diagnosis, complications, and treatment of each parent you see.
    b. **OFFER** case-specific comments which help correlate the Intern's didactic knowledge with patient assessment and management in the field setting.
    c. **PROVIDE** opportunities for the Intern to perform assessments or procedures. As the Intern progresses through the internship objectives, he/she should assume responsibility for an increasing portion of the patient's care. However, the paramedic responsible for patient care should always retain final decision making authority for patient care. The supervising paramedic should always concur with any invasive procedure before the Intern performs it, especially actions indicated under the portions of treatment protocols.
    d. **PROMOTE** problem-solving skills by asking the Intern questions. Ask the Intern why he/she chose a particular course of action.
    e. **ANALYZE** patient problems to give the Intern an opportunity to see how practicing professionals and reason.
    f. **PRESENT** the Intern with a brief critique following each ambulance run that he/she makes with you.

12. Supervise the Intern when he or she is performing activities on the ambulance. The preceptor should critically review the Intern's technique and recommend changes where appropriate.

13. Interns will ride as a third person at all times and will always be under supervision when providing patient care. Interns who are employees of agencies providing field internship sites may not count "on-duty" or "field training" time toward satisfying EMS Program requirements. Interns who are employees of agencies providing field internship sites must be evaluated objectively and without partiality.

14. Assist and evaluate the Intern until she or he meets the clinical internship objectives and performs as an ***entry-level practitioner***. The CSCC EMS Academy is competency-based. This means that the Intern is finished when he or she demonstrates the knowledge, skills, and personal behaviors and attitudes needed to function as an ***entry-level practitioner***. Competency is not defined by time spent on the unit or number or calls run. It is defined by observed, documented mastery of the internship objectives. **However, all Interns will be required to complete 240 hours to complete the field internship. Interns who fail to prove competency after 240 hours will be required to schedule additional hours above the 240 hour minimum.**

15. At the completion of each shift, the Intern will ask you to review their performance critique. Give the Intern feedback in each of the categories listed on the sheet by comparing his/her performance to the performance defined in the Field Internship Objectives. Also tell the Intern which phase he/she is performing in for each category in the Objectives, and provide an overall evaluation of the Intern's progress from novice to entry-level practitioner. The preceptor should record this information on the sheet and return it to the Intern for review and signature. THIS FORM MUST BE COMPLETED AND RETURNED FOR THE INTERN TO RECEIVE CREDIT FOR THE ROTATION. IF THE FORM IS NOT COMPLETED, THE INTERN WILL BE REQUIRED TO REPEAT THE ROTATION.

16. An attempt has been made to make all forms as self-explanatory and the definitions of performance as simple and clear as possible. If you are unsure about how to evaluate an Intern, please call the EMS Academy Office.

17. Your narrative comments are very important, especially if the Intern is not performing to standard or is not making progress. If you would prefer to discuss your observations with an EMS Academy faculty member, please contact the office.

18. The Intern must document EVERY run in the internet-based data collection service named, FISDAP. Documentation of all runs is important in assessing the quantity and quality of patient contacts during field internship. As a teaching exercise, the Intern should be required to complete his/her run form before comparing it to the form completed by the EMS personnel. DO NOT ALLOW THE INTERN TO SIMPLY COPY YOUR REPORT. STRESS TO THE INTERN THAT PATIENT NAMES ARE NOT TO APPEAR IN HIS/HER RUN REPORTS. THIS CONSTITUTES A VIOLATION OF CONFIDENTIALITY.

19. Preceptors will be given access to review the data entry of their assigned Intern through FISDAP. All patient care data will be reviewed by EMS Education faculty, but should be monitored by the assigned preceptor.

20. **To successfully complete field internship, the Intern must:**
    a. Satisfy all of the internship objectives.
    b. Obtain a Preceptor's Statement of Entry-Level Competency.
    c. Satisfy the minimum requirement of 240 hours.
    d. Satisfy the FISDAP “graduation requirements” established by the Academy

21. The Preceptor's **Statement of Entry Level Proficiency** should be completed when the Intern has mastered all objectives; satisfied all of the minimum requirements and consistently demonstrated that he/she possesses the knowledge, skills, and personal behaviors and attitudes necessary to function effectively as an ***entry-level practitioner***. The final criteria for judging entry-level competency are:
    a. Willingness of the preceptor to work with the Intern as his/her partner.
    b. Willingness of the preceptor to permit the Intern to treat a member of his/her family during an emergency.

    ONLY PERSONNEL WHO HAVE BEEN FORMALLY APPROVED AS PRECEPTORS BY THE EMS PROGRAM MAY COMPLETE STATEMENTS OF ENTRY-LEVEL PROFICIENCY

22. Although these Interns are under your supervision, you are not expected to have to discipline them or tolerate any kind of unprofessional behavior. Please call the Academy office immediately if any kind of problems arises. YOU ARE NOT REQUIRED TO WORK WITH A INTERN WHO REFUSES TO COOPERATE WITH YOU OR WHO REFUSES TO FOLLOW DIRECTIONS.

TEACHING SUGGESTIONS FOR PRECEPTORS

1. Don't forget what it was like when YOU first started. Try to make this experience what YOU WOULD HAVE WANTED if you would have had the chance.

2. Establish a relationship with your Intern early. Ask about his/her goals for learning during field internship. Find out what they consider to be their strengths and weaknesses. (You might want to let them know what your strengths and weaknesses are – you won't be able to hide them.)

3. Preceptors and Interns should discuss how they can best function together. Look for a way to work together that will be easy for both of you. Remember that the objectives are designed to take the average paramedic Intern from being an observer, through participating as a team member, to functioning as a team leader in about **100 hours**. Based on previous experience and innate ability, some Interns may be ready to progress much faster while others may take longer. THE SPEED AT WHICH THE INTERN COMPLETES THE OBJECTIVES IS NOT WHAT IS IMPORTANT. WHAT IS IMPORTANT IS THAT THE INTERN MAKES PROGRESS AND ULTIMATELY ACHIEVES MASTERY.

4. Regardless of how competent an Intern seems, throwing an Intern to the wolves by himself on the first run is NOT good teaching technique and WILL NOT be tolerated, even if that is what was done to you.

5. Most of our Interns have never experienced a competency-based system of education before. Even though the process has been explained to them several times in classroom, many Interns begin internship with an expectation that when they have "put in their time" they will be signed off. PLEASE STRESS TO THE INTERNS THAT THEY ARE FINISHED WHEN THEY HAVE DEMONSTRATED ENTRY-LEVEL COMPETENCY. BECAUSE OF A NUMBER OF FACTORS (SOME OF WHICH THEY WILL NOT BE ABLE TO CONTROL), THIS MAY TAKE LONGER THAN THE MINIMUM REQUIRED AMOUNT OF TIME OR RUNS (240 hours). THIS IS OKAY!!! THE CRITICAL POINT IS THAT WHEN THEY FINISH, THEY ARE A COMPETENT ENTRY-LEVEL PRACTITIONER. IF THEY DO NOT UNDERSTAND THIS CONCEPT, SOME INTERNS MAY PLACE THEMSELVES UNDER TREMENDOUS PRESSURE WHEN THEIR INTERNSHIP LASTS LONGER THAN THEY THINK IT SHOULD.

6. If you and your partner have worked together for a long time, remember that you may use a large number of established routines and a significant amount of non-verbal communication on calls. When you have an Intern, you may need to force yourself to start "talking out loud" again.

7. Constructive criticism is very important but **NOT** in front of the patient or your peers. Don't tell an Intern he did something wrong UNLESS you tell him or show him the right way to do it. You should seriously discuss each run. There is something to learn from them all**.**

8. During calls and during post-run discussions with the Intern, think "out loud." Within the realm of what is appropriate conversation in front of the patient, verbalize your thought process for the Intern so he/she can see how a competent practitioner approaches calls. Point out comments by the patient or observations about the patient or the patient's surroundings which were important in guiding your decisions. Remember that to a beginner, everything seems to be important and it is easy to get lost in detail. **Part of**

good clinical teaching is developing the Intern's skill in picking out what is important.

9. As the Intern progresses, ask him/her to THINK "out loud" so you can evaluate why he/she is proceeding in a particular way. Never assume that just because an Intern does the right things, he/she necessarily knows WHY the action is correct.

10. Reinforce correlations between didactic knowledge and clinical performance. **NEVER** tell an Intern, "I know they teach you this in the classroom, but this is the way things are in the real world." You might think that the Intern will begin to question everything they have learned, when in reality, they will probably begin to question you. If you must do something which is different from practice as dictated by the "book" and a NATIONAL STANDARD, explain to the Intern afterwards the rational for your decision and be ready to defend it.

11. Avoid any type of criticism in front of patients and families. If the Intern is making a mistake, correct it as quietly and appropriately as possible, but do correct it.

12. As the Intern progresses through the objectives, he/she should take more and more responsibility for each run. It is very hard for us to "sit on our hands" and watch another person do a procedure that we usually did - but that is what teaching is all about.

13. Again, if you and your partner have worked as a team for a long time, there will be a tendency for things to "just happen" on calls. Remind yourselves not to react so quickly to a situation that you do not give the Intern an opportunity to perform.

14. It is important to remain calm, no matter how inept the Intern is or how frustrated you become with their efforts. Reinforce by constructive criticism; show them the right way; but never, never yell.

15. If the Intern is simply NOT learning, call the EMS Academy Director. You KNOW it will be handled.

16. Try not to say things like, "This is your last chance, kid. If you can't get the Band-Aid on right this time, you're history." Instead, talk to the Intern about why he insists on putting the Band-Aid on wrong side down and explain why that does not work. If he still puts it on wrong, call the EMS Program for help (quickly).

17. If you do not know the answer to an Intern's question, **do not make one up**. It's OK not to know everything. Preceptors are not required to know it all, but they are required to be **honest**.

18. Remember that Interns, because they lack the fixed patterns of thinking that experts have acquired, can occasionally come up with brilliant solution to unusual problems that may not seem immediately obvious to you. When that happens, a good teacher is gracious and praises the Intern's success. **One of the benefits of teaching is that we continue to be challenged by and learn from our Interns.**

19. LAST BUT NOT LEAST, don't forget that **YOU** will learn things you never knew through this process. These Interns have been trained not to accept "because I said so" answers. They want to know WHY! You will most likely have to "hit the books" yourself to keep up with their high-level of didactic training. The more you teach – the better YOU will become. The better you become – the better we all become.

HOW TO EVALUATE FIELD INTERNSHIP INTERNS

1. BE PATIENT!

2. Become very familiar with the Field Internship Objectives. This document defines the areas in which the Interns must demonstrate proficiency to complete the internship.

3. Evaluations must be conducted based on the Field Internship Objectives and the EMS Program's Skills Performance Standards. Evaluating by the evaluator's standards rather than a consistent set of standards established by the Program reduces the reliability of the process and the consistency of the Program's final product. IF YOU HAVE SUGGESTIONS ABOUT CHANGING THE OBJECTIVES OR THE FORMAL CRITIQUE, PLEASE COMMUNICATE THEM TO THE EMS PROGRAM. BUT UNTIL YOUR SUGGESTIONS ARE IMPLEMENTED, PLEASE EVALUATE USING THE EXISTING STANDARDS.

4. Take the time to become familiar with your Intern. Ask him about perceived strengths and weaknesses. Unless you work closely with the Intern, it will be difficult to assess competency.

5. Avoid "Angel" or "Devil" effects regarding Interns. Since many of the field preceptors also teach or examine during the didactic phase of the course, information about Interns who stand out for one reason or another frequently reaches the field before the Intern begins internship. Although it is human nature to prejudge others based on reputation, preceptors must actively avoid making positive or negative assessments of an Intern based on any data other than those obtained from direct observation of performance in the field.

6. Not only do you need to observe the Intern's actions or skills, you should ask <u>WHY</u> he did something. Do not assume that just because a procedure or assessment was performed correctly the Intern understands why he did it.

7. Try to be honest with yourself and your Intern when you are providing evaluation and feedback. It does not help anyone to tell an Intern he is doing fine when he is not. Always keep in mind that someday **YOU or a member of your family may be the patient this Intern works on.**

8. Try to be specific and constructive when you criticize the Intern. First, reinforce his good points. Then identify and weaknesses. Then tell them exactly what is not to standard and why this is the case. Then follow up by reinforcing his good points again.

9. If an Intern demonstrates weaknesses in several areas, work on one or two problems at a time. Trying to do too much too fast may cause "paralysis by analysis" in which an Intern becomes progressively less able to function.

10. When you critique the Intern's performance at the end of the shift, make suggestions about what he can do before the next shift to improve. EXAMPLES: Review a particular chapter in the textbook. Go to the skills lab to practice a particular procedure.

11. Remember you are evaluating performance in relationship to an established standard. You are NOT evaluating the Intern as a person. If a serious personality conflicts occurs or if you do not feel you can evaluate an Intern fairly for any reason, please contact the

Director to discuss the problem. If the situation is not easily corrected, the Intern will be reassigned.

12. An unsatisfactory evaluation of an Intern will not invariable result in failure to complete the internship. The EMS Academy policy for dealing with unsatisfactory evaluations or failure to make progress in included in this handbook for you to refer. The policy is designed to allow "progressive corrective action" for dealing with problems to provide the Intern with every opportunity to improve.

13. The earlier a problem is identified and communicated the easier and less severe the corrective measures have to be. This is especially true when comments and suggestions accompany the less than satisfactory evaluation. (EXAMPLE: Butch has difficulty starting IV's, but I feel it is caused by being nervous.) This information probably would not be acted on, but the EMS Academy would be looking for follow-up comments**.**

14. **COMPLETE PAPERWORK WITH NARRATIVE COMMENTS ON THE INTERN'S PERFORMANCE IS VITAL. BY LAW, AN INTERN HAS THE RIGHT TO DUE PROCESS REGARDING ANY UNFAVORABLE ACTION WHICH THE PROGRAM TAKES. THIS INCLUDES THE RIGHT TO APPEAL DECISIONS TO THE PROGRAM DIRECTOR. INCOMPLETE DOCUMENTATION IS LIKELY TO RESULT IN ACTION AGAINST A INTERN BEING OVERTURNED.**

15. Preceptor observations and recommendations directly influence whether an Intern completes the course or not. Because the preceptors see the Intern perform in a setting which is closer to actual clinical practice than the classroom or in-hospital clinical sites, preceptors provide the best data regarding how the Intern will eventually function in the field. The EMS Program takes preceptor observations very seriously in determining whether or not an Intern completes the course. Therefore, you must strive to be as objective as possible.

16. Attempts by Interns to use political influence or threats of any type or to go outside the chain of command to circumvent the internship requirements or process will NOT be tolerated. THESE ACTIONS BY THE INTERN WILL RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM. INTERNS HAVE BEEN ADVISED OF THE APPROPRIATE PROCESS FOR HANDLING GRIEVANCES AND ARE EXPECTED THE ADHERE TO THIS PROCESS AS A DEMONSTRATION OF THEIR COMMITMENT TO PROFESSIONAL BEHAVIOR. THIS INCLUDES DISCUSSING ANY PROBLEMS OR CONCERNS WITH THEIR PRECEPTORS PERSONALLY BEFORE TAKING THE MATTER TO ANYONE ELSE.

CLINICAL DRESS CODE

Interns should be dressed in a professional manner while they are doing clinical and ambulance rotations. INTERNS WHO DO NOT WEAR A COLUMBIA STATE CLINICAL UNIFORM SHOULD BE ASKED TO LEAVE THE CLINICAL SITE. REPEATED OR FLAGRANT VIOLATIONS OF THE CLINICAL DRESS CODE MAY RESULT IN DISMISSAL FROM THE PROGRAM.

REQUIRED ITEMS

1. Approved "Polo style" shirt with identifying stitching (Academy)
2. Black pants.
3. Photo nametag provided by the Academy attached on the top-third of the shirt.
4. Dark dress shoes/boots.
   (Work-type footwear accepted by EMS Academy only).
5. Black Belt
6. A watch with second-hand for timing respirations and pulses.
7. Stethoscope.

PROHIBITED ITEMS

1. Baseball caps
2. Certification or ambulance affiliation patches on shirt or jacket.

CLOTHING WORN DURING CLINICAL AND AMBULANCE ROTATIONS MUST BE CLEAN AND IN GOOD ORDER.

INTERNS ARE EXPECTED TO PRACTICE GOOD PERSONAL HYGIENE DURING CLINICAL AND AMBULANCE ROTATIONS. FAILURE TO MEET THESE REQUIREMENTS WILL BE CONSIDERED A DRESS CODE VIOLATION.

ACADEMIC COUNSELING, PROBATION, AND DISMISSAL GUIDELINES

FIELD INTERNSHIP PHASE

1. Failure to demonstrate overall progress or progress in a major component for two consecutive 12 hour blocks.

Action

a. Hold a conference
b. Counsel Intern
c. Based on Intern interview and preceptor comments:
   1. Additional guided didactic study
   2. Additional work on skills in either hospital or laboratory
   3. Additional formal evaluation (cognitive or psychomotor)

2. Failure to demonstrate overall progress for three consecutive 12 hour blocks or progress in a major component for four consecutive 12 hour blocks.

Action

a. Counsel Intern
b. Impose probationary status
c. Based on Intern interview and preceptor comments:
   1. Additional guided didactic study
   2. Additional work on skills either in hospital or in laboratory
   3. Additional formal evaluation (cognitive or psychomotor)
   4. Assignment to different preceptors
   5. Assignment to different station or shift.

3. Failure to demonstrate overall progress for four consecutive 12 hour blocks or progress in a major component for five consecutive 12 hour blocks:

Action

a. Dismiss or
b. Based on review of academic record and recommendation of preceptors, reassign to different station/shift

4. After reassignment, failure to demonstrate progress after one more 12 hour block

Action

a. Dismissal

DISCIPLINARY COUNSELING AND PROBATION

An Intern may be dismissed if he/she:

1) Misstates or misrepresents a material fact on the application for admission or any other documentation required for admission.
2) Accumulates excessive or unexcused absences or otherwise violates the attendance requirements
3) Fails to complete at least two clinical rotations a month unless previously excused by the program Director
4) Violates the standards for conduct during clinical rotations
5) Violates the clinical dress code
6) Uses, is under the influence, is in possession of, or distributes alcohol or illegal drugs while participating in any phase of instruction.
7) Represents himself to be qualified at any level other than his current level of certification by the Tennessee Department Of Health
8) Engages in professional misconduct, including but not limited to:
    A. discriminating in the delivery of services based on national origin, race color, creed, religion, sex, age, disability, or economic status.
    B. abandonment of a patient
    C. violating any rule or standard that would jeopardize the health or safety of a patient or that has a potential negative effect on the health or safety of a patient.
    D. failing to follow the standard of care in patient management
    E. appropriating or possessing without authorization medications, supplies, equipment, or personal items form the EMS Program, any clinical site used by the EMS Program, or any patient or employee of the EMS Program or any clinical site used by the EMS Program
    F. materially altering any EMS related certificate or license issued by the Tennessee Department of Health or any other certificate or license issued or required as a condition for admission to or successful completion of any course offered by the EMS Program
9) Obtains or attempts to obtain any benefit to which he is not otherwise entitled by duress, coercion, fraud, or misrepresentation while engaging in activities related to the program
10) Performs advanced life support skills in any setting other than under the direct supervision of personnel at one of the approved clinical sites or under the supervision of an assigned preceptor.
11) Violates general rules, regulations, or policies established by the EMS Program or CSCC.
12) Violates the laws of the State of Tennessee or its political subdivision or rules pertaining to EMS personnel established by the State EMS Board while engaging in activities related the EMS program or under the guise of engaging in activities related to the program.
13) Engages in academic misconduct, as defined by the College's Intern Handbook.
14) Attempts to satisfy course requirements or otherwise obtain certification by fraud, forgery, deception, misrepresentation, or subterfuge.
15) Fails to comply with all lawful instruction, orders, or directions given by Program faculty, staff, or instructors; personnel of the hospitals at which clinical rotations are performed; or EMS preceptors or supervisory personnel.
16) Fails to cooperate with or attempts to obstruct any investigation by Program faculty or staff or other CSCC officials into any case of alleged misconduct or violation of the Program or CSCC rules or policies.
17) Fails to conduct themselves in a professional, reasonable, prudent and courteous manner or otherwise engages in activities which reflect poorly upon the EMS Program or CSCC.
18) Violates the provisions of the confidentiality statement.

Interns subject to dismissal on disciplinary grounds will be counseled prior to any action being decided by the Department of EMS Education. In the event of a minor infraction, the Intern may receive a verbal or written warning.

Interns may be counseled at any time regarding their conduct if, in the judgment of the lead instructor or program director, the Intern's behavior indicates he is at risk of committing a violation which could result in his dismissal from the course.

An Intern may be placed on disciplinary probation for any conduct which may lead to dismissal from the course. The decision to dismiss a Intern or to impose probation will be based on the seriousness of the violation and the nature of the Intern's previous conduct.

The terms of disciplinary probation may include:

1. A specified probationary period with beginning and ending dates indicated. The length of probation will vary according to the seriousness of the violation.
2. An affirmation that program and CSCC policies will be observed during the probationary period.
3. Special stipulations in the event there are unique personal problems that need to be addressed.

CLINICAL SUSPENSION

An Intern who demonstrates significant academic deficiencies, adjustment problems, or disciplinary problems in the clinical area may be suspended from clinical rotations until the problems are resolved.

An Intern who engages in any conduct in the clinical area or related to clinical rotations, which could subject him to dismissal from the program, may be suspended from clinical rotations for up to 90 days for each violation.

An Intern whose academic performance or behavior during the classroom phase of the course indicates a probability for significant academic deficiencies, adjustment problems, or disciplinary problems in the clinical area may be denied the privilege of beginning clinical rotations until the problems are resolved.

Any clinical rotations missed due to academic or disciplinary suspension must be completed before the Intern satisfies course requirements.

PARAMEDIC ACADEMY GOALS AND OBJECTIVES

OBJECTIVE 1:
To prepare Interns as competent entry-level EMT-Paramedics.

OBJECTIVE 2:
Upon completion of the program all Interns will demonstrate the ability to comprehend, apply, analyze, and evaluate information relevant to their role as entry level EMT-Paramedics (Cognitive Domain).

OBJECTIVE 3:
Upon completion of the program, all Interns will demonstrate technical proficiency in all skills necessary to fulfill the role of entry level EMT-Paramedics (Psychomotor Domain).

OBJECTIVE 4:
Upon completion of the program, all Interns will demonstrate personal behaviors consistent with professional and employer expectations for the entry level paramedic (Affective Domain).

ENTRY LEVEL COMPETENCIES

The following entry level competencies define the expectations of the CSCC Emergency Medical Services Program for graduates of its EMT-Paramedic course. The competencies describe the abilities and characteristics of an individual who has successfully completed the course and are based on nationally-accepted entry level competencies for practice as an EMT-Paramedic and on the expectations of the communities of interest served by the CSCC EMS Program.

PROFESSIONALISM

1. Demonstrates professional conduct and ethical practice in clinical setting.
    - A. Accept patients as they present themselves, without passing judgment.
    - B. Uses discretion regarding statements or behavior in presence of patient, family, significant others, and other members of public.
    - C. Refrains from speaking to or about patients, families, colleagues, associates in deprecating, mocking, disrespectful, or malicious manner.
    - D. Demonstrates awareness of personal and professional abilities and limitations.
    - E. Maintains confidentiality of patient information.
    - F. Follows uniform and grooming policies.
    - G. Follows clinical and administrative policies and procedures.
    - H. Understands and respects administrative chain of command and role of medical control.
    - I. Attempts to resolve ethical issues by acting in the best interests of the patient.

2. Assumes responsibility for personal and professional growth and development.
    - A. Seeks opportunities to gain new knowledge and apply it appropriately in clinical practice.
    - B. Demonstrates positive attitude toward learning.
    - C. Assists in evaluation of own performance.
    - D. Knows requirements for continuing education and recertification.
    - E. Demonstrates awareness of career pathways in emergency medical services.
    - F. Understands and participates in quality assurance/improvement process.

3. Recognizes constraints established by law and local medical control and delivers effective, appropriate patient care within those constraints.

4. Demonstrates awareness of value and relevance of research in pre-hospital and inter-facility patient care.

INTERPERSONAL SKILLS AND INTERACTION

1. Demonstrates interpersonal skills necessary to effective performance in pre-hospital and inter-facility settings, such as:

- A. Communicates with others openly and effectively.
- B. Coordinates efforts with those of other agencies and individuals who may be involved in care and transportation of patient.
- C. Builds working relationships with patients, peers, others participating in care and transportation of patient.
- D. Involves others significant to patient.
- E. Instills confidence in patient, family, and bystanders.
- F. Demonstrates awareness of impact on others.
- G. Responds appropriately to patient and significant others sense of crisis.
- H. Accepts direction when appropriate.
- I. Demonstrates ability to function as team member and team leader.

PATIENT CARE

1. Quickly and accurately performs a primary survey; recognizes patients with immediately life-threatening disorders of airway, breathing, or circulation; and initiates immediate life-saving interventions, including rapid extrication and transport, if appropriate.

2. Obtains information rapidly and accurately from observation of the environment; by interviewing others; and by performing a secondary survey including a pertinent history and physical examination, including vital signs, based on the patient's chief complaint.

3. Possesses sufficient knowledge of anatomy, physiology, pathology, pathophysiology, and pharmacology to gather appropriate data, evaluate patients for emergency intervention, assign priorities for care, and, in cooperation with medical control, develop a working diagnosis, and implement initial and continuing pre-hospital and inter-facility management for:

- A Single and multiple systems trauma involving the:
  - A. Head
  - B. Spine and spinal cord
  - C. Maxillofacial complex and eyes.
  - D. Anterior neck
  - E. Thorax
  - F. Abdomen, including the genitourinary system
  - G. Pelvis and extremities, including peripheral neural and vascular trauma
  - H. Soft tissues, including burns and electrical injuries.
  - I. Medical emergencies involving:
- B. The respiratory system, including acute airway obstruction, pneumothorax, chronic obstructive pulmonary disease, reactive airway disease, and respiratory distress.

C. The cardiovascular system, including myocardial ischemia, congestive heart failure, cardiac dysrhythmias, and cardiac arrest.
D. The endocrine system, including diabetes mellitus.
E. The nervous system, including altered level of consciousness, seizures, and cerebrovascular accident.
F. The gastrointestinal system
G. The genitourinary system.
H. The eyes, ears, nose, and throat.
I. Allergic reactions.
J. Exposure to toxic agents, including venoms and hazardous materials.
K. Exposure to extremes of heat and cold.
L. Dysbarism.
M. Near-drowning
N. Disorders of hemopoiesis and hemostasis, including hemophilia and sickle cell disease.
O. Infectious agents.
P. Drug related problems, including alcohol abuse, drug overdose, and drug addiction.
Q. Fluid, electrolyte, and acid-base abnormalities.
R. Obstetric and gynecologic emergencies, including complications of the second and third trimesters of pregnancy, bleeding, eclampsia, and precipitous delivery.
S. Behavioral and psychiatric emergencies including suicidal, assaultive, destructive, resistant, anxious, bizarre, confused, amnesic, and paranoid patients and sexual assault and abuse.

4. Possesses sufficient knowledge of anatomy, physiology, pathology, pathophysiology, and pharmacology to gather appropriate data, evaluate for emergency intervention, assign priorities for care, and, in cooperation with medical control, develop a working diagnosis and implement initial and continuing pre-hospital and inter-facility management of members of the following special patient populations:
   A. Neonates and pediatric patients, including patients suffering from croup, epiglottis, dehydration, child abuse, and meconium aspiration.
   B. Geriatric patients.
   C. Obstetric / Gynecologic patients.
   D. Oncology patients.
   E. Dialysis patients.

5. Effectively organizes delivery of pre-hospital patient care by:
   A. Appropriately integrating performance of patient care and non-patient care operational tasks, including:
      1. Radio use
      2. Scene control/incident command, including triage of multiple casualties
      3. Rescue and extrication
      4. Aeromedical operations

   B. Directing and coordinating transportation of patient by selecting best available methods and destination in conjunction with medical control.

6. Possesses ability to exercise professional judgment based on analytical thinking to provide appropriate patient care when care has been authorized in advance by standing orders, in cases where medical direction is interrupted by communications failure, or in case of immediately life threatening conditions.

RECORDKEEPING / COMMUNICATIONS

1. Documents patient information, observations, and occurrences in an accurate, complete, concise, and legible manner.

2. Communicates pertinent patient information understandably, completely, concisely, and accurately via the radio to medical control and upon arrival at hospital.

3. List all patient contact and treatments in FISDAP.

OCCUPATIONAL HEALTH AND SAFETY

1. Displays safety consciousness with patients, self, other responders, equipment.

2. Recognizes and takes appropriate action in potentially hazardous circumstances.

3. Comply with infection control principles, including appropriate use of universal precautions and aseptic technique.

4. Uses good body mechanics while handling patients and equipment.

5. Demonstrates understanding of psychological hazards of providing pre-hospital care and of techniques for stress recognition and reduction.

VEHICLES, EQUIPMENT, FACILITIES

1. Demonstrates ability to inspect and perform routine maintenance of emergency vehicle.

2. Demonstrates ability to locate equipment and supplies by storage area on mobile intensive care unit.

3. Demonstrates ability to inspect, prepare, operate, and maintain all patient care equipment in mobile intensive care unit inventory.

4. Demonstrates ability to perform station duties, including cleaning of station and surrounding areas.

PHYSICAL CONDITION

1. Demonstrates ability to lift, carry, and balance patients and patient care equipment.

2. Demonstrates physical and mental endurance necessary to function effectively throughout entire work shift.

3. Demonstrates manual dexterity necessary to perform all required tasks.

4. Demonstrates ability to bend, stoop, and crawl on uneven surfaces.

5. Demonstrates ability to withstand varied environmental conditions such as loud noises, flashing lights, heat, cold, and moisture.

6. Demonstrates ability to work effectively in low light, confined spaces, and other dangerous or stressful environments.

TECHNICAL SKILLS

1. Recognizes the need for and appropriately performs the following patient management/assessment skills:
    - A. Patient assessment
        1. Primary survey
        2. Secondary Survey
            - a. History
            - b. Physical Examination
            - c. Vital Signs
    - B. Use of basic airway and ventilation adjuncts
        1. Oxygen therapy
        2. Nasopharyngeal airway
        3. Oropharyngeal airway
        4. Mouth-to-mouth ventilation
        5. Bag-valve mask
        6. Pocket mask
        7. Demand valve
    - C. Use of advanced airway management techniques
        1. Endotracheal intubation
            - a. Oral
            - b. Nasal
            - c. Digital
        2. Esophageal intubation
        3. Surgical airway access
            - a. Needle cricothyrotomy
            - b. Surgical cricothyrotomy
    - D. Suctioning
        1. Oropharyngeal
        2. Endotracheal
    - E. Gastric Tube Placement
        1. Oral
        2. Nasal
    - F. Cardiopulmonary resuscitation
        1. Single rescuer CPR (adult, child, infant)
        2. Two rescuer CPR (adult, child, infant)
        3. Airway obstruction management (adult, child, infant)
    - G. Venipuncture / Blood Sample Collection
    - H. Blood glucose determination
    - I. Vascular access
        1. Intravenous
        2. Intraosseous
    - J. Dosage calculation, preparation, and administration of medications
        1. Intravenous
            - a. Bolus

b. Continuous infusion
2. Subcutaneous
3. Intramuscular
4. Sublingual
5. Endotracheal
6. Inhaled
a. Nebulizer
b. Metered-dose inhaler
c. Roto-haler
7. Topical
8. Oral

K. Pleural decompression
L. Obtaining and interpreting Lead II electrocardiogram
M. Electrical arrhythmia therapy
1. Defibrillation
2. Cardioversion
a. synchronized
b. unsynchronized
3. Transcutaneous pacing

N. Use of Pneumatic Anti-Shock Garment
O. Control of Bleeding and Bandaging of Soft Tissue Injuries
P. Spinal Immobilization
1. Long spine board
2. "Short" immobilization devices
3. Cervical immobilization devices

Q. Splinting of Orthopedic Injuries
1. Rigid splints
2. Soft splints
3. Traction splints

R. Vagal stimulation techniques
S. Obstetrical delivery, including fundus massage
T. APGAR scoring/routine neonatal care
U. Neonatal resuscitation techniques

2. Possesses familiarity with following monitoring / diagnostic / treatment modalities to provide a basis for developing skills required for specialized practice.
A. Urinary catheterization
B. Mechanical ventilator systems
C. IV infusion pumps / controllers
D. Pulse oximetry
E. End-tidal carbon dioxide monitoring
F. Arterial blood gas analysis
G. Central venous lines
H. Drug administration via rectal and transdermal routes

CONTACT INFORMATION

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