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Precepting in EMS: Developing the FTO

How do we “grow” new providers?

- Challenge facing every EMS agency
- Quality versus quantity
- Experience
- Paramedic programs “build” paramedics with more measurable objectives
 - NREMT Paramedic Portfolio
 - Competency based

What is the right term?

- Grow?
- Train?
- Build?
- Mentor?
- Precept?
- Pencil-whip?

Objectives:

- Concepts of Field Training Programs
 - “Precepting” ; Hospitals versus Field
- Different Types of Candidates/Trainees
 - In Class/NOT credentialed
 - Credentialed Rookie
 - New Employee/Experienced
- Compare Methods of EMS Field Training
- Discuss Challenges
 - Economics and Staffing
 - Competencies for the FTO

Terminology:

- Preceptor: mentor and field training officer; a senior and often advanced life support provider, teacher
- Candidate: provider in training, trainee; may be credentialed
- Credentialed: certified or licensed; through both state entities and employers

Disclaimer:

- This is about developing the skills of the Preceptor and FTO
- Accredited Paramedic programs require and specify training for preceptors.
 - CoAEMSP: Commission on Accreditation of Education Programs for EMS Professionals
- NOT the focus today; hopefully benefits those programs.

Field Training, Precepting, Mentoring;

So what is the GOAL?

Types of “Precepting” in EMS

- EMS Based
 - Required for completion of class
 - Patient contacts (EMT)
 - Skills (Early ALS class)
 - Team Leads (Summative/Terminal competency)
 - Operational to the department
 - BLS Provider
 - Transport or Non-Transport
 - ALS Provider

Types of Precepting in EMS

- Hospital/Clinical
 - Required for obtaining skills
 - Meets academic requirements
 - Potential career avenue for providers
 - Emergency Department
 - Operating Room
 - Communications
 - Develops relationships

Comparing Two Cultures

- EMS:
 - Team leadership
 - Autonomous
 - Physician Extender
- Hospital
 - Variable: Critical Care Transport, EMS Communications, ED Paramedic
 - Facility dependent
 - Often work with/for nurses

Similarities

- Rely on the senior, experienced staff to bring new personnel up to par
- Variable levels of “preceptor” training
- Each station, department, shift, and unit has its own culture
- Those cultures mirror off of the leadership:
 - Station Lieutenants, Captains, Battalions
 - Nurse Managers, Clinical Coordinators
- Often NOT Primary FTO or Preceptors
 - Depends on background

Complications

- Documentation
 - Poor Quality
- Training Programs often create “pencil whip” mentality
 - Do not encourage quality feedback
 - End of shift apathy
 - Want them out the door
- Orientation Programs
 - Build on existing skills
 - NOT develop fundamentals

Complications

- Staffing
 - Limited
- Pressure to perform
 - Or is there...
 - How many critical calls does it take to make a medic?
- Pressure to pass through
 - “Warm body mindset”

Focus Today

- Operational Field Training
- Preparing the new Provider
 - Driver Training
 - Basic AIC
 - Advanced AIC
 - New Employee
- Most Techniques APPLY to Initial Certification Classes

Functional Program Outline

- Beginning
- Middle
- End/New Beginning
- Final Evaluation
- Operational
- Continued mentoring and support

Types of Candidates

- In Class/NOT credentialed
 - Enrolled in class
 - Wide variation
- Credentialed Rookie
 - Fresh out of class, newly minted card
 - SHOULD have completed skills
 - Need execution
- New Employee/Experienced
 - Agency Focused: “This is how WE do it”

In Class/Not Credentialed

- May NOT operate without supervision
- Skill depends on exposure
- Require specific skills
 - IV, Assessments, Airway
- Motivation depends on role
 - Job related
 - Career seekers versus career advancement
- May have NO experience base

Intermediate to Paramedic Bridge

- Often Practicing ALS provider
 - Variable level of experience, but often a high level
 - Developed habits
- Require supervision of a Paramedic during clinical hours to provide equity to all students
 - Reality: require limited supervision
- Need support to complete program
- Often seek advice from greater experience, need the cerebral exposure

Credentialed Rookie

- Completed initial certification/licensure
 - Skill set developed, not refined
- Basic level of experience
 - Career advancement may provide motivation
 - Financial benefit
- Culture influenced
 - Will learn habits that stick
- Blended process
 - Class experience supports agency process

New Employee/Experienced

- Credentialed, brings experience to agency
- Need orientation to department processes, possibly regional or agency protocols
- Developed habits and skills
 - Quality?
- Require basic orientation
- May need to orient with most experienced provider available

Volunteer Providers

- How to develop consistent skills?
- Who can a volunteer agency rely on as an FTO?
- How does YOUR agency operate?
 - Crews?
 - Respond from home?
- Work/Life balance

Clinical Skills Application

- Classes teach basics
- Limits integration into dynamic environment
 - Airway PLUS monitor PLUS IV access PLUS
- Limited Repetition=Limited application
 - How many airways?
 - How many IV's?
 - How many meds?

Skill Development

- Muscle Memory requires THOUSANDS of repetitions
- Military: Basic Rifle Marksmanship
 - Focus on movements to achieve end result
 - Sight Picture, Posture, Hand placement
- EMS Skills
 - Intubation
 - Intravenous

Field Training Officer

- Role and Responsibilities
- Environment
- Expectations
- Compensation?
- What is the best title in EMS
 - Field Training Officer: relates to law enforcement and para-military
 - Preceptor: common medical role, relates to nursing

Choosing the RIGHT Preceptor

- Experience?
- Attitude?
- Reliability?
- Personality?
- Skill?

Mentor Defined

- From Merriam-Websters Dictionary
- ***A Trusted Counselor or Guide***
- ***Tutor, Coach***

Motivation to be a FTO

- Developing new providers
 - Patent answer
- Reduce work load
- Money
 - ALS Benefits tied to preceptor/FTO requirement
- None at all
 - Handed a ride-along for the shift

Motivation

- Motivation is CONTAGIOUS!
- Motivation is DRIVING!
- A motivated preceptor and a motivated candidate WILL succeed
 - *Rapidly*
- You always remember the people who shape who you are and how you do things

Situations of Motivation

- Motivated Preceptor/Motivated Candidate
- UN-motivated Preceptor/Motivated Candidate
- Motivated Preceptor/UN-motivated Candidate
- UN-motivated Preceptor/UN-motivated candidate
 - Let's just stop this now...

What motivates you?

The “Rookie” Preceptor

- Limited experience base
- Usually eager for responsibility
- Often reflects own, more recent experience
- May teach the book
- Often assigned “Students”

The “Veteran” Preceptor

- Often utilized
- Large body of experience
- Teaches habits, street tricks
- Blends reality with “book” teachings
- Risk for burn-out from overuse

Requirements

- Instructor?
- Years of service?
 - 2 years “cleared” as paramedic?
- Advanced Practice Credentials?
- Officer?
 - Big problem in Fire Service
 - Experienced and motivated providers get promoted
 - Pulled out of line service where experience is needed

Responsibilities

- Set Example:
 - Clinician
 - Work Ethic
- Set Expectations
- Provide Resource
- Long-term mentor
 - Be the person people come back to

What works?

- Global willingness to support learning
 - Not just one station, shift, or preceptor
 - Agency involvement
- Preceptors lead by example
 - Clinical and professional behaviors
- Hands on experience
 - If not running calls, working with scenarios, skills, drills
- Follow up: review the day, what learned?
 - From Atkins, JEN 2007

Methods of Field Training

- Environment
 - Saturation
 - Opportunity
- Resources
 - Limited staffing
 - Structured
 - Designated FTO
 - Available staff

Field Training Environment

- Saturation
 - Every shift is a training shift
 - Down time focused on skills training
 - Often assigned to designated preceptor, or a familiar secondary
 - Structured beginning and end or process
 - Formalized ending

Field Training Environment

- Opportunity
 - Jump on incidents
 - Take advantage of critical situations, available resources
 - Limited structure
 - Multiple preceptors
 - Extends the time of process

Field Training Environment

- Limited staffing
 - Units must be available to respond
 - Legal dictates for minimum staffing
 - In Virginia, a transport unit requires an Advanced Life Support provider as AIC with an EMT attendant
 - “Precepting from the front”
 - Two ALS providers, with the senior or operational AIC monitoring from the front of the ambulance during transport
 - For critical calls, either attends the patient or requires additional help

Field Training Resources

- Structured
 - Specific unit and staffing assignments
 - Allocated resources: minimum three personnel
 - AIC/Preceptor
 - Candidate or Student
 - Vehicle operator
- Designated FTO
 - Senior, experienced personnel trained and compensated for the task

Field Training Resources

- Available Staff
 - Card carrying ALS provider
 - Usually assigned due to limited options
 - May not desire to function in the capacity
 - May not have experience or understanding to provide true training support

Field Training Resources

- Factors outside of the agency
 - Call volumes
 - Acuity
 - Personal factors

Key Points

- What blend are you dealing with?
 - People, situation, facilities, plan
- What works for your agency?
 - What worked or did not work in the past?
- What do you want to accomplish?
 - Set new standard?
 - Meet needs for community or agency?
 - Sometimes, ALS is not standard nor a priority

Learn to Engage

- New medics challenged to interact with patient
 - Assertiveness
 - Bedside manner
- Key Learning
 - Blend personal experiences with class knowledge
 - Easier to talk without “clinical” aspects
 - Interacting with patient and family at an emergency

Developing Patient Interaction

- Assume that students are ethical, professional, and want to help people.
 - Explain to patient
 - Touch with confidence. Be gentle, but not weak or hesitant.
 - Accompany touch with verbal communication.
 - Applies to BP checks, 12 lead ECG, IV starts

Techniques for the FTO

- Setting Expectations
- Framing the process
- Feedback and Documentation
- Clinical Aspects
 - Critical thinking Flowsheets
 - Differential Diagnosis
 - Hands-on simulation versus real world implementation

Expectations

- Are they clear and concise?
- Enforceable
- Easily documented

Apply expectations:

- Program
- Preceptor
- Candidate

Setting Expectations

- Beginning:
 - Basics of Operations; Task functions
- Middle:
 - Coordination of “bread and butter” ALS calls
 - Recognition of “sick versus not-sick:
- Finishing/Completion of Process
 - Understanding of System
 - Competent Team Leader

Setting Expectations

- ***LEAD BY EXAMPLE!***
 - Street credentials...
- Watch, do, teach...
- When you teach;
 - Balance experiences with what is taught
- Apply experience to the new provider
- Behaviors mirror...

Setting Expectations

- Preceptor Questions, asked routinely
 - “Where are you in the process?”
 - “What do you want out of this?”
 - “What is your comfort zone?”
 - “What is outside your comfort zone?”

Setting Expectations

- Candidate questions, asked routinely
 - “What am I getting right?”
 - “What can I improve on?”
 - “What do I need to do next?”
 - “What is the expectation at completion?”

Setting Expectations

- Administrative Questions, from preceptor to the chain of command:
 - “Is there a schedule/agenda for the process?”
 - “What is the timetable for the process?”
 - “What support do I have?”
 - Equipment?
 - Personnel: extra staff?
 - Simulator time?

Setting Expectations

- Daily Topics: Preceptor
 - “Let’s talk about....”
- ESSENTIAL: the candidate needs to demonstrate initiative
 - “Tell me more about...”
 - “What about this...”

Framing the Process

- Beginning...Middle...Completion
- Crawl...Walk...Run
- Stair-step process
 - Gradual building
- Recognizes the candidates previous experiences
- Sets the individual and process up for success

Beginning

- Operational Tasks
 - Computers
- Observation
 - How “things” are done
- Skills
- BLS Calls
 - “Routine” emergencies
 - Documentation

Beginning

- Hazard Recognition
- Patient Interaction
 - Ability to talk to the patient
- Skills
 - BLS functions
 - Integration into ALS functions
- Limited ALS scene management
- Quality BLS scene management

Beginning Expectations

- Arrives Prepared
- Asks questions
 - Appropriate time and place
- Studies
- Learns the equipment
- Becomes comfortable in the Environment

Example:

- Provider cleared ALS in region; hired with Fire EMS combination service
- What is similar?
 - Protocols, medication kit
- What is different?
 - Transport times
 - Fire first response
 - BLS/ALS engines

Middle

- Skills integration
- Running “Routine” ALS calls
- Differentiate ALS versus BLS calls
- Quality patient interactions
 - Talking to the patient..
 - Interacting with first responders
- Quality patient reports
 - Hospital turnover

Middle Expectations

- Operates as the Team Leader on most calls
- Complete comfort with equipment and reporting
- Demonstrates progressive improvement with skills
 - IV and ECG interpretation
 - Airway skills
 - Human and simulation

Completion/Cleared Provider

- Demonstrates comfort in majority of situations
- Demonstrates understanding of protocol and operations
- Functions as the Attendant-in-Charge

The Newly Cleared Provider

POSSESSES:

- Basic skills
- Fundamental grasp on clinical care
- Formal Knowledge

LACKS:

- Experience
- Critical Decision making
- Tacit Knowledge

Knowledge

- Formal: can be written down and clearly communicated
 - Factual
 - Drug doses, mechanisms of action
 - Rules, regulations
- Tacit: difficult to articulate or write down; networked and multi-dimensional
 - Depends on CONTEXT
 - Running a code or critical trauma

Process: How long should this take?

- Weeks, months, cycles??
- Key questions:
 - Where is the candidate?
 - Are they making progress?
 - What are the roadblocks?
- Long, drawn out processes burn out the candidate and the preceptor

How to wrap it up?

- Old School: get the card, good to go..
- Current Curricula increases expectations
 - Once completed, possesses formal knowledge
 - Function as “Entry level” Paramedic or EMT
- Bureaucratic process
 - Two step: finish the class, then the process
 - The “card” allows entry into the process

Finishing Process

- Complete the scripted process
 - Department specific
- Peer review
 - Scenarios simulating stress levels
- Holistic view
 - What has the candidate been exposed to?
 - What are their successes?
 - What are their difficulties?

Final Steps

- Operational Medical Director endorsement
- Support from management
 - Front line supervisors
 - Training staff
- Review
 - Establish follow up AFTER candidate operational
 - How are they doing?

Feedback and Documentation

- Class rotation forms
- Shift reports
- Employee Performance Memos
- Counseling Records
- After Action Reviews
- Group Critique
- Debriefings/Defusings

Feedback and Documentation

- What works?
- What do the different forms provide?
- How do you avoid the “pencil-whip” mentality?
- How do write a feedback report when no calls were run, or if “nothing significant” occurs

Feedback: PIES

- PIES
 - Proximity, Immediacy, Expectancy, Simplicity
 - Principles of treating psychiatric wounds in combat environment
 - Adapted to provided critical feedback
- Frames both positive and negative feedback
- General purpose counseling guide

PIES

- Proximity: provide feedback in station at end of shift, at hospital after critical calls
- Immediacy: Do not delay in providing feedback, positive or negative
- Expectancy: Clearly outline actions needed for improvement, or changes to be implemented; even “Keep up the good work!”
- Simplicity: Straight and to the point

Documentation

- “If you did not write it, it did not happen, “
 - Old principle of documentation
- Necessary:
 - Supports success
 - Reinforces areas of improvement
- Difficult
 - Requires separating emotion from objective performance

Rating Systems

- 1 to 5
- Unsatisfactory to Satisfactory
- Very...
- Unacceptable, Acceptable, Superior

What works for your department?

Weakness of the ratings

- Lack of critical events?
- What are the expectations?
 - On the first day of the process, how can the person get ranked either “Unacceptable” or “Superior”
- End of shift, get out of here:
 - All ratings “acceptable”

Performance Areas: How to rate?

- Appearance/Timeliness
- Attitude/Interpersonal Skills
- Equipment and Protocol Knowledge
- Patient Interaction and Physical Assessment
- Decision Making
- Clinical Skills (may be more specific)
- Enthusiasm

STARR Tool for Evaluations

- Situation
- Task
- Action
- Result
- Recommendation
 - From MSG Paul R. Howe, US Army Retired
 - *Leadership and Training for the Fight*

Examples

- Candidate is on time, appears professional, answers all testing questions, but struggles to start IVs and engage in critical patients
- Candidate sits at table and reads protocol book all day, but does not ask questions
- Candidate responds to teaching probes with, "I got it, no problem."
- Candidate only intubates the mannequin once when its put in front of them

Documentation

- Write out statements
 - Active phrases versus passive voice
- Use bullet points
 - Break out key elements
 - Use short, factual statements

Simulation versus real world

- How much IS enough?
- Where/when/how/who trains?
- What does the simulator provide?
- What are its limitations?

Clinical Development

- Consistency
- Consideration
- Skill application

Remember: as the FTO, you are always watched!

Developing Critical Thinking

- Habit and behavior versus standards of care
- Evaluating a situation holistically
- Making decision based on clinical judgment
- Situational Awareness
 - UNDERSTANDING and APPLYING
- Differential Diagnosis

Critical Decision Making

- Boyd's Loop
 - Colonel John Boyd, USAF Fighter Pilot
 - "OODA Loop"

Observe

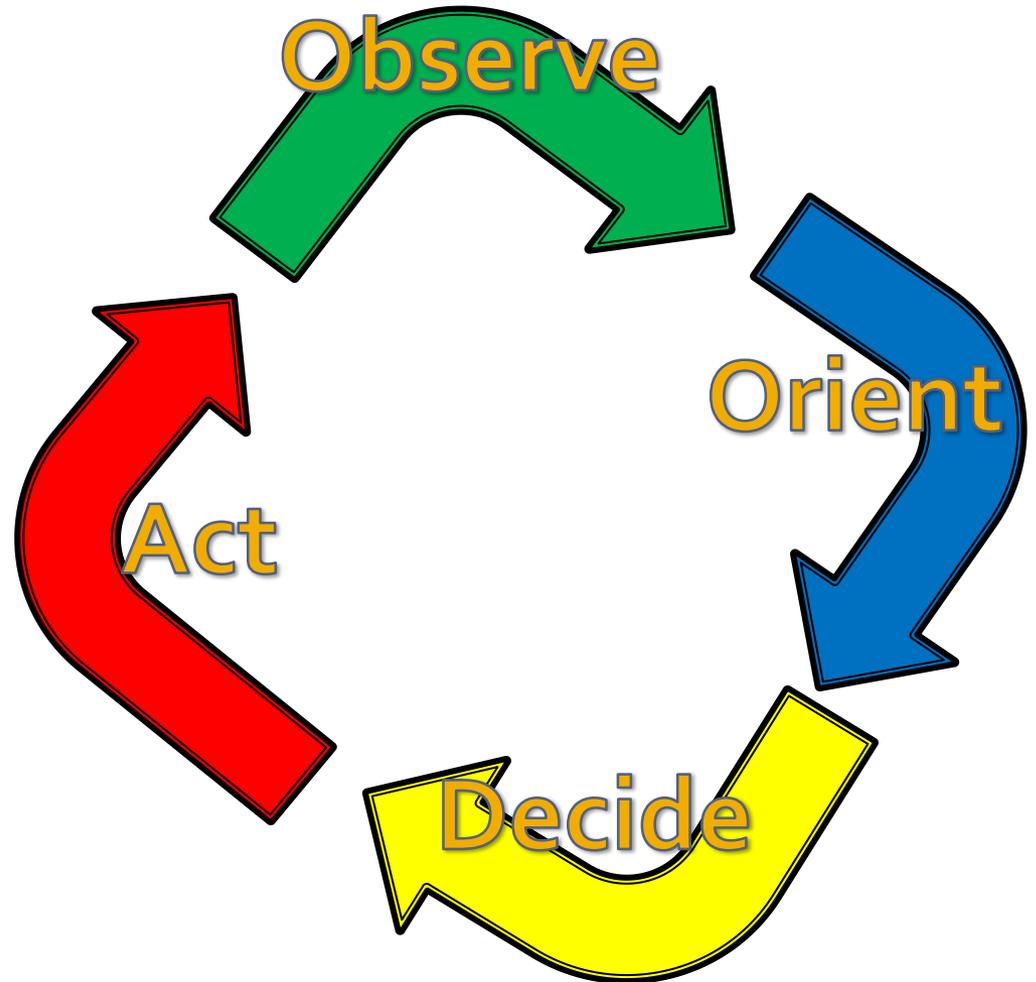
Orient

Decide

Act

Boyd's Loop

- Continuous
- Feedback
- Key:
 - Move through



Situational Awareness

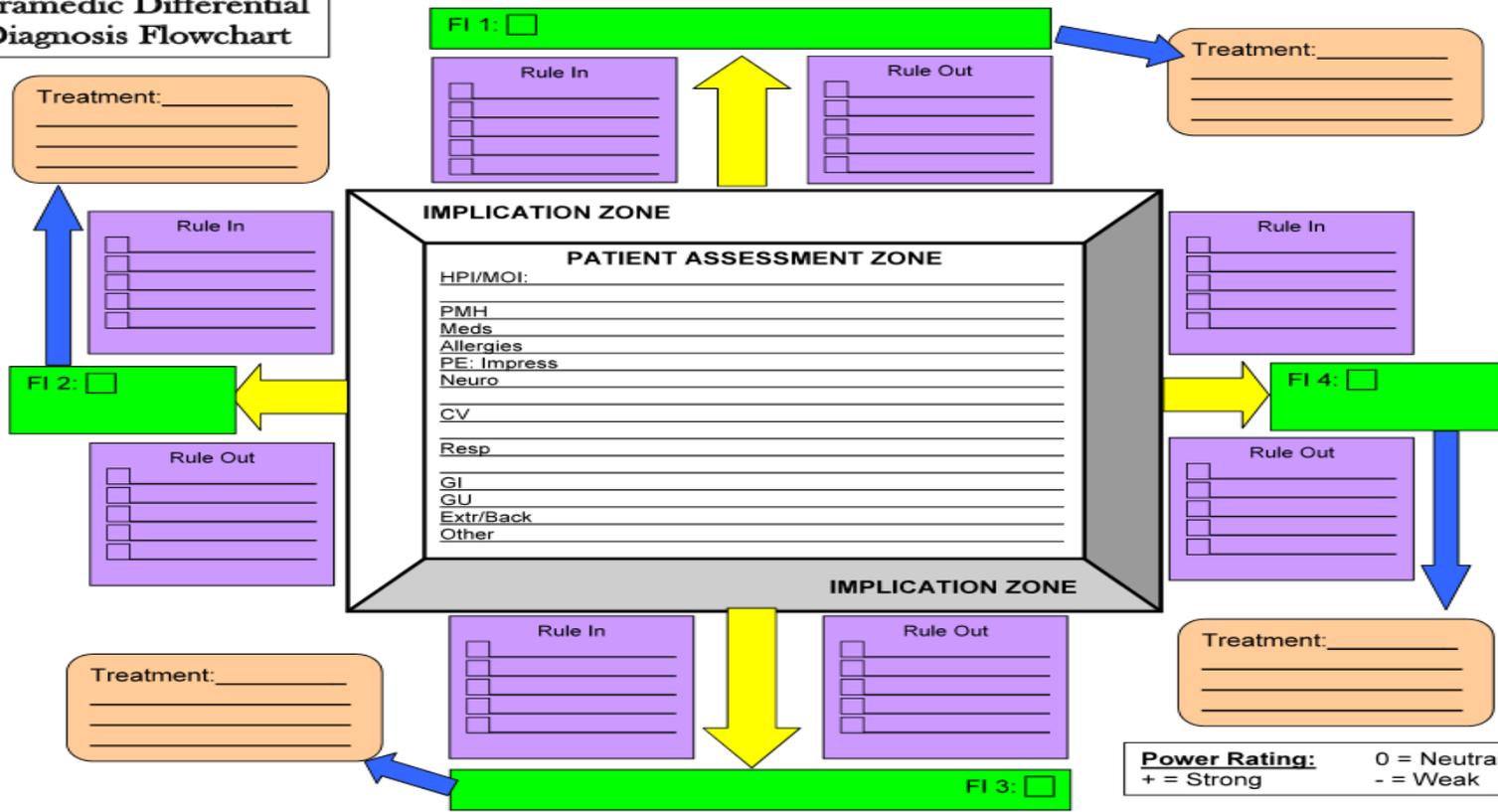
- Perception of Environment
 - Critical Elements
- Understanding
 - What is going on?
 - Implication
 - Anticipation
- Applying

Differential Diagnosis

- What could be?
- Balance: Overthinking versus Apathy

????????????????

Paramedic Differential Diagnosis Flowchart



Preceptor Guidelines

- Develop skills
- Reinforce
- Lead them down the path, but do not walk it for them.
- Correct and move forward

The One Minute EMS Preceptor Skills:

John Todaro, from NAEMSE

- Get the student to commit to a decision and action plan for the patient
- Make the student provide supporting evidence: WHY choose a course of action?
- TELL student what went right with THEIR plan and positive effects
- TEACH the student the key features of the case
- Correct mistakes; discuss what went wrong and how to avoid errors in the future

Safety

- FTO holds ultimate responsibility for crew and patient

Challenges

- Precepting a supervisor
- At the end of the process, there was no progress...
- When is this going to be over?
- Precepting from the FRONT..

John Cotton Dana

**“He who dares to teach must
never cease to learn.”**

Personal Development

- Maintain high Ethical Standards
- Set personal standards, refine and maintain them
 - Balance expectations
 - Recognize limitations

Words of Wisdom:

- “When in doubt, develop the situation”
- “It is not reality unless it is shared”
- “Listen to the guy on the ground.”
- “Don’ get treed by a chihuahua”
- “Humor your imagination.”
 - LTC Pete Blaber, *The Mission, the Men, and Me*

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