Prince Sultan Bin Abdul Aziz College for Emergency Medical Services
King Saud University

Course Supplement- EMS 425- Clinical Practice-V

Course Code	Name	Year and Semester	Training Site
EMS 425 (0+3)	Clinical Practice-V	Year-4 Semester-8	Hospitals (ICU, PER, PICU and Psychiatric)

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weekly Preceptor Evaluation

Professional Behavior Evaluation

Student name ________________	Student ID: ______________	Semester (level) :___________
Date:___________	Time : ___________	

Please rate the student in the following categories at the end of the shift:

DAILY AFFECTIVE APTITUDE EVALUATION	GRADE (CIRCLE)
Professionalism/attitude: The student's behavior demonstrated integrity, empathy, self-motivation, self-confidence, teamwork, diplomacy, respect, patient advocacy, careful delivery of service, appropriate time management, appropriate appearance and personal hygiene. Reported to clinical assignment on time and in full uniform.	**1 2 3 4**
Learner Characteristics: Demonstrates attendance within the stated program policy, independently seeks out appropriate learning experiences, participates I a multi-skilled approach to patient care, practices required skills, and seeks advice to improve skills, demonstrates the superior delivery of patient care required of a Paramedic student as stated within the program policy.	**1 2 3 4**
Communication Skills: Performs and reports patient assessments, completely and proficiently. Interacts with patients and other Health Care Professionals on a 'student role' appropriate level.	
STUDENT PERFORMANCE	
Phase/Shift Objectives: Reviews current objectives and performs the tasks to standards outlined. Interacts with and accepts constructive criticism, takes personal responsibility for self-improvement.	**1 2 3 4**
Psychomotor Skills: Student can thoroughly describe all elements of applicable procedures and accomplishes psychomotor skills independently and proficiently.	**1 2 3 4**
TEAM LEADER EVALUATION (The section is only required for advanced level (7,8)	
Interview: Completes comprehensive interviews. Demonstrated active listening	**1 2 3 4**
Exam: Completes appropriate head-to-toe and/or focused physical exam	**1 2 3 4**
Treatment: Formulates a field impression and implemented a treatment plan	**1 2 3 4**
Skill: Interventions performed were complete; satisfactory and timely	**1 2 3 4**
Leadership: Set priorities, directed team, and adapted to evolving information	**1 2 3 4**
YES ☐ NO ☐ Student successfully lead the EMS Team during patient encounters	

GRADING SCALE	DEFINITION
1 Dangerous to Practice (See comments below)	*Hazard to patients and others*
2 Needs Improvement (See comments below)	*Needs further practice and education to improve*
3 Appropriate for Experience Level	*Functioning at the level expected in the program (see objectives)*
4 Field Competent	*Employable as a Functioning Paramedic*

Preceptor comment:

____

____

____

____

____

Preceptor Name _________________ Student Signature________________________ Program Review ☐

This form has to be submitted right after each shift to be discussed with your assigned faculty, in the weekly meeting.

Kingdom of Saudi Arabia
King Saud University
Prince Sultan College for EMS
Clinical Coordination Unit

المملكة العربية السعودية
جامعة الملك سعود
كلية الأمير سلطان للخدمات الطبية الطارئة
وحدة التنسيق الميداني

Evaluation of the Preceptor

This form is to be completed by the student at the end of shift and turned into instructor at the college.

Name of Preceptor: ______________________________

Date of Evaluation: ______________

How well did the preceptor function as an intellectual guide or advisor? (Circle One)

Excellent (1) **Adequate (2)** **Not Adequate (3)**

Did the preceptor evaluate in a fair and honest manner? (Circle One)

Excellent (1) **Adequate (2)** **Not Adequate (3)**

Did the preceptor adequately supervise the paramedic intern? (Circle One)

Excellent (1) **Adequate (2)** **Not Adequate (3)**

How well did the preceptor appear to be up to date on new developments? (Circle One)

Excellent (1) **Adequate (2)** **Not Adequate (3)**

Comments:

____
____
____
____

Print Student Name: ______________________________

This form have to be filled during each shift for the encountered cases and signed from the preceptor. The faculty have to match this form with the documented cases on Fisdap.

Daily cases report

Student name __________________ **Student ID:** ________________ **Semester (level):** ________________	
Date:_____________	Time: _____________
LOCATION/DEPARTMENT (ED OR REC ROOM ICU / CCU FIELD / SRCA)	

Case 1

Time : ……………………

Chief compliant	Main interventions	Main diagnosis	Main results	HR	
				RR	
				GCS	
				BP	
				SpO_2	

Case 2

Time : ……………………

Chief compliant	Main interventions	Main diagnosis	Main results	HR	
				RR	
				GCS	
				BP	
				SpO_2	

Case 3

Time : ……………………

Chief compliant	Main interventions	Main diagnosis	Main results	HR	
				RR	
				GCS	
				BP	
				SpO_2	

Preceptor comment:

____
____
____
____

Preceptor name ____________________________________ Preceptor signature ___________________________

King Saud University, PSCEMS
Marking criteria for oral presentations

The points below should be considered when marking oral presentations.
These should be marked in accordance with the KSU marking scheme for grade boundaries (overleaf).
Oral presentations should be recorded (with consent) for review, along with ppt files, by the External Examiner.

Name of student:	
Name of marker:	
Module / component assessed:	
Date:	
1	**Clarity of the presentation**
	Was the talk well structured (introduction, aims, methods, results, discussion)? Were the slides (if used) clear and uncluttered by extraneous detail? Were illustrative figures, tables and pictures used? Did the student present the information well? **(Marks out of 40)**
2	**Understanding of the subject**
	Did the student explain and understand the subject? Did they put their work in a broader context? Was the talk intelligible? If presenting a research project: Were the methods used clearly explained and justified? Were problems discussed and dealt with appropriately? Were suggestions for future work relevant and practical? **(Marks out of 40)**
3	**Ability to deal with questions**
	Did the student answer the questions raised in a clear and concise manner? Did the answers reveal a good understanding of the project and its wider significance? (**Marks out of 20)**
4	**Did the student keep to time?**
	(**Deduct 5% for going 5 mins over and 10% for going 10 mins over)**
	Overall mark out of 100

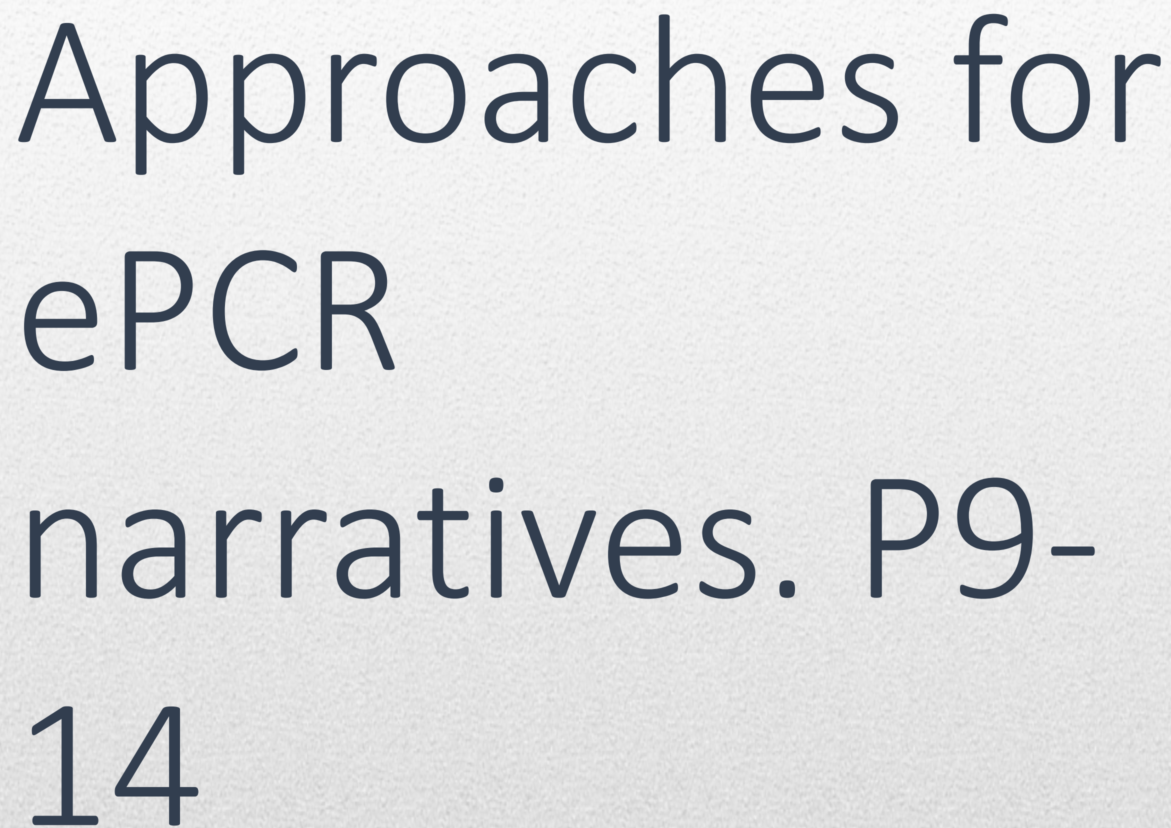
Additional comments:

Marking scheme

Mark the individual points on the marking sheet (above) out of either 40 or 20, as indicated.

%	Mark / 40	Mark / 20	Note to guide examiners
80-100	**32-40**	**16-20**	An outstanding answer. An innovative, professional piece of work showing a deep understanding of the question, comprehensive knowledge of and engagement with the relevant literature, and significant critical insight. Very well organised, argued, written and presented. English grammar and spelling should be of a high standard.
70-79	**28 - 31.6**	**14 – 15.8**	An excellent answer. An original piece of work showing a very good understanding of the question, a comprehensive knowledge of and engagement with the relevant literature, and considerable critical ability. Well organised, argued, written and presented – includes all the key points and no significant errors. English grammar and spelling should be of a high standard.
65-69	**26 – 27.6**	**13.8**	A very good answer. A well organised and well-presented comprehensive piece of work, demonstrating a clear understanding of the question and presenting a good number of corrects facts, with no significant errors. Shows a familiarity with and grasp of the relevant literature, and contains critical discussion in some depth. English grammar and spelling should be of a good standard.
60-64	**24 – 25.6**	**12 – 12.8**	A good answer. Generally a well organised and presented piece of work, demonstrating a clear understanding of the question and presenting a good number of correct facts, with no significant errors. Shows familiarity with the relevant literature, and contains critical discussion in some depth. However, evidence of one of the following may mean it falls short of a higher mark: organisation or presentation may have slipped in parts, a few relevant details may have been missed out, a lack of critical ability or insufficient grasp of the relevant literature may be demonstrated in places. English grammar and spelling should be of a good standard.

55-59	**22 – 23.6**	**11 – 11.8**	A reasonable answer. Demonstrates a reasonable, general understanding of the question, presents a good number of correct facts, and is undoubtedly sufficient to pass. However, one or more of the following may mean it falls short of a higher mark: it may not be sufficiently well organised, argued and presented, it may lack detail in places, show a lack of critical ability or insufficient familiarity with the relevant literature. English grammar and spelling should be of an acceptable standard.
50-54	**20 – 21.6**	**10 – 10.8**	An adequate answer. Has mostly understood the question, presents a good number of correct facts, and is sufficient to pass. However, is not sufficiently well organised, argued and presented, shows a lack of critical ability or insufficient awareness of the relevant literature, lacks detail in places, and may contain a couple of significant errors. English grammar and spelling should be of an acceptable standard.
40-49 Fail	**16 – 19.6**	**8 - 9.8**	An inadequate answer. Has mostly understood the question and includes a barely adequate number of relevant facts, but contains superficial information, lacks critical discussion and awareness of the relevant literature, and shows poor judgement about what is important. Contains a number of significant errors, presentation and expression are muddled.
0-39 Fail	**0 – 15.6**	**0 – 7.8**	A poor answer. Has not grasped the question set and has little understanding of the subject/core concept. The work is confused, unacceptably brief, has numerous errors, serious omissions, poor presentation, no judgement about the balance of what is important and what is trivial.



Approaches for ePCR narratives. P9-14

EMS Clinical Practice courses

Quality assurance for Paramedic Documentation

9/5/2019

Scenario
Ambulance-1 was dispatched to a residence for a 76-year-old male complaining of chest pain. Ambulance-1 responded emergent and arrived on scene without incident. Upon arrival, the patient was found sitting upright in a recliner in the living room with his wife present. The patient states he began having substernal chest pain at approximately 0730 along with pain radiating down his left arm, rating it as 7/10 chest pain. Per dispatch instructions, he took 325 mg of aspirin. The patient appears normal in color with acutely moist skin and no signs of obvious respiratory distress. His past medical history only includes a prior hip surgery and hypertension, with related prescriptions. The patient was taking all of his prescription medications this morning.

Can you imagine walking through the front door to find this patient sitting on a recliner? This is just the start of a story, not the entire narrative. This narrative adequately describes the patient

Common patient care narratives
SOAP, CHART single paragraph (and only a single paragraph) and chronological are common formats for patient care.

SOAP narrative

SOAP narratives often take the shape of four distinct paragraphs that start with an identifier like "S" or "Subjective," which helps to indicate that you're following a SOAP format.

The **Subjective** portion of the narratives includes history of the incident. What you're told, how the patient describes their symptoms, dispatch information and your perception of the scene. **Objective** comments are then added in, which include your assessment findings, vehicle damage observations, patient positioning, vital signs and other non-opinionated facts.
Your differential diagnosis, then takes form in the **Assessment** section, which basically outlines what you believe you're treating or ruling out.

Lastly is the **Plan** portion of the narrative, which depicts what you did to treat your patient. Establishing an IV, giving medications, relaying what was done prior to your arrival and what you did on-scene versus in transport.

CHART narrative

CHART narratives also follow a visual layout based on the letters in the acronym.
Starting with the chief **Complaint**, the **History** of the present illness, along with the patient's past medical history, is outlined.
Assessment findings are then documented, along with **Rx** (prescriptions) that the patient is prescribed.

Lastly is the **Treatment** section, which outlines what you've done for your patient, much like the plan section on SOAP.

ICHART is used for EMS documentation.

I	Incident • Brief details of the incident, including location and reason for dispatch • Time on scene and location of patient • How the patient was found
C	Chief Complaint (Cx) • Patient's age, gender and chief complaint • Documenting sources of information from family members, friends or bystanders with quotation marks • Reason EMS was called
H	History (Hx) • Brief history of events leading to the incident • Mechanism of injury (MOI), if applicable • SAMPLE
A	Assessment (Ax) • AVPU and OPQRST • Important findings and results of physical exam • Vital signs
R	Treatment (Rx) • List of treatments in chronological order
T	Transportation (Tx) • Why the patient required transportation by ambulance • Where the patient was transported and if any changes were noted en route

ICHART Example

(Ix) M9312 Dispatched to a private residence for a medical aid. U/A at 1325, pt sitting on the couch in a tripod position. Pt's spouse standing next to him.

(Cx) 65 Y/O M C/O of tightness in Cx and SOB. Pt's spouse states, "John was mowing the lawn when he started to clutch his Cx and complain of not being able to breathe." Pt states, "The pain is getting better, but my Cx feels tight and I can't seem to catch my breath."
(Hx) Pt states, "I felt a sharp pain in my Cx and couldn't breathe, so I stopped what I was doing and came inside to sit down." Pt C/O Cx tightness and SOB. (-) to any numbness or tingling. Not taking any Rx other than OTC multivitamins qdx1. Allergic to Penicillin.

(Ax) Appx. 1330, B/P 140/100, P 72, RR 23. Skin is pale, cool and diaphoretic. HEENT: C/O dizziness, (-) ear, neck, throat or eye pain. No evidence of trauma. Cx has equal rise/fall, L/S clear bilaterally, C/O dull chest pain. The pain started when pt was mowing the lawn and feels sharper when pt breathes in. Pain is otherwise dull and radiates out to entire Cx. Pain is 6/10 and started at appx. 1315. Abd is soft, non-tender and no masses. Pelvis is intact and no pain.

(Rx) Appx. 1331, pt placed on 02 @ 15lpm via NRB and IV 18G to L AC. Administered ASA 162mg chewable PO, NTG 0.4mg SL, and NTG ointment 1″ to L Cx. ECG Sinus tach @ 101 and stable. Pt transferred from couch to gurney with assistance and Tx to ACME Medical Center. Pt's spouse followed in POV.

(Tx) Emergency Tx was necessary because pt is suspected to have a possible MI. Contacted ACME Medical Center to notify them of pt's arrival and condition. No changes to pt's condition en route. Pt care was transferred to Jane Doe, RN at ACME Medical Center at appx. 1358.

A single paragraph

The entire patient encounter is summarized into a single paragraph, often five to six sentences long. *Thus, in terms of today's documentation standards for quality assurance and reimbursement, simply isn't enough.*

Chronological narrative

Chronological narratives focus on outlining the call as things happened. To keep the documentation visually appealing and readable, sections are often broken into different paragraphs to denote a change in environment.

Starting with your dispatch notes, response findings and initial patient impression, you can then build into your next paragraph, which includes your on-scene events.

On-scene (next paragraph), document what you performed, what the patient told you about their condition and history, what injuries you assessed and what your overall differential diagnosis of the patient is.

Based on those findings, you then decide to transport your patient (next paragraph) and begin to outline your "in ambulance" events. This section may be fairly short, as the time between the home-to-ambulance, then ambulance-to-transport may only be a few minutes. In any event, this

is the appropriate area to document what you did prior to transport, how the patient's condition changed from one scene to the ambulance and what any other pertinent scene findings may include.

On scene, vitals were assessed. IV access was obtained and a 12-Lead ECG reveals a sinus rhythm with ST-elevation noted in leads V2, V3 and V4. An anterior-wall infarction is suspected and defibrillation pads are placed on the patient, per protocol. The patient's shirt is removed and left on the scene with his wife. Lung sounds are clear bilaterally in all six fields. Nitroglycerin was considered, but not administered due to the patient's systolic blood pressure only being 110 mm Hg, along with the patient's recent prescription intake of metoprolol. SpO2 values were in the upper 90s, so oxygen was not delivered, per protocol.

In transport (next paragraph) you continue your secondary assessment, intervention follow-up, and description of new actions on your way to the hospital. Medications administered, changes in patient condition, and any new findings are all documented.

The patient was briefed on our findings and advised that transport to the closest cardiac-appropriate facility was recommended, and he agreed. City Hospital is contacted via phone with a Cardiac Alert and advised of a 10 minute ETA; no further questions were asked by the ED. The patient was able to stand with assistance and pivot onto the EMS cot. He was secured in a semi-Fowler's position of comfort and transported to the ambulance.

In the ambulance, the patient had no deterioration in initial status. His chest pain remained at 7/10 and no new symptoms were present. Emergent transport was initiated to City Hospital.
In transport, fentanyl was administered for pain management. A second IV was established and maintained at TKO. The patient's wrists were shaved of excess hair and the patient's shoes and pants were removed. The patient began to complain of new-onset nausea, so ondansetron was administered as an anti-emetic. The patient's skin remained normal in color and moist. No significant changes were noted in the patient's blood pressure or SpO2 levels. The patient's pain level decreased to 4/10 after fentanyl administration.

Repeat 12-Lead printouts reveal no new findings or changes. ETCO2 values were within normal limits and a capnography print-out revealed a normal box/plateau waveform. The patient remained otherwise calm and was explained, some potential courses of action that he may encounter while at the hospital.
Narratives, overall, don't need to be redundant. All vital signs don't need to be documented in the narrative, nor do all patient prescriptions or history findings. But findings that require your follow-up action do need to be documented. If the patient's blood pressure is low, then it's appropriate to document "96/42 mm Hg" in the narrative, followed by the fact that you started and IV and administered a 500 mL normal saline fluid challenge.

As you arrive at the hospital (new paragraph), you continue or discontinue some of your initial interventions, then transport your patient into the emergency department. The patient is transferred to the emergency department bed and you complete your hand-off report. Necessary information is relayed, and you return to your ambulance with your necessary paperwork and crew.

Upon arrival at the ED, the patient was lifted from the EMS cot to the ED bed by EMS and ED personnel. Patient information was then relayed to the ED Physician and RN staff, and care was transferred.

As an addition to any form of narrative, it may be appropriate to add a disclaimer section that notates other various actions or findings from your call. What items were left with the patient at the hospital, who signed your HIPAA/privacy and billing documents and any time discrepancies that may be noted can also be explained in this section.

HIPAA/billing documents were signed by the patient and a Notice of Privacy Practices form was left with the patient at the ED. Patient belongings, including shoes, pants, wallet and watch, were left in the ED room in the patient belongings bag provided. Some documented times may be approximate and dispatch/report times may not be synchronized.

Own the report

Lastly, own and take pride in your report. Sign your narrative so that it is easily identifiable that you wrote it rather than relying on what the computer-generated portion assumes. Signatures may include your initials, your first and last name, a combination, your employee/license number or your provider level.

Weekly discussion

Assigned faculty & students responsibilities:

i) Initiate **reflective session** with students to discuss their clinical experience covering the followings example:

1. How did the student feel about their assigned clinical site?
2. How did the student feel about their assigned preceptors?
3. What did they like the most about their previous shifts?
4. What did they hate the most about their previous shifts?

- These questions are example that can be used, although assigned faculty can use his own questions to sense how the student felt about their shifts, keeping in mind the follow-up questions.
- Student will not be scored on this session; however, the assigned faculty have to facilitate a better outcome in term of their learning process and **must submit a feedback to the main assigned faculty (i.e., AA) about this session.**
- The session is not required to be initiated each week for the same clinical site (e.g., KKUH 2 times out of 4 shifts)
- ***Session will last around 10-30 minutes.***

ii) Endorsement session. **(4 marks)**

- See below an instruction on how the endorsement should be giving.
- The session should be performed **each other week**, followed by brief discussion (*if any*)
- This session will be marked by the assigned faculty and continued reporting to the main faculty (AA).
- ***Session will last around 30 minutes.***

iii) Clinical case presentation session. (**marked by effort not quality; 2 marks)**

- Student must perform a provisional presentation (10 minutes long) during this course which will be verbally marked by the assigned faculty.
- The presentation should be about a case that the student encountered.
- The assigned faculty, *preferably*, can report back to the main assigned faculty (AA) of the student weaknesses, to, perhaps, implement workshops to improve their skills.
- Encourage students to ask their peers questions during their presentation.
- This session can be divided per student as assigned week, which means that not all students have to present on the same day.
- ***Session will last 20 minutes.***

iv) Think like a researcher session. **(marked by effort not quality; 4 marks)**

- Student must come up with **two** possible research questions during this course to be discussed during the weekly meeting, supervised by the assigned faculty.
- The research questions have to be extracted from cases the student encountered during this course.
- The research idea needs to be supported by **method (make it simple), rational, gap and possible outcomes**.
- The assigned faculty **can** support the student performing this task.
- See below for illustrated format to be marked for each student.
- ***Session will last 30 minutes.***

v) Open discussion with student about encountered cases / Q&A session.

- This session has to be performed each week
- Student must participate with at least one cases
- Assigned faculty have to help facilitate the discussion.

The assigned faculty can facilitate the session based on personal preference.
e.g., For example, mixing up two session in one

Reflecting Session

Section: **Instructor:**
Clinical site (e.g., KKUH): **Date:**

Based on the reflecting session with your students**, please fill out the following questions:**

Section 1: Clinical site

What are the pros and cons of the clinical site, based on the student's feedback?

Pros:

………
………
………

Cons:

………
………
………

Area of improvements:

………
………
………

Other comments:

………
………
………

Section 2: Clinical preceptor

How was the student experience regarding to their assigned preceptor?

Strength:

………

………

………

Weaknesses:

………

………

………

Other comments:

………

………

………

Assigned Faculty:

Signature:

Date:

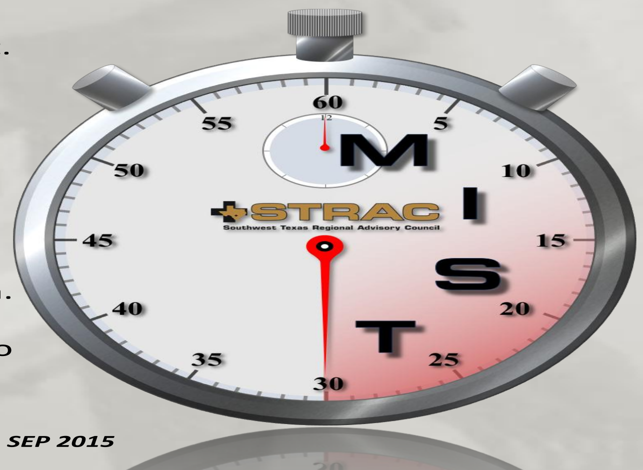
How to be good at endorsement

Regional EMS Time Out Report

M	Age/Sex, **Mechanism** or **Medical** Complaint	Age, Sex (include patient's name for handover), Mechanism of Injury or Medical Complaint/History
I	**Injuries** or **Inspections**	Time of Injury, list injuries head to toe; or Inspections (time of onset, brief medical exam/findings)
S	Vital **Signs**	Vital signs: first set and significant changes; include glucose.
T	**Treatment**	Treatment

Give EMS 30 seconds, we'll tell you everything you need to know!

- ❑ Receiving Nurse will call "EMS Time Out" when EMS arrives with patient.
- ❑ Trauma Alert, Heart Alert, & Stroke Alert Patients will remain on the stretcher during report ('Non-Alert' Patients may be moved to the gurney if the nurse is not present to receive report).
- ❑ EMS has ***30 seconds*** to provide report.
- ❑ Nurse will document report on Regional EMS Time Out Report form.
- ❑ Patient will be moved to the gurney.
- ❑ Nurse provides registration sticker to EMS.
- ❑ Patient Transfer of Care (TOC) completed.



Version 7; SEP 2015

Using IMIST-AMBO during clinical handover

The IMIST-AMBO model was selected by a Standardised Handover Protocol working group, compromising of sector representation, for use by health services and Ambulance Victoria (AV) when communicating clinical handover of ambulance patients in the ED.

The model includes:

- **I** – Identification (e.g. patient's name, age, sex)
- **M** – Mechanism of injury or Medical complaint (e.g. presenting problem, how it happened)
- **I** – Injuries or Information related to the complaint (e.g. symptoms and/or injuries)
- **S** – Signs (e.g. vital signs, such as HR, RR, BP, Temp, BGL, GCS, etc.)
- **T** – Treatment and Trends (e.g. treatment administered and patient's response to treatment, trends in vital signs)
- **A** – Allergies
- **M** – Medications (e.g. patient's regular medications)
- **B** – Background history (e.g. patient's medical history)
- **O** – Other information (e.g. social, scene, relatives present, EAR result).

Ambulance paramedics are asked to:

- Review handover details pre-arrival
- Remain with the patient during handover
- Reach agreement with the ED clinician on 'ambulance handover complete'
- Enter agreed time in VACIS.

Hospital staff are asked to:

- Ensure staff are available for handover
- Provide a suitable handover environment
- Agree on 'ambulance handover complete' time
- Acknowledge and accept responsibility for the patient
- Enter agreed time in VEMD.