Committee on Accreditation for the Emergency Medical Services Professions

When Is It a Team Lead? Variations on a Theme: What, Why, When, Where, How (many), and Who

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The Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) continues to explore the nuances of 'when it is a team lead' and 'how may team leads do we need'? Both may appear to have simple answers but clearly do not.

The *WHAT*:
Team leads are a **capstone** component. Capstone refers to a culminating student experience in which students apply the concepts that they have learned to solve real-life problems. It is an opportunity for students to demonstrate that they have achieved the terminal goals for learning established by their educational program and to demonstrate entry level competency in the profession. The CoAEMSP Policies and Procedures Manual define a capstone experience as: "Activities occurring toward the end of the educational process to allow students to develop and practice high-level decision making by integrating and applying their Paramedic learning."

The primary goal of a Paramedic program is to produce a competent, entry-level practitioner in all three domains of learning: cognitive, psychomotor, and affective. So the question becomes: How is this determined? Certainly final, summative, cumulative evaluations/examinations are key. These usually occur in the classroom environment. But the field environment, and how the student performs in the real-time patient care setting, is critical. The final crucible is the evaluation of the Paramedic student responding to all types of patient complaints under the supervision of a carefully selected, seasoned Paramedic preceptor. During the team lead phase, the preceptor is the one who deems the student capable of leading the EMS responder team in the assessment and management of a variety of patient types/complaints/calls. The preceptor observes and evaluates, and only offers advice or suggestions if crucial errors or omissions occur. The student is 'in charge' and demonstrates the knowledge, skills and attitudes to manage any call to which the unit is dispatched. During this phase the emphasis shifts from assessing the student's individual skill competency to assessing his or her ability to manage the entire scene and patient. It is not necessary for the student to perform all the skills, or any individual skills, outside of assessment. However, he or she must be the main person responsible for the choreography of the scene and direct all patient care.

The definition of a "successful team lead" is important for the program to define and teach to students and preceptors so that there is consistency in evaluation. The Psychomotor Portfolio Competency Project (PPCP) developed by a group of educators brought together by National Registry of EMTs and endorsed by CoAEMSP also provides a description of the expectations of the team lead experience with the Field Shift Evaluation Sheet: "**Team Leadership Objective**: The student has successfully led the team if he or she has *conducted a comprehensive assessment* (not necessary performed the entire interview or physical exam, but rather been in charge-of the assessment), as well as *formulated and implemented a treatment plan* for the patient. This means that *most* (if not all) of the *decisions* have been made by the student, especially formulating a field impression, directing the treatment, determining patient acuity, disposition and packaging and moving the patient (if applicable). Minimal to no prompting was needed by the preceptor. No action was initiated/performed that endangered the physical or psychological safety of the patient, bystanders, first responders or crew." The

Evaluation sheet identifies the highest rating as a: **2** - Successful/Competent no prompting. The NREMT Portfolio Project is part of the planned transition to a scenario based practical.

Does the EMS call have to be considered as Advanced Life Support (ALS) to count as a team lead? Opinions vary, but probably ALS classification is not necessary for all team leads, and indeed can be contrived by adding an IV start or obtaining an EKG. Responses that are considered Basic Life Support (BLS) often involve assessing and managing patients with complex medical problems and can be rich learning experiences. It often requires advance leave assessment skills and the application of knowledge to determine whether a call is truly BLS or ALS. A variety of ALS calls are obviously important but team leads should not exclude those situations that required a detailed assessment and application of critical thinking skills. However, inter-facility transfer calls do not typically meet the assessment and management criteria: for example transfers from a nursing home to a hospital or from one acute care facility to another. There are exceptions, but the primary goal of the field internship is response in a 911 system.

In summary, the *What* and *WHY*:
Team leads should be a capstone component and should provide the field preceptor and the program faculty the opportunity to adequately evaluate the competency of the soon-to-be graduate.

***WHEN* can this capstone experience occur?**
The CoAEMSP recognizes that some programs institute field rides early in the academic schedule and therefore allow for both *field experience* and *field internship*. In the healthcare environment, internships typically occur *after* the completion of the initial course of study. Internships provide the opportunity to apply the knowledge, skills and attitudes acquired. The CAAHEP *Standards and Guidelines* for the profession include in the Guideline language regarding the curriculum, "*Enough of the field internship should occur following the completion of the didactic and clinical phases of the program to assure that the student has achieved the desired didactic and clinical competencies of the curriculum prior to the commencement of the field internship. Some didactic material may be taught concurrent with the field internship."* The capstone team leads occur during this internship period.

To differentiate the two types of field experiences, the CoAEMSP *Policies and Procedures Manual* provides the following definitions:

Field experience: Planned, scheduled, educational student time spent on an advanced life support (ALS) unit, which may include observation and skill development, but which does not include team leading and does not contribute to the CoAEMSP definition of field internship. This experience focuses on the student's progression from attaining competency in individual skills (i.e., intravenous therapy, patient assessment, history taking, medication administration) to managing the scene, the patient, and other team members.

Field internship: Planned, scheduled, educational student time on an advanced life support (ALS) unit to develop and evaluate team leading skills. The primary purpose of the field internship is a capstone experience managing the Paramedic level decision-making associated with prehospital patients.

These definitions can be found here.

The next element is *WHERE*?
Team leads must occur in a 911 response system. As mentioned previously, while inter-facility transfer calls may be handled by any agency, only non-transfer calls may generally be precepted as team leads.

A word on the *When* of sequencing: It is tempting to initiate field rides early in the curriculum for a variety of reasons. For example, it may be easier to schedule the required hours or students desire to get to the goal environment early ('the field'). However, never lose sight of the goal of the field internship: it is a culmination of all the learning that has proceeded: classroom/didactic, laboratory, and the hospital/other clinical environments. The student should possess the knowledge, skills and attitudes to address any clinical issue presented. This includes all

types of complaints, conditions, or age groups. So for example, all of the pediatric, obstetric, and geriatric portions of the curriculum should be complete prior to team leads that are documented as part of the minimum required number.

***HOW* should team leads occur?**
Students and preceptors must be provided with specific objectives. Students should be assigned to a ***single*** (best case scenario) or a limited number of preceptors to provide an optimal environment for growth and evaluation. Evaluation tools should be specific and measurable.

And finally *WHO* should precept team leads?
Ideally, preceptors should be selected by joint agreement of the Program Director or Clinical Coordinator and the EMS agency. You may also wish to include the Medical Director in this process. Preceptors should meet some level of field experience (for example one, two, or more years), be willing to precept students, and must receive training/orientation by the Paramedic program.

A frequent question is also 'how many team leads are acceptable?' Programs are left to determine the minimum number of successful team leads required based on: input from the various communities of interest (for example the Program Advisory Committee, employers, the program Medical Director, and the faculty; evaluation of student competencies; and other programmatic assessment of successful outcomes). The number, however, cannot be based on 'that's all we can get.'

Research data from one of the commercially available tracking systems provides a valuable insight to current practices. For the most recent three (3) year period, FISDAP reported on 12,548 completed paramedic students. The mean number of team leads was 54 and the median number was 51. Tracking/documentation often involves self-reported/student entered data and of course the definition/parameters established by each program. However, this information provides a useful view into current practice.

Various current research studies support these recommendations. Below is a summary of abstracts published in the FISDAP Research Summit findings.

The Effect of Paramedic Student Internship Experience on Performance on the National Registry of Emergency Medical Technicians Exam; 2006. Salzmann, Dillingham, Kobersteen, Kaye, Page.

> Conclusions: The number of ALS runs students completed was the strongest predictor of passing the NRE-W. Paramedic programs may want to evaluate the number of ALS runs and total patient contacts their students are currently completing.

A Chance to Lead: Does Having Fewer Paramedic Preceptors Result in More Student Leadership? 2006. Page, Larmon, Howey.

> Conclusions: Working with fewer preceptors increases the encounters paramedic student leads. Paramedic programs may want to consider having their students establish a relationship with one primary preceptor.

Paramedic Student Internship Experience, Critical Thinking, and NREMTCE Success – Phase One: Do Students With More ALS and Team Lead Experience Perform Better on Critical Thinking Questions? 2009. Soucheray, Briguglio, Howey.

> Conclusions: There is a relationship between paramedic student internship experience and a students' critical thinking ability. More research is needed to determine whether this relationship is affected by other variables such as student motivation and educational methods.

When is a Paramedic Student a Competent Team Leader? 2012. Widmeier, Washick, Dinsch, Cage, Mayne, Asche.

> Conclusions: the standard of success in 18 out of the last 20 attempted team leads is a reliable predictor of continued student competency. Students may need more than the previously recommended 50 attempts to reach competency so programs should provide for sufficient team leadership opportunities.

The CoAEMSP will continue to analyze tracking and student success data and other metrics associated with student and program success as program standards are reviewed and revised to achieve the primary program goal: To prepare competent entry-level paramedics in all three domains of learning: cognitive, psychomotor, and affective.