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Clinical and Field Internship Sites

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High quality clinical and field internship sites are like rare minerals: sometimes hard to find, must be mined carefully, and should be guarded jealously. Obviously, all sites are not created equal. According to the *Standards and Guidelines*, through a combination of sites/experiences, the students shall "have access to adequate numbers of patients, proportionately distributed by illness, injury, gender, age, and common problems encountered in the delivery of emergency care…" One of the first things a new program must determine in a feasibility study is whether adequate clinical and field resources are available in the local area. For that matter, any program contemplating its continuing existence asks the same questions.

An emerging trend for some programs is to send students out of the region, or even out of state, to satisfy these experiential requirements. Whatever your approach, there are some questions to consider. How will your program orient key hospital and other clinical experience personnel to: the purposes of the student rotation; program evaluation tools; criteria for evaluating/grading; and contact information for the program? How will your faculty assess the quality of the clinical experience? How will your faculty determine if the student has developed the desired competencies? Are you only evaluating numbers or are you evaluating the *quality* of the student experience? Documentation that *all* students meet the required minimums set by the program for assessments of the various types of patient complaints and skill interventions is required. However, numbers alone do not determine competency. Also, if your students are traveling, is your student licensed or certified in the out-of-state rotation to perform the skills required in the program? And is there a medical director, with a license in that state, who is taking responsibility for this student? Does your program worker's compensation and liability insurance cover the student in this circumstance?

Additional challenges present when students complete a field internship in an out-of-state location. Additional training for preceptors is required by the *Standards,* beyond what is provided for hospital clinicals. What is your relationship with the agency? How does the program select an appropriate preceptor? How does the program determine competency? Have you abdicated all responsibility for assessing competency to a preceptor that you have never met?

The focus of the clinical experience is shifting from a specific location to include locations that can meet the rotation goals and objectives. The *Standards and Guidelines* identify seven locations for hospital/clinical affiliations. Of course, the emergency department and labor and delivery will be standards. But, for example, pediatric patients may be encountered in an emergency department, a pediatric clinic, a pediatrician's office, or other venue and not necessarily a rotation on a pediatric unit. Programs may be creative about where students get the experience but the program must insure that it is a *quality* experience. The controlled clinical settings offer ideal opportunities to: perform patient assessments; develop patient

interviewing and communication skills; and practice isolated skills such as medication administration, intravenous insertion, and airway management. Experience in the clinical setting usually provides 'pieces' while the field internship provides the 'whole'.

The field internship is a capstone experience. A capstone course offers the student nearing graduation the opportunity to summarize, evaluate, and integrate their previous coursework. In addition, student work needs to be evaluated by faculty members responsible for the program, not just the preceptor. The purpose of the field internship in the paramedic program is to provide the opportunity to assess and manage all types of calls and develop experience team leading. In other words, to pull the knowledge obtained in the classroom, skills lab, and clinical areas together to assess, manage, and treat all types of patients in the prehospital setting. The obvious dilemma for a program, especially one with limited staffing/faculty, is how to effectively provide the supervision and sequencing that truly makes this a capstone experience. At a minimum the following is required.

1. Careful selection of field precepting agencies
2. Careful matching of the preceptor and the student
3. Adequate preceptor training
4. Meaningful daily/shift evaluation by the preceptor with verbal and written feedback to the student
5. Review of patient care reports by a faculty member with feedback to the student
6. Milestone, summative evaluations by the preceptor: after a specified number of hours or shifts or patient encounters. This type of evaluation summarizes the student progress to date, based on where they are in the program, not just on a given shift.
7. Final summative evaluation of the student by the preceptor
8. Periodic communication between a program faculty member and the preceptor
9. Periodic meeting and progress review with a faculty member and the student

Each of the four components of a paramedic program is vital to student success: the classroom or didactic portion, the skills laboratory, the clinical settings, and the field internship. And equal focus must be placed on content, delivery, and monitoring student progress in each of these areas.

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