SECTION 2
PRIMARY CARE PARAMEDICINE
CLINICAL DOCUMENTATION
COMPLETION REQUIREMENTS

Quick Reference

Introduction to PCP Clinical Documentation

During the clinical session, the student is responsible for maintaining accurate records of patient contacts as well as skills performed. Medavie HealthEd has moved to a computer-based competency attainment tracking system, through Great Big Solutions based in Edmonton Alberta. Great Big Solutions will provide technical support to all users and may be contacted via one of the following methods:

Phone: Toll free – 1-866-432-3280
E-mail: support@studentlogbook.com
Online Support: Log on to www.studentlogbook.com and log in, then click the Support link and submit the case.

Great Big Solutions indicates they will respond to requests within two business days guaranteed. The office hours for Great Big Solutions are Monday to Friday 9 am to 5 pm (Mountain Standard Time). They are three hours behind us in Atlantic Canada.

Moving to the computer based tracking of competencies provides the school with an electronic version of those competencies a student is required to obtain to graduate from their program.

The school endeavors to provide a consistent and fair evaluation process for students in the PCP program. As the student transitions into the practical, live patient care environment, we seek input from preceptors on how well our students are performing the competencies they were taught in school. To aid in this process, the school provides the preceptor with a Preceptor Manual, which can be found on our website. It contains the Essential Skills Manual used to evaluate the students in the schools lab setting, as well as excerpts from the National Occupational Competency Profile. The preceptor and student are expected to reference these documents, anytime there is a question as to how a student performed a competency; the goal is to ensure the student is being fairly evaluated based on what they were taught in the class/lab setting.

It should be noted, that these evaluation tools represent an extremely important component of student clinical experience therefore care must be taken in completing them.

Incomplete Documentation

Failure to complete the required documentation will result in the student completing further hours in the required setting.

The student is strongly encouraged to ensure their assigned preceptor completes all required documentation before the end of their shift, with that preceptor.

If the student continually fails to pass in his or her documentation on time, they will receive an incomplete mark for the clinical and be advised that they will be required to complete more clinical time. The student, after receiving an incomplete will then be placed on academic probation. A learning contract will be written which will clearly outline the completion requirements and consequences of not completing them. Any costs that occur due to this extra time will be absorbed by the student.

Based on policy a student will be provided an allotted timeframe to complete their clinical placement. Failure to complete the clinical rotation in the allotted time can result in an incomplete grade. The student will fail to graduate and a diploma will not be awarded. A fail mark during clinical placements will require the student to re-enroll in the PCP program if they wish to successfully complete the program.

Performance Environment's

Based on the National Occupational Competency Profiles for Paramedic Practitioners, October 2011 developed by the Paramedic Association of Canada, "The Performance Environment specifies the setting in which the practitioner must demonstrate competence." The Performance Environment for the clinical setting is identified with a "C". (See table below) The clinical environment is a setting where the student is able to provide care to an actual patient who is seeking care in one of the following settings: hospital, health clinic, medical office, nursing home or other clinical setting where the competencies for the clinical performance environment may be obtained. It is important to note that **simulated situations cannot** be used for obtaining competencies in the clinical setting.

Area Key – Performance Environment

C	Must be evaluated in the Clinical setting for successful completion. On the Comptracker program an * indicates what competencies are mandatory in the clinical setting.
P	Must be evaluated in the Ambulance Practical setting for successful completion. On the Comptracker program an ***** indicates what competencies are mandatory in the practicum setting. Competencies identified as "C" that are not obtained in the clinical setting may be obtained in the ambulance practicum setting, but not vice-versa.
S	May be evaluated through a scenario based format
X	Student has awareness of but evaluation is not required
N	Does not apply to the students scope of practice

Defining and Evaluating Proficiency

The Evaluation tools under Clinical Preceptorship are designed to allow the preceptor to evaluate the student during the clinical experience based on the National Occupational Competencies Profile (NOCP) guidelines.

"The Paramedic Association of Canada Board of Directors has approved the following definition of proficiency: Proficiency involves the demonstration of skills, knowledge and abilities in accordance with the following principles:

- Consistency (the ability to repeat practice techniques and outcomes; this requires performance more than once in the appropriate Performance Environment)
- Independence (ability to practice without assistance from others)
- Timeliness(the ability to practice in a time frame that enhances patient safety)
- Accuracy (the ability to practice utilizing correct techniques and to achieve the intended outcomes)

- Appropriateness (the ability to practice in accordance with clinical standards and protocols outlined within the practice jurisdiction)

The preceptor should be familiar with the schools Proficiency Evaluation Key (See table below) before completing the evaluation forms. Individual competencies will either be approved or not approved by the preceptor. The preceptor may also reference a complete listing on Essential Competencies and their sub-competencies found in the Preceptor Manual.

In the clinical setting, the students will be evaluated based on individual skills only and not overall patient care. Therefore, the students will be evaluated on their ability to perform individual competencies based on the National Occupational Competency Profile.

Proficiency Evaluation Key

√	Approved – means the student was able to perform the competency on an appropriate call.
X	Not Approved – means the student was not able to perform the competency on an appropriate call.

Note: When a preceptor indicates an individual competency is not approved they will be prompted to give a reason for not approving that competency.

Clinical Objectives/Learning Requirements

The student will be required to enter a number of different clinical environments, each with a set number of minimum hours, to obtain their clinical competencies. If a competency is not obtained in the clinical environment, the student may be required to complete extra hours or obtain that competency in the ambulance practicum. The student is expected to attend the following clinical sites:

1) Emergency Room (minimum of 7 X 12 hr shifts) = Total 84 hrs
2) Operating Room/PACU (minimum of 8 hrs to a maximum of 16 hrs with 2 successfully managed airways) = Total 8 hrs
3) Nursing Home (minimum 1 X 8 hr sift) = Total 8 hrs
4) ICU/CCU (minimum 1X 12 hrs) = 12 hrs
5) 1 Day Surgery, if required
6) 1 Ambulatory Care, if required.

The lists of competencies a student may obtain in the clinical environment are identified in the table below. All competencies identified with an "*" must be obtained in either the clinical or practicum environment, by the time a student completes their program. Note all competencies require a minimum of two sign offs. **A total of 112 hrs are required.**

PCP Clinical Competencies		
1.0 Professional Responsibilities		
1.1 Function as a professional		
1.1.a	Maintain Patient Dignity	P
1.1.b	Reflect professionalism through use of appropriate language	P
1.1.d	Maintain appropriate personal interaction with patients. 2011	P
1.1.e	Maintain patient confidentiality.	P

3.0 Health and Safety		
3.1 Maintain good physical and mental health		
3.1.e	Exhibit physical strength and fitness consistent with the requirements of professional practice	P
3.2 Practice safe lifting and moving techniques		
3.2.a	Practice safe biomechanics	P
3.3 Create and maintain a safe work environment		
3.3.e	Conduct procedures and operations consistent with Workplace Hazardous Materials Information System and hazardous materials management requirements.	A
3.3.f	Practice infection control techniques	P

4.0 Assessment and Diagnosis		
4.2 Obtain patient history		
4.2.a	Obtain list of patient's allergies.	P
4.2.b	Obtain patients medication profile. 2011	P
4.2.d	Obtain information regarding patient's past medical history.	P
4.2.e	Obtain information about patient's last oral intake.	P

4.3 Conduct complete physical assessment demonstrating appropriate use of inspection, palpation, percussion & auscultation, and interpret findings		
4.3.a	Conduct primary patient assessment and interpret findings.	P
4.3.b	Conduct secondary patient assessment and interpret findings.	P
4.3.n	**Conduct pediatric assessment and interpret findings 2011**	**C**
4.3.o	Conduct geriatric assessment and interpret findings 2011	P
4.3.p	Conduct bariatric assessment and interpret findings 2011	A
4.4 Assess Vital Signs		
4.4.a	Assess pulse.	P
4.4.b	Assess respiration.	P
4.4.c	**Conduct non-invasive temperature monitoring.**	**C**
4.4.d	Measure blood pressure (BP) by auscultation.	P
4.4.e	Measure BP by palpation. 2011	S

4.4.f	**Measure BP with non-invasive BP monitor.**	**C**
4.4.g	Assess skin condition	P
4.4.h	Assess pupils.	P
4.4.i	Assess Level of consciousness. 2011	P
4.5 **Utilized Diagnostic Tests**		
4.5.a	**Conduct oximetry testing and interpret findings.**	**C**
4.5.c	Conduct glucometric testing and interpret findings.	P
4.5.d	Conduct peripheral venipuncture. 2011	A
4.5.m	Conduct 3-lead ECG and interpret findings. 2011	P
4.5.n	Obtain 12-lead ECG and interpret findings. 2011	S

5.0 Therapeutics		
5.1 Maintain patency of upper airway and trachea		
5.1.a	**Use manual maneuvers and positioning to maintain airway patency.**	**C**
5.1.b	Suction oropharynx.	S
5.1.d	Utilize oropharyngeal airway.	S
5.1.e	Utilize nasopharyngeal airway	S
5.1.f	Utilize airway devices not requiring visualization of vocal cords and not introduced endotracheally. 2011	S
5.1.i	Remove airway foreign bodies (AFB).	S
5.1.j	Remove foreign body by direct techniques 2011	A

5.3 Deliver Oxygen and administer manual ventilation		
5.3.a	**Administer oxygen using nasal cannula**	**C**
5.3.b	Administer oxygen using low concentration mask.	S
5.3.d	**Administer oxygen using high concentration mask.**	**C**
5.3.e	Administer oxygen using pocket mask.	S
5.4 Utilize Ventilation equipment		
5.4.a	**Provide oxygenation and ventilation using bag-valve-mask.**	**C**
5.5 Implement measures to maintain hemodynamic stability		
5.5.a	Conduct Cardiopulmonary Resuscitation (CPR).	S
5.5.b	Control external hemorrhage through the use of direct pressure and patient positioning.	S
5.5.c	**Maintain peripheral IV access devices and infusions of crystalloid solutions without additives.**	**C**
5.5.d	**Conduct peripheral intravenous (IV) cannulation.**	**C**
5.5.i	Conduct automated external defibrillation	S
5.5.o	Provide routine care for patient with urinary catheter.	S
5.5.p	Provide routine care for patient with ostomy drainage system.	A
5.5.q	Provide routine care for patient with non-catheter urinary drainage system.	A
EHSNS	*Use of IV pumps*	N
5.6 Provide basic care for soft tissue injuries		
5.6.a	Treat soft tissue injuries	P
5.6.b	Treat burn.	S
5.6.c	Treat eye injury.	S

5.6.d	Treat penetration wound	S
5.6.e	Treat local cold injury.	S
5.6.f	Provide routine wound care 2011	S
5.7 Immobilize actual and suspected fractures		
5.7.a	Immobilize suspected fractures involving appendicular skeleton	S
5.7.b	Immobilize suspected fractures involving axial skeleton.	P
5.8 Administer Medications		
5.8.a	Recognize principals of pharmacology as applied to medications listed in Appendix 5 2011	A
5.8.b	**Follow safe process for the responsible medication administration.**	**C**
5.8.c	Administer medication via subcutaneous route.	S
5.8.d	Administer medication via intramuscular route.	S
5.8.e	Administer medication via intravenous route. 2011	A
5.8.f	Administer medication via intraosseous route. 2011	A
5.8.g	Administer medication via endotracheal route. 2011	A
5.8.h	Administer medication via sublingual route.	S
5.8.i	Administer medication via the buccal route 2011	S
5.8.j	Administer medication via topical route.	A
5.8.k	Administer medication via oral route. 2011	S
5.8.l	Administer medication via rectal route. 2011	A
5.8.m	**Administer medication via inhalation. 2011**	**C**
5.8.n	Administer medications via intranasal route 2011	S
5.8.o	Provide patient assist according to provincial list of medications 2011	A

6.1 Integration		
6.2 Provide care to meet the needs of unique patient groups		
6.2.a	Provide care for neonatal patient.	S
6.2.b	**Provide care for pediatric patient.**	**C**
6.2.c	**Provide care for geriatric patient.**	**C**
6.2.d	Provide care for physically-impaired patient.	S
6.2.e	Provide care for mentally impaired patient.	S
6.2.f	Provide care to bariatric patient	A
6.3 Conduct ongoing assessments and provide care		
6.3.a	Conduct ongoing assessments based on patient presentation and interpret findings	P
6.3.b	Re-direct priorities based on assessment findings.	P

Completing the Electronic Forms

The following pages contain information for the preceptor, student and auditors on how to complete the electronic forms. Sample documentation includes the following:

1) Attendance Record
2) Patient Record
3) Airway Management Record
4) Preceptor Evaluation of Student (Daily/Weekly)
5) Preceptor Contact Form
6) Preceptor Assignment Form

1) Clinical Attendance Record

Completing the Documentation:

- The students attending the clinical site have a specific number of hours they must complete. The purpose of the attendance record is to track those hours.
- The student is to complete specific sections on this form, prior to the preceptor signing it. The student will complete the date, clinical site, preceptors name, start/finish times, and Total hours.
- The school staff may contact the student at anytime and request that this form be faxed to the school.
- The **preceptor** will then record the following on this form:
  - The preceptor signs or initials the form indicating the student has completed those hours. We ask that the preceptor ensure they sign this at the end of every shift.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:
  - The preceptor has signed for all the dates and hours the student has completed.
  - The student has completed all the information required under Completing the Form (above).
  - The student has completed the hours required for this component of the program. (Designated staff will check for the number of hours to be completed).

2) Patient Record

Completing the Documentation:

- When numbering the patient record start at 1 and continue until you have a total number of patient contacts for the entire time you are in any clinical setting. Eg 1, 2, 3, 4, 5, 6, 7, 8 ,9 10, 11…..50, up to your total number of patient contacts.
- This form serves at the primary evaluation tool to determine if the student is meeting the proficiency requirements based on the National Occupational Competency Profile. The preceptor uses the Proficiency Evaluation Key to rate the student on their ability to perform the competencies listed on the Patient Record Form.

- The student must be evaluated with an "approved", at least twice, on all the clinical competencies required for their program. The competencies that must be approved are those identified with a "C" on the student electronic information gathering device.

- The student will record the following on this form:
    - The patient's age and sex.
    - The patient's chief complaint.
    - Other information that is pertinent to identifying the competency the student wants to obtain. (e.g. For the NOCP regarding high concentration mask the student would have to have recorded on the Patient Record that a high concentration mask was used on the patient.)
    - The competency the student wants to be signed off on.
    - Note the student is not permitted to gather any other information on the patient, due to confidentially for the patient.

- The **preceptor** will then record the following on this form:
    - Approved or not approved for each of the competencies the student performed on that patient.
    - The preceptor then signs or initials the form, thus indicating they have evaluated the student.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:

    - The preceptor has approved or not approved and signed or initialed the competencies completed by the student.
    - The student has recorded all the information required for the competency to be signed off on the Patient Record.
    - The student was approved, at least twice, on all the clinical competencies required for their program.
    - No confidential patient information is contained on the form. Form is to contain patient's age and sex only.
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record

Note: Clinical Competencies are identified as "C's" in the NOCP Documentation, all competencies identified as a "C", must be approved minimum of twice. If a student fails to obtain the required approval at least twice they will be required to complete more hours to obtain those competencies; or to obtain the competencies in the ambulance practicum "P" setting.

3) Airway Management Record

Completing the Documentation:

- When numbering the patient record start at 1 and continue until you have a total number of patient contacts for the entire time you are in any clinical setting. Eg 1, 2, 3….. 4, up to your total number of patient contacts in this setting.

- This form serves as the primary evaluation tool for Airway Management; which will take place in an operating room (OR) or post anesthesia care unit (PACU) setting. It is used to determine the student's ability to meet the Proficiency requirements based on the National Occupational Competency Profile. The preceptor uses the Proficiency Evaluation Key to rate the student on their ability to perform the competencies listed on the Airway Management Form.

- The student must be evaluated with a minimum score of approved, at least 2 times during the OR/PACU experience.

- The student will record the following on this form:
  - The date and Patient number (which may be obtained from the Patient Record, should the student be performing these skills in another setting other than the Operating Room).
  - Patient age, sex and chief complaint. Note the student is not permitted to gather any confidential information on the patient.
  - All other information required on the form.

- The preceptor will then record the following on this form:
  - A score based on the Proficiency Evaluation Key for each competency the student performed on that patient.
  - The preceptor then initials the block for preceptor's initials, thus indicating they have evaluated the student on those competencies.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:

  - The preceptor has approved and signed or initialed the competencies completed by the student.
  - The student and preceptor have completed all the information required under Completing the Form (above).
  - The student was evaluated with a minimum score of approved, at least two times, on all the clinical competencies required for their program.
  - No confidential patient information is contained on the form.
  - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record.

Note: Clinical Competencies are identified as “C’s” in the NOCP Documentation, all competencies identified as a “C”, must be scored at a minimum of approved at least twice. If a student fails to obtain the required score at least twice they will be required to complete more hours to obtain those competencies; or to obtain the competencies in the ambulance practicum “P” setting.

4) Preceptor Evaluation of Student (Daily/Weekly)

Completing the Documentation:

- This form is to be completed by the preceptor, through Comptracker and is used to provide a general evaluation on the student’s professional responsibilities, communication skills and health and safety. If the student is with the same preceptor for a number of shifts, the preceptor is only required to complete one form; however, they may complete it on a daily basis if they choose to.
- The preceptor must assign a score (approved or not approved) based on the Proficiency Evaluation Key) and then sign or initial the box indicating the preceptor’s initials are required.
- A space is provided for a narrative of overall comments from the preceptor.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:
    - The preceptor has completed all the information required under Completing the Form (above).
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record.

5) Preceptor Contact Form

Completing the Documentation:

- The preceptor is asked to complete the preceptor information, so that we have accurate information on those professionals willing to help educate our students. This information is obtained for our records, so that we may contact the preceptor regarding the evaluation of the student.

Verification of Information (MEDAVIE HEALTHED Agent):

This form will be verified by staff at Medavie HealthEd Staff.

6) Preceptor Assignment Form

Completing the Documentation:

- The preceptor may assign a student homework based on areas where, they perceive, the student to require a stronger level of knowledge. Should homework be assigned the preceptor and student will complete a form for each occurrence.

Comptracker Quick Start Guides

The following pages contain information on using the Comptracker System's validation process.

Reference video guides for IPAD and online site