Preceptor Reference Guide

Supporting safe, consistent, and growth-focused field learning

Thank you for precepting. Your coaching, observation, and honest feedback help learners translate classroom knowledge into safe, compassionate practice. This guide provides a shared framework and practical tools for that work.

How to use this Guide

Read sections 1-6 before the first shift. Use sections 7-11 when coaching, evaluating, or responding to concerns. The appendices are ready-to-use worksheets that may be printed, copied, or adapted.

If you need to...	Go to...
Clarify roles and boundaries	Sections 2-4
Plan the first shift	Section 5
Give feedback or complete an evaluation	Sections 6-7
Support a struggling Learner	Section 7
Escalate a concern	Section 8
Run a CBD or debrief	Sections 9-10
Assign targeted practice	Section 11 and Appendices
School and wellness supports	Sections 12-13

Quick Start: Before the First Shift

- Confirm placement dates, expected hours, schedule, and contact pathway
- Discuss how feedback will be given, how responsibilities will increase and when the learner should ask for help
- Clarify expectations for reporting time, uniform, equipment, documentation, confidentiality, illness, and absences.
- Plan a brief pre-shift huddle and end-of-shift debrief for every shift

Core principle: The preceptor remains accountable for patient safety and supervision. The student is accountable for preparation, participation, communication and acting within their authorized learner scope.

1. Purpose and Guiding Principles

The purpose of preceptorship is progressive development toward safe entry-level practice. Learning should be challenging, respectful, transparent, and matched to the learner's demonstrated ability.

Principle	What it looks like in practice
Patient safety first	Intervene early when care may be delayed, unsafe, or outside scope. Debrief after the patient is stable.
Progressive independence	Move from observation to supported performance to increasing independence based on demonstrated competence – not hours alone.
Psychological Safety	Invite questions, normalize not knowing, and correct respectfully
Direct Feedback	Name the observed behaviors, their impact, and the next required action. Avoid vague reassurance or delayed surprises.
Equity and inclusion	Adapt the route to learning while maintaining the same safety and competence expectations
Evidence, not impressions	Evaluate repeated observable behaviors across calls and settings. Document examples.

2. Preceptor Responsibilities

- **Create a safe learning environment**. Set expectations, invite questions, protect dignity, and model professional behavior.
- **Maintain patient safety**. Know the learner's authorized scope and current ability; provide appropriate supervision and intervene when needed.
- **Plan progressive learning**. Select appropriate calls and tasks, increase responsibility gradually, and connect experiences to placement outcomes.
- **Observe directly**. Base evaluation on what you personally see, hear, and review.
- **Coach in real time**. Use concise prompts during care when safe; reserve deeper teaching for after the call.
- **Give timely feedback**. Provide specific feedback during the shift and a structured end-of-shift debrief.
- **Complete documentation**. Review patient documentation, complete required evaluations, and submit/sign records within program timelines.

- **Communicate concerns early**. Contact the assigned mentor or Student Success Advisor when patterns, safety concerns, or limited progression appear.
- **Respect boundaries**. Do not ask learners to act beyond their scope, conceal errors, falsify records, or work without required supervision.
- **Unexpected time off** -If you need to take an unexpected day off, per the contract with the operating company, it is the Watch Command's responsibility to make reasonable attempts to find placement for the learner for that scheduled shift.
- **Overtime**. Students are permitted to work OT with an assigned preceptor only. Courtesy emails to the placement coordinator to advise of the shift are appreciated. All other shifts beyond scheduled placement must be approved by the school.

Preceptors are not expected to remediate alone. The school can clarify expectations, build a focused learning plan, provide exercises, and coordinate additional support.

3. Student Responsibilities

- **Arrive prepared and fit for duty**. Be punctual, appropriately equipped, and ready to discuss learning goals.
- **Know and respect the scope.** Identify limits, request supervision, and never perform unauthorized skills.
- **Own the learning process.** Ask questions, seek experiences, complete assigned work, and follow through on agreed actions.
- **Communicate early.** Report uncertainty, mistakes, illness, absences, scheduling concerns, or barriers promptly.
- **Provide safe patient care.** Use a systematic assessment, reassess after interventions, and communicate changes.
- **Accept and apply feedback.** Clarify expectations, demonstrate the change, and reflect on the outcomes.
- **Complete documentation.** Record each patient's contact accurately and promptly.
- **Maintain professionalism. Protect privacy, use respectful language, and follow workplace policies.**
- **Use available support.** Engage the mentor, Student Success Advisor, and wellness resource before concerns become a crisis.

4. Shared Responsibilities and Boundaries

Shared Area	Preceptor Contribution	Student Contribution
Learning Goals	Help make goals specific and achievable	Identify needs and arrive with a goal
Patient Support	Match opportunities to risk and readiness	State readiness and ask for support
Communication	Set expectations and give clear feedback.	Confirm understanding and speak up early
Reflection	Ask questions that prompt reasoning	Explain decisions and identify next steps
Documentation	Review and provide feedback	Complete accurate records on time
Escalation	Report patterns or safety concerns early	Disclose barriers and participate in the plan.

5. A Simple Structure for Every Shift

Pre-Shift Huddle → 5 to 10 minutes

- Check readiness, wellbeing, and anything that may affect learning or safety
- Choose one clinical goal and one professional/practice goal
- Agree on the student's role: observing, assisting, leading with prompts, or leading with indirect support
- Set a pause plan: words or signals either person can use when help is needed
- Identify learning opportunities and one backup assignment for downtime.

During the shift

- Use graded responsibility based on risk and demonstrated competence
- When safe, ask the learner to verbalize priorities before acting.
- Use the least intrusive prompt needed: open question → focused cue → direction → takeover
- Make brief notes of observable examples for the end-of-shift evaluation.

End-of-shift debrief → 10 to 15 minutes

- Three questions: ask the learner what went well, what was difficult, and what they would change
- Identify one or two strengths and one or two priority growth areas with examples
- Agree on one measurable action for next shift

- Complete and review required documentation together. There should be no surprises at formal eval points.

6. Evaluation: Fair, Specific and Defensible

Evaluate performance against the program standard and the learner's stage – not against your personal style or another student. One call may be an example; a repeated pattern is stronger evidence. If frequent prompting is required, this should be considered in the grading and does not meet the entry to practice standard.

Evaluation Tips

- Separate knowledge, psychomotor skill, clinical reasoning, communication, and professionalism.
- Describe acuity, complexity, student role, supervision, and prompts required
- Document strengths as specifically as concerns
- Look for response to feedback: insight, follow-through, and later performance change.
- Avoid labels such *as lazy, anxious, unsafe,* or *not confident* without behavioral examples
- Do not inflate ratings to preserve rapport; accurate feedback is a patient-safety responsibility.

Instead of…	Write…
"Poor assessment"	"Did not obtain medication hx or complete a focused neuro exam despite one open prompt and two focused cues"
"Great call"	"Recognized shock early, requested resources, initiated warming and reassessed after each intervention without prompts."
"Not confident"	"Delayed stating a transport decision until asked three times and sought confirmation before each routine intervention."
"Bad attitude"	"Interrupted feedback twice, disputed documented timeline and did not identify an action for the next shift."

Field Evaluation Grading Scale

7 – Exceptional / Exceeds Entry to Practice Standards

Exceeds entry-to-practice level. Performance consistently reflects a strong, independent practitioner. Requires minimal to no prompting. Demonstrates advanced clinical reasoning and scene leadership.

- Anticipates complications before they occur
- Integrates assessment findings into precise differential diagnoses
- Smooth psychomotor execution under pressure
- Excellent crew resource management (CRM)
- Communication is concise, professional, and patient-centered
- Documentation is thorough and defensible

6 – Strong / Entry-Level

Clearly meets entry-to-practice standards and occasionally exceeds them.
Requires rare guidance for complex or unfamiliar presentations.

- Solid foundational skills demonstrated
- Thorough primary and secondary assessments
- Appropriate treatment and transport decisions with effective prioritization
- Minor inefficiencies without safety impact
- Demonstrates situational awareness
- Manages crew and resources appropriately
- Accurate PCRs with sound clinical justification

5 – Safe / Entry-to-Practice Standard

Minimum expected level for program or competency completion.
Safe to practice with typical new-graduate mentorship.
May require intermittent prompting for refinement, not safety.

- Systematic assessments

- Recognition of critical findings
- Appropriate treatment within scope
- Maintains patient and crew safety
- Communicates effectively with preceptor and receiving staff
- Documentation is complete; omissions are minor and non-critical

4 – Borderline Safety/Still developing
Below entry-to-practice standard. Can perform many tasks but requires frequent direction. Not reliably safe without supervision. Developing as per the program expectations.

- Assessments may be incomplete or disorganized
- Misses less obvious findings
- Treatment priorities may be delayed or incorrect
- Requires prompting for protocol adherence and resource management
- Scene awareness is developing
- Documentation lacks clear clinical linkage

3 – Developing / Significant Gaps
Demonstrates knowledge and skill deficits that impact patient care.
Requires continuous guidance; poses safety risk if unsupervised.

- Difficulty with systematic assessments
- Inconsistent interpretation of vital signs
- Hesitant or incorrect interventions
- Poor prioritization
- Communication lacks clarity
- Documentation is incomplete or inaccurate

2 – Unsafe / Major Deficiencies
Performance frequently compromises quality of care or safety.
Unable to manage patient care without direct preceptor control.

- Misses critical findings
- Performs incorrect or contraindicated treatments
- Poor infection control or scene safety practices
- Limited clinical reasoning
- Requires step-by-step instruction

1 – Unacceptable / Unsafe
Performance presents an immediate safety risk.
Unable to function in a clinical role.

- Failure to perform basic assessment and treatment tasks
- Dangerous psychomotor errors
- Inability to follow directions
- Professionalism concerns
- Documentation absent or fabricated

Important Notes

- Scores of **four** are *not* considered a pass. Learners must achieve a **five or higher** to meet passing standards.
- Please do not use a score of **1 or 2** to indicate "not applicable," as this reflects significant concern regarding performance or learning gaps.
    - For example:
        - If a learner appropriately utilizes on-scene resources or requests additional support when needed, a score of **5 or higher** may be appropriate.

        - If a learner fails to identify the need for additional resources, thereby compromising patient or partner safety (e.g., ACP, Fire, Police), a lower score may be warranted.
    - If an assessment was not completed due to patient refusal, consider whether the learner appropriately approached the scene and managed the situation. If so, a score of **4 or 5** may be appropriate.
- If there are concerns regarding mis-graded PCRs, these may be corrected by the preceptor by editing the original PCR. The learner will need to email their auditor to advise of the edit, including the PCR #.
- If you are concerned about a student's progress, please reach out early so we can assist both of you!

Developmental Expectations by Week of Shifts (12 Weeks)

Weeks of Shifts	**Stage of Development**	**Expected Score Range**	**What This Means**
Weeks 1-2	Early Practicum	2-4 Typical	• Actively observes and participates • Completes some assessments with guidance • Gathers history • Demonstrates professionalism • Accepts and applies feedback • Independence is not expected.
Weeks 3-5	Developing Learner	3-5 Typical	• Lead portions of patient encounters • Formulates working impressions, with support

			• Recommend treatment plans • May require some regular coaching and prompting.
Weeks 6-8	Novice practitioner	4-6 Typical	• Leads most low acuity patient encounters • Beginning to demonstrate sound clinical reasoning • Anticipates next steps in patient care • Participating in transport planning • May require occasional prompting
Weeks 9-11	Near Entry-to-Practice	5-6 Typical	• Functioning at a safe entry level on low acuity calls • May require guidance for complex or unfamiliar presentations. • Functions as part of the "team"
Week twelve	Entry-To-Practice Readiness	Five required, 6-7 Possible	• Managing most calls independently • Demonstrates consistent clinical judgement • Prioritizes and adapts to

			patient care needs • Functions similarly to a new graduate practitioner.

7. Troubleshooting with Adult Learners

Start with curiosity and observable evidence. Determine whether the barrier is primarily knowledge, skill, reasoning, communication, stress/confidence, professionalism, opportunity, or an unclear expectation. More exposure alone will not correct every problem.

What You Observe	Barrier	Try This
Knows facts but struggles with application	Synthesis or prioritization	Use a CBD. Ask for a one-sentence summary, top concerns, and "because/why" statements.
Freezes or waits for direction	Cognitive overload, unclear role, stress response, or limited pattern recognition	Set a call plan; use a consistent first 60-second routine; rehearse aloud; reduce prompts over time
Repeats the same errors	Feedback is vague, misunderstood, or not practiced	Name one behavior, demonstrate it, use teach-back, rehearse and reassess.
Performs tasks but misses the whole patient	Tunnel vision	Require verbalized priorities, scheduled reassessment and a "what else could this be" pause.
Avoids feedback or becomes defensive	Threat response, shame, communication mismatch, or limited insight	Move to privacy, use neutral examples, ask for their view, restate the standard, and required action
Documentation is late or weak	Time management, uncertainty, avoidance, or unclear standard	Set a deadline, review one exemplar, use a checklist and audit the next chart
Knowledge gaps are broad	Foundational learning need	Assign a topic brief/CBD and contact the mentor or

		Student Success Advisor for a structured plan
Performance varies greatly	Fatigue, wellbeing, environment, case type, or inconsistent strategy	Track patterns, simplify goals, encourage supports and escalate if safety or progression is affected

Adult-learning strategies that work

- **Make it relevant**: connect learning to a recent patient or field decision
- **Use prior experience**: ask what the learner already knows and where it fits
- **Keep goals narrow:** one or two priorities per shift are more actionable than a long deficit list.
- **Require active retrieval**: use teach-back, short cases and verbal reasoning.
- **Provide choice within structure:** offer two useful assignments while preserving required outcomes.
- **Repeat with variation:** practice the same reasoning skill across different complaints.
- **Turn reflection into action**: every debrief ends with what the learner will do differently next time.

Accommodation and standards: a learner may use a different method, pace, or support to demonstrate learning. Patient safety, scope, and entry-level competence standards remain unchanged. Refer accommodation questions to the school; do not request a diagnosis or create informal medical requirements.

8. Concerns, Safety Events and Escalation

Escalate immediately

- Patient-safety event, near miss or practice outside authorized learner scope.
- Impairment, fitness-for-duty, serious misconduct, harassment, discrimination, or boundary violation.
- Threats of self-harm, harm to others or an acute mental health crisis.
- Falsification, privacy breach, or significant documentation concern.
- A learner who cannot safely continue the shift despite support.

Escalate early – do not wait for the final evaluation

- Repeated significant prompting on routine or expected tasks
- Limited progression, recurring errors, or failure to apply feedback

- Attendance, hours, schedule, vacation, or time off concerns
- Conflict affecting learning or patient care
- A need for a focused learning plan, additional observation, or changed placement support.

Situation	First Contact	What to Provide
Routine question or early-learning concern	Assigned Mentor – greeting email with contact info is sent out early in preceptorship.	Brief examples, what has been tried and support requested
Progression concern or first-level escalation	Jessica Todhunter, Student Success Advisor (C) 902-293-6943 jessica.todhunter@medaviehealthed.com	Examples, prompt level, feedback, learner response, and evaluations
Hours, scheduling, vacation, or time off	Courtney Camera, Placement Coordinator placement.coordinator@medaviehealthed.com	Student name, placement, dates/hours, and specific concern
Immediate operational or patient-safety issue	Follow operating company's policy first; then notify the school	Facts, action taken, safety impact and needed follow-up
Active emergency or imminent risk	Emergency services/local ER, then notify the school	Do not rely on email or routine school channels

Document facts promptly. Record what occurred, the context, prompts/interventions, feedback, learner response, and who was notified. Avoid diagnosis, motive statements, or speculation.

9. Case-Based Discussions (CBDs)

A CBD is a structured conversation about a real or constructed case. It reveals how the learner gathers information, prioritizes, interprets findings, chooses treatment, anticipates deterioration, and reflects. It is not a quiz designed to catch the learner out.

Ten-minute CBD structure

I. **Set the case**: Choose a recent call or short scenario and state the purpose.
II. **Summarize**: Ask for a one-sentence problem representation.
III. **Reason**: Explore key findings, differentials, severity, and what cannot be missed.
IV. **Decide**: Explore priorities, resources, treatment, transport, and destination
V. **Adapt**: Change one variable – vital signs, history, response, geography.
VI. **Close**: Name one strength, one growth area, and one action for the next call.

High-Yield CBD Prompts

Domain	Prompts
Information gathering	What finding changes your plan most? What information is missing? Which question has the highest value?
Clinical reasoning	What are your top three differentials? Which is most dangerous? What supports or weakens each?
Severity	Sick or not sick, and why? What trend worries you? When would you request more resources?
Treatment	What is the goal? Contraindications? How will you know if it worked?
Transport	How urgent? What destination? What could deteriorate en route?
Human factors	What biases or distractions may affect this call? How will you share the plan and use your partner?
Reflection	What would you repeat? Change? Practice before the next shift?

10. Debrief Tools

Choose the shortest tool that meets the need. Routine calls need a brief debrief; complex, emotional, or safety-relevant events may require more structure.

Tool	Best for	Prompts
Plus/Delta	Fast routine debriefs	What should we continue? What can we do differently?
GAS	Skills and simulations	Gather: What happened Analyze: Talk me through your thought process Summarize: Key learning/action
Advocacy-Inquiry	Exploring reasoning	I noticed… I was concerned because… Help me understand what you were thinking
PEARLS-style blend	Complex cases	**Performance** – How did it go?

		Emotions – Did anything surprise you? **Assessment- What helped** guide you to your working diagnosis? **Reasoning-** Walk me through this… **Learning** – What's one thing you learned? **Strategies** – next time….
STOP	In-the-moment reset	Stop. Think. Observe. Plan.

11. Targeted Assignments for Additional Support

Assignment	Use when…	Deliverable	Time
One-Page Condition Map	Foundational/ pathophysiology gap	Cause → physiology → findings → risks →EMR/PCP/ACP priorities	20-30 minutes
Medication Teach-Back	Medication knowledge is memorized, not understood	Indication, goal, contraindications, dose/route, reassessment and "why"	10-15 minutes
Differential Ladder	Anchoring or narrow differentials	Most likely/dangerous/reversible/easily missed, with evidence	10-15 minutes
First 5 Minutes Plan	Slow starts, freezing, or poor prioritization	Verbal/written first give minutes, resources, and transport	5-10 minutes
PCR Reconstruction	Documentation gap	De-identified narrative from timeline; identify missing evidence	20-30 minutes
Handover Practice	Disorganized reports	30-second and 90-second SBAR/ATMIST reports	10 minutes
ECG Method Drill	Inconsistent ECG interpretation	Rate, Rhythm, intervals, morphology, ischemia, meaning, and action	10-15 minutes
Reassessment Audit	Interventions without reassessment	Timeline of findings, action, response, and next decision	10-15 minutes
Near-Miss Reflection	Safety event or close call	Event, factors, barriers, safeguards, and next action	15-20 minutes
Teach a Topic	Consolidation or communication practice	Five-minute micro-teach plus two application questions	20 min prep

State the observed need, deliverable, deadline, and how learning will be reassessed. Assignments supplement coaching; they do not replace escalation when progress or safety is a concern.

12. School Contacts and Support Roles

Role/Contact	When to contact	Brief role description
Placement Coordinator – Courtney Camera Email: placement.coordinator@medaviehealthed.com	Hours, schedules, upcoming vacation/time off, absences, shift changes	Coordinates placement logistics and helps resolve scheduling or hour completion concerns
Student Success Advisor – Jessica Todhunter Cell: 902-293-6943 Email: Jessica.todhunter@medaviehealthed.com	Early Progression concerns, repeated prompting, professionalism concerns, additional support, or first-level escalation.	Monitors the mentorship team, reviews field concerns, supports early intervention, and typically coordinates first-level escalation
Assigned Mentor – Contact info in early emails.	Routine questions, early concerns, feedback strategies, learning goals, and program expectations.	Each student and preceptor are assigned a mentor for the placement. The mentor supports both parties and identifies when further school involvement is needed.
Program Lead **EMR – Les Card** **PCP – Brad Landry** **ACP – Les Card**	Makes formal program decisions, addresses significant unresolved concerns, and escalates as directed.	Provides program oversight and participates in formal review or decision-making.
Quality and Risk Manager – Eric Beairsto	Makes formal program decisions, addresses significant unresolved	Provides program oversight for all

	concerns, and escalates as directed by SSA/Program Lead.	education and accreditation, oversees the student success team, participates in formal reviews and decision-making.
After-hours/urgent school Contact – Student Success Advisor.	Urgent concerns outside regular hours: after-hours service/emergency processes are followed.	Use according to the program's established urgent-contact process.

13. Mental Health, Wellbeing and Critical Incidents

Field learning can involve fatigue, grief, moral distress, trauma exposure, and performance stress. Support should be normalized and offered early. Preceptors are not expected to diagnose or provide counselling.

A support response

I. Move to a private, safe setting when possible.
II. Listen and acknowledge the concern without pressing for details.
III. Ask what support is needed now and whether the learner can continue safely.
IV. If there is immediate danger, impairment, or risk of harm, follow emergency/service policy and notify the school.
V. Encourage professional, peer, or school supports. Follow up later; do not promise confidentiality beyond safety/reporting obligations.

Resource	Purpose/Access
Inconfidence	Confidential support resources. **Access**: 1-877-418-1457 **Code**: 14396
Peer and Family Support	Peer/Family pathway. **Access**: 1-888-342-7555
Boots on the Ground	Peer support for public safety personnel. **Access**: 1-833-677-2668
988 Suicide Crisis Helpline	Call or text **988**. For imminent danger, call **911**.
Local service supports	Mentor, Student Success, Critical Incident

14. Quick Reference: A Good Preceptor Shift

Before	During	After
Check Readiness; set 1-2 goals; agree on role and pause plan.	Observe directly; use graded prompts; protect patient safety; note examples	Invite self-assessment; give specific feedback; set next action; complete documentation.

Appendix A – Shift Huddle and Debrief

Pre-Shift

Readiness/Wellbeing Check:

_____

Clinical Goal:

_____

Professional/Practice Goal:

_____

Planned Responsibility and Pause Plan:

_____

End-of-Shift

Learner: What went well?

_____

_____

Learner: What was difficult or what would I change?

_____

_____

Preceptor: Observed strengths with examples:

_____

_____

Preceptor: Priority growth area with examples:

_____

_____

One measurable action for next shift:

_____

Appendix B – Case-Based Discussion Record

Case/Presenting Problem:

_____

_____

One-sentence problem representation:

_____

Discussion Domain	Learner Reasoning/Evidence
Key findings and missing information	
Differentials: likely, dangerous, reversible, and easily missed	
Severity and anticipated deterioration	
Priorities, resources, and treatment	
Reassessment, transport, and destination	
Human Factors and communication	

Strength demonstrated:

_____

Growth area and agreed action:

_____

Overall (please select one):

- **Needs significant guidance.**
- **Development**
- **Meets expected level.**
- **Exceeding expected level**

Follow-up date:

_____

Appendix C - CBD 1 — Undifferentiated Shortness of Breath

Initial Presentation:

You respond to a private residence for a 72-year-old patient experiencing worsening shortness of breath. The patient has a history of COPD, hypertension and "heart problems."

The patient is seated upright, appears anxious and is speaking in short sentences.

Initial findings:

- Airway patent
- Respiratory rate: 30/min
- SpO_2: 86% on room air
- Heart rate: 112/min, irregular
- Blood pressure: 178/96 mmHg
- Skin: pale, cool and mildly diaphoretic
- Breath sounds: diminished with bilateral wheezing.
- Reports increasing dyspnea over two days.
- Reports a productive cough and difficulty sleeping flat.

Discussion Prompts

Information Gathering

- How would you summarize this patient in one sentence?
- What additional history would be most useful?
- Which physical assessment findings would help distinguish COPD from acute heart failure?
- What is the significance of the patient being unable to lie flat?
- What medications would you specifically ask about?
- What findings would suggest infection, pulmonary embolism, or acute coronary syndrome?

Clinical Reasoning

- What are your leading differentials?
- Which diagnosis appears most likely?
- What is the most dangerous alternative diagnosis?
- Does wheezing confirm COPD?
- What findings support acute pulmonary edema?
- Could COPD and heart failure be present simultaneously?

What cognitive biases could affect your interpretation of this case?

Treatment and Transport

- What are your immediate priorities?
- How would you position the patient?
- What oxygenation or ventilation support would you consider?
- Would CPAP be appropriate? Why or why not?
- What contraindications would you assess before using CPAP?
- What is the therapeutic goal of nitroglycerin in pulmonary edema?
- How will you determine whether treatment is working?
- How urgent is transport, and what destination considerations apply?

Case Progression

After initial oxygen therapy, the patient becomes increasingly fatigued.

Updated findings:

- Respiratory rate decreases to 22/min, but respiratory effort becomes shallow.
- SpO_2 remains 87%.
- Level of consciousness declines
- Air entry becomes reduced.
- Blood pressure: 164/90 mmHg

Progression Prompts

- Is the reduced respiratory rate reassuring?
- What does the change in level of consciousness suggest?
- How has your assessment of severity changed?
- What intervention should take priority?
- What additional resources would you request?
- What deterioration should you anticipate during transport?

Key Learning Points

- Wheezing is not exclusive to obstructive lung disease.
- A falling respiratory rate may indicate fatigue rather than improvement.
- Diagnosis should not delay treatment of hypoxia and ventilatory failure.
- Reassessment must include mental status, respiratory effort, air entry, and response to treatment.

Appendix D - CBD 2 — "They're Just Intoxicated"

Initial Presentation

You are called to a public location for a 46-year-old patient described as intoxicated and difficult to wake up. Bystanders report that the patient had been drinking earlier in the evening.

The patient is lying on a bench and responds to repeated verbal stimulation.

Initial findings:

- Airway currently patent
- Respiratory rate: 10/min
- SpO_2: 93% on room air
- Heart rate: 58/min
- Blood pressure: 104/68 mmHg
- Blood glucose: 3.1 mmol/L
- GCS: 12
- Skin: cool and pale
- Speech is slurred.
- Strong smell of alcohol noted.
- No obvious major trauma

Discussion Prompts

Information Gathering

- How would you summarize this patient?
- What immediate threats must be addressed?
- What information is still missing?
- What collateral history would you seek from bystanders?
- What environmental factors are relevant?
- What should be included in the physical examination?
- How would you assess occult trauma?
- What are the limitations of relying on the smell of alcohol?

Clinical Reasoning

- What are your differential diagnoses for decreased level of consciousness?
- How could AEIOU-TIPS help organize your thinking?
- Can alcohol intoxication safely explain all these findings?

- What is the significance of blood glucose?
- What findings could suggest opioid toxicity?
- What findings could suggest stroke, head injury, sepsis, or hypothermia?
- What is the danger of diagnostic overshadowing in this case?

Treatment and Transport

- What are your immediate treatment priorities?
- How would you manage the patient's glucose?
- What factors determine oral glucose versus another treatment pathway?
- Is naloxone indicated based on the information available?
- How often should the patient be reassessed?
- What position is most appropriate?
- What would determine the urgency of transport?
- What information should be included in the hospital notification?

Case Progression

During reassessment, you identify a small occipital hematoma. The patient's friend reports that the patient fell approximately six hours ago and "seemed fine afterward."

Updated findings:

- GCS decreases from 12 to 10.
- Left pupil is slightly larger than the right.
- One episode of vomiting
- Heart rate: 52/min
- Blood pressure: 142/86 mmHg

Progression Prompts

- How does this information change your differential?
- What findings are particularly concerning intracranial injury?
- What airway risks are now present?
- What should be anticipated during transport?
- Would spinal motion restriction be indicated?
- What destination is most appropriate?
- What resources or intercepts should be considered?

Key Learning Points

- Intoxication is a diagnosis of exclusion in a patient with altered mental status.

- Every altered patient requires complete medical and trauma assessment.
- A normal or plausible explanation must not prevent reassessment.
- Declining GCS, vomiting, pupillary changes, and bradycardia require urgent escalation.

Appendix E - CBD 3 — Presyncope with Conduction Abnormality

Initial Presentation

You respond to a residence for a 68-year-old patient who became dizzy and nearly fainted while walking to the bathroom. The patient did not fall and denied chest pain.

The patient reports feeling weak and “not quite right.”

Initial findings:

- Airway patent
- Respiratory rate: 18/min
- SpO_2: 96% on room air
- Heart rate: 42/min, regular
- Blood pressure: 102/64 mmHg
- Skin: pale and slightly diaphoretic
- GCS: 15
- No focal neurologic deficits
- Twelve-lead ECG demonstrates complete heart block.
- History includes hypertension and atrial fibrillation.

Discussion Prompts

Information Gathering

- How would you summarize this patient?
- What additional symptoms would you ask about?
- Which medications are important to identify?
- What assessment findings help distinguish presyncope from vertigo?
- What reversible causes of bradycardia should be considered?
- Why is a complete neurologic examination still important?
- What does the ECG show?
- How would you explain complete heart block physiologically?

Clinical Reasoning

- Is this patient stable or unstable?
- Which findings suggest reduced cardiac output?
- Can a patient be unstable without hypotension?
- How does bradycardia cause dizziness or presyncope?
- What are the complications of complete heart block?
- What findings would indicate worsening perfusion?
- What alternative diagnoses should remain under consideration?

Treatment and Transport

- What are your immediate priorities?
- What vascular access and monitoring should be established?
- What additional resources should be requested?
- What treatments are available within the learner's PCP scope?
- What treatments might an ACP consider?
- Should treatment begin before profound hypotension develop?
- What is the priority of transport?
- What destination is appropriate?
- What should be communicated during an early hospital notification?

Case Progression

During movement to the stretcher, the patient becomes increasingly weak and confused.

Updated findings:

- Heart rate: 28/min
- Blood pressure: 76/44 mmHg
- Respiratory rate: 24/min
- Skin: cool and diaphoretic
- GCS decreases to 13.
- The patient reports pressure in the chest

Progression Prompts

- What evidence now confirms hemodynamic instability?
- What intervention has become the immediate priority?
- How would you manage the patient if an ACP intercept is delayed?
- What equipment should be prepared?

- What complications should you anticipate?
- How frequently should vital signs and mental status be reassessed?
- What information must be included in the radio patch?
- Would you delay transport to wait for additional resources?

Key Learning Points

- Instability is determined by perfusion, mental status, symptoms, and trends—not blood pressure alone.
- Symptomatic bradycardia may deteriorate quickly.
- Complete heart block requires early resource activation and preparation for advanced intervention.
- Treatment, resource requests, and transport should occur concurrently.
- Reassessment should drive continuing clinical decisions.

Suggested Evaluation Areas for All Three CBDs

Evaluate whether the learner can:

- Produce a concise problem representation.
- Identify immediate threats.
- Develop prioritized differentials.
- Explain the physiology behind the presentation.
- Distinguish “most likely” from “most dangerous.”
- Select treatments and explain their intended goals.
- Recognize contraindications and limitations.
- Establish an appropriate transport priority.
- Anticipate deterioration.
- Modify the plan when new information appears.
- Identify their own strengths and learning needs.

Appendix F - Focused Learning Assignment

Assignment (please circle/select applicable):

- **Condition Map**
- **Medication Teach-Back**
- **Differential Ladder**
- **First 5 Minutes**
- **PCR Reconstruction**
- **Handover**
- **ECG Drill**
- **Reassessment Audit**
- **Near-Miss Reflection**
- **Micro-Teach**
- **Other: _____**

Instructions and expected delivery:

_____

_____

Resources suggested:

_____

_____

How will learning be reassessed:

_____

_____

Outcome/evidence of change:

_____

_____

Appendix F.1 – Condition Map Template

1. Condition Overview

In one or two sentences, describe the condition:

_____

_____

_____

2. Cause and Risk Factors

What causes this condition?

_____

_____

Common risk factors:

- _____
- _____
- _____
- _____

_____

3. Pathophysiology

Explain what is happening inside the body.

Cause or trigger → physiological change → patient findings.

_____

↓

_____

↓

_____

↓

_____

4. Expected Patient Presentation

Common Symptoms

- _____
- _____
- _____
- _____

Important Physical Findings

- _____
- _____
- _____
- _____

Expected Vital-Sign Changes

Vital Sign	Expected Finding – Why?
Heart Rate	
Blood Pressure	
Respiratory Rate	
SpO2	
Temperature	
Level of Consciousness	

5. Assessment Priorities

What should be assessed immediately?

1. _____
2. _____
3. _____
4. _____

Important history questions:

- _____
- _____
- _____

Focused physical assessment:

- _____
- _____
- _____

---

6. Differential Diagnoses

Category	Differential Findings That Support or Weaken It
Most Likely	
Most Dangerous	
Reversible Cause	
Easily Missed	

7. Red Flags

Findings that indicate a high-acuity or deteriorating patient:

- _____
- _____
- _____

---

8. PCP Management Priorities

Immediate Priorities

1. _____
2. _____
3. _____

Treatments Within PCP Scope

Treatment	Indication	Intended Effect	Contra's	Cautions

Additional Resources

When should additional resources or an ACP intercept be requested?

_____

_____

9. Reassessment

What must be reassessed after treatment or during transport?

- _____
- _____
- _____
- _____

What findings would indicate improvement?

_____

What findings would indicate deterioration?

_____

_____

10. Transport and Destination

Transport priority:

☐ Routine ☐ Urgent ☐ Emergent

Appropriate destination and rationale:

What deterioration should be anticipated during transport?

11. Clinical Communication

Provide a concise one-sentence problem representation:

What are the three most important details to include in the handover?

1.
2.
3.

12. Clinical Reasoning Summary

The most important finding in this condition is:

These finding matters because:

The most dangerous thing I could miss is:

My first treatment priority would be:

I would know my treatment is working when:

Appendix F.2 – Differential Ladder

1. One-Sentence Patient Summary

Summarize the patient using their age, chief complaint, acuity, relevant history, and most important findings.

2. Differential Ladder

Level 1 — Most Likely

What diagnosis best explains the patient's presentation?

Differential: _____

Findings that support it:

-
-
-

Findings that do not fit or weaken it:

-
-

What additional information would help confirm or exclude it?

Level 2 — Most Dangerous

What life-threatening condition must be considered or excluded?

Differential: _____

Findings that support it:

- _____
- _____
- _____

Findings that weaken it:

- _____
- _____

What assessment or action is required immediately?

_____

_____

Level 3 — Reversible Cause

Is there an immediately treatable cause contributing to the presentation?

Differential: _____

Examples: hypoglycemia, opioid toxicity, hypothermia, medication effect etc…

Findings that support it:

- _____
- _____
- _____

How would you assess it?

_____

How would you treat it within PCP scope?

_____

_____

Level 4 — Easily Missed

What condition could present subtly or be overlooked?

Differential: _____

Why could it be missed?

Findings that support it:

- _____
- _____
- _____

What targeted question or assessment finding would help identify it?

_____

_____

3. Findings That Carry the Most Diagnostic Weight

Which three findings most strongly influence your differential diagnosis?

1. **Finding:** _____
   Why it matters: _____
2. **Finding:** _____
   Why it matters: _____
3. **Finding:** _____
   Why it matters: _____

_____

4. Avoiding Anchoring

What was your initial impression?

_____

What alternative diagnosis could produce a similar presentation?

_____

What finding would make you change your working diagnosis?

_____

Is there any important finding that your current diagnosis does not explain?

_____

_____

5. Working Diagnosis

My current working diagnosis is:

I believe this because:

My level of certainty is:

☐ Low ☐ Moderate ☐ High

What remains uncertain?

6. Management Plan

Immediate assessment priorities:

1.
2.
3.

Treatment priorities:

1.
2.
3.

Additional resources required:

Transport priority and destination:

7. Reassessment and Diagnostic Time-Out

After treatment or new information, ask:

- Has the patient improved, deteriorated, or remained unchanged?
- Do the new findings still support my working diagnosis?
- Is there another diagnosis that now fits better?
- Have I addressed the most dangerous and reversible possibilities?

New or changing findings:

Does the differential ladder need to change? Why?

Updated working diagnosis and plan:

Appendix G – Concern and Escalation Note

Use objective language. This worksheet does not replace required service, incident, patient-care, or school documentation. Submitted worksheets will be placed on the student's file.

Escalation Worksheet

Student	Preceptor	Date/Time	Location/shift

Observed Event or performance concern:

_____

_____

Prompts, supervision, or intervention required:

_____

_____

Patient-safety or operational impact:

_____

_____

Feedback provided and learner response:

_____

_____

Prior related examples or patterns:

_____

_____

Actions taken and person(s) notified:

_____

_____

Follow-up plan and timeline:

_____

_____

Other Details:

_____

_____

_____

_____

Appendix H – First-Shift Orientation Checklist

- Introductions, roles, and contact info
- Placement dates, schedule, and required hours.
- Reporting time, uniform, and equipment
- Student scope and current learning level
- Patient assignment and supervision expectations
- How to request help or pause a call
- Feedback preferences and planned debrief time.
- Documentation and evaluation process
- Confidentiality, privacy, and device use
- Social media policies
- Absence, illness, vacation, and scheduling changes process
- Safety reporting and escalation pathway
- Wellness and mental health supports
- Shift learning goals.
- Ambulance orientation & Truck Check
- Base orientation
- Questions answered

Student Signature: _____ Date: _____

Preceptor Signature:_____ Date: _____