COLLIN COUNTY COMMUNITY COLLEGE
EMERGENCY MEDICAL SERVICES TRAINING

ADVISORY COMMITTEE MEETING
February 8, 2002

MINUTES

MEMBERS PRESENT:
Bob Sherard – Program Coordinator
Jackie Langford – CCCD
Kurt Hale – Addison Fire/EMS
Dave Jackson – TDH
Kala Halliburton – MCP
Anna Bennett – MCP, Respiratory Care Dept.
Pearl McGregor – CCCCD
Donnie Morrow – Clinical Coordinator
Ken Kein – Plano Fire Dept.
Regina Jobe – Presbyterian Hospital of Plano
Vivian Lilly – Associate Dean, Health Sciences
Tracy Morgan – Women's Services
Patti Allard – Gould – Presbyterian Hospital of Plano
Ken Sherman, M.D. – Medical Director
Mike Hudson – Hunt Memorial Hospital District

AGENDA ITEM	DISCUSSION
Welcome and Introductions	Bob Sherard thanked everyone for their support. Introductions were then made.
Update on EMS Programs Paramedic Certificate	Discussion was made on the Paramedic Certification program which is now a two year (5 semesters) program. It has decreased the number of students. The students can go to private services and be certified in less than a year. Prior to WECM, classes of 40 students were the rule. Now we are down to 18-20. The students also lose interest. We need to shorten the course or make it more accessible, like distance learning, shift course (A, B or C shift course), etc. The fire department does not use this program because costs are not feasible, and the course is too long. WECM (Workforce Education Manual) is trying to standardize the courses to be able to transfer these courses. WECM is based on the new National Standard Curriculum. Colleges are required to teach according to WECM which has a significantly increased course length. Non-college programs do not have to meet WECM mandates and can therefore provide a much shorter course. Bob mentioned again that we need to be more creative such as teaching on-line, etc. Otherwise, the paramedic program is in jeopardy. **Outcome: Continue to pursue more non-traditional delivery methods.**
Paramedic Degree	In September 2002, Licensure will require at least an Associate Degree in EMS. Currently, there is no incentive for people to seek licensure (no difference in pay or job status). Vivian Lilly said that by the fourth and fifth year, the degree program would not pay for itself. Cost is a factor.
EMT Basic	The EMT Basic is very strong. Normally there are 60 students per semester. Clinicals are a minimum of 48 hours, 2,880 clinical hours per semester. There are over 5,000 clinical hours per semester for EMT – Basic and paramedic students combined. That is over 500 8-hour shifts which must be scheduled. We have to have the clinical support. The paramedic students must have a minimum of 240 hours of ambulance time. Several issues need discussing.
Clinical Issues	If a student is passing, he/she can enter clinicals. Should there be minimum requirements? Students with 70 averages are not motivated. Donnie Morrow mentioned that students with C averages, more than likely will not pass the state certification exam. We should consider raising the minimum score to 80% before a student is eligible for clinicals. Dave Jackson suggested the Quality approach vs. Quantity approach to clinical evaluation. More structured clinical objectives with less clinical hours would be better. Bob mentioned that EMT – Basic is already at the 48 hour minimum. **Outcome: Consider raising minimum grade for didactic to 80%. Students less than that will not be able to go to clinicals.** The Quality Approach – There needs to be a strict definition of performance standards so the clinical preceptors know exactly what the student can accomplish and grade according to measurable criterion instead of just checking-off as accomplished. This is more labor intensive for faculty. Mike Hudson stated that this was done at Texas A&M Commerce and it significantly added more hours to the clinicals to achieve the desired objectives. Bob pointed out that there is a problem with task-specific grading criterion. Experiences vary so widely from institution to institution that experiential consistency would be a problem. Objectives have to be made so definable and specific for the student. Ken Sherman said we should consider laboratory experience as an addition to clinical experience as a way to evaluate students. Dave Jackson brought up simulation vs. live actual settings. Can students leave school being able to function in the real world without being retrained by the employer? **Outcome: Clearly define objectives for clinicals. Consider adding a laboratory component to augent clinical experience.**

Precepting Students	Bob Sherard said that we need to communicate between the programs and the hospitals. We need to have one individual to go to if there is a problem, a liason. Currently, with the number of clinical sites used, it is not possible to put a faculty member in each facility to monitor and precept students. **Outcome: Clinical sites to consider a single liason to be contacted regarding all clinical and student issues.** Preceptors and evaluators – Need to insure consistency in grading. Tracy Morgan said the objectives need to be clear. The issue was brought up that preceptors are not sure what the students should be allowed to do. Bob said that the college would verify skills before sending the student to clinicals. Mike Hudson said that they have a description of what the student can and can't do on the back of the student's ID badges. Anna Bennett said they have to literally push some students into the ER. Students are intimidated and think they need an invitation. They are afraid of being in the way. **Outcomes: Student skill verification should accompany student to clinical site so tht preceptors will be clear on skills.** **Objectives should be clearly stated in writing and preceptors should be oriented to the objectives.** Vivian mentioned that unlicensed students are working under the license of the nurse and therefore, there is reluctance to let the students do much. There should be more regulation because of lawsuits. Bob Sherard referred everyone to the handout, Section 773.009 of the Texas Health and Safety Code – Limitation of Civil Liability which states that individuals and institutions involved in the training of EMS personnel are not liable for acts of omission or commission provided that the Standard of Care was not violated. Additionally, the Nursing Practice Act allows for the delegation of nursing skills for the purpose of training non-credentialed individuals. **Outcome: Vernon's Civil Statute of the Texas Health and Safety Code, and the Nursing Practice Act, limit liability as long as the standard of care is followed.** Ken Sherman said that he prefers when students come in early to clinicals, introduces himself and lets them know what they are there for and what they are trying to learn. Donnie Morrow brought up the attitudes of the clinicals. He said it is overwhelming for the first year EMS students. He said they need to find the charge nurse, or whoever is in charge and tell them. Some are still afraid, especially at Parkland. Bob asked if should we grade knowledge or skill. The difference in terminology was then brought up. The preceptor from the old school uses different terminology than what students are learning today. Dave Jackson said that evaluation of critical thinking skills and application of knowledge are integrally related and should be evaluated at clinicals and not just internship. **Outcome: Critical thinking skills should continue to be evaluated during clinical rotations.** Another problem which was addressed was the unwillingness of clinical preceptors to honestly evaluate students for fear of confrontation. Bob mentioned that, on occasion, a preceptor will call complaining about a student but that the clinical evaluation does not reflect the problem. Nothing can be done without written documentation. The preceptor needs to accurately grade the student. Ken Sherman suggested that the evaluations should be mailed to the instructor by the preceptor. Donnie Morrow said if we left it up to the preceptor to mail evaluations back, that would place too much responsibility on the hospitals. You also have to consider the time to get the evaluations back for state exams.

	His suggestion is that we give envelopes with the evaluations. The student should return the envelope back to the instructor sealed by the preceptor. Kurt Hall suggested that the evaluations should be faxed at completion or done on-line. Vivian said that confidentiality would be a concern. Dave said that they want immediate feedback and need an honest response. They used two forms, one for behavior and appearance, and one for knowledge and performance. The students should be honestly evaluated and expectations and consequences need to be made clear to the students before clinicals. It should be a written policy given to students before clinicals that if a problem like this comes up, the student will be let go. Bob Sherard brought up the handout, Sample Clinical Internship Objective, which is used as guidelines, the current Evaluation tool that is used. He suggested having another meeting, a working meeting to discuss updating this. **Outcome: Sample objectives were given to committee members to review. Another meeting toward the end of April will be held to try and come up with specific objectives.**
What to do if a student gets injured or exposed to potentially infectious materials or patients?	The issue of needlesticks from dirty needles was brought up. An incident where a student was stuck and failed to report it until after 72 hours later because she knew she would have to pay for it brought up the need for a procedure for injury or illness while in clinicals. Bob suggested finding an insurance company willing to do it. Should we require students to have insurance? These are full-time students. With the Fire Science students, it's their own responsibility. Dave said that in Corpus Christi, the same issue was never adequately resolved. Mike said that the county has taken care of the cost as long as the student was employed by the hospital. Ken Klein said that they had packets already made up ready to take to the physician. Dave said there needs to be a plan in place at the clinical sites. Vivian said that the nursing students are treated as staff for the initial injury. After the student graduates, it's up to the student to continue follow-up or treatment. Ken's question was "Who's going to pay for it?" Bob suggested starting an EMS Club, creating a fund to be self-insured. For example, if a student contracted TB and later needed an X-ray but couldn't afford it, he could use this fund. **Outcome: Consider formation of a club to raise funds to be used in case of exposure. Continue search for an insurance company to insure students during clinicals.**
Contracts, Forms and Releases	Bob mentioned that the current paperwork on file and contracts may be outdated. Letters of Agreement and Self-renewing agreements are fine, but they need to be signed every year. They need to be department specific or facility specific. **Outcome: Committee representatives from each facility, please bring contracts or letters of agreement to next Advisory Board Meeting.**
Orientation to facilities	Each clinical site requires student orientation. It is hard to schedule orientation for students. Normally it is orally done. Parkland has a video. Students are only spending 16-24 hours in clinicals and orientating at each facility separately is not feasible. **Outcome: See if each facility could make a brief orientation video or self-studey document so that students could be oriented at the college.**
Admission Requirements for Clinicals	Discussion was brought up about admission requirements. Should we up the bar for grades? People who are not meeting the minimum requirements can't go to clinicals. The Basic EMT class is very costly. Required immunizations such as TB skin, Hepatitis B, Tetnus are expensive. Criminal history checks and drug screens are also required. Should the student or the program incur these costs? If a student comes up with a criminal or drug history, how do you handle this? Vivian said that with the nursing program, they get support from the board and their attorney if a student is recommended to withdraw. The Dean of Students also has a policy in place. Bob said that we need policies from the clinical sites as to what is allowed and what is not acceptable. Dave suggested that the student can send in an application at the start of the
	course and pay the non-refundable fee. They will hold the application for 2 years. A criminal background check would be done immediately to see if the student is certifiable

	criminal background check would be done immediately to see if the student is certifiable. This would be a courtesy to the students with questionable histories. **Outcome: Students will be informed of requirements and costs before registering for classes. Applications will be sent to TDH at the beginning of each class.** Anna Bennett asked about students who appear intoxicated while at clinicals. How do you handle this? Donnie said that you have to consider patient safety first. The student is a guest at the hospital. The preceptor has the right to send the student home and document the incident. Vivian said that if this was to happen with a nursing student, the student is unsafe, and they do not allow the student to drive. They call a cab for that student. They can also send the student to the lab to get blood work done. Also, they would get another person involved as a witness. The instructor should be contacted immediately by the preceptor should any incident arise with a student. **Outcome: To be addressed at next meeting.** Meeting adjourned at 1:32 p.m.