



Paramedic instructor perspectives on the quality of clinical and field placements for university educated paramedicine students



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SUMMARY

Objective: To determine the elements of quality clinical and field placements through the eyes of paramedic instructors.

Design: Qualitative study.

Settings: Two large paramedic services in two countries where the entry to practice qualification for paramedics has been set at the Bachelors degree level.

Participants: Fifteen purposively selected paramedic instructors were invited to voluntarily participate. The criterion for inclusion was that they had supervised at least one university paramedicine student on a field placement. Recruitment ceased when saturation was reached.

Methods: Face to face semi-structured interviews were conducted with participants who were asked their views and expectations of paramedicine student clinical and field placements. Inductive thematic analysis of the transcripts was completed using Nvivo software.

Results: The elements of quality clinical and field placements from the perspective of paramedic instructors were identified. With no agreed clinical and field placement paramedicine standards in the countries studied there is variation in the focus of placements, preferred settings, and expectations. Vocationally trained paramedics favoured paramedic service placements, whilst university educated paramedics see benefits in placements in more diverse settings.

Conclusions: Paramedic services and universities need to collaboratively address the variation in paramedicine university student clinical and field placements. Standards need to be developed that address the purpose of placements, expectations of students and instructors, and be scaffolded across the education spectrum from undergraduate student to graduate paramedic to instructor.

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Introduction

Paramedicine education in the United Kingdom, Australian and New Zealand has been in transition since the mid-1990s as university qualifications have become the main pathway to the paramedicine profession. (Joyce et al., 2009; Williams and Waxman, 2006; Cooper and Contemporary, 2005) Paramedicine workforces in these countries now include the vocationally trained and the university educated, with some paramedics vocationally trained and university educated through conversion programmes. (Council of Ambulance Authorities, 2010; Hou et al., 2013).

Unlike most other health professions, there are few agreed standards in regard to expected hours of clinical or field placement for university educated paramedicine students, where and when these placements should occur, or how to assess quality during these placements. (O'Meara et al., 2014) Clinical placements are educational activities where students experience patient contact in health settings such as hospitals and clinics. Paramedicine field placements are understood to be planned, scheduled, educational time spent in emergency paramedic services that include observation and skill development. (Commission on Accreditation of Allied Health Education Programs, 2005; Brown and Zimitat, 2012).

The question of what ought to be included in standards for paramedicine clinical education have been considered internationally. In 2011 the then British Association of Ambulance Chief Executives defined standards for paramedic student clinical placements in the United Kingdom in terms of time, committing themselves to provide field placements equivalent to half the teaching time of paramedicine programmes. (Health and Care Professionals Council, 2012; Association

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of Ambulance Chief Executives, 2011) In the United States, the 2005 paramedicine programme accreditation standards require students to:

... have access to adequate numbers of patients, proportionally distributed by illness, injury, gender, age, and common problems encountered in the delivery of emergency care appropriate to the level of the Emergency Medical Services Profession(s) for which training is being offered. (Commission on Accreditation of Allied Health Education Programs, 2005).

These U.S. standards require clinical placements in a wide range of hospital departments where students can gain access to different types of patients, whilst proposed changes specify that students and graduates gain exposure, and the assessment and management of specific patients and conditions that would be listed in the standards. Similarly, the 2014 Canadian standards for educational programmes ask programmes to:

... demonstrate that they provide adequate clinical and field placements for all students enrolled. Accredited programs are expected to provide students with a clinical rotation and a field preceptorship that enables them to perform the competencies required for entry to the profession. (Canadian Medical Association, 2014).

In addition, the Canadian programme accreditation standards consider clinical and field placement settings. These standards include a requirement that paramedic instructors (or preceptors) receive training that familiarizes them with the intended learning outcomes and assessment processes that ensures that they are able to fulfil their educational responsibilities. (Canadian Medical Association, 2014).

Throughout the world there are a number of terms used to describe the paramedic instructor. (Williams and Pointon, 2008; Willis et al., 2008; Wilson, 2013) In New Zealand for instance, paramedicine students are matched with a 'mentor', who is an experienced paramedic. In Australia, students attend individual ambulance stations for short periods and are assigned to an experienced paramedic instructor. The term to describe these experienced paramedics may be paramedic instructor, clinical instructor, supervisor, preceptor, mentor or clinical educator. Each term has a different meaning and application. (Furness and Pascal, 2013) In this article, we use the term 'paramedic instructor' to define the qualified paramedic who instructs and supervises a student or graduate during field placements and graduate internships.

Clinical education for paramedicine students can be conducted in many different ways, including placements with paramedic services, in the community, or in hospitals. (Lord et al., 2012; Lucas et al., 2013; Boyle et al., 2007; Boyd, 2012) Across the health sector there is considerable literature describing clinical learning environments and the conditions necessary for quality clinical placements (Darcy Associates Consulting Service, 2009; Siggins Miller Consultants, 2012; Brown et al., 2011), however little of this research has been in paramedic settings. Most studies focus on the disciplines of medicine and nursing in hospitals.

There are a small number of studies that have explored paramedic student field placements from the perspective of the paramedic instructor. (O'Meara et al., 2014) Through this study we aimed to add value to the existing knowledge by asking paramedic instructors about their views and expectations of paramedicine students during field placements and whether more diverse clinical placements are of value. (Canadian Medical Association, 2014).

Method

This qualitative study (Sandelowski and Leeman, 2012) was conducted during 2013 in two large paramedic services in two countries. Purposively selected paramedic instructors were invited to voluntarily participate. Arrangements were made through their employers for them to participate during paid work time, usually just as their shift

started. The criterion for inclusion was to have supervised at least one university paramedicine student on a field placement. A semi-structured interview question guide was developed that consisted of open questions about the participant's experiences with paramedicine student field placements. This guide was developed by the two experienced paramedic researchers and was designed to elicit stories about experiences of paramedic student supervision and an in-depth understanding of the changes taking place in the profession, through the eyes of expert informant. One of the three investigators (HH), a doctorally qualified social worker who was unknown to the participants, conducted face to face interviews that took 30–60 min; these interviews were audio recorded with the participant's permission and then transcribed. Recruitment ceased when saturation was reached.

The interview transcripts were imported into QSR NVivo-10 before being analysed and coded by one research investigator. Potential themes were identified inductively from the transcripts, and then refined and confirmed by the other research investigators. Our results are reported using the three domains of COREQ checklist for qualitative research. (Tong et al., 2007).

Ethics

La Trobe University Faculty of Health Sciences Human Research Ethics Committee (HREC) approved the research (FHEC12/182) as well as the Human Research Ethics Committee of Auckland University of Technology (13/286). To minimise any potential issues arising from participating in this research, several measures were implemented. Firstly, a generic email was distributed by the Ambulance service to advertise the project and invite participation. Paramedics who were interested in participating were invited to contact the research investigator (HH) who is outside the field of paramedicine. The research investigator (HH) then explained the project, obtained written consent, arranged and conducted the interview. Paramedics were able to nominate the location and time of the interview, and interviews were transcribed and de-identified before data analysis.

Results

Participant Demographics

Face to face interviews were conducted with paramedic instructors in Paramedic Service A (PSA) ($n = 6$) and Paramedic Service B (PSB) ($n = 9$). Of these instructors ($n = 15$), the average age was 40 years, one third were female ($n = 5$) and most ($n = 13$) were based in a metropolitan location. Participants represented a range of experience in paramedicine ranging from three years to 34 years (average = 14 years). In this article, pseudonyms have been used to protect the paramedic services' and the individual participants' identities.

In these settings, there were three main pathways to paramedicine: university education; vocational training through a paramedic service; and vocational training followed by completion of a university degree through one of several university conversion programmes. By chance, participants were equally distributed amongst these three groups. The first group ($n = 5$) comprised paramedics who were university educated either directly from school or from an unrelated workforce, their average experience as a paramedic was five years. The second group ($n = 5$) was made up of paramedics who had joined paramedic services and trained to be a paramedic through a series of internal and external training courses offered by their employer. These participants had worked as a paramedic for an average of 16 years. The third group of participants ($n = 5$) had joined paramedic services, were vocationally trained as paramedics and then completed a university degree programme. These participants had worked as a paramedic for an average of 19 years.

Paramedic instructors agreed that field placements are an essential element of paramedicine student education. Support for clinical

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