Preceptor Workshop

The University of Texas at Austin
Athletic Training Program

Outline

• ATP
• Definitions & Terminology
• Competencies & Proficiencies
• Roles of an Preceptor
• Preceptor qualities, skills & characteristics
• Student evaluations

• Learning Styles
• Teaching Styles
• Delivery Techniques
• Challenges in the Clinical Setting
• Reminders
• ATP P&P

ATP

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  – Program Director

• Corey Hannah
  – Clinical Education Coordinator

• James Bray, MD
  – Medical Director
Definitions

- Preceptor
- Supervision & Direct Supervision
- First Responder
- Educational Competencies
- Clinical Proficiencies
- Learning Over Time
- See handout

Definitions

- Preceptor
  - Certified/licensed professional who teaches and evaluates students in a clinical setting using an actual patient base
  - Qualifications:
    - Credentialed by the state in a healthcare profession
      - ATC, RT, LPN, RN, MT, DO, MD, DDS, EMT, RD, PA, etc.
    - Receive planned and ongoing education from the program designed to promote a constructive learning environment
    - Demonstrate understanding of and compliance with program’s policies and procedures
    - Not enrolled in ATP

Definitions

- Preceptor’s Functions:
  - Supervise students during clinical education
  - Provide instruction & assessment of the current knowledge, skills, and clinical abilities designated by the Commission
  - Provide instruction & opportunities for the student to develop clinical integration proficiencies, communication skills, and clinical decision making during actual patient care
  - Provide assessment of above
  - Facilitate the clinical integration of skills, knowledge, and evidence regarding the practice of AT
Definitions

• Direct Supervision
  – Clinical education:
    • The application of AT knowledge, skills, and clinical abilities on an actual patient base that is evaluated and feedback provided by a preceptor
    • Preceptor must be physically present to intervene
      – Don’t have to stand over ATS’s shoulder, just be there to intervene prn.
  – Proficiency assessment:
    • 1 on 1 evaluation of ATS proficiencies by Preceptor
      – More later…

Definitions

• “First Responder”
  – a.k.a. unsupervised student
  – Students must be supervised at all times!
    • Restroom / phone call, temporarily unsupervised
      – ATS will act as a “first aid provider” by stabilizing the athlete and waiting for the Preceptor to return
    • Students can NOT cover px, weights, conditioning, tx, rehab sessions, massage sessions, etc. without supervision
      – ”The JRC-AT and NATABOC have jointly not endorsed the concept of the first responder and the use of unsupervised students publicly on several occasions. We stand firmly by our definition of supervision of students and the need for intervention capabilities.”

Definitions

• Educational Competencies
  – Minimum requirements for a student’s professional education
  – Basic knowledge base for entry-level athletic trainers
  – Taught & evaluated in the classroom / lab
Definitions

• Clinical Integrated Proficiencies (CIPs)
  – Basic skills for an entry-level athletic trainer
  – Taught in the classroom / lab but evaluated by a Preceptor
  – Measure a real life application
    • Should be assessed on actual patients
      – Simulations as a last resort
  – Can they apply what they’ve learned to the clinical setting?

• Learning Over Time / Mastery of Skills
  – documented, continuous process of skill acquisition, progression, and student reflection
  – Allows the ATS to learn it, px it, get tested on it, then use it, then improve, integrate into overall skill set
  – Ex.
    • Learn to tape in KIN 219K (spring ’11)
    • Px the taping over and over (spring ’11 – fall ’12)
    • Level IA proficiency (fall ’12)
    • Incorporate the skill into a tx / rehab plan (spring ’13)

• Mastery of Skills
  – Not a “one and done”
  – MUST involve repeated integration of skill sets and knowledge
Proficiencies and Competencies

Competencies and Proficiencies

- AT Educational Competencies 5th ed.
- Basic knowledge, skills, and clinical abilities to be mastered by ATS
  - What is needed to become an entry-level athletic trainer?
    - Evidence-Based Practice
    - Prevention and Health Promotion
    - Clinical Examination and Diagnosis
    - Acute Care of Injury and Illness
    - Therapeutic Interventions
    - Psychosocial Strategies and Referral
    - Healthcare Administration
    - Professional Development and Responsibility

Proficiencies & Competencies

<table>
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<tr>
<th>Year</th>
<th>Fall Courses</th>
<th>Profs.</th>
<th>Spring Courses</th>
<th>Prof.</th>
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Prerequisites:
- CC 308M Medical & Scientific Terminology
- KIN 312K Care & Prevention of Athletic Injuries
- KIN 219K Introduction to Athletic Training
- KIN 324K Applied Human Anatomy
### Proficiencies & Competencies

<table>
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<tr>
<th>Proficiency Level</th>
<th>Related Courses</th>
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<tr>
<td>1A</td>
<td>Intro to A.T., Care &amp; Prevention, Medical Terminology, Anatomy</td>
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<td>1B</td>
<td>Modalities</td>
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<td>2A</td>
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<td>2B</td>
<td>Rehab x2, Ex Phys, Conditioning</td>
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<tr>
<td>3A</td>
<td>Topics in A.T.</td>
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<tr>
<td>3B</td>
<td>Administration, Nutrition</td>
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### Clinical Integration Proficiency:

- Can they take the info they've learned in the classroom / lab and apply it in the clinical setting, with an actual patient situation (preferably) or a realistic scenario?

- **Comprehensive real patient care**

- “…require that students demonstrate the ability to examine and diagnose a patient, provide appropriate acute/emergency care, plan and implement appropriate therapeutic interventions, and make decisions pertaining to safe return to participation.”

### Clinical Integration Proficiencies

- **Knee evaluation:**
  - Can they perform a knee evaluation correctly?
  - H.I.P.S.:
    - Not every question is needed
    - Not every special test
      - Thomas Test w/ an ACL?
    - Do they know what things mean?
      - + Lachman = ?
  - Do they know what to do as well as what not to do?
  - Are they efficient? Can they think critically?
  - Can they take this info and apply it?
    - Referral, Tx plan, rehab plan, etc
  - Do they have the knowledge and skills of an entry-level ATC?
Proficiencies & Competencies

- UT ATP’s:
  - https://education.utexas.edu/departments/kinesiology-health-education/undergraduate-programs/athletic-training-program/forms

Proficiency Evaluation

- Done by a Preceptor
- 1 on 1 setting with ATS
  - Office Hours
  - Staged scenario
  - Clinical Experiences
    - Ideal situation!
    - Real-life patient case
    - Plenty of opportunity for this!
  - Ex: Athlete reports w/ ankle injury
    - Have ATS do the eval
    - ATS reports findings to you
    - ATS suggests tx, f/u, referral, rehab etc.
    - Evaluate the ATS performance
  - Ex: Athlete reports for tx
    - Have ATS suggest tx parameters to you
    - Evaluate the ATS performance

Proficiency Evaluation

0 = unable to perform the skill safely or effectively. Should not be allowed to perform the skill in the clinical setting. Must repeat this proficiency evaluation.

1 = able to perform the skill safely & effectively with prompting from Preceptor, should be allowed to perform the skill in the clinical setting with close supervision and assistance. Must repeat this proficiency.

2 = able to perform the skill safely and effectively without prompting from an Preceptor. Should be allowed to perform the skill in the clinical setting without the need for close supervision. Need not repeat this proficiency evaluation.

- If you were not there, would you feel comfortable with the ATS performing this skill / task safely and effectively on his / her own?
- Is he / she competent, proficient, and efficient?
Proficiency Evaluation

- Some proficiencies will have a detailed form ("skills test") for you to complete, others are very self explanatory.
  - Injury evaluation vs. obtaining body weight
  - Feel free to make suggestions to ATS
  - There is seldom only one "correct way"

- Provide specific feedback to ATS

- Sign his / her proficiency log, only if he/she received a "2" on the overall score

Proficiency Completion Log

- Sign student's proficiency log, only if he/she received a "2" on the overall score

- If student receives a "0" or "1":
  - Do NOT sign log
  - "must see __" in comments
  - Lets other Preceptors know ATS needs to see you again for re-assessment

Skills Test Sheet

- "rubric sheet" for more complex skills (e.g. eval, tx)
- ATS brings form to you
- Must be used when indicated *

Proficiencies

- ATS can only perform a skill / task after they have:
  - Received formal instruction in the classroom or lab
    - ATS must be instructed on AT clinical skills prior to performing those skills on patients.
  - Been "signed off" as having proved their proficiency, (i.e. earned a "2" on their proficiency evaluation), or are using that opportunity to "sign off" a proficiency
  - "teachable moment": take advantage of opportunities
    - 1st year student performing a Lachman on an injured player, even though they have not taken the eval course yet
      - You can demonstrate and have ATS perform the Lachman with you there, however, they can not just start doing knee evals after that incident.
    - THIS IS A GOOD THING!
Reminders…

- ATS must be supervised at all times by a credentialed professional
  - ATS can not travel w/ teams w/o a Preceptor
  - Can not take the place of a credentialed healthcare provider at any time

- Proficiencies must be evaluated in a 1:1 setting
- Only sign the ATS proficiency log if they “passed” the proficiency, i.e. received a “2”
- ATS can only perform a skill after they’ve been instructed and evaluated, unless using that opportunity for the proficiency evaluation

Reminders…

- The ATS is an athletic training STUDENT
  - Academic issues have priority over clinical assignments
  - Ideal clinical hours 20±/week
    * 40 minus course load
  - MUST have at least one day off

- Give the ATS ongoing feedback
  - Address problems, praise good behaviors
  - Document problems early

“First Responder”

- Unsupervised ATS / “first aid providers” may perform the following duties:
  - Evaluation of injuries and illnesses to determine the need for EMS or immediate referral

  - First aid providers may not make decisions on whether or not an athlete may return to activity other than removing an athlete from activity for immediate referral or emergency medical care
  - In the event a first aid provider evaluates an athlete with an injury or illness that does not require (a) activation of EMS, (b) immediate referral, or (c) the provision of emergency first aid, the first aid provider may not medically evaluate the injury or illness. The first aid provider is to immediately contact the appropriate supervisor or credentialed professional, according to the clinical site’s policies and procedures to inform him or her that there is an athlete with a non-emergent injury or illness. The first aid provider is NOT to render a decision as to whether or not the athlete may return to play, nor is the first aid provider to perform any other evaluations or treatments.

  - In the event a first aid provider evaluates an athlete with an injury or illness that requires (a) activation of EMS, (b) immediate referral, or (c) the provision of emergency first aid, the first aid provider will activate the Emergency Action Plan (EAP), according to that site’s policies and procedures. After taking the appropriate actions, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.
“First Responder” cont’d…

- provide ice, compression, and elevation
  - in the event a first aid provider provides ice, compression, and or elevation, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.

“First Responder” cont’d…

- splint, immobilize, or provide support to an injury
  - in the event a first aid provider splints, immobilizes, or provides support to an injury, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.

“First Responder” cont’d…

- activate EMS
  - in the event a first aid provider activates EMS, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.
“First Responder” cont’d...

- perform CPR, rescue breathing, and / or AED procedures
  - in the event a first aid provider performs CPR, rescue breathing and / or AED procedures, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.

“First Responder” cont’d...

- provide first aid care for “medical emergencies”
  - in the event a first aid provider provides first aid, the first aid provider will notify the appropriate supervisor according to the site’s policies and procedures and document the incident on the appropriate forms.

“First Responder” cont’d...

- Unsupervised students / first aid providers may NOT provide “athletic training services”. Activities which are NOT to be performed by an unsupervised student include:
  - providing treatments for injuries other than the activities listed above
  - providing or supervising rehabilitation procedures
  - making decisions about the disposition of an injured or ill athlete other than the activities listed above
Clinical Supervision

• Students are required to notify the PD or CEC immediately if they feel that they are inadequately supervised in the clinical setting.

• Students may not travel with a team, in the capacity of an ATS, unless a credentialed professional also accompanies the team and will supervise the ATS as a Preceptor.

Clinical Education

• All sites where students are involved in patient care or observation-only experience must have an affiliation agreement or memorandum(s) of understanding that is endorsed by the appropriate administrative authority (i.e. those bearing signature authority) at both the sponsoring institution and site. – AD, Principal, etc.

Clinical Education

• Clinical education must provide students with authentic, real-time opportunities to practice and integrate athletic training knowledge, skills, and clinical abilities, including decision-making and professional behaviors required of the profession in order to develop proficiency as an Athletic Trainer.
Clinical Education

• The variety of patient populations, care providers, and health care settings used for clinical education must be consistent with the program’s mission statement.

• Students must gain clinical education experiences that address the continuum of care that would prepare a student to function in a variety of settings with patients engaged in a range of activities with conditions described in athletic training knowledge, skills and clinical abilities...

• Examples of clinical experiences must include, but should not be limited to:
  – Individual and team sports;
  – Sports requiring protective equipment (e.g., helmet and shoulder pads);
  – Patients of different sexes;
  – Non-sport patient populations (e.g., outpatient clinic, emergency room, primary care office, industrial, performing arts, military);
  – A variety of conditions other than orthopedics (e.g., primary care, internal medicine, dermatology).

Clinical Education

• All clinical education sites must be evaluated by the program on an annual and planned basis and the evaluations must serve as part of the program’s comprehensive assessment plan.
  – ATS site visit
  – CEC site visit
Clinical Education

- Per CAATE Standards, all clinical education experiences must be educational in nature.

- All students must have at least one “day off” in every seven-day period – on which the student is NOT involved with any type of clinical education experience.

Policies on Clinical Educational Experience Hours

- Students should not be pressured into missing classes, lab sessions, or educational meetings for clinical education experiences.
  - In the event that a student feels that he or she is being pressured by a Preceptor to do so, the student is expected to report the incident to the PD or CEC immediately.

- Students are not required to miss class or course related activities (labs, review sessions, etc.) in order to participate in clinical education experiences.

- Students are not to be used as laborers or in place of credentialed staff and, therefore, should not be required or pressured into reporting for an extraordinary number of clinical education hours.
Policies on Clinical Educational Experience Hours

• Although students are not “employed” during the clinical rotation hours, the University’s policy on student employment is a good rule to follow. The policy states:
  – “an undergraduate student’s combined University employment and semester-hour course load may not exceed forty hours a week in any semester or summer term.”

• This is not to say that students should “clock out” at a certain hour mark or report, “just to be there”. It is up to the student and his or her Preceptor to determine a sufficient number of hours that lead to a beneficial experience, however, the emphasis needs to be placed on the quality of the education associated with the hours and not on quantity of clinical education hours.

Policies on Clinical Educational Experience Hours

• While school is in session:
  – Students should report for a minimum of 75 and a maximum of 600 clinical education hours per academic semester, while complying with the following guidelines:
    • Students should report for an average over the semester of at least five hours of clinical education experience per week. This is not to say that students should report for five hours “just to be there” each and every week. It should be an average per week over the semester – meaning approximately 25 hours over the semester at a minimum.
    • Students should report for an average over the semester of 40 minus the students’ course credit load per week maximum. This is not to say that students should punch out at a certain number of hours each and every week. It should be an average per week over the semester – meaning there may be some weeks with more clinical education hours due to more exposures and some weeks with less. As an example, this would be approximately 25 hours per week and 375 hours over the semester for a student enrolled in 15 credit hours.

• In the event a student feels that he or she is being pressured by a Preceptor to report for an extraordinary number of clinical hours, is being limited to too few clinical education hours, and/or is not granted at least one day off per week, the student is expected to report the incident to the PD or CEC immediately.
Policies on Clinical Educational Experience Hours

• While the BOC guidelines no longer require students to track clinical hours in order to sit for the BOC examination, students must submit documentation of clinical hours to the Preceptor, CEC, and/or PD to ensure compliance with the above-mentioned guidelines.
  – It is the students’ responsibility to document these hours, obtain a supervisor’s signature acknowledging those hours, and keep track of the documents.

Clinical Education

• An active communicable or infectious disease policy as determined by the institution must be established and made publicly available.
  – Must follow with Dr. Bray, through me, if ATS missed clinicals b/c illness
  – Please let PD or CEC know if ATS misses b/c of injury or illness especially if ATS is injured or becomes sick related to clinicals

Clinical Education

• The program must establish and ensure compliance with a written safety policy(ies) for all clinical sites regarding therapeutic equipment. The policy(ies) must include, at minimum, the manufacturer’s recommendation or federal, state, or local ordinance regarding specific equipment calibrations and maintenance.

• The program must provide proof that therapeutic equipment at all sites is inspected, calibrated, and maintained according to the manufacturer’s recommendation, or by federal, state, or local ordinance.
  – GFIs too!
Clinical Education

- BBP training and procedures:
  - A detailed post-exposure plan that is consistent with the federal standard and approved by appropriate institutional personnel must be
    - provided to the students
    - Immediately accessible to all current students and program personnel including Preceptors
    - Notify PD or CEC if ATS is unsafely exposed to BBP

Clinical Education

- BBP training and procedures:
  - Students must have access to and use of:
    - appropriate blood-borne pathogen barriers and control measures at all sites.
    - proper sanitation precautions (e.g. hand washing stations) at all sites.

Clinical Education

- All sites must have a venue-specific written Emergency Action Plan (EAP) that is based on well-established national standards or institutional offices charged with institution-wide safety (e.g. position statements, occupational/environmental safety office, police, fire and rescue).
- The program must have a process for site-specific training and review of the EAP with the student before they begin patient care at that site.
- Students must have immediate access to the EAP in an emergency situation.

Clinical Education

- All program documents must use accurate terminology of the profession and program offered
  - Athletic training, athletic trainer (AT not ATC)
  - Athletic training facility or clinic not “room”
  - Athletic training student not student trainer or student athletic trainer
  - Athletic Training Program not AT Education Program
  - BOC certification (not NATABOC or NATA, etc.)

Orientation Meeting w/ ATS

- Mandatory BEFORE 1st day of rotations
  - Expectations of ATS
    - Starting date, reporting date and times, specific clinical responsibilities
  - Site specific EAP(s)
    - Location of equipment (AED, splints), location of phone, 911 vs. 9-911…, location of written EAP
  - Site specific P&P
    - Documentation procedures, distribution of OTCs, equipment/supply check out, use of office supplies equipment (phone, computer), dress code, field/court set up, BBP exposure plan, travel policy

Orientation Meeting w/ ATS

- How proficiencies will be managed
- Location of general equipment/supplies
- Use of modalities
- Introductions to faculty, staff, students, coaches, admins, etc.
Roles of a Preceptor

- Teaching
  - Formal & informal
    - Teachable moment
  - Competencies & proficiencies
  - Required info & “real-world” info
  - Classroom & clinical
  - Promote critical thinking
    - Create a clinician not a technician!

- Evaluating
  - Formal evaluation of clinical proficiencies
    - One on one setting
    - Office hours (staged)
    - Clinical Rotations (real)
    - ATS “performance” in the clinical setting
    - Skills & knowledge not just personal characteristics
  - Ongoing process
    - Formally 2/semester

Being a Preceptor
Roles of a Preceptor

- **Supervision**
  - All ATS must be supervised
  - Direct (1-on-1) supervision during proficiency evaluation

- **Mentoring**
  - Teach them what it is like to be an AT, a professional, an adult, etc.
  - Taking advantage of the (+)
  - dealing with the (-)
  - Advise on future plans
  - Assist w/ future plans
  - Helping them be a "better" student, person, professional, etc.

Qualities, Characteristics, & Skills of an Affective Preceptor

- **Legal & ethical behavior**
  - ATS & Preceptor must follow:
    - NATA Code of Ethics,
    - Texas State laws,
    - NCAA rules,
    - ATP P&P,
    - CAATE guidelines,
    - etc.

- **Communication skills**
  - w/ ATS, program director, etc.
  - Non-threatening, tactful, honest, encouraging
  - Express interest in ATS as a whole
  - Be open to ATS feedback

- **Supervisory Skills**
  - Create a positive learning environment
  - Clarify goals, objectives, & expectations
    - Initial meeting / orientation
  - Provide timely feedback
    - Don’t let it pile up
  - Open & supportive to ATS
  - Provide appropriate supervision
Qualities, Characteristics, & Skills
of an Affective Preceptor

• Instructional Skills
  – Knowledgeable in A.T.
    • Things have changed since we were in school
  – Understand level of ATS and their prior knowledge
    • Appropriate clinical responsibilities based on proficiency completion
  – Know different teaching & learning styles
  – Encourage critical thinking & problem solving skills, not just fact recall

• Performance Evaluation Skills
  – Provide clear & objective ATS performance evaluations
  – Frequent, objective, & specific feedback
  – Address mistakes & reinforce good performance

• Clinical Competence
  – Knowledge of 8 domains of A.T.
    • Evidence-Based Practice
    • Prevention and Health Promotion
    • Clinical Examination and Diagnosis
    • Acute Care of Injury and Illness
    • Therapeutic Interventions
    • Health Care Delivery and Patient Safety
    • Healthcare Administration
    • Professional Development and Responsibility
  – Things have changed since some of you were in school!
    • Heart auscultation
    • Body fat analysis
    • Laser therapy
    • Manual therapy skills
Qualities, Characteristics, & Skills of an Affective Preceptor

- **Administrative Skills**
  - Time management
  - Completing & submitting appropriate paperwork in a timely fashion
  - D.O. evals
  - ATS evals
  - Proficiency evals
  - Etc.

- **Professional Development**
  - Demonstrate professionalism
  - Promote professionalism to ATS
  - Aid ATS in understanding their professional responsibilities
  - Encourage ATS participation in meetings, organizations, etc.
  - Introduce ATS to professional peers

Evaluating ATS

- **Formative feedback to ATS**
  - Continuous corrective feedback
  - (+) reinforcement
  - Correct mistakes,
  - Reinforce good performance

Evaluating ATS

- **Assessing ATS clinical performance**
  - Documents ATS skill acquisition, level of ability, & progression
  - Provides feedback re: instructional techniques & quality of clinical instruction
  - Evaluate ATS ability to perform psychomotor skills & ability to apply and integrate psychomotor skills & attitudes in their clinical experiences
  - Evaluate the ATS overall clinical performance
    - Preferably evaluate the ATS performance of proficiencies on real patients w/ real injuries
Evaluating ATS

- Be honest
- Be consistent
- Be objective
- Provide comments
  - Be specific
- Review w/ the ATS
- Both ATS & Preceptor sign & date the form

Challenges in Clinical Education

- Climate
  - Learning environment / atmosphere
    - Conducive to learning?
    - Non-threatening?
    - Encouraging?
    - Professional?
- Management
  - Be firm but fair
  - Support ATS
  - Have a plan for what they do

Challenges in Clinical Education

- Expectations:
  - Of Preceptor
  - Of ATS
  - Address at orientation
    - Within 1 week of beginning the rotation
    - Clear, written expectations
    - General to ATEP
    - Specific to Preceptor
- Feedback
  - Timely
  - Daily interaction
  - Objective
  - Constructive
  - Focused on task
  - Address errors
  - Reinforce / praise good behaviors
Challenges in Clinical Education

- **Communication**
  - B/t Preceptor & program director
  - B/t Preceptor & ATS
  - Be approachable & non-confrontational
  - Both the ATS & Preceptor are responsible for communicating with each other

- **Assessment**
  - Be fair
  - Be firm
  - Be objective

- **Time Management**
  - Being an Preceptor takes time
  - Meetings
  - Tx
  - Rehab
  - Proficiencies
  - mentoring
  - Being an ATS takes time also
  - CLASS & Labs
  - Meetings
  - Clinical duties

- **Collaboration**
  - "interaction the Preceptor & ATS have with others”
  - Preceptor should promote the ATS as a professional to athletes, coaches, physicians, administrators, parents, etc.
  - Encourage coaches & athletes to see ATS as part of the team, not an outsider
  - Cooperation b/t Preceptors, b/t Preceptor & program director,

- **Financial Issues**
  - Preceptors are not paid
  - We ask for as little of your time as possible
  - Being an Preceptor in exchange for ATS assistance
  - You don’t have to be an Preceptor if you don’t want to…

- **Student Behavior**
  - Address issues with the ATS early
  - DOCUMENT problems early
  - Violation report
  - Let the program director know
  - Address expectations in orientation
  - Don’t let it get personal
Challenges in Clinical Education

• Enforcing / Following Policies & Procedures
  – Institutional Policies
  – ATEP P&P manual
  – ATEP Preceptor manual
  – Clinical sites P&P manual
  – CAATE guidelines
  – TDLR guidelines

ATP Website

Learning Styles
Learning Styles

• Students have different learning styles
• Instructors need to adapt to the students’ learning styles
• How you learn, doesn’t work for everyone
• Students are not easily classified into 1 learning style, they use many different styles at different times (if not, they don’t learn well)

Learning Styles

• “a specific pattern of behavior & /or performance the learner utilizes in approaching learning experiences, the way information is processed, retained, and utilized”

Learning Styles

• Sensory Learning Styles
  – Visual
  – Imitative
  – Auditory
  – Bodily-kinesthetic
• Expressive Learning Styles
  – Individual
  – Group
  – Oral expressive
  – Written expressive
  – Sequential
  – global
Sensory: Visual Learners

• Prefers to see words / numbers in a book, board, chart, workbook, models, computers, etc.
• Typically write down much of what they hear
• Typically a holistic learner
  – All or none
  – “Aha, I get it”
• Good w/ whole systems, major concepts, inductive learning, problem solving
• How would you teach the concept to a hearing impaired person?

Sensory: Visual Learners...

• Remember what they see not what they hear – show them
• Are not step by step learners, give them the “big picture” first
• Have poor rote memory

Sensory: Imitative Learners

• The student observes and models your behavior
• Problematic b/c
  – Student’s learn how, not why
  – Student’s don’t have the experience to alter things when needed
Sensory: Auditory Learners

- Prefer to vocalize to themselves, move their lips when reading
- Audiotapes, lectures, discussions are useful

Sensory: Bodily-Kinesthetic Learners

- Learn best by doing or being involved, experiencing

Expressive: Individual

- Think and work alone...introverted
- Self-motivated
- Not good w/ groups
- Usually good at thinking through concepts
- Need clear instruction, goals, objectives
- ~25% of all students, but are the top 85%
Expressive: Group Learner

- Studies in groups
- Interacts w/ others
- Are stimulated by others’ opinions, thoughts
- Benefit by group discussions

Expressive: Oral Expressive

- Prefers to verbalize things instead of write them down

Expressive: Written Expressive

- Best with written reports, essays, journals, notes, etc.
- Good w/ taking & learning from notes
- Need time before expressing themselves verbally
Expressive: Sequential Learner

• Needs structure and pre-planned activities
• Uses logic to problem solve
• Pays attention to detail
• Makes lists of goals
• Usually work on one task at a time, complete it, then move on

Expressive: Global Learner

• Unstructured ordering of thoughts & ideas
• Wants to know the main idea, then creates their own way of completing the tasks to get there
• Works on many tasks at a time

Teaching Styles
Teaching Styles

- Teaching students in the manner in which you were taught does not always work
- Common Styles:
  - Assertive
  - Suggestive
  - Collaborative
  - Facilitative

Teaching Styles

- Need to gradually change style to accommodate students’ progress
- In the beginning the teacher is the show
  - ATS needs detailed instructions / guidance
- As ATS progresses, Preceptor should provide + reinforcement to ATS & encourage the ATS to “push” themselves into new things
- As ATS pushes themselves to learn and do new things, the Preceptor should allow the ATS to do more w/ less instruction / supervision
- Later the teacher should guide the show and allow the ATS to run it (under supervision)

Changing leadership / teaching style

<table>
<thead>
<tr>
<th>Style</th>
<th>Preceptor action</th>
<th>Level of guidance / supervision</th>
<th>ATS level of readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling</td>
<td>gives explicit instructions</td>
<td>High, close supervision</td>
<td>Low, ATS is insecure in ability</td>
</tr>
<tr>
<td>Telling / coaching</td>
<td>Explain rationale for decisions, provide opportunity for ATS clarification</td>
<td>Mod high supervision</td>
<td>Moderate, ATS feels unable but willing to perform</td>
</tr>
<tr>
<td>Participating</td>
<td>Share ideas &amp; facilitate decision making processes w/ ATS</td>
<td>Mod low supervision</td>
<td>Moderate, ATS feels able but insecure in ability</td>
</tr>
<tr>
<td>Delegating</td>
<td>Give decision making responsibility to ATS</td>
<td>Low, little supervision, but always supervised</td>
<td>High, ATS feels able &amp; confident in ability</td>
</tr>
</tbody>
</table>
Teaching Styles

• Student-centered teaching styles promote creative problem solving & critical thinking skills
  – Use open ended questions
  • Fosters analytical thinking not recollection of facts
  – Helps the student understand the need for lifelong learning
• Too many of us stay with the teacher centered teaching style

Essential Teaching Elements for Preceptors

• Comprehension
  – The Preceptor determines what is known / unknown (by the Preceptor & ATS)
• Transformation
  – The Preceptor organizes & transfers info into teachable content & format
• Instructional performance
  – The Preceptor identifies teaching methods that are in tune w/ the ATS ’s learning style
• Reflective evaluation
  – The Preceptor analyzes both the ATS ’s and Preceptor’ s performance
• New comprehension
  – The Preceptor gains new knowledge from the teaching experience

Teaching Clinical Skills

• Skill learning can be categorized into these steps:
  – Initially understanding the task /skill / movement
  – Performing the task/ skill/ movement
  – Refinement of the skill
  – Committing the skill to memory
Teaching Clinical Skills

1. Preceptor establishes a problem that leads to a goal
   - Create an assignment, test, project, etc.
   - The ATS will recognize the need for certain knowledge to overcome this problem

2. Preceptor engages the ATS
   - How do they learn best?
   - Use a variety of methods (visual, auditory, self-directed problem solving activities, etc.)

3. Preceptor controls the learning environment
   - Make it realistic / real life
   - Allow ATS to px their skills on real people or real-like simulations

4. Preceptor provides timely feedback
   - Focus on the behavior not the student
   - Feedback should be descriptive & specific not judgmental

Teaching Clinical Skills

- Must introduce in a common sense fashion
- Must provide increasing difficulty

Stages of Psychomotor Skill Acquisition

- After the ATS learns the skills in the classroom they should practice the skill then...
- They should be allowed to perform the skill in the clinical setting under direct supervision, then...
  - After proving their proficiency
- The ATS should be allowed to perform the skill w/o direct supervision
Stages of Psychomotor Skill Acquisition

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distinguish</td>
<td>ATS displays the ability to visually identify basic components of various skills</td>
<td>Identify a valgus stress test from a Lachman’s</td>
</tr>
<tr>
<td>Set</td>
<td>ATS assumes physical position</td>
<td>Assures hand placement to perform the Lachman’s</td>
</tr>
<tr>
<td>Guided response</td>
<td>ATS duplicates the skill demonstrated by the Preceptor</td>
<td>ATS is able w/ assistance to pull the tibia anteriorly</td>
</tr>
<tr>
<td>Mechanism</td>
<td>ATS responds to Preceptor feedback</td>
<td>ATS refines hand placement and force application, etc.</td>
</tr>
<tr>
<td>Complex overt response</td>
<td>Coordination of individual maneuvers into a complex task</td>
<td>ATS demonstrates the ability to perform the task independent</td>
</tr>
<tr>
<td>Adaptation</td>
<td>ATS self-modifies the technique to obtain the best result</td>
<td>ATS adapts the Lachman to a person w/ large leg girth</td>
</tr>
<tr>
<td>Origination</td>
<td>ATS develops new maneuvers</td>
<td>ATS creates an alternative form of stressing the ACL</td>
</tr>
</tbody>
</table>

Methods for Teaching Clinical Proficiencies

- Cognitive Apprenticeship
  - ATS participates with Preceptor to learn knowledge, physical skills, procedures, thinking processes & professional culture of the field

- 4 dimensions to ideal teaching / learning environment
  - Content
  - Method
  - Sequence
  - Sociology

Dimensions to ideal teaching / learning environment

- Content
  - Domain knowledge
  - Facts, concepts, procedures of A.T.
  - "book knowledge"

- Teaching Methods
  - Modeling
  - Coaching
  - Scaffolding
  - Articulation
  - Reflection
  - Exploration
Dimensions to ideal teaching / learning environment

Teaching Methods

• Modeling
  – ATS observes Preceptor
  – ATS sees how task should look

• Coaching
  – Preceptor observes ATS while ATS performs a task
  – Preceptor provides verbal or physical feedback / assistance
  – Allows ATS to participate while Preceptor guides them

• Scaffolding
  – Preceptor support ATS before or during a task
  – Hints, directions, reminders
  – Backward chaining:
    • Demonstrate last step then each preceding step
    • Gives ATS an idea of what the outcome should be
    • Best for longer procedures
  – Forward lengthening
    • Demo 1st step, they px
    • Demo 2nd step, they px...
    • Best for short procedures

• Articulation
  – Preceptor watches their actions after / while the ATS verbalizes their knowledge, reasons, thinking processes
  – Otherwise, the Preceptor has to make inferences about the ATS knowledge, reasons, etc based on their actions

• Reflection
  – ATS compares their practice w/ previous px or with the Preceptor’s px
  – Not just replay the event, but analyze it

• Exploration
  – Create opportunities for ATS to identify and solve real practice problems on their own
Dimensions to ideal teaching / learning environment

- **Sequencing**
  - Appropriate sequencing of learning experiences to help ATS acquire, integrate, and use knowledge
  - Increase complexity throughout sequence
  - Increase diversity throughout sequence
  - Different scenarios / settings / contexts
  - Present global skills before local skills
    - Have student participate in an entire process, then break it down for them

- **Sociology**
  - Professional practice & interactions w/ professionals & other students
  - ATS observes "role models" in action
  - ATS experience the professional culture
  - Student intrinsically wants to learn more / improve skills so they can participate more
  - Cooperation & competition amongst students
    - ATS get together to assist one another in learning vs.
    - ATS compare their experiences to others’ or discuss how they would have addressed the situation