

Agenda Item 8 Clinical Education Oversight INFORMATION

Respiratory Care Clinical Education: A Needs Assessment for Preceptor Training

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BACKGROUND: There has been a growing interest in the use of volunteer clinical preceptors to provide clinical instruction to respiratory therapy (RT) students. However, many RT preceptors have had little or no training in preceptorship. We sought to identify the preceptor training needs of programs that lead to the Registered Respiratory Therapist or Certified Respiratory Therapist credential (RT programs). **METHODS:** Via e-mail we asked the directors of accredited RT programs to respond to a Web-based survey. **RESULTS:** Seventy-four RT program directors, from programs across the United States, responded. Eighty-two percent of the respondents' programs offer an associate's degree and 16% offer a baccalaureate degree. The majority of the respondents' programs use unpaid clinical preceptors. Thirty-two percent of the respondents indicated that the preceptors had received no preceptor training. Among the preceptors who did receive training, the duration of training ranged from 1 hour to 6 weeks. The training was typically delivered by the director of clinical education or program faculty. Eighty-one percent of the respondents believed there is a need for a standardized preceptor-training program. The respondents' understanding of, curriculum for, and implementation of preceptor training differed considerably, and there were substantial differences in the content and duration of the existing preceptor-training programs. Seventy-two percent of the respondents had experienced barriers to preceptor training. **CONCLUSIONS:** A standardized preceptor-training program is needed to improve the quality of preceptorship and assure that RT programs prepare graduates for 21st-century RT practice. *Key words:* preceptor, respiratory therapy education, respiratory care education, clinical education. [Respir Care 2009;54(7):868–877. © 2009 Daedalus Enterprises]

Introduction

In recent years there has been a growing interest in the use of volunteer clinical preceptors to provide clinical instruction to respiratory therapy (RT) students. Today's preceptors play a vital role in teaching the next generation of RTs at the bedside. Without proper training and support, however, preceptors are often set up to fail at this important task.

As educators we seek the best strategies to facilitate our students' acquisition of the necessary knowledge, skills, and attitudes to prepare them for practice in today's com-

plex health-care environment. RT students need appropriate clinical experiences, with opportunities to perfect the performance of patient-care skills, to validate theory and knowledge, and to acquire abilities that can only be acquired through clinical practice.¹ An unsatisfactory or irrelevant clinical experience can lead to learner dissatisfaction with the career.² We believe that the use of qualified preceptors is important for exposing RT students to the complex practitioner role they need to understand.

Dr Rye presented a version of this paper at the OPEN FORUM at the 53rd International Respiratory Congress of the American Association for Respiratory Care, held December 1-4, 2007, in Orlando, Florida.

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The authors have disclosed no conflicts of interest.

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Table 1. Respondents' Institutions and Degree Types (n = 74)

	No.	%
Type of Institution		
2-year college	53	72
4-year college	11	15
University	7	10
Offers both 2-year and 4-year degrees	3*	4
Degrees Offered		
Associate degree	61	82
Baccalaureate degree	12	16
Other	1*	1

* Some programs offer both a 2-year and a 4-year degree, or other degrees such as a bridge or masters.

Preceptorship, in which the learner works with a professional practicing clinician, is the model of choice for clinical teaching in undergraduate and postgraduate health-care education.¹⁻⁶ RT educators are concerned about the preparation of RT preceptors. Increasing our preceptors' awareness of the learning processes in the clinical environment is crucial. Historically the "see one, do one, teach one" method has been useful in clinical education, but it is now apparent that learners must have the opportunity to weigh their performance against an accepted standard and to refine their practice until they achieve sufficient expertise.¹ We believe the preceptorship model can both provide those opportunities and inspire RT students' learning, influence their role socialization, and reinforce their competence.

A preceptorship is a one-on-one, reality-based clinical experience in which an experienced professional is teamed with a learner.² The literature clearly demonstrates the benefits of preceptorship to both the preceptor and the learner. Indeed, the study by Ohrling and Hallberg⁷ revealed that preceptorship reduces the risk of nursing students feeling helpless and empowers them in their learning at the bedside. The literature also demonstrates that preceptoring promotes learners' role socialization (ie, how students internalize the occupational role and learn the attitude and behavior norms of the health-care culture) and thus helps integrate the learner into the profession.⁷⁻⁹

Billay and Uonge identified attributes that preceptors should possess, including: being a role model and a facilitator; having good communication skills; being knowledgeable about the field; and understanding the principles of adult education.³

We have observed that many RT preceptors are thrown into preceptorship with little to no direction as to what is expected of a preceptor. At the 2005 American Association for Respiratory Care (AARC) Summer Forum, Debra Gray presented the preceptor-training model that was

adopted by the American Physical Therapy Association. After that symposium, 35 RT members of the AARC Education Section, most of whom were already running preceptor-training programs, formed an ad hoc committee to study RT preceptor-training and develop and implement a national RT preceptor-training program. Joseph G Sorbello MEd RRT, of the Department of Respiratory Therapy Education at Upstate Medical University, State University of New York, in Syracuse, New York, is the committee chair. Over about a year the committee gathered information on preceptor-training content, content-delivery methods, suggestions, et cetera, then decided to conduct a needs-assessment for a national RT preceptor-training program. We designed a survey to gather opinions and information about existing RT-preceptor-training program content, barriers, and content-delivery methods. We asked:

- Is there a need for a national RT-preceptor-training program? If so:
- What content should be included?
- What content-delivery methods should be used?
- What are the barriers to starting a national RT-preceptor-training program?

Methods

The institutional review board of the University of Arkansas for Medical Sciences approved this study.

The survey instrument (Appendix) was developed in 2 stages. First, from the literature we identified relevant measures of preceptor-training needs and drafted a 32-item survey instrument. Second, the draft was reviewed by a panel of experts for content and face validity. The panel consisted of 5 registered RTs who hold faculty appointments at 2 university-based RT programs, two of whom had previously developed preceptor-training programs. The draft instrument was also reviewed by a qualitative-methods expert who is not an RT, to assess content and face validity. Following review, we revised the instrument based on the panel's recommendations.

Via e-mail we invited 248 program directors of accredited RT programs listed at the Web site of the Committee on Accreditation for Respiratory Care. Two-hundred forty-six of the invitees were directors of programs that lead to the Registered Respiratory Therapist credential, and 44 were directors of programs that lead to the Certified Respiratory Therapist credential. Twenty-one of the program directors in the Committee on Accreditation for Respiratory Care database did not list an e-mail address, and 21 of the e-mail addresses were incorrect. The invitation e-mail gave instructions on how to access the survey Web site, and provided a password. The invitees were advised that

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Table 2. Survey Responses About Existing Preceptorship Systems

	Range	Mean ± SD	Mode
Total clinical hours per student	200–1,664	892 ± 223	700
Number of clinical instructors or preceptors (full-time clinical assignments)	0–35	2.6 ± 5.6	0
Number of paid full-time-equivalent preceptors with clinical assignments	0–10	2.1 ± 2.2	2
Paid part-time faculty teaching clinical courses	0–12	2.6 ± 3.6	1
Paid full-time faculty teaching clinical courses	0–5	1.9 ± 1.3	2
Actual hours of clinical instruction by paid program faculty per student	0–1,680	432 ± 410	500
Number of primary clinical affiliates	0–40	8.4 ± 6.7	5
Maximum student-to-instructor ratio in the clinic	1.1–10.1	3.7 ± 2.1	2
Number of clinical instructors or preceptors employed by the affiliate and with assigned workload	0–200	24 ± 33	10
Number of clinical sites	1–40	8.5 ± 6.7	5

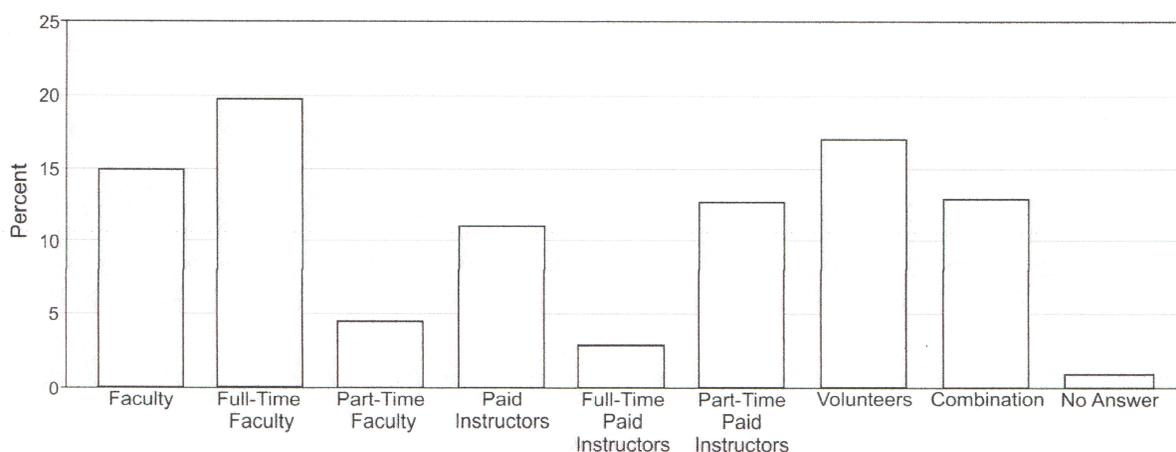


Fig. 1. Supervision of clinical instruction of respiratory-therapy students, as reported by directors of respiratory-therapy programs who responded to our survey.

they were free to refrain from answering particular questions, and to withdraw from the study at any time.

The survey was administered with survey software (Perception, Questionmark, Norwalk, Connecticut). Respondent-identification factors were not requested or used, and the respondents were informed that the demographic data would be used for descriptive reporting and to develop a preceptor-training program.

Results

Seventy-four (30%) of the 248 invited program directors responded. Fifty-three respondents (72%) were from 2-year institutions, 18 (24%) were from 4-year institutions, and 3 (4%) were from institutions that grant both 2-year and 4-year degrees. Four percent of the respondents were also located at academic health-science centers. The RT programs settings were: 53% urban, 18% suburban, 23% small town, and 7% rural. The associate's degree is offered at 82% of the institutions, and the baccalaureate degree at 16% (Table 1).

Though all RT programs must offer at least an associate's degree for accreditation, some 4-year colleges and universities also offer associate's degrees in RT rather than baccalaureate degrees. Sixty-one of the respondent programs grant the associate's degree. One institution also offers an associate's degree of applied science and an integrated master's program.

Table 2 summarizes the responses on the existing preceptorship systems at the respondents' institutions. Fifteen percent of the respondents reported that in their programs clinical instruction is directly supervised by college faculty members, 20% of whom were full-time and 4.5% were part-time. Seventeen percent of the respondents reported that they use volunteer, unpaid clinical preceptors (Fig. 1).

Fifty-six percent reported that clinical instructors or preceptors receive some type of training prior to receiving students, and 32% indicated that no training is provided (Fig. 2). Among the programs that indicated that they do provide preceptor training, 63% indicated that the training was an "orientation to the program," usually by the direc-

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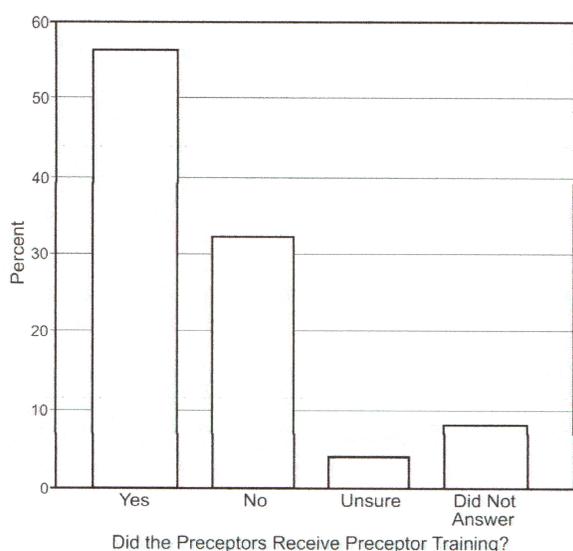


Fig. 2. Responses on whether the clinical instructors/preceptors receive any type of training prior to receiving students.

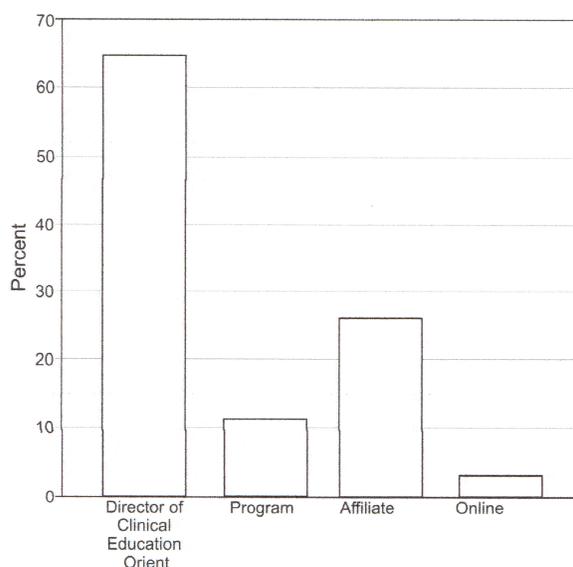


Fig. 3. Types of training received by clinical instructors/preceptors.

tor of clinical education, and these orientations ranged from 1 hour to 8 hours. Twenty-six percent of the respondents reported that their programs have formal preceptor training. In the programs that do provide formal preceptor training the duration range was 2 hours to 4 days. Twenty-six percent of the respondents reported that the training is provided by the clinical affiliate. Three percent of the respondent programs use online preceptor training (Fig. 3). We did not ask about the duration of preceptor training provided by the clinical affiliates or online. The respondents indicated that the preceptor training was provided by program faculty (32%), the director of clinical education (60%), affiliate personnel (6%), or the college (2%).

Eighty-one percent of the respondents thought that there is a need for a standardized preceptor-training program, 13% thought such a program is not needed, 1% were uncertain about the need, and 5% did not answer this question. Eighty percent of the respondents rated the importance of such a program positively (ie, a rating of > 6 on the 1–10 scale), and 32% of the respondents rated it as “most important” (rating 10) (Fig. 4).

The respondents estimated that up to 75 preceptors would need training in their institutions annually (estimate range 0–75, estimate mean \pm SD 17 \pm 14).

The respondents’ importance-rankings of the various preceptor training needs included: how to assess/evaluate clinical performance 57%; how to provide effective feedback 44%; understanding the preceptor’s roles and responsibilities 41%; communication skills 26%; understanding of inter-rater reliability 19%; dealing with difficult students 17%; understanding student needs 15%; and principles of adult learning 15%. Lower-ranked training needs

included learning styles, teaching strategies, critical thinking skills, balancing workload with teaching, legal issues, teachable moments, and dealing with the exceptional student (Table 3).

Seventy-two percent of the respondents reported that they had experienced barriers to providing preceptor training. The top 4 barriers reported were lack of time or resources (37%), lack of incentives for preceptors to participate (16%), lack of curriculum (12%), and staffing limitations at clinical affiliate sites that would prevent preceptor participation (12%).

The respondents’ ratings of the effectiveness of content-delivery methods in preceptor training indicated that they believed workshops (median number of respondents 8) were followed closely by computer-based training (median number of respondents 7) or an online format (median number of respondents 7) as being the most effective delivery methods. The other content-delivery methods video, classroom, and Web-conference received median ratings of 6.5, 6.5, and 6.0, respectively. However, the respondents thought that the classroom or Web-conference format would be most preferred by the preceptor-training participants (Fig. 5).

Fifty-five percent of the respondents believed that RT department managers in their areas would support preceptor training, in various degrees. Some respondents believed that the department managers would be willing to provide the use of institutional technology to deliver the program (36%), grant employees paid time off to attend preceptor training (23%), or pay registration fees (22%).

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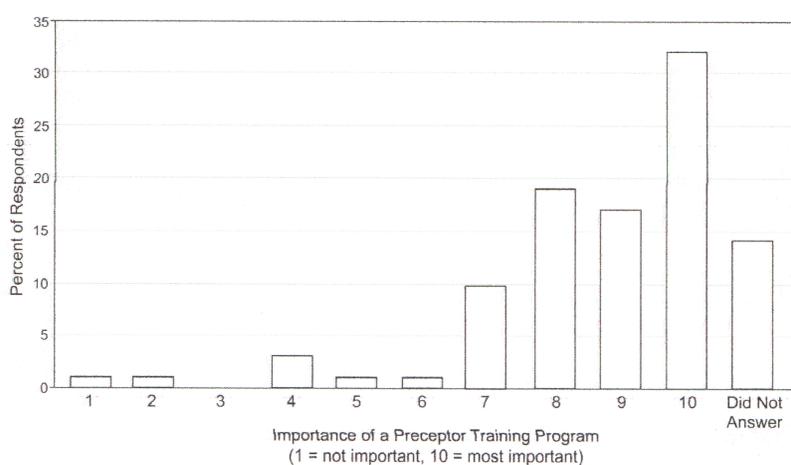


Fig. 4. Respondents' ratings of the importance of a preceptor-training program. Fourteen respondents did not answer this question.

Table 3. Respondents' Opinions About the Most Important Needs in Preceptor Training

	No.*	%
Assessment/evaluation of clinical performance	31	57
Effective feedback	24	44
Preceptor roles and responsibilities	22	41
Communication skills	14	26
Inter-rater reliability	10	19
Dealing with the difficult student	9	17
Student needs	8	15
Principles of adult learning	8	15
Learning styles	4	7
Teaching strategies	3	6
Critical-thinking skills	2	4
Balancing workload and teaching responsibilities	2	4
Legal issues	1	2
Teachable moments	1	2
Dealing with the exceptional student	1	2

* Number of respondents who rated this answer as most important.

Thirty-one percent of the respondents thought that department managers would support a 4-hour preceptor training, 36% thought department managers would support an 8-hour preceptor training, and 5% thought department managers would support a 2-day (16-hour) preceptor training.

Seventy-nine percent of the respondents thought that preceptors would desire continuing-education credit for preceptor training. Sixty-seven percent thought the preceptor-training program should lead to certification for the preceptor, perhaps because 39% of the respondents did not believe that practitioners were receiving any type of reward for preceptorship from their employer. Though 18% of the respondents thought that many practitioners are required (by job description) to precept, they also thought

that the rewards available to practitioners included career advancement (30%), increased pay (18%), and recognition or awards (11%). It was also postulated that some preceptors receive other rewards, such as continuing-education credits, use of palmtop computers, better schedules, tuition assistance, or payment of conference fees.

Discussion

According to Newble and Cannon, "It is a fact that clinical teaching is the most neglected area of all teaching, despite being the one where more deficiencies have been found than in any other."¹⁰ Furthermore, they described many medical clinical teaching encounters as "haphazard, mediocre, and lacking in intellectual stimulation."¹⁰ One hundred years after the Flexner report, which led to important reforms in medical education, preceptorship has been reestablished in medical education to assure that medical students have adequate observation, supervision, and mentoring.⁶ There is also widespread acceptance of preceptorship in nursing education.¹¹⁻¹⁴ The American Physical Therapy Association developed and adopted a national clinical-instructor credentialing program.¹⁵

Many RT programs struggle to find qualified and competent preceptors who can serve as role models and mentors. According to Schmitt, "It is time that our profession unites and assumes responsibility for the development of successful clinicians."¹⁶ Currently, many RTs practicing full-time and precepting students have few resources available for developing their preceptor qualifications and competency.

The present study affirms the course that the original ad hoc group charted. According to Sorbello:

Much of the program, in design, quality and philosophy, will mirror what the physical therapists

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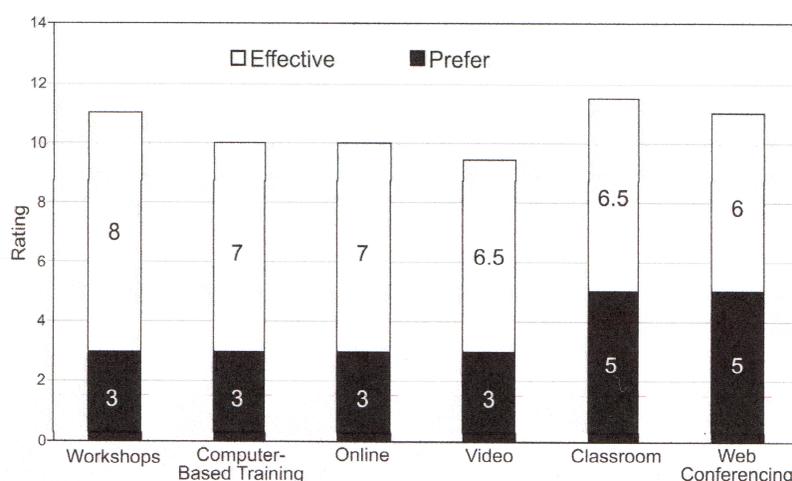


Fig. 5. Respondents' ratings of their preferences about content-delivery methods and the effectiveness of those methods.

have created to educate and train their clinical preceptors/instructors. It is our plan to deliver a variety of lecture presentations, interactive discussions, break-out sessions, question-and-answer periods, written and practical testing delivered and facilitated by those who are expert and well-seasoned in all the critical aspects of clinical instruction. We want this to be recognized as a very high quality program. We are very, very concerned with quality control and continuous quality improvement. Consumer utility, satisfaction, and validity are top concerns. As such, we want to be absolutely sure that this process be done properly, so we hope everyone is patient with its growth and development. (Personal communication, Joseph G Sorbello MEd RRT, Department of Respiratory Therapy Education, State University of New York, Upstate Medical University, Syracuse, New York.)

The work group also recognizes the importance of awarding continuing-education credits and keeping the cost reasonable. The initial preceptor-training course was presented at the 2008 AARC Summer Forum in Phoenix, Arizona, to about 150 participants. We are also working towards offering the course via distance education. We certainly embrace the concept of looking at alternative ways to meet the needs of hard-working clinicians and having the preceptor-training be at their convenience. Distance-education delivery has been highly requested, because not everyone gets to attend the Summer Forums, International Congresses, or AARC state meetings. We do want to make the distance-education version available as soon as possible (personal communication, Joseph G Sorbello MEd RRT, Department of Respiratory Therapy Education, State University of New York, Upstate Medical University, Syra-

cuse, New York), and online and other distance-education technologies are rapidly becoming more effective, popular, cost-effective, and time-efficient.

The respondents' understanding of, curriculum for, and implementation of preceptor training differed considerably, and there were substantial differences in the content and duration of the existing preceptor-training programs. Seventy-two percent of the respondents had experienced barriers to preceptor training, and one of the major barriers was the lack of access to a preceptor-training program. We defined access as the distance between preceptors and the training being sought, the time needed for the delivery or communication of that training, and the availability of information (curriculum) for the training. At least 37% of the respondents indicated that they do not have the opportunity to offer a preceptor-training program because of lack of time or other resources to develop such a program. Another 12% indicated that the lack of an appropriate curriculum is a barrier.

Though the low (30%) survey-response rate (without repeated mailings) is a limitation of our results, we believe that our findings are an important addition to the body of knowledge on this topic. We plan to survey RT department managers on their perceptions of the need for a standardized preceptor-training program.

To study how our respondents may have differed from those who did not respond (Figs. 6 and 7) we compared our data about the respondent programs to data from the web site of the Commission on Accreditation of Allied Health Education Programs (CAAHEP), which lists information about RT programs in the United States, including type of institution, degrees awarded, and location. The majority of RT programs listed at the CAAHEP Web site and the majority of our respondent's programs are in 2-year



Fig. 6. United States regions sampled in this study.

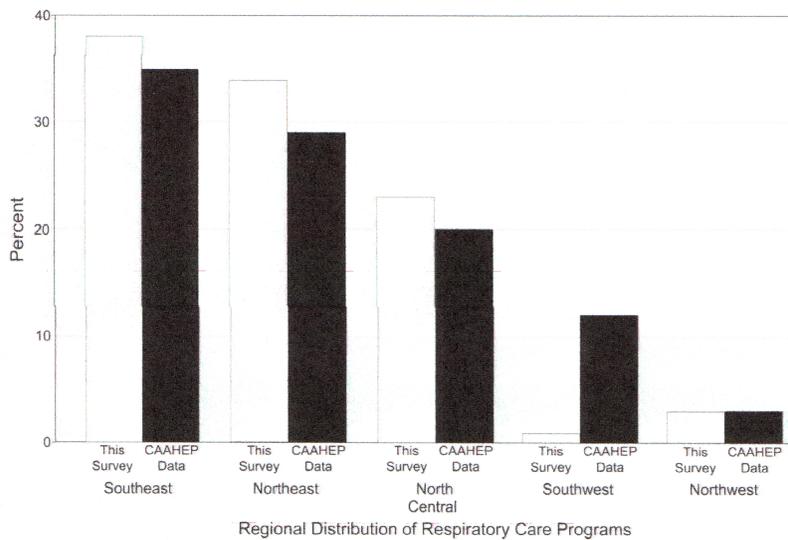


Fig. 7. Regional distribution of respiratory-therapy programs that responded to our survey, versus regional distribution of respiratory-therapy programs listed on the web site of the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

institutions and offer the associate's degree. Our respondents' locations also correspond fairly closely with the CAAHEP data, except in the southwest region. We believe our respondents provide a fairly representative cross-section of the population in terms of institution type, degrees awarded, and locations, except in the southwest region.

Conclusions

To improve RT education we need to develop and implement a standardized and easily accessible preceptor-

training program, and there is probably value in working directly with the RT programs to invest in making the preceptor-training curriculum readily available to practitioners.

Preceptor training is definitely an important component in an RT's professional development, and is a long-range strategy for strengthening the professionalism and stature of the field of respiratory therapy. This is a necessary step to assure that RT programs achieve standards of excellence. Certifying instructors to teach the preceptor-training

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program, solidifying commitment and support for the program from the AARC, and developing a system for evaluating the preceptorship program will be essential. Once the program is fully developed and the curriculum validated, it could be offered through partnerships with health-care institutions and RT programs that would improve the preceptor-training program and the quality of RT education.

ACKNOWLEDGMENTS

Special thanks to David C Shelledy PhD RRT, Rush University, Chicago, Illinois; R Randall Baker PhD RRT, Medical College of Georgia, Augusta, Georgia; and Michael E Anders PhD RRT and Diane Heestand Skinner EdD, University of Arkansas for Medical Sciences, Little Rock, Arkansas, for reviewing and assisting with the validation of the survey instrument.

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Appendix

Survey of Directors of Respiratory Therapy Programs
Respiratory Therapy Preceptor Training Needs Assessment

Part 1: Demographics

1. Type of institution (check all that apply): 2-year college University Academic health science center
 Private Public
2. Location of institution (state): _____
3. Location of institution: Urban Suburban Small town Rural
4. Degree offered by your program: Associate degree Baccalaureate degree Other (specify _____)
5. How many total clinical hours per student are included in your curriculum?
6. How many actual hours of clinical instruction by paid program faculty per student are included in your curriculum?
7. Number of paid full-time faculty teaching clinical courses?
8. Number of paid part-time faculty directly teaching students at the bedside?
9. Number of paid FTE faculty directly teaching students at the bedside?
10. Number of clinical instructors/preceptors employed by the clinical affiliate who devote full-time effort to the clinical instruction of your students when they are assigned to that affiliate?
11. Numbers of clinical instructors/preceptors employed by the clinical affiliate who participate in the clinical instruction of your students when they are assigned to the affiliate, but who also have an assigned patient workload?
12. What is the maximum number of students receiving clinical instruction per instructor/preceptor (ie maximum student: instructor ratio in any clinical setting)?
13. Number of primary clinical affiliates?
14. Please indicate the number of clinical sites utilized by your program for each of the following clinical specialties:
 NICU Asthma education PICU Pulmonary rehabilitation Home care Intubation
 Pulmonary function testing Bronchoscopy General care Adult critical care Sleep laboratory
15. Who directly supervises the clinical instruction of respiratory therapy students in your institution? (check all that apply)
 College faculty: full-time part-time
 Paid clinical instructors: full-time part-time
 Volunteer, unpaid clinical preceptors
 Please explain if a combination of the above is used.
 Other: please explain: _____

Part 2: Preceptor-Training Needs

1. Do clinical instructors/preceptors receive any type of training prior to receiving students?
 Yes
 No. Please go to Question 4.
If yes, please describe the type of training that they receive.
If yes, please describe the length of training that they receive.
2. Who delivers that training?
- 2b. Is the training designed to meet the specific needs of respiratory care clinical preceptors?
3. I believe there is a need for a standardized preceptor-training program available for use by respiratory therapy education programs:
 Yes
 No. If no, thank you for completing this survey. You may submit your survey now.
 Uncertain
4. Please rate the importance of having a preceptor-training program available for use by your education program:
Not At Somewhat Most
All Important Important Important
1 2 3 4 5 6 7 8 9 10
5. Please estimate the number of clinical preceptors who would need training each year to meet the needs of your program: _____
6. Please rate the following content areas' importance in preceptor training and development
Not At Somewhat Most
All Important Important Important
1 2 3 4 5 6 7 8 9 10
Roles and responsibilities

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- Writing behavioral objectives
- Basic principles of learning
- Characteristics of the adult learner
- Learning styles
- Student needs in the clinical environment
- Principles of student assessment
(Formative and summative)
- Evaluation of student clinical performance
- Establishing inter-rater reliability
- Providing effective feedback
- Selecting a teaching strategy
- Legal issues in clinical education
- Dealing with the difficult student
- Dealing with the exceptional student
- Communication skills

7. What are the 3 most important preceptor-training needs at your institution?
8. What are the 3 most important barriers to conducting successful preceptor training at your institution?
9. Please rate the effectiveness of each of the following methods of delivery to achieve the training needs of clinical preceptors in your program.

	Not very Effective		Somewhat Effective				Very Effective			
	1	2	3	4	5	6	7	8	9	10
Classroom										
Video										
Online										
Workshops										
Computer-based training										
Web conferencing										

10. Please rank the preferred delivery methods in the order you feel would be most effective to achieve the training needs of clinical preceptors in your program from 1 (most desirable) to 6 (least desirable).

- Classroom
- Video
- Online
- Workshops
- Computer-based training
- Web conferencing

11. I believe department managers in my area would support preceptor training:

Strongly Disagree	Disagree		Neutral		Agree		Strongly Agree		
1	2	3	4	5	6	7	8	9	10

12. In which of the following ways would the department managers in your clinical affiliates support preceptor training and development? Check all that apply.

- Paid time off to attend a workshop
- Payment of registration fees
- Use of institutional technology to complete a course
- Other: please describe: _____

13. I believe most department managers in my area would agree to the length of a preceptor-training program at: _____

___ ½ day (4 hours) ___ 1 day (8 hours) ___ 2 days (16 hours)

14. I believe preceptors would desire continuing education credit for this activity:

Strongly Disagree	Disagree		Neutral		Agree		Strongly Agree		
1	2	3	4	5	6	7	8	9	10

15. I believe the preceptor-training program should ultimately lead to certification for the clinical preceptor:

Strongly Disagree	Disagree		Neutral		Agree		Strongly Agree		
1	2	3	4	5	6	7	8	9	10

16. What do you think a reasonable fee for delivering the equivalent of a 4-hour preceptor-training program that was fully approved for continuing-education credit would be? Please type in a dollar value per preceptor trained in the space provided: _____

17. Do practitioners who act as clinical preceptors in your area receive any type of reward from their employer (eg, career-ladder opportunities, additional pay)?

SECTION 6 – REQUIREMENTS FOR PROGRAMS WITH CLINICAL COMPONENT

Key Program Personnel

DA6.1 The sponsor must appoint, at a minimum, a Director of Clinical Education and a Medical Advisor.

Evidence of Compliance:

- Documentation of Employment;
- Written job descriptions including minimal qualifications.

Interpretive Guideline:

Faculty includes all persons employed by the institution who are assigned primarily to the respiratory care program, and whose job responsibilities include teaching, regardless of the position title. For the Director of Clinical Education (DCE), the length of the appointment must be sufficient to allow her/him to fulfill these responsibilities (as identified in DA6.2). The DCE and the Medical Advisor (or co-advisors) are not required to have full-time appointments. Documentation of employment must include Letters of Appointment and Acceptance (templates are available on the CoARC website). Key program personnel must have academic appointments and privileges comparable to other faculty in the institution with similar academic responsibilities. At a minimum, a listing of both the key personnel and the program faculty should be published on the program's website.

Director of Clinical Education

DA6.2 The Director of Clinical Education (DCE) must be responsible for all aspects of the clinical experiences of students enrolled in the program including: organization, administration, continuous review and revision of these experiences, planning for and development of appropriate locations for evolving practice skills; provision, training for and ongoing evaluation of student supervision during clinicals; and the general effectiveness of the clinical experience. There must be evidence that sufficient time is devoted to the program by the DCE so that these educational and administrative responsibilities can be met.

Evidence of Compliance:

- CoARC Teaching and Administrative Workload Form;
- Institutional job description.

Interpretive Guideline:

The DCE workload should balance teaching and administrative responsibilities. Documentation of sufficient release time to meet administrative duties should be provided as evidence of compliance with this Standard. The DCE may also be DCE for the Entry into Practice Program, if applicable.

DA6.3 The DCE must have earned at least a master's degree from an academic institution

accredited by a regional or national accrediting agency recognized by the USDE.

Evidence of Compliance:

- Academic transcript denoting the highest degree earned.

Interpretive Guideline:

Degrees are acceptable if they were awarded by an institution that is accredited by a national or regional accrediting body recognized by the USDE. Degrees from non-accredited institutions do not meet this Standard, and individuals holding such degrees are not acceptable as DCEs. The degree earned can be in any field of study.

For degrees from institutions in countries other than the United States, the CoARC will use a foreign educational credentials evaluation service (e.g., www.naces.org) to determine whether the foreign transcript is equivalent to that of the required minimum degree.

DA6.4 The DCE must have a:

- a) valid RRT credential;
- b) current professional license or certificate unless exempted from licensure under state or federal law;
- c) minimum of four (4) years' experience as an RRT of which at least two (2) years must include experience in clinical respiratory care;
- d) minimum of two (2) years' teaching experience in clinical respiratory care, research, management, or education associated with an accredited respiratory care program.

Evidence of Compliance:

- Documentation of a valid RRT credential;
- Documentation of a current state license;
- Curriculum vitae.

Interpretive Guideline:

Documentation of credential validation can include a copy of the NBRC certificate or an NBRC Credentials Verification Letter. Expired credentials are not valid. The CoARC Curriculum Vitae Outline for Program Faculty (available on the CoARC website) can be used as a curriculum vitae.

If a program is offered by distance education and the DCE resides in a different state than the base location, or if a program is located near a state border and the DCE resides in a neighboring state, the DCE may hold a license in his/her state of residence, unless required by the program sponsor to hold a license in the state in which the program is located. In a state or jurisdiction where licensing is not available, a credential comparable to licensing should be used.

Regardless of accreditation status, all programs accepting applications for vacancies in Key Personnel positions are required to comply with this Standard.

DA6.5 The DCE must have regular and consistent contact with students, clinical faculty, and clinical affiliates in all program locations.

Evidence of Compliance:

- Results of student course evaluations;
- Documentation of DCE contact with clinical faculty and clinical affiliates;
- Results of the CoARC DA Student and Personnel Program Resource Surveys.

Interpretive Guideline:

The DCE must be available and accessible (e.g., in-person, phone, or on-line) to students when they are actively taking clinical professional coursework. Student course evaluations and on-site interview responses should demonstrate that the DCE is/was accessible to students throughout their course of study and that the degree of interaction between the DCE and students facilitates the achievement of program goals. Examples of contact documentation between DCE and clinical faculty/affiliates can include communications log, copies of email correspondence, or program faculty meeting minutes.

Medical Advisor

DA6.6 A Medical Advisor must be appointed to provide competent medical guidance, and to assist the PD and DCE in ensuring that both didactic and supervised clinical instruction meet current practice guidelines. The Medical Advisor must be a licensed physician and Board certified (as recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA)) in a specialty relevant to respiratory care.

Evidence of Compliance:

- Copy of state license and board certificate(s);
- Curriculum vitae;
- Appointment Letter/Contractual Agreement;
- Records of interaction with Key Personnel including attendance at Advisory Committee meetings;
- Documentation of physician interaction with students;
- Results of annual program resource assessment as documented in the CoARC RAM.

Interpretive Guideline:

The Medical Advisor works with the PD and DCE to ensure that both didactic instruction and supervised clinical practice experiences meet current practice standards as they relate to the respiratory therapists' role in providing patient care. The Medical Advisor must be a member of the Advisory Committee. The Medical Advisor may also be Medical Advisor for the Entry into Practice Program, if applicable. If the PD is an MD or DO, s/he cannot also act in the capacity of the Medical Advisor.

Documentation of credential validation can include a copy of the board certificate or Credentials Verification Letter from the appropriate credentialing agency. Expired board certificates are not valid. Documentation of license validation can include a copy of the license certificate or License Verification Letter from the appropriate licensing agency. Expired licenses are not valid. The CoARC Curriculum Vitae Outline for Program Faculty (available on the CoARC website) can be used as the curriculum vitae. Documentation of appointment as Medical

Advisor by the program must include letters of appointment and acceptance (templates are available on the CoARC website). Examples of documenting physician interaction with students can include a physician interaction log in the student clinical handbook, evidence of student presentations to physicians in the didactic and clinical settings, or documentation of student participation in research activities supervised by a physician.

Instructional Faculty

DA6.7 In addition to key personnel (DCE, MA), there must be sufficient personnel resources to provide effective instruction in the clinical setting. At each location to which a student is assigned for instruction, there must be an individual designated to arrange for the supervision of the student and for assessment of the student's progress in achieving expected competencies.

Evidence of Compliance:

- Results of annual program resource assessment as documented in the CoARC RAM;
- Student surveys of faculty performance (e.g., course evaluation);
- Course class lists and faculty teaching schedules.

Interpretive Guideline:

For programs providing clinical education as part of required coursework, the program must ensure that sufficient, appropriately credentialed clinical instructors (clinical faculty) are available for students at each clinical site. Clinical faculty can include off-site clinical supervisors, preceptors, or similar personnel who do not hold employment contracts with the program sponsor. However, all clinical preceptors who are not program faculty must be employed by the clinical site at which they are teaching. Clinical instructors should have at least one valid clinical specialty credential (e.g., NPS, PFT, ACCS, SDS) or have board certification as recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) in a specialty relevant to respiratory care.

Instructional faculty participate in the evaluation of student performance during clinicals. The program should have documentation that program personnel have provided them with orientation regarding the roles and responsibilities of clinical instructors, the policies and procedures of the program related to the competencies being evaluated, and inter-rater reliability training.

Clinical Practice

DA6.8 The program/sponsor must secure formal, written, duly executed agreements or memoranda of understanding from all clinical education sites. These agreements/memoranda must describe the relationship between the program and the clinical site and clearly delineate the roles of the program, its sponsor, and the clinical site.

Evidence of Compliance:

- List of all sites used for clinical training;

- Copies of current, formal, written clinical affiliation agreements or memoranda of understanding for each site.

Interpretive Guideline:

The program's responsibility for coordinating clinical rotations involves identifying, contacting and evaluating locations for suitability as a required or elective site, as well as identifying and contacting qualified individuals employed at these sites as potential clinical faculty.

Affiliate agreements typically include specific notations acknowledging the terms of participation between the program/sponsor and the clinical affiliate and usually specify which policies govern students during their time at that facility. The program is encouraged to provide copies of clinical schedules as additional evidence of compliance.

DA6.9 The program must be solely responsible for the selection of clinical sites, the coordination of clinical training and for ensuring that the type, length, and variety of clinical experiences are sufficient for students to acquire all required competencies. Students must not be responsible for: the selection of clinical sites; the determination as to which competencies should be mastered at a given clinical site; or the acquisition of clinical instructors at these sites.

Evidence of Compliance:

- Detailed clinical schedules;
- Formal written clinical affiliation agreements or memoranda of understanding;
- Results of CoARC DA Graduate Surveys.

Interpretive Guideline:

Coordinating clinical experiences involves identifying, contacting and evaluating sites and preceptors for their suitability for clinicals based on curricular requirements. Students may make suggestions to program faculty regarding sites and preceptors but must not be required to do so. Student suggested sites and preceptors must be evaluated by the program and may be approved when appropriate. In addition, student experience at such sites must be assessed to determine that outcomes are equivalent to those at sites chosen by the program.

Clinical Site Evaluation

DA6.10 The program must define and maintain consistent and effective processes for both the initial and ongoing evaluation of all clinical sites to ensure that clinical resources and student supervision at each site are sufficient to facilitate achievement of program goals.

Evidence of Compliance:

- Program evaluation plan and results of these evaluations for all clinical sites and preceptors;
- Results of student evaluations of clinical courses, sites, and preceptors;

- Results of CoARC DA Student and Personnel Program Resource Surveys.

Interpretive Guideline:

Clinical site evaluation involves both monitoring the sites used for supervised clinical practice experiences and modifying them as necessary to ensure that expected learning outcomes will be met by each student upon program completion. Faculty should be able to document that the use of different clinical sites to achieve the same competency does not affect the overall accomplishment of expected learning outcomes. The evaluation should also show that while students are on supervised clinical practice rotations, preceptors are providing feedback and mentoring. An effective evaluation process requires that the program establish criteria for the evaluation of new sites and clinical faculty as well as for those with an ongoing relationship with the program.

In addition to the results of the evaluation process(es), the program should include a narrative describing, in concise terms, the types and frequency of the methods it used to evaluate both clinical sites and clinical instructors, as well as any available evaluations of the program and its clinical sites by the program's sponsor.

Safeguards

DA6.11 Students must be appropriately supervised at all times during their clinical education coursework and experiences. Students must not be used to substitute for clinical, instructional, or administrative staff during clinical rotations. Students shall not receive any form of remuneration in exchange for work they perform during programmatic clinical coursework.

Evidence of Compliance:

- Results of student course evaluations;
- Work study contracts;
- Program policies and procedures;
- Affiliate contracts/agreements.

Interpretive Guideline:

Programs should include a service work statement in the program materials available to both students and clinical supervisors which states that during clinical rotations respiratory care students must not be substituted for paid staff or used as back-ups in the absence of the clinical site's paid staff. This does not prohibit a paid/unpaid internship but is designed to ensure that students who opt to reinforce competencies and skill sets in this manner are adequately supervised and do not receive educational credits for this experience.

Students with specific prior knowledge, experiences and skills may assist faculty in didactic and laboratory sessions by sharing their knowledge and skills with other students. However, such students may not be the primary instructor or instructor of record for any component of the curriculum.

DA6.12 The health, privacy, and safety of patients, students, and faculty associated with the educational activities and learning environment of the students must be adequately safeguarded.

Evidence of Compliance:

- Evidence of compliance with requirements of all clinical agreements/memoranda of understanding;
- Published policies, from both the program and the clinical sites, showing that information addressing student exposure to infectious and environmental hazards is provided to students before they undertake any educational activities that would place them at risk;
- Program policy on immunization of students based on current Centers for Disease Control recommendations for health professionals;
- Records of student immunization or student declination of immunizations.

Interpretive Guideline:

Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff. Policies related to infectious and environmental hazards should address methods of prevention; procedures for care and treatment after exposure, including definition of financial responsibility; and the effects of infectious and environmental disease or disability on student learning activities.

All individuals who provide patient care or have contact with patients should follow all standards of risk management, thus ensuring a safe and healthy environment. The agreement/MOU for each clinical site must include clinical site health, safety and security policies and requirements, and students must be informed of these prior to their clinical experience at each site. The program should ensure that, prior to clinical training, all students have sufficient training in preclinical and clinical asepsis, infection risks/consequences, biohazard control and disposal of hazardous waste. The program should also provide documentation that students have completed HIPAA training provided by either the program, program sponsor, or a clinical site. The confidentiality of information pertaining to the health status of individual students/faculty should be strictly maintained.