FREQUENTLY ASKED QUESTIONS

(Ensuring Consistent Student Clinical Evaluations)

Is it true that a web-based clinical tracking system will take care of many IRR issues for the program?

IRR is independent of type of student evaluation system. The main point of IRR is to ensure that all preceptors are interpreting and using the evaluation tool the same, regardless of whether it is on paper or electronic. In addition, it is important to make sure that expectations regarding student performance are clearly communicated, regardless of whether it is on paper or electronic. The student evaluation system does not specifically address IRR.

What does CoARC expect us to do about the preceptors who lack motivation, interest, desire to comply as it relates with online preceptor training?

First, remember there is no expectation that programs have 100% IRR. You need to select a % agreement that you feel is reasonable and will produce acceptable consistency in student evaluations. Then it is important to carefully consider the quality of the instruction provided by the preceptor in question. I provided an example during the presentation of a preceptor that provides excellent clinical instruction, but insists on using his slightly more challenging evaluation scale. Since my % agreement is well within what I believe is acceptable, and I believe the students benefit from experience with this preceptor, I continue to allow students to be assigned to him. If I were concerned about the experience the students were having with the preceptor, I would request that he be placed on the "do not use" list of preceptors.

I am not sure how you want to address the question about preceptors that do not complete preceptor training? I would suggest an in-person meeting to at a minimum go over expectations and to make sure the preceptor was aware of the grading criteria, and then document this meeting as part of your plan. But I think you also need to re-evaluate if you want to include this preceptor or not – if they are not interested in precepting do you really want to place students with them?

Can you give a little more detail on quantifying % Agreement? Do you have a specific example you could share?

Determining % agreement is like grading a test. You evaluate the performance of the student (live or video-taped) using the evaluation instrument. This becomes the key. Simultaneously (live) or at another time (video-taped) you ask each preceptor to also evaluate the same performance using the same evaluation instrument and you compare answers. Then calculate the average by skill and overall.

	Faculty (key)	Preceptor 1	Preceptor 2	Preceptor 3	% agreement
Oxygen	O	O	O	S	2/3 agree = 66%
MDI	S	S	S	S	3/3 agree = 100%
NTS	S	S	O	S	2/3 agree = 66%
				Overall % agreement	77%

Then you would need to repeat this for a sample of actual student evaluations. When you are visiting a clinical facility, observe a student performing care and complete an evaluation. Then compare the assigned preceptor's evaluation of the student to yours. Do this with a few more students and preceptors then calculate the average – this will give you % agreement for actual student evaluations.

	Faculty (key)	Preceptor
Student 1	S	O
Student 2	S	S
Student 3	O	O
Student 4	O	O
Student 5	S	S
	Overall % agreement	4/5 agree = 80%

If your results do not meet the minimum % agreement you have specified in your plan, you need to develop and implement an action plan to improve IRR.

How do you handle a situation where the preceptor reports on the last day of the student's rotation that the student knows nothing! But the student reports they had a wonderful experience at the respective rotation and would like to work there!

I would encourage you to include more frequent reporting of student evaluations to minimize the chance of this happening. I also feel regular communication with preceptors is important so you have a chance to address any concerns as they develop.

I am a new PD (with previous DCE experience) to a long established program. IRR is vague so I'm feeling as though I'm starting from the beginning. Also, limitations (I'm told) at local hospitals are directly related to preceptor motivation. Yes, I'm ready to get our DCE on board with the technical components (PEP program and Database)... but... I feel if I don't address motivation... we'll get nowhere. Thoughts on where/how to start with motivation?

Just a couple of suggestions based on literature on improving motivation. Recognition of a job well done can go far to improve motivation. And this does not have to be extravagant or expensive. A hand-written thank you note, a basket of chocolate with an attached note for the break room, a small poster signed by the students displayed in the department… all can recognize the extra effort people put into precepting, and encourage them to keep it up. And including the students in the recognition also allows the preceptors to see the bigger picture and see how their contributions are helping develop the future of the profession – this can also help increase motivation. You can also include the preceptors in the process of developing expectations for student performance so they have a sense of ownership in the process and fell like they are an integral part of the education team.

Are the CoARC site visitors looking at the program's clinical evaluations forms to see they meet these criteria?

No.

How often does IRR need to be done?

Standard 3.07 Interpretive Guidelines:
Initial preceptor evaluations must be conducted within the first year of assignment. Subsequent preceptor evaluations must be conducted when: (1) significant changes to the program's clinical evaluation processes occur; (2) curricular content changes occur after revision of the national credentialing agency content outline; (3) new accreditation Standards are published; and (4) student or program assessments (e.g., evaluation of instruction by students and program surveys) identify variability in clinical evaluations.

Is there a magic number or percentage of preceptors that must complete training? We have a relatively high turnover in preceptors/staff RTs.

I believe the Standard is meant to encompass all preceptors.

How do you get the preceptors from your sites to "buy in" to the trainings? Most do not get a differential or extra pay to be preceptors and do not want to spend extra time doing clinical PEP.

I include an explanation that completing the training is required by our accreditation agency, and I include a $5 Starbucks gift card in the materials I send as a small incentive/thank you to complete.

Is "met", "not met" appropriate?

If criteria for "Met" and "Not Met" are clearly specified and communicated and consistently applied, yes. You would need to evaluate this evaluation system the same as you would any other evaluation system.

The practice for our program allows clinical instructors 1 hour per/week to work directly with the student at the clinical site so our students are routinely assigned to staff therapists who may or may not be great preceptors. How do we ensure consistency in IRR? Will a rubric and/or a 5 to 7 category range address this?

It is critical that your evaluation instrument incorporate the strategies discussed in the webinar to improve the likelihood that your preceptors will be able to consistently evaluate your students. This must be paired with training regarding use of your evaluation instruments and communication of your expectations.

Is IRR to be related to evaluating clinical competencies and/or the day to day clinical performance such as a "daily evaluation"?

You need to define the parameters in your IRR plan, but I believe your plan should include all types of evaluations performed by preceptors, including competencies and professional attributes.

So preceptors are not required to be trained every year?

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