ATHLETIC TRAINING EDUCATION JOURNAL

www.natajournals.org
ISSN: 1947-380X
DOI: 10.4085/1403182

ORIGINAL RESEARCH

Preceptors' Frequency and Supervision of Athletic Training Students' Medical Documentation During Clinical Education

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Context: Athletic trainers (ATs) who serve as preceptors for athletic training students must model, facilitate, and guide professional skills and behaviors, including medical documentation. Preceptors have the unique ability to combine skill practice with real-time patient encounters for athletic training students.

Objective: To describe the frequency of preceptors who allow athletic training students to complete medical documentation and rationale for their decisions.

Design: Cross-sectional.

Setting: Qualitative study.

Patients or Other Participants: Of 9578 ATs, 1150 responded to an electronic survey (access rate = 12.0%), and 385 of 1150 respondents who completed an electronic survey (33.5%) indicated being a preceptor for a professional athletic training program. Respondents (age = 34 ± 11 years, clinical practice experience = 11 ± 10 years) were predominantly female (53.8%, n = 207) and held a master's degree (67.3%, n = 259).

Main Outcome Measure(s): A 3-member data analysis team coded the open-ended responses following the consensual qualitative research approach. Each member coded 50 responses and a consensus codebook was created. The principal investigator coded the remaining responses, and the data analysis team confirmed the findings. Data were organized into emergent domains and categories. Frequency counts were calculated for each category.

Results: A majority of preceptors (81.8%, n = 315) allowed their athletic training students to document patient care. Respondents indicated an intention for student involvement (domain 1), whereby they wanted students to engage in learning and develop knowledge (43.4%, n = 167) or practice and gain experience (41.3%, n = 159). However, others discussed deterrents (20.0%, n = 77) working against the preceptor's intentions. Respondents also indicated a need to mentor (domain 2). Specifically, they reported needing to manage the logistics of documentation (63.6%, n = 245) and the degree of oversight (48.8%, n = 188) needed during practice (either direct [79.8%, n = 150 of 188] or indirect [20.2%, n = 38 of 188]).

Conclusions: Although preceptors intend to integrate students into medical documentation, they may benefit from formal guidance from the academic program on how to best integrate athletic training students into documenting day-to-day patient care.

Key Words: Administration, mentorship, supervision

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Full Citation:
Neil ER, Welch Bacon CE, Nottingham SL, Kasamatsu TM, Eberman LE. Preceptors' frequency and supervision of athletic training students' medical documentation during clinical education. *Athl Train Educ J.* 2019;14(3):182–190.

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KEY POINTS

- Preceptors should allow athletic training students numerous guided opportunities to complete medical documentation during clinical education.
- Athletic training students benefit from practice experiences and feedback while they continue to learn the skill of medical documentation.
- Athletic training programs should consider preceptor development opportunities that specifically address how preceptors can integrate students and mitigate deterrents regarding medical documentation.

INTRODUCTION

Medical documentation is a leading form of communication between health care providers.[1] For optimal patient care, accurate medical records are needed to ensure continuous communication among health care professionals. Medical documentation and records encompass data including the patient's diagnosis, any treatments that they have received, and future plans for their care.[2] Despite the fact that clinicians report that documentation is important, recent research has indicated that athletic trainers (ATs), specifically in the secondary school setting, perceive that their medical documents are of a low quality.[3] Employers have also noted that organization and administration, the overarching component for medical documentation, is the largest area of concern for newly credentialed entry-level clinicians.[4,5]

Clinical education is a required component of an athletic training student's educational experience and is designed to help athletic training students translate the knowledge gained in the classroom through application during patient care in a safe, mentored environment.[6] Preceptors, who teach and evaluate students during clinical experiences with real-time patient encounters,[7] play a vital role in the overall quality of the clinical education experience for athletic training students through clinical supervision, mentorship, and evaluation.[7] The preceptor serves as the facilitator and gatekeeper of athletic training student task performance, which can directly affect the student's experiences. A preceptor should provide supervised autonomy based on the level of education and knowledge of the student,[8] thus allowing the athletic training students to practice the skills they have learned in the classroom with guidance readily available.[9] Furthermore, supervised autonomy is a form of anticipatory socialization and assists in preparing the athletic training students for their transition to practice.[10]

Given the importance of quality medical documentation in patient care, it is imperative that athletic training students gain meaningful learning opportunities and practice during clinical education experiences. The purpose of our study was to explore how preceptors integrate students into medical documentation tasks, including how often they allow students to complete documentation tasks, how they supervise medical documentation entries, and the rationale for their decisions.

METHODS

Design

The research team used a cross-sectional survey design with open-ended questions to determine if ATs serving as a preceptor allowed athletic training students to document patient care, why they allowed or did not allow athletic training students to document, and, if they did allow athletic training students to document, how they supervised the documentation. Before its distribution, the Indiana State University Institutional Review Board deemed this study exempt.

Participants

We recruited ATs who are credentialed members of the National Athletic Trainers' Association in good standing. A random selection of 9578 e-mails was purchased from the membership directory that included ATs in all districts and job settings. A total of 1150 of 9578 participants accessed our survey (12.0% access rate), 1053 completed at least 1 portion, and 904 completed the survey in its entirety (85.8% completion rate). The purpose for this selection was to review only the responses of those who were actively serving as a preceptor for athletic training students, and 385 out of 1150 respondents (33.5%) met this criterion. We gained informed consent at the start of the survey, and respondents were able to skip any questions they did not wish to answer and could withdraw at any point by simply clicking out of the Web link.

Instrumentation

For the purpose of this study, we used preceptor-related questions from a larger study that had been created to evaluate medical documentation behaviors of ATs.[11,12] Three questions were used to determine whether the preceptor allowed the athletic training student to document patient care, the rationale for this decision, and, if the preceptor did allow the athletic training student to document, how the activity was supervised (Table 1). We used a panel of experts ($N = 4$; 3 women and 1 man) for content validation of the survey. The experts had 14 ± 4 years of clinical experience, and 2 of the experts had 11 ± 1 years of survey research experience. Experts indicated if items were "sufficient as written" or "required modifications." When indicating that modifications were required, the experts were asked to provide comments to help make revisions. We synthesized the feedback and made changes to the survey where appropriate; no changes were made to these specific items.

Table 1. Preceptor-Related Questions

Question	Response Type
Do you allow athletic training students to document patient care?	Yes/no
Why or why not?	Open ended
How do you supervise this activity?	Open ended

Procedures

We recruited potential participants via e-mail through a Web-based survey platform (Qualtrics, Provo, UT). A follow-up e-mail was sent every week for 4 weeks to those who had not responded. Data were collected for 5 weeks during the spring of 2017 (March and April). The initial e-mail was sent on a Wednesday morning at 7:30 AM EDT and each subsequent reminder was sent on a Wednesday morning at 7:30 AM EDT. The survey was closed 1 week and 2 days after the last reminder at 11:59 PM EDT. All data were stored securely in Qualtrics.

Data Analysis and Management

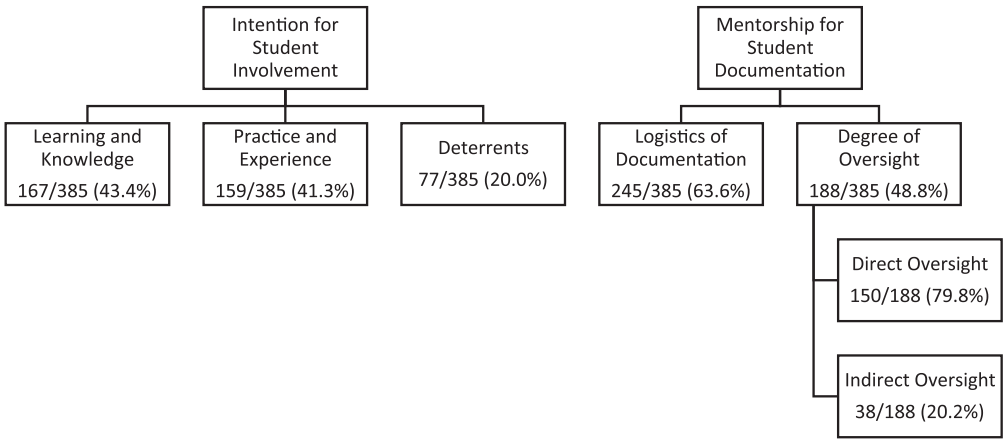
A qualitative approach was used in this study and was guided by the consensual qualitative research (CQR) tradition, which included a 3-person data analysis team (E.R.N., C.W.B., L.E.E.) to reach consensus.[12,13] The additional 2 research team members served as content experts for the survey validation and auditors. Consensual qualitative research allows for multiple perspectives from the various members of the data analysis team to check for accuracy within the codes.[13,14] By using this approach, the ideas and opinions of the respondents can be better represented. Table 2 provides additional information on the research team. Quantitative data and categorical data were analyzed using frequency counts and percentages (Excel; Microsoft, Redmond, WA).

A codebook was created with domains, categories, and subcategories as outlined by best practice for CQR. Initially, we established consistency by allowing the data analysis team to consider multiple perspectives to reach consensus on the coding. The use of the data analysis team helped to reduce the amount of bias that might have occurred with a single coder. The first 50 responses were analyzed by the data analysis team, with ideas compared until consensus was reached and a codebook was created.[13,14] At this point, the principal investigator coded the remaining responses based on the codebook. Once the principal investigator had completed the coding in its entirety, the information was sent to the data analysis team. The other members of the data analysis team then determined if they agreed upon the coding that was performed by the principal investigator. Upon completion, the data analysis team convened for a consensus meeting. If there was a disagreement on the coding, the majority decision (2 of 3) was conferred and the codes were finalized. A total of 17 responses were deemed unrelated to the questions and were discarded from review. Each response was individually coded per respondent and could be coded under multiple categories during analysis. When the data analysis team concluded its work, the survey questions, consensus codebook, and coded response document were shared with the other 2 members of the research team for auditing. Saturation of the data was

Table 2. Descriptions of the Research Team

Roles and Experience					
Researcher Role	1 Principal investigator and data analysis team member	2 Data analysis team member	3 Research team member	4 Research team member	5 Senior investigator and data analysis team member
Research experience	Novice qualitative researcher	Expert qualitative researcher with extensive experience in various forms of qualitative inquiry	Expert qualitative researcher with extensive experience in various forms of qualitative inquiry	Expert qualitative researcher with extensive experience in various forms of qualitative inquiry	Expert qualitative researcher with extensive experience in various forms of qualitative inquiry

Figure. Domains, categories, and subcategories.



ensured and trustworthiness was established by the use of multiple researchers and internal auditing.

The final stage of analysis consisted of frequency counting, which allowed the team to determine the frequency of each category across the whole sample.[14] Categories were assigned as *general* if identified in more than 359 cases. Categories were deemed *typical* if identified in 193 to 358 cases and *variant* if identified in 77 to 192 cases. We classified a category as *rare* if identified in 76 cases or fewer.

RESULTS

Respondents were aged 34 ± 11 years, with 11 ± 10 years of clinical practice experience. Additionally, the respondents were predominantly female (53.4%, n = 207) and held a master's degree (67.3%, n = 259). A majority of respondents (81.8%, n = 315) allowed their athletic training students to document patient care, whereas 18.2% (n = 70) did not. The Figure characterizes the domains, categories, and subcategories. Respondents indicated an intention for student involvement (domain 1), whereby they wanted students to engage in learning and gaining knowledge and practicing and gaining experience. Additionally, respondents discussed deterrents working against their intentions to provide athletic training students with opportunities to complete medical documentation and mentor their development of this skill (domain 2). Specifically, they discussed needing to manage the logistics of documentation and the degree of oversight needed during practice (either direct or indirect). Table 3 describes the frequency for each category.

Intention for Student Involvement

The domain *intention for student involvement* comprised the reasons why preceptors allowed their athletic training students to complete medical documentation, including responses such as the need for skill preparation, feedback to the athletic training student, and any issues that would hinder an ideal situation for an athletic training student to learn medical documentation. The *learning and knowledge* category was used to identify both positive and negative responses that focused on the goal of learning or increasing knowledge, whereas the *practice and experience* category was used when preceptors indicated they wanted their students to practice the skill and gain experience. The *deterrents* category was used when preceptors indicated there were challenges that prohibited them from effectively involving their athletic training student in medical documentation.

Table 3. Participant Cases by Category (N = 385)

Category	Frequency	No. of Participant Cases
Learning and knowledge	Variant	159
Practice and experience	Variant	167
Deterrents	Variant	77
Logistics of documentation	Typical	245
Degree of oversight	Variant	188

Learning and Knowledge. Some respondents allowed athletic training students to document the patient encounter and then reviewed the work with the student. During this process, the athletic training student was given the opportunity to either learn or review information and begin to develop proficiency by having the work assessed by the preceptor and another opportunity to revise the medical documentation. There was a perceived value in having athletic training students demonstrate proficiency so they would be prepared to graduate from their professional program. One respondent explained this process of developing competence through feedback:

> *I discuss each documentation experience with [students] and edit their work while we discuss before submitting it to the [electronic medical record (EMR)]. How can I expect students to successfully document when they graduate if they do not practice now? I view [documentation] as a clinical skill.*

Similarly, respondents reported reviewing the athletic training students' documentation to ensure that it is accurate and complete. Another respondent concurred by stating a responsibility to teach students medical documentation habits so they could continue to evolve and correct their skills:

> *Everything our ATSs [athletic training students] do is directly supervised and double-checked to ensure completeness and accuracy. For this reason, there is no risk in allowing them to document. I also feel that it is absolutely critical that student[s] learn appropriate documentation measures in today's medical environment. I hope and feel that I create a sense of responsibility, concern, and need within our students for appropriate documentation.*

It is imperative that athletic training students be allowed not only time to review a skill, but critical refinement of those skills through repetitions and feedback. One respondent noted allowing students to complete medical documentation:

To enforce good habits and develop their skills. They should be able to accurately document in practice, the best way to learn and develop these skills is with purposeful practice and guidance.

Practice and Experience. The *practice and experience* category encompass preceptors allowing the athletic training student the opportunities to perform medical documentation in real-time patient encounters. One respondent summarized the need and rationale for why they allow athletic training students to have medical documentation opportunities. One particular reason is that the athletic training student will soon be a practicing clinician and will be responsible for medical documentation for the patients he or she sees:

Athletic training students need to practice documentation and all the information that needs to be included based on the situation. I always look at their work afterwards to see if they got everything or if they need to get more detail or change something next time. It gets them more comfortable with the process and increases the amount of documentation they will do in the future as ATs or other allied health care providers.

Similarly, a respondent noted that documenting as a student would help socialize the athletic training student on some common transition-to-practice issues.

It's good practice for them. Someday, the student will be responsible for his/her own documentation, and I believe it's better to not be surprised at how much of your time is used for documentation and the detail needed.

Deterrents. Deterrents were coded when respondents identified factors that negatively affected or prevented the integration of athletic training students in medical documentation. Respondents often indicated that they did not allow students to document within systems because they perceived it posed a privacy issue. They described having their athletic training student document patient care in a separate document before inputting the information into the EMR. This allowed them to edit any potential issues before the note was formalized within the EMR. This process, which we termed *double documentation*, can increase the time commitment for the preceptor:

They document in a [W]ord document, but are not allowed to enter in the EMR. I read all their documentations, make corrections, and then enter it into the EMR. Previously I had them entering into the EMR directly, but if they made a mistake, I couldn't change [it].

One respondent described an increased workload from having to correct athletic training students' incorrect medical documentation:

[Athletic training students] missed important data (diagnosis, treatment codes, etc) and that [error] caused more work for me, so I don't let them [athletic training students] have access to the EMR anymore.

Other respondents indicated structural barriers to student integration into this part of their clinical practice. Specifically, in one case the preceptor indicated being limited by the program: "[Athletic training education program] does not allow it [athletic training student to complete medical documentation]."

In other cases, the structural barriers were related to the preceptor's workplace restrictions:

Because we work with professional athlete[s] [we do not let them document]. We do however have the student[s] document on our college summer program athletes and review it with them.

Respondents had legal concerns about allowing athletic training students to document patient care. Some preceptors believed that medical documentation cannot occur until someone is credentialed. One respondent indicated it was "illegal [because] they are not certified..." Another reason respondents did not traditionally allow their athletic training students to document was a strongly held belief that the students needed to focus the limited time they have in clinical experiences practicing other skills:

I'd rather [athletic training student] focus on clinical skills and review documentation as necessary, but they typically practice documentation in the classroom setting.

Mentorship for Student Documentation

The domain *mentorship for student documentation* focused specifically on the ways preceptors allow athletic training students to perform the skill of medical documentation and the subsequent supervision. The *logistics* category focused on the "who, what, when, why, and how" approach for determining what actually occurred during documentation by an athletic training student. The category for *degree of oversight* was used to describe the amount of supervision that the preceptor provided to the athletic training student and if it was done directly or indirectly. Direct supervision was defined as times that the athletic training student and the preceptor completed the medical documentation together or reviewed the materials before submission together. Indirect supervision was chosen when the respondent did not review the athletic training student's materials or did not review the medical documentation with the student present.

Logistics of Documentation. Respondents described the specific logistics of how they completed their medical documentation with the athletic training students, detailing how mentoring occurred for the athletic training students. Similar to the way they described their intent to provide learning opportunities and develop knowledge, the respondents described a step-by-step process that allowed the athletic training students to complete medical documentation, followed with review, feedback, and correction: "[Athletic training students] write basic notes which I check over, edit, and evaluate daily" and "I am able to check their work, give feedback, or make corrections when necessary."

Some respondents described a different mentorship style that led to supervised autonomy:

I introduce the [athletic training student] to our system and how/where things are documented. I then allow the students to document what they did after they perform a treatment, rehab, etc. I will then look over it with them, discuss any necessary changes and why, then I will sign my name under

theirs to show that it was reviewed and approved by a licensed medical provider.

One respondent detailed what was and was not permitted, and how that guided the varying levels of mentorship provided to athletic training students:

[Athletic training students] are allowed to dictate notes in physician visits and put notes in but they have to be signed off by a certified AT. It's only the upper-class students who are allowed to do this. It is good for them to learn what all needs to be included.

Degree of Oversight. *Oversight* was the degree to which the preceptor was involved in the athletic training student's documentation activities. It was categorized as direct (79.8%, n = 150/188) or indirect supervision (20.2%, n = 38/188). One preceptor described a direct approach to medical documentation, requiring that the athletic training student complete the documentation immediately and providing critique using "one-on-one discussion, teaching, and immediate feedback and evaluation." Yet another method of mentoring exists in which students are given the freedom to write the note independently and the preceptor reviews and signs off on the note:

Allow the student to complete the documentation and sign their work, then review the documentation and make any necessary changes then sign the note to indicate my agreement.

Some preceptors preferred a more indirect form of mentoring by having their athletic training student complete medical documentation at home and then following up the next day.

[Athletic training students] perform their evals that day, 3–5 [times] and go home and write their documentation. They bring it back the next day and I read over it and edit if necessary.

Other preceptors would only review medical documentation at specific times: "I go back weekly and check and meet with the student to discuss changes and/or improvements."

Regardless of whether there was direct or indirect supervision, having both the athletic training student and the preceptor sign the document was a common way of concluding a medical documentation entry:

[Athletic training students] write SOAP [subjective, objective, assessment, plan] notes/injury evaluation forms. I review what they wrote, ask questions, and help them to fill in any blanks. I then sign off on the document, in addition to their signature.

DISCUSSION

This study identified common reasons why preceptors allowed their athletic training students to perform medical documentation and the need for mentorship to facilitate this task effectively. Athletic training students provide patient care under the direct supervision of preceptors, and medical documentation is part of patient care. Current athletic training education is guided by the educational competencies,[6] and in the coming years, content will be guided by the curricular content standards.[15] These competencies and standards include identifying components of a comprehensive medical record, understanding the safety and security of protected health information, and demonstrating the ability to use a comprehensive patient-file–management system for appropriate chart documentation, risk management, outcomes, and billing.[6,15] In accordance with educational standards,[8] a majority (82.3%) of athletic training students were allowed to complete medical documentation during their clinical education; however, it is concerning that 17.7% of preceptors did not permit their athletic training students to practice this skill. To assist in skill development and translation of knowledge to clinical practice, preceptors should be encouraged to integrate students in all aspects of patient care, including medical documentation.

Intention for Student Involvement

The purpose of clinical education is for the athletic training student to take the didactic curriculum, integrate the knowledge gained, and apply it to real-life patient encounters through clinical education and experiences. This curricular model allows for experiential learning to occur and has been a historic approach to health care education for over a century. Ideally a preceptor would facilitate this learning by engaging the athletic training student in concrete experiences with medical documentation and then encouraging the athletic training student reflection on the experience and what learning has occurred.

Then, in the final stage of experiential learning, the athletic training student will have the opportunity to experiment and try again.[16] Our respondents indicated that they wanted learning to occur so that the athletic training students could develop knowledge in medical documentation. Many shared that they were active facilitators of the learning, specifically assisting with feedback and revision through the process of documentation. They also described progressive opportunities, where students at different stages of their education were provided more autonomy to document patient care. These preceptors were engaging the athletic training students in experiential learning to facilitate competence.

The NATA *Best Practice Guidelines for Athletic Training Documentation*[17] state that every patient encounter, including communication, must be documented. Based on this premise, every clinical site must be frequently engaged in medical documentation, and preceptors should provide athletic training students with opportunities to increase knowledge in medical documentation. Previous research identified that 10% to 15% of assigned clinical experiences are unengaged waiting time.[18] Rather than having athletic training students fill unengaged waiting time with extra managerial tasks, such as cleaning the facility or restocking supplies, preceptors should consider allocating unengaged time for guided learning and experiences with medical documentation.[14] A coordinator of clinical education (or athletic training program administrator) should purposefully select preceptors who model best practice and provide sufficient opportunities of real-time medical documentation. If this is not occurring, we suggest that preceptors and sites should be deselected and that these skills be seamlessly integrated with standardized patient encounters or other forms of simulation.[19,20]

Previously, the notion existed that in order for someone to develop expertise, they must complete a task for 10 000

hours.[21] Although we believe this premise is flawed, both in the principle (expertise is aspirational)[22] and execution (unlikely for learners to have that many opportunities in professional education),[23] it is imperative that athletic training students be given as many opportunities as possible to increase their knowledge in clinical skills, including documentation. Simply allowing students to perform a task once will not allow them to improve on their skills and abilities. Instead, preceptors should provide opportunity and feedback that transitions an athletic training student from interdependence to independence. In health care, these kinds of day-to-day activities are referred to as entrustable professional activities, whereby residents are permitted to engage in activities without direct oversight or supervision throughout their training.[24] Because medical documentation requires a cosignature of the supervising AT, it is possible that this kind of activity can be done with independence, but also complemented with feedback and consultation.

Respondents within our study noted several reasons for not allowing athletic training students to complete medical documentation, including a perceived lack of ability by the student, restrictions by the AT's employer, and the additional time burden of teaching athletic training students. Previous researchers have indicated that ATs surpass 40-hour work weeks,[25] and this time burden is noted as the primary reason that medical documentation does not occur, specifically within the secondary school setting.[3] Additionally, ATs have stated they are required to spend their working hours covering practices and competitions at their place of employment rather than performing tasks related to organization and administration.[3] This role conflict and required prioritization has led to a decreased time for new patient injury evaluations and medical documentation.[3]

Within our research, we noticed that several ATs were engaged in double documentation, where they or their athletic training student completed multiple drafts or forms of the same set of documentation. An example of this phenomenon is having a student write the medical documentation on a piece of paper or a separate document and then having either the student or the AT redo the documentation for the actual patient record. Preceptors should consider methods such as directly typing into an EMR without saving the information or working alongside athletic training students who still require interdependence to complete the medical documentation. Alternatives may also decrease potential patient privacy violations while also managing the time associated with mentoring students.

Another concern with double documentation is legal in nature. It may be imperative that, if the initial documentation occurred on paper, it be properly disposed of, as it may contain protected health information.[26] Examples of proper disposal include shredding the papers that were used or both deleting the document and clearing the recycling bin if the document was saved electronically.[26] Failure to comply with the strict methods protecting patients through the Health Insurance Portability and Accountability Act[27] and the Family Educational Rights and Privacy Act[28] can result in steep financial fines, as well as possible imprisonment for the supervising AT if a report is filed by a patient. To provide a learning opportunity without legal risks and privacy concerns, preceptors can create a test patient in an EMR system for athletic training students to practice on as a low-stakes learning task.[29]

Mentorship

According to the NATA *Best Practice Guidelines for Athletic Training Documentation*,[17] ATs should be performing initial injury evaluations for every patient encounter. If an AT is modeling best practice for an athletic training student, the students will have the opportunity to practice patient care documentation.[7] Medical documentation should occur either during or immediately after a patient encounter for the purposes of accuracy and congruity.[17] Following best-practice guidelines, the preceptor should review the medical documentation with the student and make any adjustments that are necessary to accurately reflect the patient care experience. Both the signature of the athletic training student and the preceptor should be included within the medical documentation.

In order to have effective mentoring and role modeling, the role of preceptor is one that requires time, dedication, and altruism.[30] Respondents indicated that additional time is required to provide the athletic training student with a quality clinical experience. Clinical experiences require instruction and assessment for real-time patient encounters.[15] In terms of medical documentation, students should be given opportunities to complete medical documentation after patient encounters. Direct supervision includes the ability for the preceptor to intervene on the behalf of both the student and the patient.[15] Because medical documentation does not involve any direct risk of harm to the patient, preceptors can allow autonomy with supervision and mentorship occurring as a result of cosigning the record. By being near and available for the athletic training student, the preceptor is able to address any questions or concerns that may arise while completing the medical documentation.[10,31] We advise that preceptors allow students to first practice and work through any complications they may have with medical documentation, followed by the preceptor immediately reviewing the document with the student and providing feedback.

The concept of *social learning* denotes that a person learns through observation, imitation, and modeling of the behaviors, actions, and skills.[32] Bandura,[32] who is credited with describing social learning theory, denotes 4 parts of the theory: attention, retention, reproduction, and motivation. Athletic training students will continue to mimic the behaviors that they are shown within their clinical experience, and therefore it is important that preceptors model proper documentation habits.

Many of the responses from this survey were seemingly related to a lack of knowledge from the preceptors on both Commission on Accreditation of Athletic Training Education standards for the athletic training student they supervise and a gap in the best practices for training professional students. A few of the respondents within the survey noted that athletic training students could not complete the documentation or would not allow for them to begin practicing these skills until they were at the end of their educational career. To model best practice, preceptors should be up to date on standards for medical documentation and how to integrate athletic training students into their practice.

LIMITATIONS AND FUTURE RESEARCH

This study was exploratory in nature, but helped to preliminarily discover the reasons behind and intentions for preceptors to allow athletic training students to complete medical documentation. The key findings allowed us to understand intentions and mentorship relative to integrating athletic training students into medical documentation practices. Self-selection is an inherent limitation to survey research, and as such preceptors who demonstrated interest in medical documentation may have opted to complete this part of the study. A study that focuses specifically on preceptors may help us identify professional development needs for better student integration. In addition, open-ended responses are limited in nature and follow-up questioning is not possible. Future qualitative inquiry into the day-to-day experiences of preceptors and athletic training students may help identify educational interventions for both audiences to ensure high-quality medical documentation experiences are developed and implemented.

CONCLUSIONS

Athletic trainers who are serving as preceptors varied in how they allowed athletic training students to complete medical documentation but noted deterrents within this process. The preceptors described a genuine intention to provide learning opportunities through feedback and experiences through regular practice to ensure the athletic training student is proficient. The preceptors also described that mentorship and various degrees of oversight are needed to effectively integrate athletic training students into this part of their clinical practice. Athletic training program administrators should be monitoring whether athletic training students are being afforded opportunities to practice medical documentation, providing additional training to preceptors who do not provide these experiences, or supplementing clinical experiences with simulation and standardized patients that require documentation. Preceptors are role models and mentors, and as such they must expose athletic training students to best practices to ensure they have the knowledge, skills, and abilities to properly participate in the medical documentation process.

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