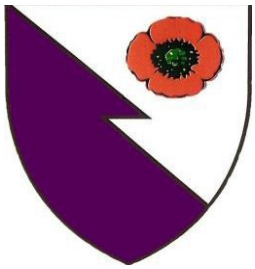

Appendix 1

Emergency Medicine
Work-Place Based Assessment System

RCEM
2015

Appendix 1

Summary

The 2015 WPBA schedule builds on the current 2010 iteration, and is informed by lessons learnt from its use. In designing it, RCEM has taken into account feedback from trainees, trainers, heads of training, the latest research into work place based assessment methods and commissioned expertise in WPBA systems. The assessment system for ACCS is unchanged for 2015, pending intercollegiate review. The key changes are, therefore to WPBA in ST3-6 and include:

- Simplification of the requirements for WPBA
- Reduction of the numbers of assessment overall
- Uncoupling WPBA from curriculum coverage in ST3-6
- Aligning assessment to developmental milestones in ST3-6
- A requirement to observe practice over a period of time, as opposed to reviewing individual cases, using the new Extended Supervised Learning Event (ESLE) tool in ST3-6
- Providing feedback on wider aspects of clinical care, including non-technical skills
- Individual assessments are aligned to independence or progress instead of merit in ST3-6
- A greater role for expert training faculty opinion in adjudging progress

These changes to WPBA sit alongside changes to the formal examination system and will be evaluated for their impact and suitability. Piloting has suggested that, in the round, WPBA will become less tick box. By sampling a wider range of skills, the schedule can access the hitherto untapped potential of the training faculty to share hard won experience to prepare trainees for the absorbing, challenging and ultimately rewarding role of independent clinician in EM.

The 2015 RCEM WPBA Schedule

1. Purpose

The purpose of assessing trainees in the workplace is:

- To provide opportunities for observation and feedback at regular intervals throughout training (a formative purpose or 'assessment for learning').
- To identify for more detailed assessment trainees displaying delayed development of their clinical skills.
- To identify for more detailed assessment trainees displaying generic problems that are likely to be a barrier to clinical practice.

2. How WPBA evolves through EM training

To these ends, specialty trainees in Emergency Medicine are required to engage with a programme of workplace based assessment (WPBA). This WPBA schedule is designed to reflect the stages a trainee will pass through, from novice to independent practitioner. In early training (ACCS) assessment is presentation focussed and relatively prescriptive. This ensures core principles underpinning emergency medical are solid, with clear standards for trainees and trainers. As trainees pass through training to the mid point, WPBA reflects the need to integrate this core development with the rounded skill set needed to provide the most senior input to the ED at times. The latter stages of training are more focussed still on providing detailed high-level feedback to the trainee on the range of non-technical skills and attributes needed for independent practice. The nature of WPBA evolves, therefore, through training from ensuring curriculum coverage to supporting the application of curriculum mastery to the complex and varied roles enacted by the senior ED clinician.

Early Training

WPBA in ACCS

Assessment in ACCS is unchanged from the 2010 schedule pending an intercollegiate review.

Trainees are assessed against the ACCS curriculum in each of EM, AM, ICM and anaesthesia. The focus of WPBA in ACCS is the development of competences relating to the care of individual patients presenting acutely. The majority of assessments are formative events, offering the opportunity for feedback, reflection, development and the pursuit of excellence. Assessment in ACCS also includes summative events (see below). These are pass/fail encounters with consultant assessors. The purpose of these is to identify any problems with mastering key elements of core skills required for the safe and effective care of acutely ill or injured

patients and they include clear descriptors against which trainees can be judged. These summative encounters can be repeated following focussed work, and identify areas of practise where a trainee might need additional time or support to master. Completion of ACCS indicates an EM trainee possesses the core skill-set to progress to the next stage of development. In Emergency Medicine this is development towards the complex collection of knowledge, skills and behaviours needed to ultimately lead a clinical shift in the ED.

Summative Assessment- Assessment of Performance (AoP)

Summative assessments are assessments of performance and are chiefly designed as setting a standard for practice that must be achieved. They are therefore pass/ fail, but can be repeated. The presentations that must be sampled in this way are clearly outlined in the ACCS curriculum and below. Both parties (trainer and trainee) need to know that the assessment is being used in this way. In order to be clear as to what is expected, detailed content has been developed for these assessments, enabling the trainer to more easily identify those areas that need improvement. This content is not intended to limit the trainer, but to provide a framework to which trainers can add additional detail. Descriptors of unsatisfactory practice have also been developed to facilitate more precise feedback. Summative assessments are to be undertaken with consultant trainers or equivalent and will be by Mini-CEX or CbD.

Transition to higher training

WPBA in ST3

Assessment in ST3 has two facets. It is the time in training when paediatric EM skills are further developed and evaluated. The WPBA schedule in PEM reflects the acquisition of a sound grounding in PEM competence to take into HST for further refinement.

In addition, assessment in ST3 also focuses on supporting readiness for the next phase of training in HST. This includes integration of the core skills gained in ACCS and PEM with a developing non-technical skill set. As the trainee develops to independence the milestone of entry into HST is important and fundamental, as it includes working as the most senior clinician in the ED at times. This role requires a degree of autonomy with the sickest patients in the ED, and additional skills of teamwork, supervision, prioritisation, delegation, motivation and leadership. To this end, WPBA in CT3 reflects the need to support the development of such skills. This is the start of a programme of WPBA for non-technical skills that will support the development of trainees through to independent practise. The training faculty supporting the trainee through CT3 will be asked for any concerns about readiness for HST. This faculty statement will be used, along with clinical performance, engagement with training, feedback from WPBA

and the opinion of the Educational Supervisor by the ARCP panel to adjudge suitability to progress to HST.

Higher Training

WPBA in HST

WPBA in HST is there to support progress against the developmental milestones outlined below in Table 1. Examples are given of what is expected at each stage of development, and of concerns that would need to be addressed. Clearly these are not exhaustive, but act as a prompt for a dialogue between trainee and trainers that will be informed by the engagement with the WPBA schedule.

The domains of clinical development listed are from the assessment blueprint(See main curriculum). Examples of non-technical skills that relate to these aspects of workplace activity are also listed. By focussing in more depth on this non-technical skill set, the time spent between trainee and trainer is prioritised to this end. Inthe main, there is no longer a requirement to continue demonstrating coverage of a set list of individual presentations from the curriculum by WPBA in HST. Trainees are, however, required to continue to record curriculum coverage and may use any of the WPBA tools listed below to do so if they choose.

There remains, however, a requirement in HST that trainees continue to demonstrate development in managing more complex cases in PEM, and so 'traditional' case based WPBAs are still required for this purpose.

Additionally, skills in ultrasound are assessed in HST.

Table 1 Examples of clinically aligned developmental milestones for Higher Training

Developing as an ED clinician to independence	Core knowledge and skills ***Non-technical skills***	By the end of ST3	By the end of ST4	By the end of ST5	By the end of ST6	Markers of concern
Evaluate	History taking Clinical Examination Imaging USS • ***Maintenance of standards*** • ***Gathering information***	Build on ACCS PEM Injuries Trauma Can safely evaluate typical cases independently in all areas of the ED Can reliably seek help in evaluating complex cases in all areas Can use available information expertly and efficiently	Can evaluate complex cases in all areas independently in the large majority of cases Has effective strategies for evaluation when there is uncertainty in history or examination	Can evaluate any case, regardless of complexity injury, multi-trauma, paediatrics, concerning presentation in all but exceptional circumstances Can support and develop the expertise of the team in history taking and examination	Can evaluate any case, regardless of complexity injury, multi-trauma, paediatrics, concerning presentation	• Weaknesses in core knowledge • Misses significant cues in history • Under-developed examination technique • Inadequate knowledge or understanding of key investigation modalities • Misses key examination findings • Fails to seek help when unsure • Downplays findings that may refute a working diagnosis

Decide and treat	Core clinical knowledge Procedural skills • ***Option Generation*** • ***Selecting & Communicating Options*** • ***Outcome review***	Can derive a plan of care for the majority of patients attending the ED, regardless of complexity and can seek support appropriately Is proficient in indications and risks of all key investigatory modalities for EM care Has experience of all key procedures required for ED care (ACCS procedure list completed)	Can derive and deliver a plan of care for complex cases in all areas independently in the large majority of cases Can interpret all key investigations within EM skill set and develop the team in interpreting investigations Can support the development of the team in decision making and the use of guidelines Is aware of the risks in supporting decision making of others, and has an effective approach to managing this risk.	Can derive and deliver a plan of care regardless of complexity in all but exceptional circumstances Can anticipate and act when decision making may be challenging, related to the nature of the decision making task, person making it, the context in which it is made	Can derive a plan of care for any patient presenting to the ED and deliver all key ED treatments	• Weaknesses in core knowledge • Under estimates case acuity • Underdeveloped awareness of risk • Does not use available information effectively to generate options • Unsafe procedural technique

Resuscitate	History taking Clinical Examination Imaging USS Procedural skills • ***Authority & assertiveness*** • ***Quality of communication*** • ***Option Generation*** • ***Selecting & Communicating*** • ***Options*** • ***Outcome review*** • ***Gathering information*** • ***Updating the team***	Knows and deploys the key initial interventions consistently Can lead typical resuscitation cases (trauma and non-trauma) to disposal in adult and paediatric care Knows when to seek help for complex cases and can do so in a timely manner Can effectively lead a trauma team	Can effectively lead resuscitation through to disposal, regardless of complexity, in the large majority of cases Authoritative leader from whom others can learn	Lead resuscitation through to disposal regardless of complexity in all but exceptional circumstances with authority Retains situational awareness across more than one resuscitation and can utilise/optimise resources to provide safe care Be aware of the potential impact on the team of resuscitation cases and can effectively debrief and support the team after resuscitation,	Leads any complex resuscitation through to disposal. Oversees care for resuscitation cases in parallel, utilising resources optimally	• Weaknesses in core knowledge • Doesn't know his/her limits. • Fails to recognise emergencies. • Lacks authority and /or appropriate assertiveness • Ineffective communication • Poor option generation • Unable to supervise more than one resuscitation case at a time

Work with others	Core clinical and medico-legal knowledge **Maintenance of Standards** **Supervision & Feedback** **Authority & assertiveness** **Quality of communication** **Option Generation** **Selecting & Communicating Options** **Outcome review** **Gathering information** **Updating the team**	Able to provide support to junior medical and nursing colleagues on the majority of clinical questions and has an effective approach for those that can not be answered Can communicate effectively with patients, care givers and colleagues.	Actively supports junior medical and nursing team members including case supervision, developmental support and the provision of feedback Can supervise junior colleagues in new procedures	Considers the department as a whole and works to build team effectiveness	Able to provide support to the team on all clinical and medico-legal matters in the workplace. Can motivate and support the team, supervise any member of the team and provide high level feedback on skills and behaviours. Can communicate expertly with patients, care-givers, colleagues outside agencies.	• Weaknesses in core knowledge • Ineffective verbal or written communication • Not calm and effective at times of challenge • Causes conflict

Manage the ED	***Maintenance of Standards*** ***Workload management*** ***Supervision & Feedback*** ***Team building*** ***Authority & assertiveness*** ***Quality of communication*** ***Option Generation*** ***Selecting & Communicating Options*** ***Outcome review*** ***Gathering information*** ***Anticipating*** ***Updating the team***	Is aware of the need to manage workload across the ED Can prioritise own work at times of high through put. Can communicate concerns about departmental workload pressure to nursing and medical colleagues	Can anticipate key risks in the ED through times of high occupancy, i.e. availability of space, overall acuity of patients Maintains awareness of the demands on each area of the ED and the potential risks posed. Can delegate work to others to improve safety. Can communicate the need to escalate concerns about departmental workload effectively.	Can provide effective leadership to the ED in all but the most challenging situations Understands the burden of risk in the ED from acuity of patients, workforce issues and lack of patient flow. Can authoritatively communicate the need for allocating resources to reduce risk. Can allocate tasks optimally to self and others to best manage the workload.	Takes a lead in working for structural change in the department where existing staffing levels, clinical space, protocols or workflow practises are consistently failing to meet demand Can provide effective leadership to the ED, even at most challenging times.	• Ineffective management of own workload and that of others • Poor anticipation of potential issues, eg staffing, clinical space • Unable to delegate effectively • Communicates ineffectively • Unable to effectively gather information regarding risk or demand • Retreats into own work at times of challenge

The WPBA tools in ST3-6

For trainees in ST3-6 there are no summative assessments. However, there is a requirement that trainees engage with the WPBA schedule and interact with training faculty from the outset of their post. In this way the assessment schedule can be used to its best advantage. With early interaction, the training faculty can better support trainee development across the academic year. Early interaction can also help identify concerns and targeted assessment of performance can be built into the training year if required. Early engagement with the WPBA programme will be evaluated at a quarter year educational meeting, and engagement is one factor used in deciding suitability to progress in training.

Extended Supervised Learning Event (ESLE)

In the 2015 WPBA schedule the ESLE is introduced for ST3-6. This is a tool that supports evaluation of performance over a period of observation. It is constructed to give scope for recording and providing feedback on progression to independence -in particular the development of non-technical skills. Its use encourages reflection and the formulation of an educational prescription for further focussed work andre-evaluation. It is outlined in more detail below.

Alignment to independence

To aid in providing feedback on the progression to independent practise, all WPBA e.g. Mini-CEX, CbD in ST3-6 are aligned to independence, rather than notions of merit or of satisfactory performance as they are in ACCS. Recent evidence suggests that this yields better reliability and a greater spread of responses, and therefore lead to more valuable feedback. [1] This approach will be evaluated with the launch of the 2015 WPBA schedule and will be considered for early training in ACCS.

1. Weller JM, Misur M, Nicolson S, Morris J, Ure S, Crossley J, et al. Can I leave the theatre? A key tomore reliable workplace-based assessment. Br J Anaesth. 2014;112(6):1083-91.

Highlighting concern

Assessment tools in ST3-6 also now include enquiry into areas of concern. Hitherto, WPBA responses have been aligned to merit, and concerns have had to beimputed from such a scale. In this current schedule, there is a request that trainers outline any training concerns illuminated by the encounter. A review of current evidenceon raising concerns yielded categories of behaviour that relate to future problemsin providing satisfactory care, these being: irresponsibility, diminished capacity forself-improvement, immaturity, poor initiative, impaired relationships, and unprofessional behaviour associated with anxiety, insecurity or nervousness.

Such concerns will be shared with the educational supervisor. There is an expectation that the engagement with addressing such concerns, and progress against resultant educational recommendations will inform judgement about progression at year-end.

3. Assessment tools

Generic WPBA tools

- Mini-Clinical Evaluation Exercise (Mi or mini-CEX, in anaesthesia A or Anaes-CEX)
- Direct Observation of Procedural Skills (D or DOPS)
- Multi-Source Feedback (M or MSF)
- Case-Based Discussions (C or CbD)
- Patient Survey (PS)
- Acute Care Assessment Tool (ACAT)
- Audit Assessment (AA)
- Teaching Observation (TO)

These are described in the main curriculum

Speciality specific EM tools:

The ACAT-EM

This tool was originally used by GIM when trainees do ward rounds and has been modified for the ED environment. This tool provides the opportunity to assess the trainee working over a longer period of time, over a number of important domains, with a number of cases, interacting with a larger number of staff in a busy ED environment with all that that entails. This tool should only be used formatively.

Testing of this tool in the ED has indicated that:

1. The assessment may take more than one shift as not all the domains may be observed by the assessor in one shift. The assessor should ensure that as many domains are covered as possible
2. That the assessor should seek the views of other members of the ED team when judging performance
3. That the trainee should be aware when the ACAT-EM is being undertaken
4. Each ACAT-EM can be used to assess up to 5 acute presentations. For each acute presentation the case notes and management plan should be reviewed by the CS before it is signed off on the ACAT.
5. ACAT-EM cannot be used as a summative tool. If the assessor judges the performance for a particular AP of concern (i.e. scores 1-3) this AP should be further assessed using Mini-CEX or CdD,

6. ACAT-EM can be used in all areas of the ED including CDU ward rounds and review clinics.

ACAT –EM	
Assessment Domains	Description
Clinical assessment and clinical topics covered	Quality of history and examination to arrive at appropriate diagnosis- made by direct observation and note review No more than 5 AP should be covered in each ACAT and this should involve a review of the notes and management plan of the patient
Medical record keeping	Quality of recording of patient encounters including drug and fluid prescriptions
Investigations and referrals	Quality of trainees choice of investigations and referrals
Management patients	Quality of treatment given to patients(assessment, investigation and treatment given)
Time management	Prioritisation of cases
Management of take/team working	Appropriate relationship with and involvement of other health professionals
Clinical leadership	Appropriate delegation and supervision of junior staff
Handover	Quality of handover of care of patients between EM and in patient teams and in house handover including obs/CDU ward
Patient safety	Able to recognise effects of systems, process, environment and staffing on patient safety issues
Overall clinical judgement	Quality of trainees integrated thinking based on clinical assessment, investigations and referrals. safe and appropriate management, use of resources sensibly

The ACAT-EM form which these assessment domains relate to is in appendix 2.

The Extended Supervised learning Event (ESLE)

As previously outlined, the main focus of workplace-based assessment in Higher Specialty Training (ST4-6) is the development of higher level, non-technical skills. This will be facilitated by the 'ESLE'. This is an extended event of observation in the workplace across cases. It covers interactions, decision-making, management and leadership, as well as the trainee's individual caseload.

The event will characteristically be 3 hours in length, with around two hours of observation followed by around one hour of feedback. The trainee will be observed during their usual work on shift, but the consultant observer will be supernumerary, i.e. 'not in the clinical numbers'. Feedback will take place in a debrief using the RCEM non-technical skills feedback tool. This is derived from a validated instrument [2], and is used to guide feedback across all observed domains of practise. Trainees are given a rating aligned to independence in each domain observed by the consultant supervisor. The purpose of so doing is to provide expert opinion on development against expectation and to generate learning outcomes for further work in the ED and future ESLEs. This approach has been piloted for feasibility and acceptability to trainers and trainees and has been found to be so.

These events will be completed by the educational/ clinical supervisor and at least one other consultant or equivalent. Each will yield an educational prescription to facilitate development across the academic year. The first must be completed in the three months of the post and a minimum of three is required in ST4 and ST5 and two in ST6.

[2] Flowerdew *et al*. Development and Validation of a Tool to Assess EmergencyPhysicians' Nontechnical Skills. Annals of Emergency Medicine Volume 59, Issue 5 , Pages 376-385.e4, May 2012

	Assessment Domains	Examples of Good behaviour	Examples of poor behaviour
Management & Supervision	**Maintenance of Standards**	• Notices doctor's illegible notes and explains the value of good note keeping • Explains importance of ensuring sick patient is stable prior to transfer • Ensures clinical guidelines are followed and appropriate pro forma is complete	• Fails to write contemporaneous notes • Does not wash hands (or use alcohol gel) after reviewing patient • Fails to adhere to clinical safety procedures
	Workload Management	• Sees a doctor has spent a long time with a patient and ascertains the reason • Ensures both themselves and other team members take appropriate breaks • Deals with interruptions effectively	• Fails to act when a junior is overloaded and patient care is compromised • Focuses on one particular patient and loses control of the department • Fails to escalate appropriately when overloaded
	Supervision & Feedback	• Gives constructive criticism to team member • Takes the opportunity to teach whilst reviewing patient with junior doctor • Gives positive feedback to junior doctor who has made a difficult diagnosis • Leads team through appropriate debrief after resuscitation	• Criticises a colleague in front of the team • Does not adequately supervise junior doctor with a sick patient • Fails to ask if junior doctor is confident doing a practical procedure unsupervised
Teamwork & Cooperation	**Team Building**	• Even when busy, reacts positively to a junior doctor asking for help • Says thank you at end of a difficult shift • Motivates team, especially during stressful periods	• Harasses team members rather than giving assistance or advice • Speaks abruptly to colleague who asks for help • Impolite when speaking to nursing staff
	Quality of Communication	• Gives an accurate and succinct handover of the department • Ensures important message is heard correctly • Gives clear referral to specialty doctor with reason for admission (e.g. SBAR)	• Uses unfamiliar abbreviations that require clarification • Repeatedly interrupts doctor who is presenting a patient's history • Gives ambiguous instructions
	Authority & Assertiveness	• Uses appropriate degree of assertiveness when inpatient doctor refuses referral • Willing to speak up to senior staff when concerned • Remains calm under pressure	• Fails to persevere when inpatient doctor refuses appropriate referral • Shouts instructions to staff members when under pressure • Appears panicked and stressed

Decision making	**Option Generation**	• Seeks help when unsure • Goes to see patient to get more information when junior is unclear about history • Encourages team members' input	• Does not look at previous ED notes/ old ECGs when necessary • Fails to listen to team members input for patient management • Fails to ensure all relevant information is available when advising referral
	Selecting & Communicating Options	• Verbalises consideration of risk when sending home patient • Discusses the contribution of false positive and false negative test results • Decisive when giving advice to junior doctors	• Uses CDU to avoid making treatment decisions • Alters junior doctor's treatment plan without explanation • Forgets to notify nurse-in-charge of admission
	Outcome Review	• Reviews impact of treatment given to acutely sick patient • Follows up with doctor to see if provisional plan needs revising • Ensures priority treatment has been given to patient	• Fails to establish referral outcome of complicated patient • Sticks rigidly to plan despite availability of new information • Fails to check that delegated task has been done
Decision	**Gathering Information**	• Uses Patient Tracking System appropriately to monitor state of the department • 'Eyeballs' patients during long wait times to identify anyone who looks unwell • Notices doctor has not turned up for shift	• Fails to notice that patient is about to breach and no plan has been made • Ignores patient alarm alerting deterioration of vital signs • Fails to notice that CDU is full when arranging new transfers
	Anticipating	• Identifies busy triage area and anticipates increased demand • Discusses contingencies with nurse-in-charge during periods of overcrowding • Prepares trauma team for arrival of emergency patient	• Fails to anticipate and prepare for difficulties or complications during a practical procedure • Fails to ensure that breaks are planned to maintain safe staffing levels • Fails to anticipate and plan for clinical deterioration during patient transfer
	Updating the Team	• Updates team about new issues such as bed availability or staff shortages • Keeps nurse-in-charge up to date with plans for patients • Communicates a change in patient status to relevant inpatient team	• Notices the long wait but fails to check the rest of the team is aware • Fails to inform team members when going on a break

The full ESLE form, is available in appendix2

Practical Procedures

Using a similar approach to Mini-CEX, RCEM has described in more detail the practical skills needed to be demonstrated. These detailed descriptors are in appendix 2.

It is important to note that these descriptors do not result in unsatisfactory/satisfactory performance (i.e. they are not summative) but that the trainee can repeat these assessments as many times as appropriate.

Practical procedures are also accompanied by a template for describing unsatisfactory performance (see below), which should be used in conjunction with the generic DOPs tool.

Observed behaviour	Task Completed
Did not understand the indications and contraindications to the procedure	
Did not properly explain the procedure to the patient	
Did not understand the relevant anatomy	
Failed to prepare properly for the procedure	
Did not communicate appropriately with the patient or staff	
Aseptic precautions were inadequate	
Did not perform the technical aspects of the procedure correctly	
Failed to adapt to unexpected problems in the procedure	
Failed to demonstrate adequate skill and practical fluency	
Was unable to complete the procedure	
Did not complete relevant documentation	
Did not issue clear post procedural instructions to patient and or staff	
Did not maintain an appropriate professional demeanour	

Summative assessment tools for ACCS

1. **Summative Mini-CEX**

In order to facilitate assessment the RCEM has:

a. Provided descriptors for **satisfactory performance** in the Mini-CEX for each area chosen for assessment. These detailed descriptors are in appendix 2. It is important that trainees always systematically develop a full differential diagnosis and always consider the potentially life threatening conditions and not list by probability alone. Clearly for each Mini-CEX there is a spectrum of severity and underlying causes and the assessment will need to be tailored to that situation. The Mini-CEX examples in appendix 2 have deliberately included the whole patient encounter and not simply examination. This reflects the reality of practice.

b. Provided descriptors of **unsatisfactory performance** that can be used in feeding back to the trainee. These are include in the table below

Dimension	Descriptor of unsatisfactory performance
History taking	• History taking was not focused • Did not recognise the critical symptoms, symptom patterns • Failed to gather all the important information from the patient, missing important points • Did not engage with the patient • Was unable to elicit the history in difficult circumstances- busy, noisy, multiple demands
Physical examination	• Failed to detect /elicit and interpret important physical signs • Did not maintain dignity and privacy
Communication	**Communication skills with colleagues** • Did not listen to other views • Did not discuss issues with the team • Failed to follow the lead of others when appropriate • Rude to colleagues • Did not give clear and timely instructions • Inconsiderate of the rest of the team • Was not clear in referral process- was it for

	opinion, advice, or admission **Communication with patients** • Did not elicit the concerns of the patient, their understanding of their illness and what they expect • Did not inform and educate patients/carers • Did not encourage patient involvement/ partnership in decision making
Clinical judgement-clinical decision making	• Did not identify the most likely diagnosis in a given situation • Was not discriminatory in the use of diagnostic tests • Did not construct a comprehensive and likely differential diagnosis • Did not correctly identify those who need admission and those who can be safely discharged. • Did not recognise atypical presentation • Did not recognise the urgency of the case • Did not select the most effective treatments • Did not make decisions in a timely fashion • Decisions did not reflect clear understanding of underlying principles • Did not reassess the patient • Did not anticipate interventions and slow to respond • Did not review effect of interventions
Professionalism	• Did not respect confidentiality • Did not protect the patients dignity • Insensitive to patients opinions/hopes/fears • Did not explain plan and risks in a way the patient could understand
Organisation and efficiency	• Was slow to progress the case
Overall care	• Did not ensure patient was in a safe monitored environment

- Did not anticipate or recognise complications
- Did not focus sufficiently on safe practice
- Did not follow published standards guidelines or protocols
- Did not follow infection control measures
- Did not safely prescribe

2. Summative Case Based Discussions – CbD

Case based discussions are designed to evaluate clinical reasoning and decision making based on the history, examination, investigation, provisional diagnosis and treatment of the caseselected.

The CbD tool can be used for summative assessment. The trainee should bring their notes and relevant investigations. The trainer should invite the trainee to describe what they did. They should be asked to explain their actions and justify their diagnosis and treatment. This is an opportunity to explore how the trainee came to their conclusions. Has the trainee demonstrated a systematic prioritised approach? Have they derived a reasonable differential diagnosis and how did they do this?

For each domain (descriptions of expected behaviour given below) the assessor should rate the trainee as below at or above the expected level for their grade and experience and make an overall satisfactory/unsatisfactory judgement. EM consultants, or equivalent, must complete summative assessments.

Domain descriptor	Expected behaviour
Record keeping	Records should be legible and signed. Should be structured and include provisional and differential diagnoses and initial investigation & management plan. Should record results and treatments given.
Review of investigations	Undertook appropriate investigations. Results arerecorded and correctly interpreted. Any Imaging should be reviewed in the light of the trainee'sinterpretation
Diagnosis	The correct diagnosis was achieved with an appropriate differential diagnosis. Were any important conditions omitted?
Treatment	Emergency treatment was correct and response recorded. Subsequent treatments appropriate and comprehensive

Planning for subsequent care (in patient or discharged patients)	Clear plan demonstrating expected clinical course, recognition of and planning for possible complications and instructions to patient (if appropriate)
Clinical reasoning	Able to integrate the history, examination and investigative data to arrive at a logical diagnosis and appropriate treatment plan taking into account the patients co-morbidities and social circumstances
Overall clinical care	The case records and the trainee's discussion should demonstrate that this episode of clinical care was conducted in accordance with good clinical practice and to a good overall standard

The CbD form to accompany these descriptors is available in appendix 2.

4. Assessment Schedule

In ACCS and CT3 PEM, assessment is closely mapped to curriculum coverage. There is clearly defined curricular content for these periods of training that are identified and assessed in the following ways.

1. Major and acute presentations that must be assessed using Mini-CEX or CbD by consultant or equivalent

2. Major and acute presentations that must be assessed using either Mini-CEX/CbD. or ACAT-EM (which can be used to cover up to 5 acute presentations in one assessment)

3. The remaining acute presentations that may be covered by the trainee in a variety of ways, such as successful completion of e-learning modules, FOAM ED content, reflective diary entries in the e-portfolio (with clear learning outcomes), audit and teaching assessments that relate to acute presentations, or additional ACATs.

4. Practical procedures, which are assessed in EM using the DOPs generic tool

5. The 25 Common competences, each of which is described by levels 1-4.

a) Trainees during CT1-3 should aim to reach level 2 in at least 23/25 areas.
b) Trainees by the end of HST should have reached level 4 in at least 23/25 areas.
c) Many competences are an integral part of clinical practice and as such will be assessed concurrently with the clinical presentations and procedures assessments.
d) Trainees should use these assessments to provide evidence that they have achieved the appropriate level.
e) For a small number of common competences alternative evidence should be used e.g. assessments of audit and teaching, completion of courses, management portfolio

ACCS

The ACCS curriculum has been written to closely integrate the specialties. The AM/EM and part of the ICM content is presented as 6 major presentations and 38 acute presentations. These should be covered over the typical 18/12 period allocated for AM/EM and ICM.

There are 45 items listed under practical procedures (including anaesthesia and ICM items), which trainees should aim to cover over the first 2years.

The responsibility for providing the opportunity for assessments lies with all four specialties.

During a typical 6 months in EM it will be expected that the trainees will submit themselves to:

Major presentations (MPs)

Two or more of the six major presentations, which will be covered summatively using Mini-CEX or CbD.

It is essential that EM consultants, or equivalent, complete all summative assessments or equivalent e.g. an associate specialist who has completed assessment training as defined by GMC.

Trainer and trainees should note that the assessment of cardiac arrest is also part of the anaesthetic assessment regimen and could be assessed during that time. Schools may wish to explore the opportunity of using simulation to assess anaphylaxis given its low frequency.

Acute Presentations (AP)

The trainee should be assessed summatively using Mini-CEX or CbD for the following 5 acute presentations:

1 CAP7 Chest pain,
2 CAP1 Abdominal pain
3 CAP 6 Breathlessness 4
CAP30 Mental health 5
CAP18 Head injury

These assessments are to be completed by EM consultants or equivalent

Another 7 APs should be covered using an ACAT-EM or Mini-Cex/CbD.

Guidance for the completion of an ACAT-EM, are contained in appendix 2. A single ACAT can cover up to 5 APs.

It is intended that when the trainee is working in Acute Medicine, they will similarly cover 2 MPs and 10 or more acute presentations using Mini-CEX/CbD or ACAT.

During the year of AM and EM, trainees should be aiming to sample the remaining 18 acute presentations.

The RCEM would recommend that 9 should be covered whilst in EM by successful completion of

E-learning modules or FOAM ED content
Teaching and audit assessments
Reflective entries that had a recorded learning outcome into the e-portfolio
Additional ACAT-EMs.

Trainees at the end of their EM training should seek a summary description of the number and location of patients they have seen, which are available from ED computerised records (i.e. total number seen, number aged <16, number seen in resuscitation area, major side and minors)

Practical procedures (PP)

EM has agreed to undertake a minimum of 5 assessments for PP whilst the trainee is in EM in the first 2 years of training. These PPs are

1 Airway protection
2 Trauma primary survey
3 Wound management
4 Reduction of dislocation / fracture
5 Plus one other PP from list

These assessments will be done using the generic DOPs tool but RCEM has written detailed descriptors of expected trainee performance to assist in assessment and feedback. Whilst these DOPs are not summative assessments the assessor should indicate however if the DOPs should be repeated.

If the opportunity arises, additional practical procedures may be completed in EM using the generic DOPs tool provided and available on the trainee's e-portfolio.

Common competences

Trainees should seek evidence of level 2 competence for >50% of the common competencies in these first 2 years

Transition to Higher Training

ST3

There are no summative assessments in ST3.

WPBA in ST3 Paediatric Emergency Medicine

Curriculum content in ST3 Emergency Medicine

1. Paediatric Emergency medicine
    a. There are 6 major presentations (PMP)
    b. There are 19 acute presentations (PAP)
    c. There are 3 practical procedures (PP)

The trainee will be expected to complete the following:

Major Presentations

Successful completion of APLS or EPLS/EPALS can be used as a proxy assessment for the major presentations.

Trainees should also complete:

Two of the six Major Presentations using ST3 Resuscitation Mini-CEX or CbD with a consultant or equivalent in the workplace, one within 3 months of commencing.

Given the rarity of paediatric cardiac arrest and anaphylaxis, Schools may wish to explore the opportunity of using simulation to aid assessment.

Acute Presentations

The trainee should be assessed using general Mini-CEX or CbD for the following five acute presentations with a consultant or equivalent
Two of which must be within 3 months of commencement using Mini-CEX.

1. PAP1 Abdominal pain
2. PAP5 Breathing difficulties
3. PAP9 Fever in all age groups
4. PAP15 Pain in children
5. PAP6 Concerning presentations (assessed using CbD)

The remaining 14 APs should be sampled by successful completion of

ACAT-EM
Mini-CEX/CbD if the opportunity occurs
RCEM learning modules or FOAM ED content
Teaching and audit assessments,
Reflective entries that had a recorded learning outcome in the e-portfolio

CT3 PEM Practical procedures

The following 3 practical procedures in children should be assessed during CT3

1 Venous access
2 Airway assessment and maintenance,
3 Primary survey

If the opportunity arises, additional practical procedures may be completed in EM using the generic DOPs tool provided and available on the trainee's e-portfolio.

WPBA in ST3 Adult Emergency Medicine

Curriculum content in ST3 Adult EM

a. major presentations: Major trauma (with five sub-headings)
b. Acute presentations: Seven C3APs

WPBA from this point in training are mapped to the clinically aligned milestones in table 1. Trainees are also required to continue sampling and recording evidence of coverage of major and acute presentations Evidence is recorded in the e-portfolio, and can be from a number of sources, as outlined below.
The WPBA listed below are a minimum. Further WPBA may provide evidence of curriculum coverage, and trainees are also encouraged to record and seek feedback on further individual cases that highlight complexities or challenges.

Six Resuscitation cases by Mini-CEX or CbD (including trauma assessment) with consultant assessors or equivalent. Three must be assessed by Mini-CEX, the first within 3 months of commencing the post.

Major & Acute Presentations

The five CT3 EM major presentations and the seven CT3 EM acute presentations may be sampled by: ESLE
Resusitation Mini-CEX or CbD
ACAT, Mini-CEX or CbD (if the opportunity occurs)
RCEM learning modules or FOAMed content
Teaching and audit assessments

Extended supervised Learning Event (ESLE)

Two will be conducted in Adult Emergency Medicine, the first by 3 months. The first is to be conducted by the clinical/educational supervisor.

Practical procedures (PP)

There are no new practical procedures during CT3 EM. Trainees should ensure that they have sampled assessments for all 45 areas listed, which should ideally have been completed in the first 2 years.

Common competencies

Should have demonstrated achievement of level 2 in at least 23/25

Curriculum content in HST Emergency Medicine

In HST, a trainee will need to provide evidence of curriculum coverage for

1. **36 HST Acute Presentations (HAP)**
2. **6 Paediatric Emergency Medicine Acute Presentations**

WPBA in ST4

Extended Supervised Learning Event (ESLE)

Three ESLEs will be completed, the first within 3 months of commencement and the second within 6 months. The educational/clinical supervisor will conduct the first, and at least one other consultant or equivalent will conduct another.

ESLEs will sample activity in all available areas of the ED and must include resuscitation room care.

18 acute presentations may be covered by the trainee in a variety of ways (see curriculum coverage below):

ESLE

Mini-CEX or CbD (if the opportunity arises)

RCEMlearning modules or FOAM Ed content

Reflective diary entries in the e-portfolio with clear learning outcomes

Audit and teaching assessments

ST4 Paediatric Emergency Medicine

3 complex major or acute presentations of must be assessed using either

Mini-CEX or CbD

Trainees will undertake those procedures introduced in core training repeatedly and should maintain a log of such procedures.

Ultrasound training occurs during HST and is described in the documentRCEM EMUS Level 1 ultrasound.

Trainees should be working towards level 4 for the common competences.

ST4 Ultrasound

It is recommended in ST4 that the following is covered

- Section A- trainee information, theory training and log summary
- Commence triggered assessments B-D

The EMUS assessment system is provided in appendix 7 and is also available on the RCEM web site.

WPBA in ST5

Extended Supervised Learning Event (ESLE)

Three ESLEs will be completed. The first within 3 months of commencement and the second within 6 months. The educational/clinical supervisor will conduct the first, and at least one other consultant or equivalent will conduct another. ESLEs will sample activity in all available areas of the ED and must include resus.

The remaining 18 acute presentations may be sampled by:

- ESLE
- Mini-CEX or CbD (If the situation arises)
- RCEMlearning modules or FOAM ED content,
- Reflective diary entries in the e-portfolio with clear learning outcomes,
- Audit and teaching assessments

ST5 Paediatrics

3 complex major or acute presentations must be assessed using either
Mini-CEX or CbD,

ST5 Ultrasound

Continue triggered assessments.

The EMUS assessment system is provided in appendix 7 and is also available on the RCEM web site.

WPBA in ST6

During this year the trainees' focus is on the FCEM exam and no new material is introduced.

Any curricular content as yet uncovered should be completed.

Extended Supervised Learning Event (ESLE)

Two ESLEs will be completed, one of which must be within the first 6 months. These will focus on leading the department and during these ESLEs the trainee will be supernumerary and will work alongside the consultant running the shift. The trainee will receive all the calls and enquiries the consultant would usually receive and will respond under consultant supervision. The RCEM non-technical skills feedback tool will be used to debrief the trainee and used to formulate an educational prescription.

ST6 Ultrasound

Trainees will complete all triggered assessments and final signoff.

Common competences

Trainees should have achieved level 4 for 95% of common competences.

5.WPBA for trainee progression

In the 2010 curriculum the review of WPBA at ARCP to decide on progression is ostensibly to ensure they are completed. As WPBA is unchanged in ACCS in this current schedule, the standard for progression is to complete all summative assessments and complete the required curriculum coverage using the WPBA tools outlined above.

In the 2015 iteration, RCEM has recognised the ability of an expert faculty to make judgements on the suitability of a trainee to progress in training. This judgement should be as transparent as possible. To that end, trainers and trainees can refer to the table of developmentally aligned milestones. The minimum requirement of WPBA is designed for trainees progressing satisfactorily through these milestones in time. The decision about progression based on WPBA will be made over the whole training year. If trainees are having difficulties in particular areas, then the schedule is designed to identify these early in the year, with early engagement mandated. An educational programme would be put in place to allow the trainee to address concerns and chart progress. In this way a number of additional data-points and the opinion of a range of assessors would be available to inform decision-making at year-end.

The decision as to whether a trainee is ready to progress is multi-factorial, and ultimately the responsibility of the ARCP panel. The range of tools now available to cover both technical and 'non-technical' skills provides the potential for a comprehensive portrait of a trainee's progress for this purpose. At present, not enough is known about the performance of WPBA reflecting higher-level skills to give a defined rubric for their use. However, to give trainees an impression of how WPBAs are to inform judgement on their progress the following recommendations are made:

Trainees in all years of training would not be expected to progress to the next stage of training if significant concerns highlighted by WPBA were unresolved.

Progression in ACCS

All summative assessments must be completed by year-end, and curriculum coverage must be evidenced as laid out in this document.

Progression from ST3

Assessments of key PEM presentations must be complete.

Six Resuscitation cases: If trainees were consistently rated as requiring direct supervision for typical cases at the end of ST3 then progression to ST4 would be inappropriate.

ESLE: If a trainee is rated as at the level of a 'core trainee' in the majority of the domains of non-technical skills it would be inappropriate to progress to ST4.

Progression in HST

ST4-5

ESLE: If a trainee is consistently rated at a level below their current seniority, then progression would be inappropriate.

ST6

ESLE: If a trainee is consistently rated as working to the level of a consultant in only a small minority of the domains of practise, it would be inappropriate for them to exit training.

Remediation

Trainees with such findings in the first ESLE of the year should work with their educational or clinical supervisor to arrange further targeted events, with clear educational goals. These goals form a plan for the next event and these will build through the year to provide a comprehensive picture of progress. Ultimately though, delays in training are not punitive and reflect the complexity of the skill set required for independent EM practise and the variation that exists between practitioners.

6. EM curriculum coverage

Summary of presentations and year of coverage.

The collation of evidence of curriculum coverage is mapped to years of training to ensure that curriculum coverage is spread across the years of training. Key presentations in ACCS have a specified approach to coverage and around 50% will be by a direct interaction with the trainer using Mini-CEX and CbD. Likewise in CT3 PEM, curriculum coverage is based on paediatric presentations with a requirement for required trainee/trainer interaction to ensure key competences are covered. Otherwise, from ST3-5 curriculum coverage is divided across the years to ensure coverage is continual until the final year.

The Table below summarises all the presentations and when they should be covered. For each presentation the trainee should have a recorded e-portfolio entry. As previously described, there are presentations that must be assessed using Mini-CEX and CbD tools i.e. face-to-face interaction between trainee and trainer and these are indicated by (M). For the remainder a combination of the ACAT, ESLE, reflective entry into the e portfolio, completion of RCEMlearning modules or FOAM ED content and relevant audit and teaching should be used to indicate coverage of the curriculum (so called additional assessment tools). The requirements for curriculum coverage by year are referenced to the curriculum and are summarised in table2.

CMP Core major presentations in ACCS 1&2
C3MP Additional curricular material for major presentation in CT3
PMP Paediatric major presentation covered in CT3
HMP Additional curricular material for major presentations covered in ST4-7
CAP Core acute presentations in ACCS 1&2
C3AP Core acute presentations introduced in CT3
PAP Paediatric acute presentations covering CT3 and HST
HAP Higher specialist training additional curricular material for acute presentations introduced in HST4-7

Table 2. Curriculum coverage by year

Major Presentations	ACCS	CT3	CT3 PEM	ST4-7
Anaphylaxis	CMP1		PMP1	HMP1
Cardio-respiratory arrest	CMP2		PMP 3	HMP2
Major trauma	CMP3	C3MP(subset a-e)	PMP4	HMP3
Septic patient	CMP4			
Shocked patient	CMP5		PMP5	HMP4
Unconscious patient	CMP6		PMP6	HMP5
Apnoea stridor and airway obstruction			PMP2	

Acute Presentations	ACCS	CT3	CT3 PEM	ST4-7 PEM	ST4-7
Abdominal pain including loin pain	CAP1(M)		PAP1(M)	PAP1	HAP1
Anal pain and rectal bleeding					HAP4
Testicular pain		C3AP8	Covered by PAP1		
Acute back pain	CAP3			Covered by PAP16	HAP2
Urinary retention		C3AP9			
Alcohol and substance abuse					HAP3
ALTE			PAP3		
Blackout/ collapse	CAP5				HAP5
Blood disorders			PAP4	PAP4	HAP7
Blood gas interpretation		C3AP3			
Breathlessness	CAP6(M)		PAP5(M)		HAP6
Chest pain	CAP7(M)				HAP8
Concerning presentations in children			PAP6 (M)		
Confusion	CAP8				
Cough	CAP9				
Dental problems					HAP9
Dehydration in children			PAP7	PAP7	
Diarrhoea	CAP11		Covered by PAP7		
Dialysis patient					HAP10
Dysuria		C3AP5			

Environmental emergencies					HAP11
Falls	CAP13				HAP13
Fever	CAP14		PAP9(M)	PAP9	HAP14
Fits/ Seizure	CAP15		Covered by		HAP15
Floppy child			PAP10		
Haematesis/Maelena	CAP16		PAP11		HAP16
Headache	CAP17		PAP12	PAP12	HAP17
Jaundice	CAP19				
Limb pain, swelling, and joint pain	CAP20		PAP16		HAP18&19
Neonatal presentations			PAP13	PAP13	
Needlestick injury		C3AP7			
Oncology emergencies					HAP21
Palpitations	CAP25				HAP23
Patient with abnormal blood glucose		C3AP4			
Painful penile conditions					HAP24
Poisoning/self-harm	CAP27		PAP2	PAP2	HAP25
Rash	CAP28		PAP18		HAP28
Vomiting/ nausea	CAP36			Covered by	
Weakness and paralysis	CAP37				
Acute weakness not due to stroke					HAP33
Dizziness and vertigo	CAP12				
Abdominal swelling	CAP2				
Head injury	CAP18 (M)				
Mental Health	CAP30 (M)				

Wound assessment	CAP38				HAP34
Ophthalmology/Painful eyes	CAP29		PAP14		
Painful ears/ENT	CAP24		PAP8		HAP12
Traumatic limb	CAP33	C3AP2 A&B	PAP17		HAP14
Pelvic pain	CAP26				
Vaginal bleeding	CAP34				
Medical problems in pregnancy					HAP27
Cyanosis	CAP10				
Sore throat	CAP31		PAP19		
Sexually transmitted diseases					HAP31
Sudden visual loss					HAP32
Sexual assault					HAP30
Aggressive/ disturbed behaviour	CAP4				
Neck pain	CAP21				
Syncope and pre-syncope	CAP32				
Patient in pain	CAP23		PAP15 (M)	PAP15	
Ventilatory support	CAP 35				
The oliguric patient (to include fluid challenge)	CAP22				
Major incident					HAP20
Observational medicine					HAP22
Pre-hospital Care					HAP26
Complex older patients					HAP35

Patients with chronic disease					HAP36
TOTAL	38	7	19	8	36

2. **Summary of practical procedures to be assessed.**
The table below summarises all the practical procedures to be undertaken in adults and children. These should all be covered by the end of CT3. Where a specialty is indicated, that specialty has the responsibility for assessment. A blank box means that any of the ACCS specialties can undertake the assessment. It does not mean that the procedure should not be assessed. The ARCP decision aid summarizes the proportion of procedures to be covered for each year.

Practical procedures	GIM(A)	EM	ICM	Anaesthesia
1. Arterial cannulation			**D**	
2. Peripheral venous cannulation			**D**	
3. Central venous cannulation			**D**	
4. Arterial blood gas sampling			**Mi, D**	
5. Lumbar puncture				
6. Pleural tap and aspiration				
7. Intercostal drain Seldinger				
8. Intercostal drain - Open				
9. Ascitic tap				
10. Abdominal paracentesis				
11. Airway protection		**D**		
12. Basic and advanced life support				**D**
13. DC Cardioversion				
14. Knee aspiration				
15. Temporary pacing (external/ wire)				
16. Reduction of dislocation/ fracture		**D**		
17. Large joint examination				
18. Wound management		**D**		
19. Trauma primary survey		**D**		
20. Initial assessment of the acutely unwell				
21. Secondary assessment of the acutely unwell				

22. Connection to a mechanical ventilator			**D**	
23. Safe use of drugs to facilitate mechanical ventilation			**C**	
24. Managing the patient fighting the ventilator			**C**	
25. Monitoring Respiratory function			**C**	
26. Delivers a fluid challenge safely to an acutely unwell patient				**X**
27. Describes actions required for accidental displacement of tracheal tube or tracheostomy				**A**
Initial Assessment of Competence (IAC) as listed below form Preoperative assessment to Emergency surgery				**A**
28. Preoperative assessment				**A**
29. Management of spontaneously breathing patient				**A**
30. Administer anaesthesia for laparotomy				**A**
31. Demonstrate RSI				**D**
32. Recover patient from anaesthesia				**D**
33. Demonstrates function of anaesthetic machine				**D**
34. Transfer of patient to operating table				**D**

35. Demonstrate CPR resuscitation on a manikin				**D**
36. Technique of scrubbing up and donning gown and gloves				**C**
37 Basic competences for pain management				**C**
38. Patient Identification				**C**
39. Post op N&V				**C**
40. Airway assessment				**C**
41. Choice of muscle relaxants and induction agents,				**C**
42. Post op analgesia				**C**
43. Post op oxygen therapy			**Mi, C**	
44. Emergency surgery				
45. Safe use of vasoactive drugs and electrolytes				

Paediatrics	
Venous access in children	CT3 DOPs - see descriptors in appendix2
Primary survey in a child	CT3 DOPs - see descriptors in appendix2
Basic airway manoeuvres	CT3 DOPs - see descriptors in appendix2
Equipment and guidelines	CT3 DOPs – see descriptors in appendix2