Appendix 2

ACCS Specialty Specific Assessments forms & and EM Work Place Based Assessment Forms

RCEM
July 2015

(May 2019 amendment)

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Royal College of Emergency Medicine
Summative Mini-Clinical Evaluation Exercise -Mini-CEX

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)		**Diagnosis**	
Focus of assessment –			
History	**Examination**	**Diagnosis**	**Management**	**Communication**

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Initial approach					
History and informationgathering					
Examination					
Investigation					
Clinical decision making andjudgment					
Communication with patient,relatives, staff					
Overall plan					
Professionalism					
For summative Mini-CEX				**Unsuccessful**	**Successful**

Things done particularly well

Learning points

Action points

Assessor Signature:	**Trainee** Signature:

Royal College of Emergency Medicine
Formative Mini-Clinical Evaluation Exercise -Mini-CEX

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)		**Diagnosis**	
Focus of assessment –	**Examination**	**Diagnosis**	**Management**	**Communication**
History				

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Initial approach					
History and informationgathering					
Examination					
Investigation					
Clinical decision making andjudgment					
Communication with patient,relatives, staff					
Overall plan					
Professionalism					

Things done particularly well

Learning points

Action points

Assessor Signature:	**Trainee** Signature:

Mini-CEX Descriptors for UnsatisfactoryPerformance

Dimension	Descriptors of satisfactory performance	Descriptors of unsatisfactory performance
History taking	• Recognised the critical symptoms, symptom patterns • Clear context to history gathering, related to differential diagnosis of presenting complaint • Engagement with the patient where possible	History taking was not focused • 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	A methodical approach with mastery of key examination skills Maintains patient comfort and dignity throughout	Failed to detect /elicit and interpret important physical signs Did not maintain dignity and privacy
Communication	Communication skills with colleagues • Listens to other views • Discusses issues with the team • Follows the lead of others when appropriate • Gives clear and timely instructions Communication with patients • Elicits the concerns of the patient, their understanding of their illness and what they expect • Informs and educates patients/carers	Communication skills with colleagues • Rude to colleagues • 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 encourage patient involvement/ partnership in decision making
Clinical judgement-clinical decision making	• Identifies the most likely diagnosis in a given situation	• Did not select the most effective treatments • Did not make decisions in

	• Was discriminatory in the use of diagnostic tests • Constructs a comprehensive and likely differential diagnosis • Correctly identifies those who need admission and those who can be safely discharged. • Recognises atypical presentation • Recognises the urgency of the case	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	• Respects confidentiality • Protects patient dignity • Explains plans and risks in a way the patient could understand	• Insensitive to patients opinions/hopes/fears •
Organisation and efficiency	Able to work effectively through the case	Was slow to progress the case
Overall care	• Ensures patient was in a safe monitored environment • Anticipated and recognised complications • Focussed on safe practice • Used published standards guidelines or protocols where available	• Did not follow infection control measures • Did not safely prescribe

ACCS Mini-CEX Summative Descriptors for MajorPresentations

1. Anaphylaxis
2. Unconscious/Altered Mental State
3. Shock
4. Trauma
5. Sepsis

Note that MP2 - Cardio Respiratory Arrest can by covered during anaesthesia as part of the Initial Assessment of Competence sign off.

1 Anaphylaxis		
	Descriptor of Satisfactory Performance	Descriptor of Unsatisfactory performance
Initial approach	• ABCD approach, including GCS • Asks for vital signs including SPaO2, blood sugar • Requests monitoring • Recognises physiological abnormalities • Looks for obvious cause ofshock e.g. bleeding • Secures iv access	
History	• Obtains targeted history from patient • Obtains collateral history form friends, family, paramedics-cover PMH • Recognises the importance of treatment before necessarily getting all information • Obtains previous notes	• 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
Examination	Detailed physical examination which must include physical signs that would differentiate between haemorragic, hypovolaemic , cardiogenic and septic causes for shock	• Failed to detect /elicit and interpret important physicalsigns • Did not maintain dignity and privacy
Investigation	Asks for appropriate tests- • arterial blood gas or venous gas and lactate • FBC, • U&Es, • clotting studies,	

	• LFTs, toxicology, • Cross match as indicated • blood and urine culture, • CK and troponin, • ECG, • CXR, • Familiar with use of US to look for IVC compression andcardiac tamponade	
Clinical decision making and judgement	Forms diagnosis and differential diagnosis including: • Trauma-haemorrhagic, blood loss control form direct pressure, pelvic splintage, emergency surgery or interventional radiology • Gastrointestinal - upper and lower GI bleed, or fluid loss form D&V • Cardiogenic - STEMI, tachy and brady dysrhythmia • Infection- sepsis, knows sepsis bundle • Endocrine - Addison's disease, DKA • Neurological - neurogenic shock • Poisoning - TCAs, cardio toxic drugs	• 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
Communication	Effectively communicates with both patient and colleagues	**Communication skills withcolleagues** • 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
Organisation and efficiency		• Was slow to progress the case
Overall plan	Identifies immediate life threats and readily reversible causes Stabilises and prepares for further investigation, treatment and admission	• 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
Professionalism	Behaves in a professional manner	• 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

2 Unconscious/altered mental status	
	Descriptor of Satisfactory performance
Initial approach	• ABCD approach, including GCS

	• Asks for vital signs including SPaO2, blood sugar • Secures iv access • Looks for lateralising signs, pin point pupils, signs of trauma, considersneck injury • Considers opiate OD, alcoholism, anticoagulation
History	• Obtains history- friends, family, paramedics- cover PMH, previous ODsetc • Obtains previous notes
Examination	Detailed physical examination includingfundoscopy
Investigation	Asks for appropriate tests • arterial blood gas • FBC • U&Es • clotting studies • LFTs, toxicology • blood and urine culture • CK and troponin • HbCO • ECG • CXR • and CT
Clinical decision making and judgement	Forms diagnosis and differential diagnosisincluding: • Trauma- SAH, Epidural and subdural • Neurovascular- stroke, hypertensive encephalopathy • Cardiovascular- dysrhythmia, hypotension • Neuro- seizure or post ictal • Infection- meningitis, encephalitis, sepsis • Organ failure- pulmonary, renal, hepatic • Metabolic- glucose, sodium, thyroid disease, temperature • Poisoning • Psychogenic
Communication	Effectively communicates with both patient andcolleagues
Overall plan	Identifies immediate life threats and readily reversible causes Stabilises and prepares for further investigation, treatment and admission
Professionalism	Behaves in a professional manner

3 Shock	
	Descriptor of satisfactory performance
Initial approach	• ABCD approach, including GCS • Asks for vital signs including SPaO2, blood sugar • Requests monitoring • Recognises physiological abnormalities • Looks for obvious cause of shock e.g. bleeding • Secures iv access
History	• Obtains targeted history from patient • Obtains collateral history form friends, family, paramedics- cover PMH • Recognises the importance of treatment before necessarily getting all information • Obtains previous notes
Examination	Detailed physical examination which must include physical signs thatwould differentiate between haemorragic, hypovolaemic , cardiogenic and septic causes for shock
Investigation	Asks for appropriate tests • arterial blood gas or venous gas and lactate • FBC • U&Es • clotting studies • LFTs, toxicology • Cross match as indicated • blood and urine culture • CK and troponin • ECG • CXR • Familiar with use of US to look for IVC compression andcardiac tamponade
Clinical decision making and judgement	Forms diagnosis and differential diagnosisincluding: • Trauma-haemorrhagic, blood loss control form direct pressure, pelvic splintage, emergency surgery or interventional radiology • Gastrointestinal - upper and lower GI bleed, or fluid loss form D&V • Cardiogenic - STEMI, tachy and brady dysrhythmia, • Infection- sepsis, knows sepsis bundle • Endocrine - Addison's disease, DKA

	• Neurological - neurogenic shock • Poisoning - TCAs, cardio toxic drugs
Communication	Effectively communicates with both patient andcolleagues
Overall plan	Identifies immediate life threats and readily reversiblecauses Stabilises and prepares for further investigation, treatment and admission
Professionalism	Behaves in a professional manner

4 Major trauma	
	Descriptor of satisfactory performance
Initial approach	• Knows when to activate the trauma team (based on localguidelines) • Able to perform a rapid primary survey, including care of the c spineand oxygen delivery • Can safely log roll patient off spinal board • Able to assess disability, using AVPU or GCS • Asks for vital signs • Able to request imaging at end of primary survey • Knows when to request specialty opinion and/or furtherimaging
History	• Obtains history of mechanism of injury from paramedics • Able to use AMPLE history
Examination	After completing a primary survey is able to perform • detailed secondary survey
Investigation	Asks for appropriate tests • Primary survey films • CT imaging • arterial blood gas • FBC • U&Es • clotting studies • PT • toxicology • ECG • FAST • UO by catheterisation • Appropriate use of NG
Clinical decision	Forms differential diagnosis and management plan basedon:

making and judgement	• Able to identify and mange life threatening injuries as part of primary survey • Able to identify the airway that may be at risk • Can identify shock, know it classification and treatment • Safely prescribes fluids, blood products and drugs. • Can identify those patients who need urgent interventions or surgery before imaging or secondary survey • Can safely interpret imaging and test results • Demonstrates safe disposition of trauma patient after secondary survey • Able to identify those patients that be safely discharged home
Communication	Effectively communicates with both patient and other members of the trauma team
Overall plan	Identifies immediate life threats and readily reversible causes Stabilises and prepares for further investigation, treatment and admission
Professionalism	Behaves in a professional manner

5 Sepsis	
	Descriptor of satisfactory performance
Initial approach	Initial approach based on ABCD system- ensuring early monitoring of vital signs including temperature,SPaO2, bloodsugar • Can interpret early warning medical score as indicators of sepsis (EMEWSor similar) • Aware of systemic inflammatory response criteria (SIRS), and that 2 or more may indicate sepsis o T>38 or < 36 o HR > 90 o RR > 20 o WCC > 12 or < 4
History	• Obtains history of symptoms leading up to illness • Able to take a collateral history, form paramedics, friends and family • Able to use AMPLE history • Looks specifically for conditions causing immunocompromise
Examination	Able to perform a competent examination lookingfor • Possible source of infection • Secondary organ failure
Investigation	Asks for appropriate tests • FBC • U&Es

	• clotting studies
	• ABGs or VBGs
	• Lactate, ScVo2
	• Blood cultures
	• ECG
	• CXR
	• Urinalysis +/- catheterisation
	• Other interventions which may help find source of sepsis
	  o Swabs
	  o PCR
	  o Pus
	Considers need for further imaging

Clinical decision making and judgement	Form a management plan with initial interventions being: • Oxygen therapy • Fluid bolus, starting with 20 mls/Kg • IV Antibiotics, based on likely source of infection • Documentation of a physiological score, which can be repeated • Be able to reassess Recognises and is able to support physiological markers of organdysfunction, such as:- • Systolic BP < 90 mm Hg • PaO2 < 8 Kpa • Lactate > 5 • Reduced GCS • Urine output < 30 mls/hr Demonstrates when to use invasive monitoring,specifically • CVP line • Arterial line Demonstrates when to start inotropes, Noradrenaline v dopamine Demonstrates how to set up an inotropeinfusion
Communication	Effectively communicates with both patient and other members of the acute care team
Overall plan	Identifies sepsis Implements 4 hour sepsis bundle Stabilises patient, reassesses and able to inform and/or hand over to critical care team
Professionalism	Behaves in a professional manner

ACCS Mini-CEX Summative Descriptors for AcutePresentations

1. Chest pain
2. Abdominal pain
3. Breathlessness
4. Mental Health
5. Head Injury

1 **Chest pain.**	
	Descriptor of satisfactory performance
Initial approach	• Ensures monitoring, i.v. access and defibrillator nearby. • Ensures vital signs are measured including SpO_2
History	• Takes focused history (having established conscious with patient airway) of chest pain including o site o severity o onset o nature o radiation o duration o frequency o precipitating and relieving factors o Previous similar pains and associated symptoms • Systematically explores for symptoms of life threateningchest pain • Assesses ACS risk factors • Specifically asks about previous medication and pastmedical history • Seeks information from paramedics, relatives and pastmedical notes including previous ECGs
Examination	On examination has ABCD approach with detailed cardiovascularand respiratory examination including detection of peripheral pulses, blood pressure measurement in both arms, elevated JVP, palpation of apex beat, auscultation e.g. for aortic stenosis and incompetence, pericardial rub, signs of cardiac failure, and pleural rubs
Investigation	Ensures appropriate investigation • ECG (serial) • ABG • FBC, U&Es • troponin and d dimer if indicated • Chest x-ray

Communication	Effectively communicates with both patient andcolleagues
Prescribing	Able to relieve pain by appropriateprescription
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case.
Overall plan	Stabilises and safely prepares the patient for further treatmentand investigation
Professionalism	Behaves in a professional manner

2 Abdominal pain	
	Descriptor of satisfactory performance
Initial approach	• Ensures appropriate monitoring in place and ivaccess • Establishes that vital signs measured
History	• Takes focused history of abdominal pain including o site o severity o onset o nature o radiation o duration o frequency o precipitating and relieving factors o previous similar pains and associated symptoms • Systematically explores for symptoms of life threateningabdominal pain • Specifically asks about previous abdominal operations • Considers non abdominal causes- MI, pneumonia,DKA, hypercalcaemia, sickle, porphyria • Seeks information from paramedics, relatives and past medical notes
Examination	Able to undertake detailed examination for abdominal pain (ensuring adequate exposure and examining for the respiratory causes ofabdominal pain) including o Inspection, palpation, auscultation and percussion of theabdomen o Looks for herniae and scars o Examines loins, genitalia and back o Undertakes appropriate rectal examination

Investigation	Ensures appropriate investigation- o ECG o ABG o FBC o U&Es o LFTs o amylase o erect chest x-ray o and abdominal x-rays if obstruction or perforationsuspected
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case
Communication	Effectively communicates with both patient andcolleagues
Prescribing	Able to relieve pain by appropriateprescription
Overall plan	Stabilises (if appropriate)and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

3 Breathlessness	
	Descriptor of satisfactory performance
Initial approach	o Ensures monitoring, iv access gained, O2 therapy o Ensures vital signs are measured including Spa O2
History	o If patient able, trainee takes focused history ofbreathlessness including onset, • severity • duration • frequency • precipitating and relieving factors • previous similar episodes • associated symptoms o Systematically explores for symptoms of life threatening causesof breathlessness o Takes detailed respiratory history o Specifically asks about medication and past medical history o Seeks information from paramedics, relatives and past medical notes including previous chest x-rays and blood gases
Examination	On examination has ABCD approach with detailed cardiovascular and

	respiratory examination including, work of breathing, signs of • respiratory distress • detection of wheeze • crepitations • effusions • areas of consolidation
Investigation	Ensures appropriate investigation • ECG • ABG • FBC • U&Es • troponin and d dimer if indicated • Chest x-ray Able to interpret chest x-ray correctly
Clinical decision making and judgement	Able to formulate a full differential diagnosis and the most likely cause in this case Knows BTS guidelines for treatment of Asthma and PE
Communication	Effectively communicates with both patient andcolleagues
Prescribing	• Able to prescribe appropriate medication including oxygen therapy, bronchodilators, GTN, diuretics • Able to identify which patients would benefit from NIV
Overall plan	Stabilises and safely prepares the patient for further treatment and investigation
Professionalism	Behaves in a professional manner

4 Mental Health

Mental health issues are a common problem within the ED (typically combinations of overdose, DSH, suicidal ideation but also psychotic patients). Selection of patients suitable for min-CEX assessment must be undertaken thoughtfully.

	Descriptor of satisfactory performance
Initial approach	Ensures assessment takes place in a safeenvironment.
History	History taking covers • presenting complaint, • past psychiatric history, • family history, • work history,

	• sexual/marital history, • substance misuse, • forensic history, • social circumstances, • personality. Undertakes mental state examinationcovering • appearance and behaviour • speech • mood • thought abnormalities • hallucinations • cognitive function using the mini mental stateexamination • insight Elicits history sympathetically, is unhurried Searches for collateral history- friends and relatives, general practitioner, past medical notes, mental healthworkers
Examination	Ensures vital signs are measured Undertakes physical examination looks for physical causes ofpsychiatric symptoms- head injury, substance withdrawal, thyroid disease, intoxication, and hypoglycaemia
Investigation	Ensures appropriate tests • U&E • FBC • CXR • CT • toxicology
Clinical decision making and judgement	Ensures no organic cause for symptoms Forms working diagnosis and assessment of risk- specifically of suicide and toxicological risk in those with overdoses
Communication	Effectively communicates with both patient andcolleagues
Prescribing	Knows safe indications, routes of administration of common drugsfor chemical sedation
Overall plan	Identifies appropriately those who will need further help as an inpatient and who can be followed up as an outpatient Is able to assess capacity Have strategies for those who refuse assessment or treatment orwho abscond
Professionalism	Behaves in a professional manner

5 Head Injury	
	Descriptor of satisfactory performance
Initial approach	Ensures ABC are adequate and that neck is immobilised in the unconscious patient and those with neck pain. Ensures BM done
History	• Establishes history- o mechanism of injury o any loss of consciousness and duration o duration of any amnesia o headache o vomiting o associated injuries especially facial and ocular • Establishes if condition is worsening • Gains collateral history from paramedics, witnesses, friends/relatives and medical notes • Establishes if taking anticoagulants, is epileptic
Examination	After ABC undertakes systematic neuro examinationincluding • GCS • papillary reactions and size • cranial nerve and peripheral neurological examination • and seeks any cerebellar signs • Looks for signs of basal skull fracture • Examines scalp • Looks for associated injuries- neck, facial bones including jaw • Actively seeks injuries elsewhere
Investigation	Is able to identify the correct imaging protocol for those with potentially significant injury -specifically the NICE guidelines
Clinical decision making and judgement	Is able to refer appropriately with comprehensive and succinct summary Knows which patients should be referred to N/surgery Is able to identify those patients suitable for discharge and ensuressafe discharge.
Communication	Effectively communicates with both patient andcolleagues
Prescribing	Able to safely relieve pain in the head injuredpatient
Overall plan	Stabilises and safely prepares the patient for further treatmentand investigation or safely discharges patient
Professionalism	Behaves in a professional manner

Royal College of Emergency Medicine
Summative Case Based Discussion CbD

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)		**Diagnosis**	

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Record keeping					
Review of investigations					
Diagnosis					
Treatment					
Planning for subsequent care (in patient or discharged patients)					
Clinical reasoning					
Patient safetyissues					
Overall clinical care					
For summative CbD				**Unsatisfactory**	**Satisfactory**

Things done particularly well
Learning points
Action points

Assessor Signature:	**Trainee** Signature:

Royal College of Emergency Medicine
Formative Case Based Discussion CbD

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)		**Diagnosis**	

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Record keeping					
Review of investigations					
Diagnosis					
Treatment					
Planning for subsequent care (in patientor discharged patients)					
Clinical reasoning					
Patient safetyissues					
Overall clinical care					

Things done particularly well

Learning points

Action points

Assessor Signature:	**Trainee** Signature:

CbD descriptors

Domain descriptor	
Record keeping	Records should be legible and signed. Should be structured and includeprovisional and differential diagnoses and initial investigation & management plan. Should record results and treatments given.
Review of investigations	Undertook appropriate investigations. Results are recorded and correctly interpreted. Any Imaging should be reviewed in the light of the traineesinterpretation
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 planningfor possible complications and instructions to patient (ifappropriate)
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
Patient safety issues	Able to recognise effects of systems, process, environment and staffing on patient safety issues
Overall clinical care	The case records and the trainees discussion should demonstrate that this episode of clinical care was conducted in accordance with good clinical practice and to agood overall standard

Royal College of Emergency Medicine
Direct Observation of procedural Skills -DOPs

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Procedure observed (including indications)			

Please TICK to indicate the standard ofthe trainee's performance in eacharea	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellentpractice
			Must address learning points highlighted below	Should address learning points highlighted below	
Indication for procedure discussedwith assessor					
Obtaining informedconsent					
Appropriate preparation including monitoring, analgesia andsedation					
Technical skills and asepticteчnique					
Situation awareness and clinicaljudgement					
Safety, including preventionand management ofcomplications					
Care /investigations immediately post procedure					
Professionalism, communication and consideration for patient, relatives and staff					
Documentation in thenotes					
Completed taskappropriately					

Things done particularly well

Learning points

Action points

Assessor Signature:	**Trainee** Signature:

Practical procedures DOPsdescriptors

1. Basic airway
2. Trauma - primary survey
3. Wound management
4. Fracture manipulation and joint reduction

1 Basic airway management including adjuncts e.g. BVM, oxygen delivery	
Observed behaviour	Task Completed
1. Is able to assess the adult airway and in the obstructed patient provide a patent airway by simple manoeuvres and the use of adjuncts andsuction.	
2. Undertakes this in a timely and systematicway.	
3. Assesses depth of respiration and need for BVM.	
4. Can successfully BVM.	
5. Knows and can show how to deliver high flow02	
6. Knows other O2 delivery systems typically in ED- fixed concentration masks, nasal specs, Mapleson C circuits.	
7. Consents the patient	

2 Perform a primary survey of a potentially multiple injured trauma patient	
Observed behaviour	Task Completed
1. Ensures safe transfer of patient onto EDtrolley	
2. Assesses airway, establishes if obstructed, corrects and ensures delivery of 100%O_2	
3. Concurrently ensures cervical spine immobilisation (using collar, sandbags and tape)	
4. Exposes chest identified raised respiratory rate, chest asymmetry, chest wall bruising, air entry (anteriorly and laterally) and percussion (laterally). Identifies life threatening problems and correctly carries out associatedprocedures	
5. Examines for signs of shock, ensures monitoring established and has gained ivaccessX2	
6. If shocked looks for potential sites of blood loss- abdomen, pelvis and limbs.	
7. Can formulate differential for shocked patient	
8. Establishes level of consciousness and seeks lateralising signs	
9. Examines limbs, spine and rectum ensuring safe logroll.	

10. Will have identified and searched for potential life threatening problems in a systematic and prioritised way	
11. Reassesses if any deterioration with repeat of ABCD	
12. Elicits full relevant history from pre-hospital care providers	
13. Ensured appropriate monitoring 14. Will have placed lines, catheter and NG tubes as appropriate	
15. Ensured appropriate blood testing (including crossmatch). 16. Plain radiology trauma series undertaken	
17. Ensures adequate and safe pain relief	
18. Directs teamappropriately	
19. Notes of primary survey are clear and legible	

3 Wound management	
Observed behaviour	Task Completed
1. Wound assessment- takes history of mechanism of injury, likely extent and nature of damage, and possibility of foreign bodies. Establishes tetanus status and drug allergies.	
2. Assesses the wound- location, length, depth, contamination, and structures likely to be damaged	
3. Establishes distal neurovascular and tendon status with systematic physical examination	
4. Consents the patient	
5. Provides wound anaesthesia (local infiltration, nerve or regional block).	
6. Explores wound – identifies underlying structures and if damaged or not.	
7. Ensures good mechanical cleansing of wound andirrigation.	
8. Clear understanding of which wounds should not be closed	
9. Closure of wound, if indicated, without tension, with good suture technique. Can place and tie sutures accurately.	
10. Provides clear instructions to patient regarding follow up and suture removal and when toseek help.	

Instructions for Use of ACAT-EM

Testing of this tool in the ED has indicated that it may work best if:

1. The assessment is best conducted over more than one shift (typically 2-3) 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 is beingundertaken
4. That clinical notes and drug prescriptions should be reviewed especially relating to patients cared for in the resuscitation room.
5. That this is an opportunity to follow up the care of the critically ill patients looked after during the ACAT –EM assessment.
6. The ACAT can be used to confirm knowledge, skills and attitudes for the cases reviewed by the assessor.
7. The CEM would recommend that an individual ACAT-EM does not cover more than 5 APs and that the case notes and management plan for each patient should be reviewed by the CS before itis signed off on the ACAT.
8. ACAT-EM can never be used as a summativetool
9. Could be used in a variety of setting within the ED- cdu ward rounds, clinics as well as major/minor/resuscitation and paediatric areas

ACAT –EM	
Assessment Domains	Description
Clinical assessment and clinical topics covered	Quality of history and examination to arrive at appropriatediagnosis-made by direct observation in different areas especially in the resuscitation room. No more than 5 AP should be covered in each ACAT and thisshould involve a review of the notes and management plan of thepatient.
Medical record keeping	Quality of recording of patient encounters including drug andfluid prescriptions
Investigations and referrals	Quality of trainees choice of investigations and referrals
Management of patients	Quality of treatment given (assessment, investigation, urgenttreatment given involvement of seniors)
Time management	Prioritisation of cases
Management of take/team working	Appropriate relationship with and involvement of otherhealth professionals
Clinical leadership	Appropriate delegation and supervision of juniorstaff
Handover	Quality of handover of care of patients between EM and in patientteams 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, useof resources sensibly

Royal College of Emergency Medicine
The Acute Care Assessment Tool (ACAT-EM) form

Name of trainee:		GMC number	
Assessor		Grade	
Setting, ED, CDU, Clinic,other		Date	
Timing, duration and levelof responsibility			
Acute presentations covered (5max for EM)			

Please TICK to indicate the standard ofthe trainee's performance in eacharea	Not observed	Further core learning needed	Demonstrates goodpractice		Demonstrates excellent practice
			Must address learning points highlighted below	Should address learning points highlighted below	
Clinical Assessment					
Medical record keeping					
Time management					
Management of theteam					
Clinical leadership					
Patient safety					
Handover					
Overall Clinical Judgement					

Which aspects were donewell	Learning points
Unsatisfactory AP?	Plan for further AP assessment, specify WPBA tooland review date
Trainees Comments	Action points
Assessors signature	Trainees signature

ROYAL COLLEGE OF EMERGENCY MEDICINE MULTI-SOURCE FEEDBACK(MSF)

Thank you very much for completing this form, which will help me to improve my strengths and weaknesses. This form **is completely anonymous.**

Name of trainee:		**Year of Training:**	
Grade of assessor:		**Date**	**/ /**

UNKNOWN	**1**	**2**	**3**	**4**	**5**
Not Observed	*Performance* ***Does Not Meet***	*Performance* ***Partially Meets*** *Expectations*	*Performance* ***Meets*** *Expectations*	*Performance* ***Exceeds*** *Expectations*	*Performance* ***Consistently Exceeds*** *Expectations*

Good Clinical Care		**1-5 or UK**	**Comments**
1	*Medical knowledge and clinicalskills*		
2	*Problem-solving skills*		
3	*Note-keeping – clarity; legibility and completeness*		
4	*Emergency Careskills*		
Relationships with Patients		**1-5 or UK**	
1	*Empathy and sensitivity*		
2	*Communicates well with all patientgroups*		
3	*Treats patients and relatives withrespect*		
4	*Appreciates the pyscho-social aspects of patient care*		
5	*Offersexplanations*		
Relationships with Colleagues		**1-5 or UK**	
1	*Is a team-player*		
2	*Asks for others' point of view and advice*		
3	*Encourages discussion Empathy and sensitivity*		
4	*Is clear and precise withinstructions*		
5	*Treats colleagues withrespect*		
6	*Communicates well (incl. non-vernal communication)*		
7	*Is reliable*		
8	*Can lead a team well*		
9	*Takesresponsibility*		
10	*"I like working with thisdoctor"*		
Teaching andTraining		**1-5 or UK**	
1	*Teaching is structured*		
2	*Is enthusiastic aboutteaching*		
3	*This doctor's teaching sessions arebeneficial*		
4	*Teaching is presented well*		
5	*Uses varied teaching skills*		
Global ratings andconcerns		1-5 or UK	
1	*Overall how do you rate this Dr compared to other ST1 Drs*		
2	*How would you rate this trainees performance at* ***this stage*** *of training*		
3	*Do you have any concerns over this Drs probity or health?*		

Royal College of Emergency Medicine - Patient SurveyTool

Communication with patients is a very important part of quality medical care. We would like to know how you feel about the way your doctor communicated with you. Your answers are completely confidential, so please be as open and as honest as you can.
Thank you very much for your help and co-operation.

The doctor	Poor	Fair	Good	Very Good	Excellent
Greeted me in a way that made me feel comfortable	1	2	3	4	5
Treated me with respect	1	2	3	4	5
Showed interest in my ideas aboutmy health	1	2	3	4	5
Understood my main healthconcerns	1	2	3	4	5
Paid attention to me (looked at meand listened carefully)	1	2	3	4	5
Let me talk withoutinterruptions	1	2	3	4	5
Gave as much information as Iwanted	1	2	3	4	5
Talked in terms I couldunderstand	1	2	3	4	5
Checked to be sure I understood everything	1	2	3	4	5
Encouraged me to askquestions	1	2	3	4	5
Involved me in decisions as much asI wanted	1	2	3	4	5
Discussed next steps including any follow up plans	1	2	3	4	5
Showed care and concern	1	2	3	4	5
Spent the right amount of time withme	1	2	3	4	5

EM Doctors name:- Validated by:-

Specialty Specific assessments for Acute Medicine

WPBA forms

1. Mini-CEX
2. CbD
3. DOPS
4. ACAT
5. Audit assessment
6. Teaching assessment

Mini-Clinical Evaluation Exercise (mini-CEX)

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year

Trainee's GMC Number

Assessor's Registration Number (e.g.GMC, NMC, GDC)

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ **SAS** ☐ **SpR** ☐ **SHO** ☐ **GP** ☐ **Nurse** ☐ Other ☐

Brief Summary of Case:

Setting for Assessment (e.g. A&E, GP Surgery etc.):

Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
Medical Interview Skills						
☐	☐	☐	☐	☐	☐	☐
Physical Examination Skills						
☐	☐	☐	☐	☐	☐	☐
Counselling and Communication Skills						
☐	☐	☐	☐	☐	☐	☐
Clinical Judgement						
☐	☐	☐	☐	☐	☐	☐
Consideration for Patient/Professionalism						
☐	☐	☐	☐	☐	☐	☐
Organisation/Efficiency						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Competence						
☐	☐	☐	☐	☐	☐	☐

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Based on this observation please rate the level of overall competence the trainee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below Level expected during Foundation Programme	Demonstrates basic consultation skills resulting in incomplete history and/ or examination findings. Shows limited clinical judgement following encounter	☐
Performed at the level expected at completion of Foundation Programme / early Core Training	Demonstrates sound consultation skills resulting in adequate history and/ or examination findings. Shows basic clinical judgement following encounter	☐
Performed at the level expected on completion of Core Training/ early Higher Training	Demonstrates good consultation skills resulting in a sound history, and/or examination findings. Shows solid clinical judgement following encounter consistent with early Higher Training	☐
Performed at level expected during Higher Training	Demonstrates excellent and timely consultation skills resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows good clinical judgement following encounter	☐
Performed at level expected for completion of Higher Training	Demonstrates exemplary consultation skills resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows excellent clinical judgement following encounter consistent with completion of Higher Training.	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Trainee's Signature..... Assessor's Signature.....

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Case-based Discussion (CbD)

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year ☐

Trainee's GMC Number ☐☐☐☐☐☐☐

Assessor's Registration Number (e.g.GMC, NMC, GDC) ☐☐☐☐☐☐☐

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ SAS ☐ SpR ☐ SHO ☐ GP ☐ Nurse ☐ Other ☐

Brief Summary of Case:

Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
Medical Record Keeping						
☐	☐	☐	☐	☐	☐	☐
Clinical Assessment						
☐	☐	☐	☐	☐	☐	☐
Investigation and Referrals						
☐	☐	☐	☐	☐	☐	☐
Treatment / Management Plan						
☐	☐	☐	☐	☐	☐	☐
Follow-up and Future Planning						
☐	☐	☐	☐	☐	☐	☐
Professionalism						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Judgement						
☐	☐	☐	☐	☐	☐	☐

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Based on this observation please rate the level of overall clinical judgement the trainee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below level expected during Foundation Programme	Demonstrates little knowledge and lacking ability to evaluate issues resulting in only a rudimentary contribution to the management plan	☐
Performed at the level expected at completion of Foundation Programme / early Core Training	Demonstrates some knowledge and limited evaluation of issues resulting in a limited management plan	☐
Performed at the level expected on completion of Core Training/ early Higher Training	Demonstrates satisfactory knowledge and logical evaluation of issues resulting in an acceptable management plan consistent with early Higher Training	☐
Performed at level expected during Higher Training	Demonstrates detailed knowledge and solid evaluation of issues resulting in a sound management plan	☐
Performed at level expected for completion of Higher Training	Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues resulting in an excellent management plan consistent with completion of Higher Training	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Trainee's Signature..... Assessor's Signature.....

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Direct Observation of Procedural Skills (DOPS):

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year ☐

Trainee's GMC Number ☐☐☐☐☐☐☐

Assessor's Registration Number (e.g.GMC, NMC, GDC) ☐☐☐☐☐☐☐

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ SAS ☐ SpR ☐ SHO ☐ GP ☐ Nurse ☐ Other ☐

Clinical Setting (e.g. A&E, ICU, In-Patient):

Procedure:

Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
Demonstrates understanding of indications, relevant anatomy, technique of procedure:						
☐	☐	☐	☐	☐	☐	☐
Obtains informed consent:						
☐	☐	☐	☐	☐	☐	☐
Demonstrates appropriate preparation pre-procedure:						
☐	☐	☐	☐	☐	☐	☐
Appropriate analgesia or self-sedation:						
☐	☐	☐	☐	☐	☐	☐
Technical ability:						
☐	☐	☐	☐	☐	☐	☐
Aseptic technique:						
☐	☐	☐	☐	☐	☐	☐
Seeks help where appropriate:						
☐	☐	☐	☐	☐	☐	☐
Post procedure management:						
☐	☐	☐	☐	☐	☐	☐
Communication skills:						
☐	☐	☐	☐	☐	☐	☐
Consideration of patient/professionalism:						
☐	☐	☐	☐	☐	☐	☐
Overall ability to perform procedure:						
☐	☐	☐	☐	☐	☐	☐

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Based on this observation please now rate the level of independent practice the trainee has shown for this procedure:

Level of Independent Practice	
Rating	
Unable to perform the procedure	☐
Able to perform the procedure under direct supervision/assistance	☐
Able to perform the procedure with limited supervision/assistance	☐
Competent to perform the procedure unsupervised and deal with complications	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Trainee's Signature…… Assessor's Signature……

Acute Care Assessment Form (ACAT)

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year ☐

Trainee's GMC Number ☐☐☐☐☐☐☐

Assessor's Registration Number (e.g.GMC, NMC, GDC) ☐☐☐☐☐☐☐

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ SAS ☐ SpR ☐ SHO ☐ GP ☐ Nurse ☐ Other ☐

List of cases seen (please include the curriculum competence level being assessed where applicable):

How has the trainee's acute work been assessed?

Post Take Ward Round	☐
During Acute Unselected Take- Day	☐
During Acute Unselected Take- Night	☐
Specialty Take	☐
Critical Care	☐
Regular Ward Round	☐
Other (please specify)	☐
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	

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Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
Clinical Assessment:						
☐	☐	☐	☐	☐	☐	☐
Medical Record Keeping:						
☐	☐	☐	☐	☐	☐	☐
Investigations and Referrals:						
☐	☐	☐	☐	☐	☐	☐
Management of Critically Ill Patient:						
☐	☐	☐	☐	☐	☐	☐
Time Management:						
☐	☐	☐	☐	☐	☐	☐
Management of Take/Team Working:						
☐	☐	☐	☐	☐	☐	☐
Clinical Leadership:						
☐	☐	☐	☐	☐	☐	☐
Handover:						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Judgement:						
☐	☐	☐	☐	☐	☐	☐

Based on this observation please rate the level of overall competence the trainee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below Level expected during Foundation Programme	Trainee required frequent supervision to assist in almost all clinical management plans and/or time management	☐
Performed at the level expected at completion of Foundation Programme / early Core Training	Trainee required supervision to assist in some clinical management plans and/or time management	☐
Performed at the level expected on completion of Core Training/ early Higher Training	Supervision and assistance needed for complex cases, competent to run the acute care period with senior support	☐
Performed at level expected during Higher Training	Very little supervising consultant input needed, competent to run the acute care period with occasional senior support	☐
Performed at level expected for completion of Higher Training	Able to practise independently and provide senior supervision for the acute care period	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Trainee's Comments:

Trainee's Signature:.....

Assessor's Signature:.....

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Audit Assessment Tool

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year ☐

Trainee's GMC Number ☐☐☐☐☐☐☐

Assessor's Registration Number (e.g.GMC, NMC, GDC) ☐☐☐☐☐☐☐

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ **SAS** ☐ **SpR** ☐ **StR** ☐

Basis for assessment:

Presentation ☐ Report ☐

Title or brief description of audit:

Please score the trainee on the scale shown. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training	*Below expectation for stage of training*	*Borderline for stage of training*	*Meets expectation for stage of training*	*Above Expectation for stage of training*	*Well above expectation for stage of training*	*Unable to Comment*
1. Audit Topic						
☐	☐	☐	☐	☐	☐	☐
2. Targets for Performance						
☐	☐	☐	☐	☐	☐	☐
3. Audit Methods						
☐	☐	☐	☐	☐	☐	☐
4. Results and Interpretation						
☐	☐	☐	☐	☐	☐	☐
5. Changing Performance: Conclusions and Implementation Plan						
☐	☐	☐	☐	☐	☐	☐
6. Plan for Evaluation						
☐	☐	☐	☐	☐	☐	☐

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Based on this observation please rate the level of overall quality of clinical audit shown:

Overall Quality of Audit		
Rating	**Description**	
Below expected standard of clinical audit	Significant guidance required throughout the audit process. Inappropriate audit topic or poor methodology resulting in inappropriate conclusions or conclusions of limited practical use. Inadequate consideration of future direction of audit	☐
Expected standard of clinical audit	Limited guidance required throughout audit process. Sound audit methodology in a relevant topic, resulting in conclusions with practical clinical importance. Plans for future direction of audit highlighted	☐
Exemplary standard of clinical audit	Audit topic related to an important clinical problem, detailed and exhaustive methodology applied, resulting in conclusions with significant clinical importance. Plans for future direction of audit highlighted. An exemplary clinical audit	☐

Which aspects of the audit were done well?

Any suggested areas for improvement for future audit projects

Trainee's Signature……

Assessor's Signature……

Teaching Observation

Date of Assessment (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Trainee's Surname

Trainee's Forename

Trainee's Year ☐

Trainee's GMC Number ☐☐☐☐☐☐☐

Assessor's Registration Number (e.g.GMC, NMC, GDC) ☐☐☐☐☐☐☐

Assessor's Name

Assessor's Email

Assessor's Position:

Consultant ☐ SAS ☐ SpR ☐ StR ☐

Institution/Setting:

Learner Group:

Number of Learners:

Less than 5 ☐ 5-15 ☐ 16-30 ☐ More than 30 ☐

Title of Session:

Brief Description of the Session:

INTRODUCTION **e.g.** • Introduction of self • Gained attention of group • Stated the objectives	

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DEVELOPMENT **e.g.** • Key points emphasised • Clear, concise delivery • Knowledge of subject • Logical sequence • Well paced • Good use of voice/tone • Resources supported topic • Quality of resources • Effective group participation • Effective use of questioning • Appropriate teaching methods used • Management of teaching activities • Appropriate assessment techniques	
CONCLUSION **e.g.** • Summarised key points • Objectives were met • Kept to time limit	
GENERAL COMMENTS & ACTION POINTS	

Trainee's Signature..... Assessor's Signature.....

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The Royal College of Anaesthetists

Initial Assessment of Competence Certificate

This is to certify that: _____

GMC number | | | | | | | | College Reference Number | | | | | | |

has satisfactorily passed the workplace assessments and demonstrated the following clinical learning outcomes for the initial assessment of competence:

- Safe general anaesthesia with spontaneous respiration to ASA 1-2 patients for uncomplicated surgery in the supine position
- Safe rapid sequence induction for ASA 1-2 patients aged 16 or older and failed intubation routine
- Safe perioperative care to ASA 1E – 2E patients requiring uncomplicated emergency surgery

On _____/_____/_____ (day/month/year).

Final signoff must be done by two Consultant Anaesthetists

Signed:_____ Name (Print):_____ Date:_____

Signed:_____ Name (Print):_____ Date:_____

Hospital or department date stamp

The original of this certificate should be kept by the trainee with copies held by the School of Anaesthesia and/or hospital. A copy should also be sent to the Training Department at the Royal College of Anaesthetists in order to confirm the completion date of initial assessment of competence.

Record of assessments

Assessment	Completion date	Competent Signed/dated
Anaesthesia Clinical Evaluation Exercise		
IAC_ A01		
IAC_A02		
IAC_A03		
IAC_A04		
IAC_A05		
Direct Observation of Procedural Skills		
IAC_D01		
IAC_D02		
IAC_D03		
IAC_D04		
IAC_D05		
Case Based Discussion		
IAC_C01		
IAC_C02		
IAC_C03		
IAC_C04		
IAC_C05		
IAC_C06		
IAC_C07		

Assessments may be performed by an appropriately trained consultant anaesthetist or non-consultant career grade doctor. Career grade doctors must be registered as a trainer with the College.

Specialty specific assessments for Anaesthesia

Assessments to be used for the initial Assessment of Competence - IAC

A-CEX	Task Completed
1. Preoperative assessment of a patient who is scheduled for a routine operating list (non urgent or emergency)	
2. Manage anaesthesia for a patient who is not intubated and is breathing spontaneously	
3. Administer anaesthesia for laparotomy	
4. Demonstrate rapid sequenceinduction	
5. Recover a patient form anaesthesia	

DOPS	Task Completed
1. Demonstrate functions of the anaestheticmachine	
2. Transfer a patient onto the Initial operating table and position them for surgery (lateral, Llloyd Davis or lithotomyposition)	
3. Demonstrate cardio-pulmonary resuscitation on a manikin.	
4. Demonstrates technique of scrubbing up and donning gown and gloves.	
5. Basic Competencies for Pain Management – manages PCA including prescriptionand adjustment of machinery	

Case-Based Discussion	Task Completed
1. Discuss the steps taken to ensure correct identification of the patient, the operation and the side of operation	
2. Discuss how the need to minimise postoperative nausea and vomiting influenced the conduct of the anaesthetic	
3. Discuss how the airway was assessed and how difficult intubation can be predicted	
4. Discuss how the choice of muscle relaxants and induction agents was made	
5. Discuss how the trainee's choice of post-operative analgesics was made	
6. Discuss how the trainee's choice of post operative oxygen therapy was made	
7. Discuss the problems emergency intra-abdominal surgery causes for the anaesthetist and how the trainee dealt with these	

Anaesthesia Mini-CEX

Surname:		**First Names:**	
Observation:			
Code number:			
Observed By:		**GMC number**	
Date:			
		Signature of supervising doctor	

Clinical setting: Theatre ☐ ICU ☐ A&E ☐ Delivery suite ☐ Pain clinic ☐ Other ☐

●	**Practice was satisfactory**	
●	**Practice was unsatisfactory**	

If the performance was judged to be unsatisfactory, please tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.

Examples of good practice were:

Areas of practice requiring improvement were:

Further learning and experience should focus on:

Did not give clear timely instructions	
Is rude to colleagues	
Practical work was poorly carried out	
Was clumsy	
Handled tissues and uses instruments roughly	
Did not follow an appropriate sequence in practical procedure	
Procedure failed due to the operators lack of skill	
Cannot explain how to operate equipment or makes mistakes	

Anaesthesia DOPS

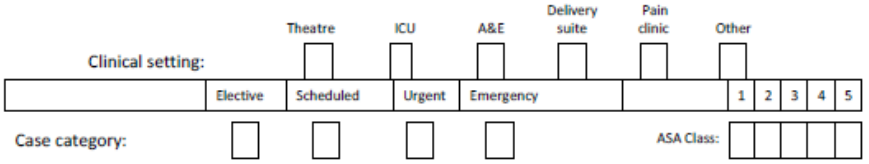
Surname:		**First Names:**	
Observation:			
Code number:			
Observed By:			
Date:			
			Signature of supervising doctor
●	**The standard of practice was good**		
●	**The standard of practice was unsatisfactory**		
If the performance was judged to be unsatisfactory, please tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.			
Examples of good practice were: Areas of practice requiring improvement were: Further learning and experience should focus on:			

If you have rated the performance unsatisfactory please indicate which elements were unsatisfactory:

Did not understand the indications and contraindications to the procedure.		
Did not properly explain the procedure to the patient.		
Does 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 properly complete the procedure		
Did not properly complete relevant documentation		
Did not issue clear post-procedure instructions to patient and/or staff		
Did not maintain an appropriate professional demeanour		

Case-based Discussion (CbD) – Anaesthesia

Surname:		**First Names:**	
Case:			
Code number:			
Observed By:		**GMC number:**	
Date:			



		Signature of supervising doctor
●	**Practice was satisfactory**	
●	**Practice was unsatisfactory**	

If the performance was judged to be unsatisfactory, please tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.

Examples of good practice were:

Areas of practice requiring improvement were:

Further learning and experience should focus on:

Special Focus of discussion:	

	Please grade the following areas:	Below your expectation for their grade and experience	Appropriate for grade and experience	Above your expectation for their grade and experience	Not observed or not applicable
1.	Record keeping:				
2.	Assessment and review of investigations:				
3.	Identification of potential problems and difficulties:				
4.	Understanding of clinical alternatives:				
6.	Justification of clinical decisions shows understanding of risks and benefits				
7.	Planning for future care:				
8.	Quality of written instructions for future care:				
9.	Overall clinical care:				
5.	Understanding of the issues surrounding the clinical focus chosen by the assessor				

Assessor's name:

Assessors Signature .....

Case-based Discussion (CbD) – Anaesthesia

Case-based discussion is designed to evaluate trainee clinical practice, decision-making and the interpretation and application of evidence, by reviewing their record of anaesthetic practice. Its primary purpose is to enable a conversation between trainee and assessor about the presentation and anaesthetic management of a patient. It is not intended as a test of knowledge, or as an oral or clinical examination. It is intended to assess the clinical decision-making process and the way in which the trainee used medical knowledge when managing a single case.

The trainee should bring to their assessment a copy of the anaesthetic record of three patients they have dealt with independently. The assessor will select one case. The trainee should be asked how they proceeded with each stage of the anaesthetic. In particular questions should be directed towards asking them to explain and justify the decisions they made. It is important to ask questions that bear directly upon the thought processes of the trainee during the anaesthetic case being discussed and not to digress into a long exploration of their knowledge of theory.

The assessor should also identify one particular issue that should have influenced the anaesthetist's decision making in this case. They should explore the trainees thinking in relation to the impact of this issue. This exercise is to explore in greater depth the way that the trainee reacts to events. If this specific focus is relevant to the case then the trainee should have taken its impact into account in their planning and decision-making. If they believed their knowledge of the issue to be inadequate they should have sought advice before proceeding. Therefore the trainee does not need to have prior notice of the focus the assessor will discuss. If their knowledge and understanding of the clinical problem is inadequate this will be reflected by the marking.

Such discussions will also incorporate an assessment of the adequacy of a trainee's record keeping, although this is not the primary purpose of CbD.

In practical terms, the trainee will arrange a CbD with an assessor (Consultant or senior trainee) and bring along a selection of three anaesthetic records from cases in which he/she has recently been solely involved. The assessor selects one and then engages the trainee in a discussion around the pre-operative assessment of the patient, the choices and reasons for selection of techniques and the management decisions with respect to pre-, intra- and post-operative management. The assessor then scores the trainee in each of the seven domains described below, using the standard form. It may be appropriate only to score three or four domains at a single event, and it should be emphasised that the purpose of the tool is to understand the decision making processes and thinking of the trainee. CbD is the trainee's chance to have somebody pay close attention to an aspect of their clinical thinking and to provide feedback. Feedback and discussion is mandatory.

Domain Descriptor

1. Record keeping:	The records should be legible, signed, dated and timed. All necessary records should be completed in full.
2. Assessment and review of Investigations:	The trainee should have conducted a proper pre-operative evaluation of the patient and should be aware of all important aspects of their pre-operative state. They should have ordered additional investigation and prescribed pre-operative treatments where this was indicated.
3. Identification of potential problems and difficulties:	Did the trainee identify potential problems?
4. Understanding of clinical alternatives:	Can the trainee explain the clinical alternatives they considered?
5. Justification of clinical decisions shows understanding of risks and benefits	Did the trainee show understanding of the different risks of their possible courses of action?
6. Understanding of the issues surrounding the clinical focus chosen by the assessor	The trainee should show knowledge of the issues that is appropriate to their decision to proceed with the case. Their decision making should reflect an understanding of the issues.
7. Planning for future care:	Planning should show an understanding of possible complications, their likelihood and their severity.
8. Quality of written instructions for future care:	All instructions to other staff should be timely, legible and understandable. Important issues relating to risks, possible complications and the need for special attention should be clearly indicated.
9. 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 practice and to a good overall standard.
9. Understanding of the issues surrounding the clinical f focus chosen by the assessor	The clinical focus must be one of the topics identified in the assessment schedule. The trainee should show an understanding ***appropriate to their experience***.

ICM Mini-Clinical Evaluation Exercise
(ICM Mini-CEX)

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)			

Focus of assessment – History	**Examination**	**Diagnosis**	**Management**	**Communication**

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed or practice unsafe	Safe - supervision required (BASIC)		Minimal supervision required (INTERMEDIATE)		No supervision and manages complications (ADVANCED)	
		Direct	Immediate	Distant - often	Distant – rare	Partially independent	Totally independent
History and informationgathering							
Immediate management and stabilisation							
Further management and decisionmaking							
Clinical judgement							
Safety, including management plan/monitoring/help							
Communication with patient, relatives, staff							
Organisation/efficiency							
OVERALL CLINICAL CARE							

Things done particularly well
Suggested areas for development

Assessor	**Trainee**
Signature:	Signature:

ICM Case- based discussion
(ICM CbD)

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Case discussed (briefdescription)			

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed or practice unsafe	Safe - supervision required (BASIC)		Minimal supervision required (INTERMEDIATE)		No supervision and manages complications (ADVANCED)	
		Direct	Immediate	Distant - often	Distant – rare	Partially independent	Totally independent
History and informationgathering							
Immediate management and stabilisation							
Further management and decision making							
Safety, including managementplan/help							
Communication with patient, relativesand staff							
Documentation in thenotes							
OVERALL CLINICAL CARE							

Things done particularly well
Suggested areas for development

Assessor **Trainee**

Signature:	Signature:

ICM Direct Observation of proceduralSkills
(ICM DOPS)

Name of trainee:		**Year of Training:**	
Assessor:		**GMC No:**	
Grade of assessor:		**Date**	/ /
Procedure observed (including indications)			

Please TICK to indicate thestandard of the trainee's performance ineach area	Not observed or practice unsafe	Safe - supervision required (BASIC)		Minimal supervision required (INTERMEDIATE)		No supervision and manages complications (ADVANCED)	
		Direct	Immediate	Distant - often	Distant – rare	Partially independent	Totally independent
Indication for procedure discussedwith assessor							
Obtaining informedconsent							
Appropriate preparation including monitoring, analgesia andsedation							
Technical skills and aseptic technique							
Situation awareness and clinicaljudgement							
Safety, including preventionand management ofcomplications							
Care /investigations immediately post procedure							
Professionalism, communication and consideration for with patient, relatives and staff							
Documentation in thenotes							
OVERALL CLINICAL CARE							

Things done particularly well	
Suggested areas for development	
Assessor Signature:	**Trainee** Signature:

IBTICM Multi-source feedback (ICM MSF)

Date

Dear Colleague

Trainees in Intensive Care medicine – Multi–source feedback

Multi–source feedback is now a required part of the assessment process for trainees in intensive care medicine and we would be grateful if you would take a few minutes to complete the attached form.

The form is anonymous but we ask that you complete a limited number of personal details to enable us to check that a suitable cross-section of people have been asked to comment on thetrainees' performance.

Please return the form to ----------in the envelope provided

by (*adddate*)----------.

Thanks you for agreeing to complete this multi-source feedbackform.

Yours faithfully,

----------IBTICM
(add name)

IBTICM Multi-source feedback
(ICM MSF)

Name of trainee:					**Year of Training:**	
Assessor details	Male		Female		**GMC No:**	
Doctor specialty					**Date**	/ /

Consultant		Nurse (Theatres/PACU)		• Please use the free text part of this form to comment on particularly good behaviour or any behaviourcausing concern • If you want to comment on attitude pleaseprovide evidence of behaviour. This should reflect the trainee's behaviour over time – not usually a single incident. • The trainee will receive private feedback, butyouwill not identified • If enough observers regard a trainee as giving causefor concern they will be offered help andsupport
SAS Grade		Nurse (ICU/HDU)		
SpR 4-5 (StR 6-7)		Nurse (Ward)		
SpR 1-3 (StR 3-5)		ODP		
StR 1-2 (CT 1-2)		Admin/Secretarial		
FY 1-2		Other		

Please TICK to indicate thestandard of the trainee's performance ineach area	**Areas of concern**			
	None	**Some**	**Major**	**Cannot comment**
Maintaining trust/professional relationships withpatients • Listens • Is polite and caring • Shows respect for patients' opinions, dignity and confidentiality • Is unprejudiced anddresses appropriately				
Verbal communicationskills • Gives understandable information • Speaks good English, at an appropriate level for thepatient				
Team working/working withcolleagues • Respects others' roles andworks constructively in theteam • Hands over effectively and communicates well. Isunprejudiced, supportive and fair				
Accessibility • Is accessible • Takes proper responsibility • Only delegates appropriately • Does not shirk duty • Responds when called • Arranges cover for absences				

Comments

Adult EM ST3

Royal College of Emergency Medicine
ST3 Resuscitation - Mini-CEX

Trainee:		Trainee GMC no.	
Assessor:		Assessor GMC no.	
Grade of assessor:		Date	/ /

Presentation – please see curriculum fornumber Case complexity (pleasetick) • Average or below ☐ • Above average ☐ • High complexity ☐	Case observed (briefdescription)

This observation should serve both learning and assessment purposes:

1) **Use the discussion to provide specific & meaningful feedback with the trainee's benefit in mind, and agree between you concrete actions for improvement.**

2) **Then use the scales and boxes below to record their current observed performance level as a benchmark against which to measure development.**

ABC assessment

1	2	3	n/a
failed to make a rapid assessment of ABC status, or made an inaccurateassessment	made an accurate assessment of ABC status…	…did so whilst using time, people and equipment expertly and efficiently	I didn't see this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee misjudged the acuity of the situation (overestimated or underestimated) □
Concern: the trainee failed to call others required from the outset of the case □

First intervention

1	2	3	n/a
did not know or efficiently deploy the appropriate first intervention	knew and deployed the appropriate first intervention(s)…	…did so whilst using time, people and equipment expertly and efficiently	I didn't see this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge □
Concern: the trainee failed to recognise the limits of his/her competence□

Case progression: informationgathering

1	2	3	n/a
missed or misinterpreted important further information (history, change in condition, result etc.)	continued to collate all appropriate information to support decision making…	…expertly optimised information gathering whilst maintaining momentum	I didn't see this aspect of performance – or this question doesn't apply

Comments:

Concern: the trainee was unable to change strategy in response to new information☐

Case progression: deciding and doing

1	2	3	n/a
the working assessment or management plan was wrongor missing	the working assessment and management plan were appropriate…	…and were decisive, clearly communicated, and efficiently implemented	I didn't see this aspect of performance – or thisquestion doesn't apply

Comments:

Concern: the trainee was unable to provide or effectively facilitate a key therapeutic intervention☐

Team leadership

1	2	3	4	n/a
did not effectively lead the team	effectively led theteam	led authoritatively, in a way from which others can learn…	…and showed awareness of the impact of the case on others (including debrief or support where needed)	I didn't see this aspect of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee lacked authority or appropriate assertiveness □
Concern: the trainee was unable to effectively involve others in appropriate patient management □
Concern: the trainee communicated ineffectively □

Overall

Based on my observation of this trainee, to manage a similar case, I think the trainee needs…

1	2	3	4	5
Direct supervisor observation/involvemen t , able to provide immediate direction/	Supervisor on the ED 'shop-floor', monitoring at regular intervals	Supervisor within hospital for queries, able to provide delayed direction/assistance	Supervisor 'on call' from home for queries, able to provide directions via phone	No supervisor involvement

In addition, I have concerns over the following generic aspects of performance...

☐ Lack of conscientiousness,

☐ Impaired capacity for self-improvement,

☐ Poor initiative,

☐ Impaired professional relationships,

☐ Impaired performance associated with anxiety, insecurity or nervousness.

☐ Other, please specify……..

☐ None of the above

Adapted from Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Acad Med. 2004;79(3):244-9.

Feedback

Areas of strength

Areas for development (mandatory if any 1sgiven)

Would you recommend another resuscitation mini-CEX on a similar case before progressionto HST?

Yes ☐ No ☐

If yes: what must the trainee aim to demonstrate next assessment?

Information

Case complexity guidance:

Low complexity	**Medium complexity**	**High complexity**
Common, single-system problem, presenting in a typical way, that can be managed according to an existing clinical guideline or algorithm.	Either less common, or multi-system, or presenting atypically but can still be managed according to one moreexisting guideline or algorithm.	Highly atypical or complicated problem which requires the trainee to make management decisions outside ofexisting guidelines.

Signoff and actions

Assessor signature(dated)	Trainee signature(dated)

Concerns must be discussed with the trainee unless there is a clear justification to do otherwise, and must be passed on to the trainee'ssupervisor.

Royal College of Emergency Medicine

ST3 Resuscitation - CBD

Trainee:		Trainee GMC no.	
Assessor:		Assessor GMC no.	
Grade of assessor:		Date	/ /

Presentation – please see curriculum fornumber Case complexity (pleasetick) • Average or below ☐ • Above average ☐ • High complexity ☐	Case discussed (briefdescription)

This discussion should serve both learning and assessmentpurposes:

1) **Use the case discussion to probe the thinking behind the trainee's assessment and management; if there were any difficulties, try to understand why.**

2) **At the end of the discussion provide specific & meaningful feedback with the trainee's benefit in mind, and agree between you concrete actions for improvement.**

3) **Then use the scales and boxes below to record their current observed performance level asa benchmark against which to measure development.**

ABC assessment

1	2	3	n/a
failed to make a rapid assessment of ABC status, or made an inaccurateassessment	made an accurate assessment of ABC status	understands the principles soundly enough to assess any case accurately	we didn't discuss this part ofthe resuscitation – or this question doesn't apply

Comments:

Concern: the trainee misjudged the acuity of the situation (overestimated or underestimated) ☐

Concern: the trainee failed to call others required from the outset of the case☐

First intervention

1	2	3	n/a
did not know or efficiently deploy the appropriate first intervention	knew and deployed the appropriate first intervention(s)	understands the principles soundly enough to choose the best of several initial interventions in any similarcase	we didn't discuss this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge☐

Concern: the trainee failed to recognise the limits of his/her competence☐

Case progression: informationgathering

1	2	3	n/a
missed or misinterpreted important further information (history, change in condition, result etc.)	continued to collate all appropriate information to support decision making…	understands the principles soundly enough to achieve efficient ongoing re-evaluation in any similar case	we didn't discuss this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee was unable to change strategy in response to new information☐

Case progression: deciding and doing

1	2	3	n/a
the working assessment or management plan was wrong or missing	the working assessment and management plan were appropriate…	understands the principles soundly enough to reach and implement an effective management plan in any similar case	we didn't discuss this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee was unable to provide or effectively facilitate a key therapeutic intervention☐

Team leadership

1	2	3	n/a
did not effectively lead the team	effectively led theteam	understands the principles of team leadership soundly enough to lead almost anyteam	we didn't discuss this part of the resuscitation – or this question doesn't apply

Comments:

Concern: the trainee lacked authority or appropriate assertiveness☐

Concern: the trainee was unable to effectively involve others in appropriate patient management☐

Concern: the trainee communicated ineffectively ☐

Overall

Based on my discussion with this trainee, to manage a similar case, I think the trainee needs…

1	2	3	4	5
Direct supervisor observation/involvemen t , able to provide immediate direction/	Supervisor on the ED 'shop-floor', monitoring at regular intervals	Supervisor within hospital for queries, able to provide delayed direction/assistance	Supervisor 'on call' from home for queries, able to provide directions via phone	No supervisor involvement

In addition, I have concerns over the following generic aspects of performance...

☐ Lack of conscientiousness,

☐ Impaired capacity for self-improvement,

☐ Poor initiative,

☐ Impaired professional relationships,

☐ Impaired performance associated with anxiety, insecurity or nervousness.

☐ Other, please specify……

☐ None of the above

Adapted from Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Acad Med. 2004;79(3):244-9.

Feedback

Areas of strength

Areas for development (mandatory if any 1sgiven)

Would you recommend another resuscitation CBD on a similar case before progression to HST?

Yes ☐ No ☐

If yes: what must the trainee aim to demonstrate next assessment?

Information

Case complexity guidance:

Low complexity	**Medium complexity**	**High complexity**
Common, single-system problem, presenting in a typical way, that can be managed according to an existing clinical guideline or algorithm.	Either less common, or multi-system, or presenting atypically but can still be managed according to one moreexisting guideline or algorithm.	Highly atypical or complicated problem which requires the trainee to make management decisions outside ofexisting guidelines.

Signoff and actions

Assessor signature(dated)	Trainee signature(dated)

Concerns must be discussed with the trainee unless there is a clear justification to do otherwise, and must be passed on to the trainee'ssupervisor.

EM ST3-5 Generic Forms

Extended Supervised Learning Event (ESLE) form
Royal College of Emergency Medicine

Please Complete PART 1 whilst observing the trainee. PART 2 is completed during the feedback session off the shopfloor.

Trainee name ……..

Trainee GMC number……

Date ……..

Educational/ Clinical Supervisor name ……

GMC number ……..

Specific elements of performance on which trainee seeks feedback in this session

……

……

……

PART 1

Time Line: Please refer to the NTS matrix and record relevant events for discussion in part 2.

Clinical cases covered:

Summary of key learning points from clinical cases

PART 2

Review of Non-technical skills

This is an opportunity to consider the session as a whole. The focus is on the skills and behaviours that may be observed during interaction with other team members, between patients or across the session. Please use the tool below to reflect Non-Technical Skills performance. Please rate those domains observed. Please then summarise the evaluation and agree learning objectives that follow.

Evaluation of EM physicians' non-technical skills For rating options please see over **Please indicate if Not Observed "N"**

	Element		Rating	Observations
Management & Supervision	**Maintenance of Standards**	Subscribes to clinical and safety standards as well as considering performance targets. Monitors compliance.		
	Workload Management	Manages own and others' workload to avoidboth under and over-activity. Includes prioritising, delegating, asking for help and offering assistance.		
	Supervision & Feedback	Assesses capabilities and identifies knowledge gaps. Provides opportunities for teaching and constructive feedback.		
Teamwork & Cooperation	**Team Building**	Provides motivation and support for theteam. Appears friendly and approachable.		
	Quality of Communication	Gives verbal and written information conciselyand effectively. Listens, acknowledges receipt of information and clarifies whennecessary.		
	Authority & Assertivenes s	Behaves in an appropriately forceful manner and speaks up when necessary. Resolves conflict effectively and remains calm when underpressure.		

Decision- Making	**Option Generation**	Uses all resources (written and verbal) to gather information and generate appropriate options fora given problem or task. Involves team membersin the decision making process.		
	Selecting & Communicating Options	Considers risks of various options and discusses this with the team. Involves clearly stating decisionsand explaining reasons, ifnecessary.		
	Outcome Review	Once a decision has been made, reviewssuitability in light of new information or change in circumstances and considers new options. Confirms tasks have been done.		
Situational Awareness	**Gathering Information**	Surveys the environment to pick up cues thatmay need action as well as requesting reports from others.		
	Anticipating	Anticipates potential issues such as staffing or cubicle availability in the department anddiscusses contingencies.		
	Updating the Team	Cross-checks information to ensure it isreliable. Communicates situation to keep team 'in the picture' rather than just expecting action.		

Rating options for non-technical skills

A= Performance expected of anearly core trainee	**E= Performance expected of asenior core trainee/ Early HST**	**H= Performance expected in HST**	**C = Performance of someone ready to be a consultant**
Demonstrates rudimentary skills inthis domain. This is concerning and indicates the need for further development. Please give specific examples.	Demonstrates basic skills in thisdomain.	Demonstrates sound skills in this domain .	Demonstrates skills of a consistently high standard. A model for other team members.

Performance descriptors

		Examples of Good behaviour	Examples of poor behaviour
Management & Supervision	**Maintenance of Standards**	• Notices doctor's illegible notes and explains the value ofgood 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 reviewingpatient • 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 memberstake 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 withjunior doctor • Gives positive feedback to junior doctor who has made a difficult diagnosis • Leads team through appropriate debrief afterresuscitation	• Criticises a colleague in front of the team • Does not adequately supervise junior doctor with a sickpatient • 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 forhelp • Says thank you at end of a difficultshift • 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 foradmission (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 wheninpatient doctor refuses referral • Willing to speak up to senior staff when concerned • Remains calm under pressure	• Fails to persevere when inpatient doctor refusesappropriate 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	• Does not look at previous ED notes/ old ECGs when necessary • Fails to listen to team members input for patient management

		about history • Encourages team members' input	• 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
Situational Awareness	**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

Summary of Non Technical skills evaluation (any concerns must be described)

Learning Objectives

Royal College of Emergency Medicine

ST3-6 General - Mini-CEX

Trainee:		Trainee GMC no.	
Assessor:		Assessor GMC no.	
Grade of assessor:		Date	/ /

Presentation – please see curriculum fornumber Case complexity (pleasetick) • Average or below ☐ • Above average ☐ • High complexity ☐	Case observed (briefdescription)

This observation should serve both learning and assessment purposes:

4) **Use the discussion to provide specific & meaningful feedback with the trainee's benefit in mind, and agree between you concrete actions for improvement.**

5) **Then use the scales and boxes below to record their currentobserved performance level as a benchmark against which to measure development.**

Clinical evaluation

1	2	3	n/a
did not provide a safe evaluation	provided a safe evaluation…	…did so using available information expertly & efficiently	I didn't see this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge☐

Concern: the trainee missed important cues in the history ☐

Concern: the trainee displayed under-developed examination technique☐

Concern: the trainee missed key examination findings☐

Concern: the trainee downplayed findings that challenged the workingdiagnosis☐

Concern: the trainee failed to seek help when unsure☐

Management planning

1	2	3	n/a
did not provide a safe management plan	provided a safe management plan…	…did so using resources and time expertly and efficiently	I didn't see this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge☐

Concern: the trainee displayed inadequate understanding of key investigation modalities☐

Concern: the trainee underestimated case acuity ☐

Concern: the trainee failed to seek help when unsure☐

Treatment delivery

1	2	3	n/a
did not provide safe treatment	provided safe treatment…	…did so undertaking all procedures expertly and efficiently	I didn't see this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge☐

Concern: the trainee underestimated procedural risk ☐

Concern: the trainee demonstrated poor procedural technique☐

Concern: the trainee failed to seek help when unsure☐

Working with colleagues

1	2	3	4	n/a
did not interact effectively with medical, nursing and other colleagues	engaged effectively with medical, nursing and other colleagues	…did so in such a way as to enhance the function of the team	… also motivated and built team effectiveness by nurture and example	I didn't see this aspect of performance – or this question doesn't apply

Comments:

Concern: the trainee displayed ineffective verbal or written communication☐

Concern: the trainee caused disruption in the team ☐

Working with patients & families

1	2	3	n/a
did not interact effectively with the patient or familiy	engaged effectively with patient and family	…did so in such a way as to win their trust	I didn't see this aspect of performance – or this question doesn't apply

Comments:

Concern: the trainee did not treat the patient or family with respect☐

Overall

Based on my observation of this trainee, to manage a similar case, I think the trainee needs…

1	2	3	4	5
Direct supervisor observation/involvement, able to provide immediate direction/ assistance	Supervisor on the ED 'shop-floor', monitoring at regular intervals	Supervisor within hospital for queries, able to provide delayed direction/assistance	Supervisor 'on call' from home for queries, able to provide directions via phone	No supervisor involvement

In addition, I have concerns over the following generic aspects of performance...

☐ Lack of conscientiousness,

☐ Impaired capacity for self-improvement,

☐ Poor initiative,

☐ Impaired professional relationships,

☐ Impaired performance associated with anxiety, insecurity or nervousness.

☐ Other, please specify……

☐ None of the above

Adapted from Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Acad Med. 2004;79(3):244-9.

Feedback

Areas of strength

Areas for development (mandatory if any 1sgiven)

Would you recommend another resuscitation mini-CEX on a similarcase before rotation?

Yes ☐ No ☐

If yes: what must the trainee aim to demonstrate next assessment?

Information

Case complexity guidance:

Low complexity	**Medium complexity**	**High complexity**
Common, single-system problem, presenting in a typical way, that can be managed according to an existing clinical guideline or algorithm.	Either less common, or multi-system, or presenting atypicallybut can still be managed according to one more existing guideline or algorithm.	Highly atypical or complicated problem which requires the trainee to make management decisions outside of existingguidelines.

Signoff and actions

Assessor signature (dated)	Trainee signature (dated)

Concerns must be discussed with the trainee unless there is a clear justification to do otherwise, and must be passed on to the trainee'ssupervisor.

Royal College of Emergency Medicine

ST3-6 General - CBD

Trainee:		Trainee GMC no.	
Assessor:		Assessor GMC no.	
Grade of assessor:		Date	/ /
Presentation – please see curriculum for number Case complexity (please tick) • Average or below ☐ • Above average ☐ • High complexity ☐		Case discussed (brief description)	

This discussion should serve both learning and assessment purposes:

1) **Use the case discussion to probe the thinking behind the trainee's assessment and management; if there were any difficulties, try to understand why.**

2) **At the end of the discussion provide specific & meaningful feedback with the trainee's benefit in mind, and agree between you concrete actions for improvement.**

3) **Then use the scales and boxes below to record their current observed performance level as a benchmark against which to measure development.**

Clinical evaluation

1	2	3	n/a
did not provide a safe evaluation	provided a safe evaluation…	understands the principles soundly enough to assess any case accurately	we didn't discuss this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge ☐

Concern: the trainee missed important cues in the history ☐

Concern: the trainee displayed under-developed examination technique ☐

Concern: the trainee missed key examination findings ☐

Concern: the trainee downplayed findings that challenged the working diagnosis ☐

Management planning

1	2	3	n/a
did not provide a safe management plan	provided a safe management plan…	understands the principles soundly enough to choose the best of several management plans in any similar case	we didn't discuss this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge ☐

Concern: the trainee displayed inadequate understanding of key investigation modalities ☐

Concern: the trainee misjudged case acuity (underestimated or overestimated)☐

Concern: the trainee failed to seek help when unsure☐

Treatment delivery

1	2	3	n/a
did not provide safe treatment	provided safe treatment…	understands the principles soundly enough to implement effective treatment in any similar case	we didn't discuss this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee lacked core knowledge☐

Concern: the trainee underestimated procedural risk ☐

Concern: the trainee demonstrated poor procedural technique☐

Concern: the trainee failed to seek help when unsure☐

Working with colleagues

1	2	3	n/a
did not interact effectively with medical, nursing and other colleagues	engaged effectively with medical, nursing and other colleagues	understands the principles of team working soundly enough to work effectively in almost any team	we didn't discuss this aspect of performance– or this question doesn't apply

Comments:

Concern: the trainee displayed ineffective verbal or written communication☐

Concern: the trainee caused disruption in the team ☐

Working with patients & families

1	2	3	n/a
did not interact effectively with the patient or family	engaged effectively with patient and family	displays an attitude towards patients that would win the trust of most patients and families	we didn't discuss this part of the encounter – or this question doesn't apply

Comments:

Concern: the trainee did not treat the patient or family with respect☐

Overall

Based on my discussion with this trainee, to manage a similar case, I think the trainee needs…

1	2	3	4	5
Direct supervisor observation/involvement , able to provide immediate direction/ assistance	Supervisor on the ED 'shop-floor', monitoring at regular intervals	Supervisor within hospital for queries, able to provide delayed direction/assistance	Supervisor 'on call' from home for queries, able to provide directions via phone	No supervisor involvement

In addition, I have concerns over the following generic aspects of performance...

☐ Lack of conscientiousness,

☐ Impaired capacity for self-improvement,

☐ Poor initiative,

☐ Impaired professional relationships,

☐ Impaired performance associated with anxiety, insecurity or nervousness.

☐ Other, please specify……

☐ None of the above

Adapted from Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND. Acad Med. 2004;79(3):244-9.

Feedback

Areas of strength

Areas for development (mandatory if any 1sgiven)

Would you recommend another resuscitation mini-CEX on a similarcase before rotation?

Yes ☐ No ☐

If yes: what must the trainee aim to demonstrate next assessment?

Information

Case complexity guidance:

Low complexity	**Medium complexity**	**High complexity**
Common, single-system problem, presenting in a typical way, that can be managed according to an existing clinical guideline or algorithm.	Either less common, or multi-system, or presenting atypicallybut can still be managed according to one more existing guideline or algorithm.	Highly atypical or complicated problem which requires the trainee to make management decisions outside of existingguidelines.

Signoff and actions

Assessor signature (dated)	Trainee signature (dated)

Concerns must be discussed with the trainee unless there is a clear justification to do otherwise, and must be passed on to the trainee'ssupervisor.